August 17, 2021

Via Electronic Submission
Mandy Weeks-Green
Rules Coordinator
Office of the Insurance Commissioner
PO Box 40260
Olympia, WA 98504-2060

Dear Ms. Weeks-Green,

On behalf of Sedera, Inc., I submit the following letter in response to the Washington Office of the Insurance Commissioner's ("OIC") request for comments on the stakeholder draft for OIC's Health Care Sharing Ministry ("HCSM") Rulemaking (R 2021-17).

Sedera respects the role that the Washington OIC plays in licensing insurance companies and producers to preserve solvency and protect Washington consumers from harm but believes that the current draft's focus on the "1999" requirement confounds that role and does not serve their interests, as I will detail below. Sedera strives to work collaboratively with regulators and policymakers across the country to promote best practices for medical cost sharing organizations and welcomes the opportunity to work collaboratively with the OIC on a legislative effort to ensure that healthcare consumers are informed and protected, and that medical cost sharing organizations operate in a responsible manner, while preserving the non-insurance status of responsible, ethical medical cost sharing organizations.

About Sedera

Sedera was founded in 2014 as a medical cost sharing community offering an affordable, innovative, non-insurance approach to a community in need of the means to manage large, unexpected healthcare expenses. Sedera is centered around ethical principles rooted in love, community, personal responsibility, freedom and autonomy in healthcare decision-making, and a dedication to sharing each other's burdens. Sedera believes that there is no one-size-fits-all solution to consumers bearing the costs of healthcare, and that they should have a variety of options available to them, including medical cost sharing. By encouraging price transparency and empowering its members to be engaged healthcare consumers, Sedera hopes to make a positive impact on the affordability and quality of healthcare in the United States. To do so, Sedera goes to

great lengths to educate its members and empower them to take responsibility for their healthcare apart from, and without, the tools, tactics, and foibles of the insurance industry.

Sedera does not assume indemnity responsibility for its members or pay providers, utilize a network, issue ID cards, or require pre-authorization of medical procedures. Because members maintain responsibility for their medical bills, Sedera has an extensive education and enrollment process and provides a dedicated team of Member Advisors to help members navigate the healthcare system as cash pay patients. Over the last several years, Sedera has dedicated a tremendous amount of time, resources, and talent to building a cutting-edge sharing platform to facilitate direct member-to-member sharing and make its member experience more transparent and secure.

Sedera also does not claim to meet the definition of a healthcare sharing ministry, as defined by federal law and incorporated by reference by the State of Washington in RCW 48.43.0009, in part because it was created after December 31, 1999. Instead, Sedera provides its members with access to a non-insurance medical cost sharing community, through which participating members commit to caring for the community by voluntarily sharing medical burdens with fellow members and engaging in ethical and health-conscious lifestyles, consistent with Sedera's applicable guidelines.

Although Sedera has and continues to make every effort to facilitate the sharing of medical expenses incurred by its members, it has never assumed the risk of its members and its members have never assumed the risk of one another. Payment for medical expenses is never guaranteed; although over the last seven years, Sedera has facilitated the sharing of more than $32 million in medical expenses between its members. In fact, to date, the Sedera community, which currently has approximately 30,000 members, has shared 100% of eligible member needs.

Unlike many of the sharing organizations that OIC has sanctioned, Sedera is accredited by the Better Business Bureau and holds an A+ rating for its operations. There are no complaints regarding Sedera on file with BBB, and Sedera has average consumer ratings of 4.7/5 and 4.8/5 stars on Birdeye and Google Reviews, respectively. Sedera is dedicated to member satisfaction and has facilitated amicable resolution of all member appeals of eligible needs. Indeed, the final arbiter of needs sharing is a Member Appeals Board mainly consisting of members, which has never had occasion to address an appeal. Sedera was named a finalist in the Austin A-List awards for Tech & Innovation and a finalist in the Better Business Bureau's Torch Awards for Marketplace Ethics. Sedera's 6th place award from the Austin Business Journal for being one of the 2021 Best Places to Work is a testament to our team's dedication and culture. We are not aware of any pending consumer complaints in Washington or any other state.

