FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

April 23, 2018

Honorable Alex Azar
Secretary
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

Mr. David Kautter
Acting Commissioner, Internal Revenue Service
Department of the Treasury
1111 Constitution Avenue, NW
Washington, DC 20224

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

Mr. Preston Rutledge
Assistant Secretary, Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Comments on Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P)

Dear Secretary Azar, Administrator Verma, Acting Commissioner Kautter, and Assistant Secretary Rutledge,

Families USA appreciates the opportunity to comment in response to the proposed rule on short-term limited-duration insurance. Families USA is national non-profit organization, dedicated to the achievement of high-quality, affordable health care and improved health for all.

Families USA writes with strong objection to the proposed rule on short-term limited-duration insurance. The proposed rule rescinds restrictions on short-term plans, thereby allowing insurers to offer junk insurance policies to millions of consumers. These plans can and do exclude coverage for critically important health care services; vary premium rates by gender, health status, and age; reject some people upfront due to their medical conditions, and for others, subject bills to post-claims underwriting, thus denying payment for treatment after it has already occurred; often have no provider networks; and put individuals and families at significant financial risk. Plan marketing materials are confusing to consumers who do not understand the extremely limited coverage they receive. In many states, oversight and regulation of these plans is minimal: the plans are exempt from all or most state consumer protection laws that apply to comprehensive health coverage, just as they are exempt from the Affordable Care Act's protections. Expanding their duration (and thereby expanding their sales) will thus imperil many consumers.

In addition, expanding these types of plans will undermine the individual market by pulling healthy individuals away and leaving an older, sicker risk pool behind, and disrupting the market dynamic that prevented many "bare counties for the 2018 plan year. Many individuals who rely

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on comprehensive coverage – including women, older adults, and people with chronic conditions – would be left without affordable, comprehensive options.

Short-term policies fail to meet the needs of consumers.

A case that the DC Health Care Ombudsman brought to our attention illustrates this:

> A gentleman bought a short-term policy with a stated maximum of $750,000. After purchasing the policy, he needed heart surgery for which **he was billed $211,690**. Initially, the plan denied payment entirely due to its determination that the member had a pre-existing condition based on his father's medical history and that the patient was treated for conditions that were predisposed to coronary artery disease, even though the patient was never diagnosed. Eventually, as a result of the ombudsman's intervention, the **plan paid $11,780** of this bill, leaving he patient liable for the rest. This low payment resulted because each service was also capped: For the member's hospital stay, the maximum benefit payable was $1000 a day for 6 days, plus $1,250 for one day in the ICU. The surgeon fee maximum was $2500 for a triple bypass surgery. Payment for other medical services, such as testing, labs and xrays, were small payments that did not cover the full cost of services received, and after a time were no longer paid because the maximum payable benefits had been reached for a particular service.
>
> The Ombudsman writes that in other short-term policy cases the office has handled, "a simple wellness check or OB/GYN visit will be denied based on a pre-existing condition, or an agent will contact an individual and tell them that the plan complies with the ACA when it does not."[1]

Short-term, limited-duration insurance is intended to provide *temporary* insurance during unexpected coverage gaps. This type of coverage is exempt from the definition of individual health insurance coverage under the Affordable Care Act (ACA) and, therefore, does not have to comply with the law's core consumer protections. The proposed rule, therefore, promotes and will increase take up of skimpy, junk insurance coverage with minimal protections for consumers. Specifically, such coverage:

- Has high out of pocket costs,
- Limits the coverage people can receive each year and over their lifetime,
- Prices based on health status, age and gender
- Excludes coverage of pre-existing conditions
- Denies coverage based on health status
- Can be retroactively canceled (rescinded)
- Excludes basic health care services, including both entire classes of essential benefits (such as no coverage for mental health/substance use, no coverage for prescription

[1] Personal correspondence with Caridss Jacobs, Associate Health Care Ombudsman, Office of the Health Care Ombudsman and Bill of Rights, District of Columbia Government, February 21, 2018.

