June 22, 2020

Jessica Altman
Commissioner, Pennsylvania Department of Insurance
Chair, NAIC Health Insurance and Managed Care "B" Committee
Pennsylvania Insurance Department
1326 Strawberry Square
Harrisburg, Pennsylvania 17120

Dear Commissioner Altman:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. The members of NAHU work daily to help millions of individuals and employers of all sizes purchase, administer and utilize health insurance coverage. Many of our members are small-business owners and their professional expertise is in the technicalities of health-plan purchasing and administration. Since the start of the COVID-19 pandemic, NAHU members have been working tirelessly to assist companies with employment and benefit-plan issues related to the economic downturn.

On May 4, 2020, the Department of Labor's Employee Benefit Security Administration (EBSA) and the Internal Revenue Service jointly issued a new emergency regulation titled "Extension of Certain Timeframes for Employee Benefit Plans, Participants and Beneficiaries Affected by the COVID–19 Outbreak." This regulation is raising many real-world implementation concerns for sponsors of group health plans and other employee benefit professionals, including NAHU members. Compliance professionals in our association have identified numerous areas where group plan sponsors need more information and compliance relief. Most of these issues concern the IRS and EBSA directly, so our association sent the attached letter to the IRS on June 1, 2020. However, our members also have identified several key areas where state-level regulation comes into play. As such, we would like to bring these issues to your attention with the hopes that you will raise them with your fellow insurance regulators through the National Association of Insurance Commissioners' Health Insurance and Managed Care "B" Committee.

The "Extension of Certain Timeframes for Employee Benefit Plans, Participants and Beneficiaries Affected by the COVID–19 Outbreak" regulation is retroactive to March 1, 2020. It changes numerous employee benefit plan deadlines and will have a particularly significant impact on COBRA administration. The regulation creates what is to be known as "the outbreak period," which lasts until 60 days after the day the Trump Administration announces the end of the COVID-19 national emergency. Employer group plan sponsors must disregard the "outbreak period" when calculating the timeframe for many group benefit plan administrative

matters, including the initial COBRA election period, the deadline for making COBRA coverage premium payments, and the timeframe for employers to provide COBRA election notices.
Specifically, we believe that this new regulation may impact:

- State-level continuation-of-coverage requirements for employees of businesses not subject to COBRA and state-level continuation-of-coverage programs for individuals who have exhausted COBRA continuation-of-coverage options
- State-level laws to extend group coverage eligibility to dependents beyond the federal requirement of up to age 26
- State-level health insurance exchange marketplace enrollment
- State-level prompt-payment requirements
- State-level balance-billing requirements
- Financial obligations of state-regulated stop-loss carriers that insure self-funded employer group health insurance plans
- State-level oversight of self-funded multiple employer welfare arrangements (MEWAs)
- Fully insured group health insurance rate filings for the 2021 plan year and beyond
- Medical loss ratios for the 2021 plan year and beyond

There will be state-by-state variations on all of these global issues we've identified and some might not apply to every state, but these are issues that might have multistate implications. Accordingly, our association would welcome the guidance and consistency you and your fellow commissioners might bring to these issues.

State-Level Continuation-of-Coverage and Extension-of-Coverage Requirements
The emergency rule does not apply to state-level continuation-of-coverage requirements for employees of businesses not subject to COBRA, or to the few state-level continuation-of-coverage programs for individuals who have exhausted COBRA. Nor does it have any specific bearing on state-level requirements to extend coverage to adult children beyond the federal requirement of 26 years of age. However, the preamble of the regulation specifically encourages both the states and health insurance issuers offering coverage in connection with a group health plan to operate, respectively, in a consistent manner. Our members already are encountering questions from employer group clients about how this rule and its deadline extensions apply when state law requires continuation of coverage following the exhaustion of COBRA, or to cover older adult dependents. Additionally, employers that are not bound by COBRA requirements due to their size are inquiring if they will eventually have to comply with similar deadline extensions and, if so, what might the parameters be.