State Regulation of HCSMs

HCSMs were first defined in federal law as part of the individual mandate provisions of the Affordable Care Act ("ACA"). Part of the ACA's individual mandate effectively exempts individuals who are members of HCSMs that meet the federal HCSM definition. While the ACA's HCSM definition was never relevant to state-level insurance regulation and the vast majority of states have rejected its requirements, this federal definition lost all significance following Congress's removal of the individual mandate penalty in 2017.

The ACA's HCSM definition, which has been adopted by reference in Washington, has five elements for an organization to qualify:

> (1) which is described in section 501(c)(3) and is exempt from taxation under section 501(a),
>
> (2) members of which share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs and without regard to the State in which a member resides or is employed,
>
> (3) members of which retain membership even after they develop a medical condition,
>
> (4) which (or a predecessor of which) has been in existence at all times since December 31, 1999, and medical expenses of its members have been shared continuously and without interruption since at least December 31, 1999, and
>
> (5) which conducts an annual audit which is performed by an independent certified public accounting firm in accordance with generally accepted accounting principles and which is made available to the public upon request.

The first, second, third, and fifth elements of the ACA's HCSM definition were designed to limit recognition to those HCSMs that have put in place certain operational requirements to protect their members and ensure that the HCSMs embodied certain public policy goals, like ensuring that members retained membership after developing a medical condition and requiring that HCSMs be audited. Unlike the operationally-focused elements of the definition, the 1999 requirement does not demand any indication of quality or values.

Thirty-one states, including Washington, define and exempt HCSMs from their insurance codes. Washington is one of only four states that have either incorporated the federal HCSM definition or otherwise adopted the requirement from the federal HCSM definition that to be recognized as

an HCSM, the entity must have been created prior to and continuously sharing medical expenses since at least December 31, 1999.

OIC's Rulemaking Stakeholder Draft

Under Washington's HCSM safe-harbor, organizations that satisfy the federal HCSM definition are not deemed health carriers. RCW 48.43.009. The stakeholder draft elaborates on this HCSM safe-harbor in four ways: (1) defines certain terms; (2) restates the five elements in the federal HCSM definition; (3) requires that HCSMs respond to OIC inquiries within fifteen days; and (4) further elucidates what it means for an HCSM to have been continuously sharing medical expenses for purposes of meeting the state's "1999" requirement.

Unfortunately, instead of promoting additional operational safeguards for sharing organizations, the only truly substantive provision of the stakeholder draft focuses on the law's 1999 requirement by interpreting what it means for an organization to have "continuously shared" medical expenses. The law's 1999 requirement is bad policy and bad law. Ironically, the inclusion of this interpretive provision to further refine and restrict what it means to have continuously shared medical expenses since 1999, is an acknowledgement that the 1999 requirement does not effectively keep out bad actors or otherwise protect consumers because, as discussed in more depth below, many sharing organizations claiming pre-1999 status have acquired or merged with pre-1999 HCSMs for the explicit purpose of claiming the statutory exemption.

The 1999 Requirement is Unconstitutional and Discriminatory

As of December 31, 1999, there were approximately one hundred HCSMs in operation. Almost all of them served small and closed Anabaptist or Mennonite communities. There were three HCSMs, however, that served a broader population of evangelical Christians. Following passage of the ACA, a number of HCSMs that were created after 1999 merged or acquired small, obscure, and near-dormant Anabaptist or Mennonite HCSMs to benefit from the special status afforded to pre-1999 HCSMs.

Today, a majority of the HCSMs that claim to meet the 1999 requirement are new market entrants that have merged with or acquired these smaller, nearly dormant HSCMs that were in existence in 1999. Some of the organizations that have taken advantage of the merger loophole and claim "pre-1999" status have received numerous consumer complaints across the country and are subject to regulatory action for misleading consumers, while other market actors appear to be acting in

accordance with high standards.[1] At least two HCSMs that claimed pre-1999 status via the merger loophole have been the subject of enforcement actions by OIC.[2]

As noted, there are actors of dubious ethics that claim pre-1999 status and there are quality sharing organizations created after 1999. The 1999 requirement is an arbitrary date stamp, and does not serve as a harbinger of quality, only as an artificial constraint to competition and innovation, and serves to protect entities that either have gone to great lengths to acquire or merge with obscure ministries that were created before December 31, 1999, or are among the handful of organizations that were indeed created before the date cutoff.