drugs) and fine-print exclusions (hernia surgery, school sports injuries, medical treatment following a suicide attempt or self-inflicted injury).
- May have no provider network, leaving the consumer liable for large differences between covered amounts and provider bills

Short-term plans discriminate against individuals based on their health status. Because short-term plans are exempt from the ACA's pre-existing condition protections, plans deny coverage altogether or deny coverage of specific services based on health status and medical history. Some insurers go as far as defining a condition to be preexisting if a member had symptoms within the prior five years "that would cause a reasonable person to seek diagnosis, care or treatment," even if she did not receive care, and even if she was not aware of the condition. For example, a woman between jobs in Atlanta bought a short-term plan in 2014 unaware that she had breast cancer. The insurer considered the disease a pre-existing condition refused to cover it. She was left with $400,000 in medical bills.[i]

Short-term plans are not required to cover essential health benefits. In addition to being able to exclude coverage for pre-existing conditions, these plans are also allowed to categorically exclude certain benefits, such as routine maternity and newborn care, prescription drugs, mental health care, substance use services, and preventive services like birth control and tobacco cessation. Without these essential benefits consumers will lack adequate coverage. Current examples of common short-term plan exclusions include:

Benefit	Exclusion Language
Emergency care	Excluded: "Charges for use of hospital emergency due to illness." (See for example UnitedHealthOne)[ii]
Women's reproductive health	Excluded: "Expenses for the treatment of normal pregnancy or childbirth, except for complications of pregnancy and normal newborn care; expenses for voluntary termination of normal pregnancy or contraception; infertility treatments or sterilization." (See for example IHC Secure Lite)[iii]
Gender transition-related services	Excluded "Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies." (See for example IHC Secure Lite)[iv]
Mental health care	Excluded: "Treatment of mental health conditions, substance use disorders; and outpatient treatment of mental and nervous disorders, except as specifically covered." (See for example National General)[v]
Prescription drugs	Excluded entirely. (See for example LifeShield/Agile); or covers only inpatient drugs (Secure Edge/Standard Security Life)
Pediatric services	Exclude pediatric dental and vision. None of the plans listed above covers pediatric dental care, for example.

Even plans that seem to cover a benefit include fine-print exclusions that consumers are not likely to notice or consider when purchasing a policy.
Examples of these include:
- LifeShield covers mental disorders and substance abuse, but excludes injury resulting from being under the influence of alcohol and drugs and excludes willfully self-inflicted injury or sickness.[vi]

- PivotHealth's brochure says it covers surgery but excludes tonsillectomy, most hysterectomy, herniorraphy, and several other surgeries for 6 months – even though as we understand current regulations, the policy cannot currently be sold for a period longer than 3 months. PivotHealth's website now says "A new feature we offer is the opportunity to apply for a total of four 90-day certificates of insurance at one time, affording you coverage beyond the standard 90-day duration" (https://www.pivothealth.com/product/short-term-health-insurance/). Further, smaller print on the plan's brochure describing benefits explains, "This is a partial list of exclusions and limitations. Please see the certificate for detailed information about these and other policy exclusions and limitations…."[vii]

Insurers who sell short-terms plans frequently discriminate based on gender, including charging women higher premiums. ACA protections prohibit plans from basing premiums on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. Before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating (charging women higher premiums than men). These predatory practices used to cost women approximately $1 billion a year[viii] and are still commonplace among insurers selling short-term plans. Health questionnaires are also often used by short-term plans to identify and deny coverage to people with preexisting conditions, including pregnancy. The application process includes explicit language excluding applicants who are pregnant or an expectant father. Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services, such as surgery.

Short-term plans also impose lifetime and annual limits. An individual or family could quickly meet their annual and lifetime limit with expensive health care costs and treatment for a catastrophic medical emergency. The impact on individuals and families could be financially devastating and leave them without coverage. One insurer, for example, caps covered benefits, including treatment, services and supplies at just $750,000 per coverage period. Another insurer provides per-service limits such as $1000 per day for hospital room and board, $500 per day for emergency room services, $250 per trip for ambulance, and $10,000 for AIDS treatment.[ix] These limits amount to woefully inadequate coverage for consumers and their families.