While NAHU members recognize that any state-level action to address these issues may require legislative action, it would be helpful if states would articulate how, if at all, this new rule may apply to existing related policies.

Health Insurance Exchange Marketplace Enrollment

Any change in COBRA-election and payment requirements could have an impact on health insurance exchanges. Not only could it impact enrollment, it may create confusion regarding special enrollment rights. Communication and guidance for potential exchange enrollees is critical, and it is also necessary for any professionals who may work with or advise individuals considering exchange-based coverage. For example, health insurance exchange navigators and call-center operators may not be fully aware of the new COBRA requirements, as they likely have limited exposure to group health insurance requirements. States that operate their own exchanges, or may be rolling out new state-based exchanges this fall for the 2021 plan year, should consider how they will address and communicate any related issues. Does the NAIC as an organization, or you and your fellow commissioners on an individual level, have any plan to address how the new rule will impact state-level health insurance exchanges and individual coverage enrollment?

Impact on the Current Employer Group Coverage System

It is the observation of NAHU members that various fully insured health plans, stop-loss carriers that insure self-funded plans and COBRA administrators have different viewpoints on the new regulation. Specifically, reinstating coverage to people who were terminated for nonpayment of premiums during the outbreak period prior to the release of this regulation is the subject of much debate. Similarly, there are varying opinions in circulation about the ability of a group plan to "pend" a person's eligibility in the outbreak period until premiums are paid. Accordingly, our association has asked the Trump Administration to provide clarifying guidance on these points on an immediate basis.

Since no such guidance has been issued to date, there are already some real-world benefit plan administrative issues arising due to the mandate to provide coverage to beneficiaries with outstanding premium payments during the outbreak period. These issues will likely persist even if the Administration quickly provides clarification as to whether or not the employer must provide full coverage or pending coverage contingent on payment of past-due premiums. First, even if clarifying guidance establishes that these new COBRA rules do not obligate group health plans to pay immediate claims for people who have elected coverage during the outbreak period but are in arrears on their premiums, that does not necessarily mean that existing provider network contracts will allow a group plan to hold claims payments until the unspecified end date of the outbreak period. In fact, most contracts prohibit retroactive payment of claims in this manner. Also, carriers are bound by state prompt-payment laws that will require timely payment of incurred claims.

Right now, confusion abounds about how to handle people with COBRA eligibility and delinquent premiums as per the new regulation. Should the employer group terminate its coverage? Reinstate these people if they've

already been terminated? Keep them as eligible for coverage? Create some type of new pending status? Most health plans do not have the ability to assign a person pending status in their systems. The person will either appear as enrolled in the group coverage or as someone whose coverage was terminated. When providers call to check on a person in this position's coverage status, if they are listed as terminated, then any provider other than an emergency room can make the choice whether or not to provide treatment. Given the COVID-19 precautions currently in place at most medical facilities nationwide, with advance check-ins and insurance confirmations and no means for cash payments, many individuals who are eligible for the outbreak-period COBRA payment relief cannot actually access care. They are, in many cases, being turned away due to lack of insurance eligibility. As such, it is crucial that employers, health plans and providers get immediate resolution to the issue of how to handle the claims of people in the outbreak period with unpaid premiums.

We believe that insurance commissioners may have an interest in these issues as well. Specifically, NAHU members are concerned about how this new rule will interface with existing state-level prompt-payment and balance-billing requirements. We also believe there will be a significant financial impact on state-regulated stop-loss carriers that insure self-funded employer group health insurance plans, and the rate filings and medical loss ratios of fully insured group health plans could be affected for the 2021 plan year and well beyond.