In addition to being an artificial and unfair barrier to entry divorced from ordinary notions of quality and ethical behavior, the 1999 restriction is also discriminatory, unconstitutional, and bad for consumers. As noted above, all of the HCSMs that were created prior to 1999 exclusively served members of certain Christian denominations (Anabaptist, Mennonite, Evangelical). There were no Muslim, Hindu, Sikh, Jewish, or ethically-based HCSMs that were created prior to 1999. As such, restricting recognition of HCSMs to only the narrow sliver of Christian HCSMs that were created before 1999 is a prohibited "denominational preference" and violates the Establishment Clause of the First Amendment.

Not only does it violate the First Amendment, but the 1999 restriction also rewards HCSMs that use their religious orientation to discriminate against unwed mothers, those with substance abuse problems, and members of the LGBTQ community. While Sedera's founders include people of deep Christian faith, Sedera is one of the few operating sharing organizations that does not discriminate based on sexual orientation or gender identity.

Washingtonians Deserve an Even-Handed and Fair Regulatory Framework

Based on its public statements, recent enforcement actions against sharing organizations, and the very existence of this rulemaking, it is clear that OIC has concerns regarding the operation of certain sharing organizations and desires to improve the regulatory framework for HCSMs. Sedera shares some of those concerns and has developed a series of best practices to ensure that Sedera's prospective and current members understand how medical cost sharing operates and differs from

[1] As an example, Trinity Healthshare, which was launched in the last several years and the subject of a variety of regulatory actions and consumer complaints, announced in January 2020 that it partnered with Faith Driven Life Church, which had been helping its members share their medical expenses since 1997. *See* Trinity HealthShare Announces Agreement with Faith Driven Life Church, available at https://www.businesswire.com/news/home/20200129005685/en/Trinity-HealthShare-Announces-Agreement-with-Faith-Driven-Life-Church.

[2] *In re OneShare Health LLC*, Wash. Off. of Ins. Commr., Docket No. Order No. 20-0252; *In re Trinity Healthshare*, Inc., Wash. Off. of Ins. Commr., Docket No. 19-0252.

insurance, and that members' contributions are shared responsibly, securely, and transparently. These include requirements that sharing organizations facilitate the direct sharing of funds between members and do not pool funds; and requirements that sharing organizations do not utilize the tools, tactics, and terminology of the insurance industry, such as paying providers, utilizing provider networks, and issuing ID cards.

Instead of doubling down on an unconstitutional, discriminatory, arbitrary, and anti-competitive 1999 provision, Sedera would welcome the opportunity to work with OIC and other industry participants to craft legislation in Washington that would address OIC's valid pro-consumer concerns regarding the operation of sharing organizations, while creating a level playing field for all sharing organizations, regardless of formation date. If OIC wishes to restrict the sharing marketplace, it should do so based on which entities operate responsibly, instead of when they were formed or who they acquired. We propose that such legislation incorporate best practices and expand the reporting obligations of sharing organizations to state regulators, while ensuring that member funds are treated responsibly and that consumers understand what sharing is and how it differs from insurance. This will expand consumer choice for managing large, unexpected medical expenses, while empowering those Washington residents to better control their expenditures and care. The Colorado legislature has considered similar legislation the last two legislative sessions, and if adopted in Washington with improvements from both industry participants and OIC, this type of legislation could serve as a national model for the equitable and forward-thinking regulation of sharing organizations.

Sedera appreciates OIC's interest in improving the regulatory landscape for cost sharing and hopes that it can work collaboratively with OIC to achieve these shared goals. OIC should consider a holistic regulatory framework that increases transparency, expands consumer choice, and promotes operational safeguards instead of the current rulemaking draft, which demonstrates an entrenchment regarding the law's arbitrary, discriminatory, and unconstitutional 1999 requirement. Sedera stands ready to discuss and promote such a framework in concert with the OIC.

Sincerely,

Jenny Aghamalian
Chief Strategy Officer
Sedera, Inc.