Short-term plans are also not subject to "out-of-pocket maximum" protections, which can leave consumers facing major, unpredictable financial risk. The ACA limits out-of-pocket maximums to $7,350 for individual coverage for the entire year, but some short-term plans may require out-of-pocket costs in excess of $20,000 per individual per policy period.[x] In some cases, out-of-pocket maximums for short-term plans are misleading and appear to be smaller than they are because the deductible does not count toward the maximum.

Information about provider networks can be misleading or non-existent; short-term plans are not subject to the network adequacy protections of comprehensive plans. For example, browsing IHC short term plans using a District of Columbia zip code yields instant quotes for Secure STM plans. The "Plan Details" brochure includes the following paragraph:

> "Utilize a network provider and save. With your Secure STM short-term medical plan, you have the freedom to choose any provider. In certain markets, you also have access to discounted medical services through national preferred provider organizations (PPOs). These network providers have agreed to negotiated prices for their services and supplies. While you have the flexibility to choose any healthcare provider, the discounts available through network providers for covered services may help to lower your out of-pocket costs."

If the shopper notices that the provider network is only in certain markets, he or she might click on "find a doctor" and then learn that there are none in the District of Columbia. In February, we called the agent number on the website to find out in what markets IHC does have networks. We were transferred to an agent who said, "We are the health insurance marketplace, you'll have to talk to the company for that information." "Do you mean you are healthcare.gov?" I asked. "We are the health insurance marketplace." "How can I talk to STM?" Agent hung up.[xi]

When there is no network, the amount that the consumer is reimbursed may have no relationship to their liability.

Expanding the availability of short-terms plans creates an uneven playing field and will raise the cost of comprehensive care.

Due to discriminatory, predatory practices, short-term plans are able to offer low premiums and attract younger and healthier individuals, leaving older, sicker and costlier risk pools behind in the ACA-complaint market. If healthier individuals are syphoned from the individual market, costs will increase and plan choices will decrease for individuals remaining in those markets. Consumers who need comprehensive coverage, including those with pre-existing conditions, and middle-class consumers with incomes too high to qualify for subsidies, would face rising premiums and likely fewer plan choices. The absence of unfair competition from short-term plans was important in contracting with plans to avoid rural "bare counties" for the 2018 plan year.

Further, if consumers are in plans for long periods of time that do not provide coverage of routine services (such as periodic dental care for children and vaccines), their untreated (but preventable) conditions will be costlier once they do enroll in comprehensive coverage. Last year, due to insurer concerns that consumers were waiting too long to enroll in comprehensive coverage, the administration reduced plan special enrollment periods. Yet the effect of this rule is likely to further delay the enrollment of many consumers into comprehensive plans, and when they do enroll, they will need more care.

Lengthening the duration of short-term coverage to nearly a year is inconsistent with federal law

The proposed rule is inconsistent with relevant law, as it defines "short-term limited duration coverage" to include coverage that is up to 364 days and 23 hours, which is not short-term by

any reasonable reading of the statute.

The exclusion of short-term limited duration coverage from the definition of individual insurance coverage was established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In defining short-term limited duration coverage on an interim basis in 1997 and then in finalized regulations in 2004, the department described it as anything shorter than 365 days, which is the standard length for major medical coverage. Such a definition belies the statutory language; no one would call a 119-minute movie a short movie, compared to one lasting 120 minutes, or a 13-day 23-hour vacation a short vacation compared to a 2-week one.
This understanding of the meaning of "short-term" as being for a limited time period, rather than any coverage that is technically shorter than standard coverage, is consistent with how the product was marketed when HIPAA was adopted. Short-term coverage was for people who were between jobs or school terms and coverage terms were generally "short" as the word is commonly understood. Some states defined short term coverage as lasting no more than three months or six months; other states excepted "short term" coverage from certain state benefit mandates if coverage lasted for no more than six months.