State-Level Balance-Billing and Prompt-Payment Requirements

Regarding state-level prompt-payment requirements, typically a health plan is required to make claims payments to providers in a timely manner on behalf of covered beneficiaries. In the states with balance-billing legislation, there are additional requirements regarding claims payment disputes. This new rule creates confusion with regard to both types of state laws. The uncertain status of individuals who are COBRA-eligible but fail to make timely COBRA payments and how a health plan is supposed to handle the coverage status complicates matter further. Our association members have identified three potential claims payment scenarios, and we have unresolved questions about each:

1. If a health plan terminates the status of such an individual, the person will appear to be uninsured if a provider attempts to verify their coverage. However, if this individual ultimately pays past-due premiums following the end of the outbreak period, they will be considered to have continuous health insurance coverage throughout the potentially very lengthy period for which they were in arrears. Whose responsibility will it be to track all potential claims incurred during this timeframe? At what point do state-level prompt-payment laws come into play? How will this situation impact state-level balance-billing requirements?

2. If health plans are required to place individuals who are not making timely COBRA payments during the outbreak in some type of pending status, it is unclear how plans will handle that. It is also unclear how providers will verify their coverage, and how claims should be coded. Again, how would plan

obligations pay claims incurred by plan participants in a timely manner in this scenario? How do any state-level balance-billing requirements relate? If, at the conclusion of the outbreak period, the claimant fails to make the COBRA payments related to the period in which the claim was incurred, if these claims must be paid according to state law, shall they also be refunded? By whom?

3. If COBRA-eligible individuals must be reinstated and treated as if they have continuous health insurance coverage, even though they may have not made timely premium payments, then presumably the group health plan is bound by contract and state law to pay any claims on time. The group plan and providers would also have to comply with any state-level balance-billing requirements. However, if at the conclusion of the outbreak period, the claimant fails to make the COBRA payments related to the period in which the claim was incurred, if these claims must be paid according to state law, shall they also be refunded? By whom?

Is there anything state insurance commissioners do to provide clarification regarding these three scenarios?

Longstanding Cost Impact on State-Regulated Concerns

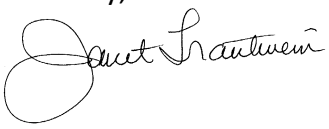
NAHU members are very concerned about the potential costs and consequences of this new rule for employer-based group plan offerings and various state-regulated insurance matters. COBRA generally involves a degree of adverse selection but, under normal circumstances, the risk period is known: 60 days. Current plan rates, for both fully insured and self-funded group coverage, are based on the current grace period, not for the possibility of adverse selection for an indeterminant length of time.

The potential cost consequences of the new rule are severe for all types of group health plans, but they are perhaps the greatest for self-funded employer group plans, including state-regulated MEWAs. Accordingly, there will be a spillover cost impact on state-regulated stop-loss carriers. Catastrophic claims costs, such as those being incurred currently by some COVID-19 patients, and extensive future claims costs that may well be incurred by people who are experiencing delays in necessary care due to pandemic restrictions, are not absorbed by the claimant's individual premium costs. Instead, they are spread over the entirety of the risk pool. Without catastrophic cost relief, perhaps through a reinsurance mechanism, and clearer guidance on coverage parameters and claims payment responsibilities and timeframes, the potential for future stop-loss health insurance premiums to rise astronomically in 2021 is all but certain. We expect the rates for fully insured group coverage to increase due to these factors as well. Additionally, all of the administrative complications this rule and the COVID-19 crisis generally will have on fully insured group coverage plans will surely have a negative impact on medical loss ratios, and relief may be required.

While we understand that resolution to many of these issues will require federal efforts, or state and federal collaboration, we would welcome a dialogue with you and the NAIC about what might be done to reduce costs and preserve employer-based coverage moving forward. We thank you for your attention to these important

concerns. If you have any questions or would like to discuss these matters further, please do not hesitate to contact me at either (202) 595-0787 or jtrautwein@nahu.org.

Sincerely,



Janet Stokes Trautwein
Chief Executive Officer
National Association of Health Underwriters

cc: Jennifer Cook
Jolie Matthews
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