The proposed definition of short-term limited duration coverage is not only contrary to the plain statutory language, but also inconsistent with the statutory scheme established by Congress through the ACA. Under the pre-existing HIPAA definition, an insurer would be able to avoid the ACA's insurance reforms simply by limiting coverage to 364 days and specifying that the insurer had to consent for the policy to be renewed. Allowing for such plans would not only deprive consumers of the ACA's protections, but also seriously threaten the ACA's individual market risk pools, since healthy people could purchase underwritten short-term limited duration coverage that excluded preexisting conditions for far less than the cost of ACA exchange coverage, leaving people with health problems in an ever smaller and costlier individual coverage market. Eliminating this very problem, the creation of separate risk pools for the healthy and the sick, was a primary goal of the ACA. *See* 42 U.S.C. 18032. Finally, allowing for short-term coverage that was virtually the same length as standard coverage would create a serious risk of consumer confusion—consumers who bought "short-term" coverage that would cover them for virtually the entire year might not appreciate that they were purchasing something wholly different from individual insurance coverage, and thus might not know that they would still owe the individual mandate penalty if they purchased the so-called "short-term" coverage.
Given that the definition of "short-term" coverage is both inconsistent with the statutory text and the structure of the ACA, as set forth above, the department's proposed regulation as drafted is arbitrary, capricious, and contrary to law.

Specific Recommendations

I. Short-term limited-duration plans should not be expanded to more than three months (§54.9801-2 / §2590.701-2 / §144.103).

Short-term plans are designed to fill *temporary* gaps in coverage. These policies should not exceed three months.

The proposed rule would allow short term plans to enroll individuals for as long as 364 days. Allowing extensions of these policies expands the period of time in which people may be underinsured, leaving consumers with inadequate coverage and at financial risk if they fall ill. Yearlong short-term plans would create consumer confusion about whether the coverage is the same as would be available through ACA-compliant one-year plans. Moreover, consumers could be left with uncovered bills and/or find themselves "uninsurable." Because insurers can deny a new contract if the enrollee becomes sick or injured during the coverage term, consumers may believe they can extend or renew coverage until rejected by the issuer. If their short-term plan ends before Marketplace open enrollment, their loss of coverage would not qualify for a special enrollment period, leaving a consumer to wait until the next annual open enrollment period to select a new plan. This will lead to a gap in coverage for many consumers.

Consumers seeking coverage for three months or longer can get covered through the Marketplaces. Federal policymakers should address any remaining enrollment issues through improvements in open and special enrollment periods, and not by undermining comprehensive coverage. Allowing short-term plans longer than three months undermines the ACA and the risk pools in the individual market by encouraging healthy people to use short-term plans as an alternative to ACA plans. This would drive up premiums in the individual market, making comprehensive coverage with pre-existing condition protections less affordable for consumers, particularly those that are ineligible for premium tax credits.[xii]

We strongly oppose the proposed changes to the regulation at §54.9801-2 / §2590.701-2 / §144.103. The existing definition limiting the duration of short-term limited-duration insurance to "less than 3 months" should remain, as should the language "taking into account any extensions that may be elected by the policyholder with or without the issuer's consent."

II. Consumer notices should be explicit, in multiple languages, about ACA requirements that do not apply to short term plans (§54.9801-2 / §2590.701-2 / §144.103).

We support efforts in the proposed rule to help consumers who purchase short-term, limited-duration policies to understand the coverage they are purchasing. We believe notice is vital for consumers to understand the limits of short-term plans and that they are not comprehensive coverage. We appreciate the specific language that clarifies that the plan does not comply with federal requirements and that enrollees might have to wait until an open enrollment period to get other health insurance coverage.

We recommend, however, that the notice be clearer to be more easily understood by consumers, and that the notice be available in multiple languages. As the preamble notes, allowing short-term plans to provide coverage for longer time periods will make it more difficult for consumers to distinguish between short-term plans and ACA plans. The notice must make clear how short-

term plans differ from ACA plans. We recommend listing specific examples of ACA protections in the notice, including preexisting conditions and essential health benefits. The draft notice language also is not clear enough that loss of eligibility or coverage in a short-term plan does not trigger a special enrollment period.

In addition to adjusting the wording in the large print required notice, we recommend requiring plans to provide an explicit outline of benefits and exclusions, similar to the summary of benefits and coverage requirement that applies to comprehensive coverage. At a minimum, information about provider networks (or lack thereof), each exclusion and benefit limit, and pre-existing condition limitations and look-back periods should be available and easily accessible to consumers on the web before they purchase a policy.

III. If the rule is finalized, contrary to our recommendation, the effective date of the rule should be delayed (§ 54.9833–1/§2590.736/§146.125).

We strongly recommend that the proposed rule be rescinded in its entirety, since it is contrary to the intent of the law and consumers' interests and would undermine comprehensive insurance. But if it is finalized contrary to our recommendation, insurers need time to appropriately design and price comprehensive plans. Allowing expanded short-term plans to be offered in 2019 creates risk and uncertainty for health insurers in the individual market.[xiii] Insurers may have to build in rate increases associated with uncertainty if expanded short-term plans are allowed in 2019. Delaying implementation until 2020 will give insurers time to adjust to the insurance market without the individual mandate penalty and allow them to see which insurers are expanding or entering the short-term market. A delay would also allow states time to respond, through legislative or regulatory changes, to the impact of expanded availability of short-term plans on their markets.

We strongly oppose the proposed effective and applicability date of this rule. The effective date of the rule should be delayed until the 2020 plan year, if the rule is finalized.

IV. Short-term plans should never be allowed to continue for 12 months or longer.

Short-term limited-duration insurance is, by name, meant to be for a short, limited duration. As noted above, allowing these plans to continue for 12 months or longer places people in plans with limited coverage and at significant financial risk. This risk is compounded significantly when the plans are renewable. The case Miller v Fid Sec Life Ins Co, 294 F 3d 762, illustrates this point. When an Ohio consumer purchased a policy for two consecutive three month terms, the insurer would not pay claims during the second policy period for symptoms that manifested during the first policy period. Similar disputes, with various outcomes, are likely if short-term plans are renewed for multiple periods at the insurers' discretion.

Allowing renewals would suggest clear intent to circumvent the ACA and undermine the risk pools in the ACA-compliant individual market. States are the primary regulators of insurance

and should maintain authority to regulate the renewability of these plans and the application and reapplication process. We strongly oppose any consideration of allowing short-term health plans to exceed three months, much less 12 months or longer.

V. Short-term Plans Will Pull Millions Away from ACA Individual Market

The estimates in the fiscal impact statement on the number of people to be enrolled undercounts the individual insurance market. The NAIC report on which the estimate was based fails to include short-term plans sold by discretionary associations or similar arrangements. Recent reports have suggested enrollment in short-term plans may be closer to one million today under current rules.[xiv] The Urban Institute has estimated that, as a result of this proposed rule, 4.3 million people would enroll in short-term plans in 2019.[xv] The Urban Institute also estimated that the effect of the proposed rule, in combination with the elimination of the individual mandate penalty, would reduce enrollment in ACA-compliant plans by 18.3 percent.[xvi] The American Academy of Actuaries reaffirms the argument that short-terms plans will attract healthy individuals, causing the potential for market segmentation and adverse selection, and therefore increase premiums in the ACA-compliant market. Wakely, in its study for the Association for Community Affiliated Plans, estimates that the extension of short-term plans under this rule would increase premiums in ACA-complaint plans by 0.7%-1.7% the first year, and by 2.2% to 6.6% in future years[xvii].As noted throughout our comment, this rule will have the effect of undermining and weakening the ACA-compliant market – leaving people with higher premiums and fewer plan options.

Thank you for the opportunity to comment on the Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P). We once again urge the Departments to preserve and fully implement the Affordable Care Act as the most effective strategy to promote affordable consumer choice for health coverage. If you have any questions about our comments and recommendations, please contact me at cparcham@familiesusa.org.

Sincerely,

Cheryl Fish-Parcham
Director of Access Initiatives

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[iv] The IHC Group. "Secure Lite: Short-term Medical Insurance for Individuals and Families."
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