national partnership for women & families
Because actions speak louder than words.

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
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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,

The National Partnership for Women & Families appreciates the opportunity to comment in response to the proposed rule on short-term limited-duration insurance. The National Partnership represents women across the country who are counting on the preservation and continued implementation of the Affordable Care Act (ACA).

The National Partnership for Women & Families 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 dangerous and discriminatory plans exclude coverage for critically important health care services; vary premium rates by gender, health status, and age; and put individuals and families at significant financial risk. 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. Many individuals who rely on comprehensive coverage – including women, older adults, and people with chronic conditions – would be left without affordable, comprehensive options.

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Short-term policies offer junk insurance that fails to meet the needs of consumers.

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,
- Discriminates against individuals, and
- Excludes basic health care services.

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.[1] Some plans also specifically exclude services that disproportionately affect women, such as chronic fatigue, chronic pain, and arthritis.

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)[2]
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)[3]
Gender transition-related services	Excluded "Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies." (See for example IHC Secure Lite)[4]
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)[5]

We are particularly concerned about the exclusion of women's health services including contraception and routine maternity care – lack of coverage for these vital services will negatively affect women's health and financial security. For example, decades of scientific research have demonstrated that contraceptives are effective at preventing unintended pregnancy.[6] Contraception also improves health outcomes for women and children, because unintended pregnancies have higher rates of short- and long-term health complications.[7] The ability to use contraception to plan and space pregnancies enables women to pursue education and career advancement and enhances the economic security of women and families.[8] Allowing women to control if and when they will have a child also plays a critical role in addressing gender inequalities, including the existing pay gap between men and women.[9]

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[10] 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, like 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 to 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. At least one 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.[11] These limits amount to woefully inadequate coverage for consumers and their families.

Short-term plans are also not subject to out-of-pocket maximums, 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.[12] 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.

Expanding the availability of short-terms plans creates an uneven playing field. 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 potentially fewer plan choices.

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. 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.[13]

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 needs to 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 just under one year 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.

The Departments should adjust the proposed notices at §54.9801-2 / §2590.701-2 / §144.103 to the following language:

> *THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT,* ***SUCH AS COVERAGE OF PREEXISTING CONDITIONS AND ESSENTIAL HEALTH BENEFITS****. BE SURE TO CHECK YOURPOLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOESN'T COVER.* ***EXPIRATION OR LOSS OF ELIGIBILITY FOR THIS COVERAGE DOES NOT TRIGGER A SPECIAL ENROLLMENT PERIOD****, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE.*

III. The effective date of the rule should be delayed (§ 54.9833–1/§2590.736/§146.125).

We recommend that the proposed rule be rescinded in its entirety, but if finalized, insurers need time to appropriately design and price plans. Allowing expanded short-term plans to be offered in 2019 creates risk and uncertainty for health insurers in the individual market.[14] 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. 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 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.[15] 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.[16] 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.[17] 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. As noted throughout, 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 or concerns about our recommendations, please contact Katie Martin, vice president of health policy and programs, at kmartin@nationalpartnership.org or 202-986-2600.

Sincerely,

Debra L. Ness, President

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[2] United Health One. "Short Term Medical Plans." Retrieved on 11 April 2018 from https://www.uhone.com/FileHandler.ashx?FileName=43853C1-G201703.pdf

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

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

[5] National General Accident and Health. "Short Term Medical." Retrieved on 11 April 2018 from https://www.insubuy.com/national-general/short-term-medical-insurance.pdf

[6] *See* American College of Obstetricians and Gynecologists. (2016, December). *Women's Preventive Services Initiative: Recommendations for Preventive Services for Women Final Report to the U.S. Department of Health and Human Services, Health*

Resources & Services Administration (p. 82). Retrieved 27 November 2017, from https://www.womenspreventivehealth.org/final-report/; *see also* Trussell, J. (2011, May). Contraceptive failure in the United States. *Contraception*, *83*(5), 397–404

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[8] *See, e.g.,* Frost, J.J., & Lindberg, L.D. (2013, April). Reasons for using contraception: Perspectives of US women seeking care at specialized family planning clinics. *Contraception*, *87*(4), 465–472; Sonfield, A., Hasstedt, K., Kavanaugh, M.L., & Anderson, R. (2013, March). *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*. Retrieved 4 December 2017, from the Guttmacher Institute website: https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf; Goldin, C., & Katz, L.F. (2002). The power of the pill: Oral contraceptives and women's career and marriage decisions. *Journal of Political Economy, 110*(4), 730–770; Sonfield, A., Hasstedt, K., Kavanaugh, M.L., & Anderson, R. (2013, March). *The Social and Economic Benefits of Women's Ability to Determine Whether and When to Have Children*. Retrieved 4 December 2017, from the Guttmacher Institute website: https://www.guttmacher.org/sites/default/files/report_pdf/social-economic-benefits.pdf.

[9] See, e.g., Bailey, M.J., Hershbein, B., & Miller, A.R. (20120, June). *The Opt-In Revolution? Contraception and the Gender Gap in Wages* (p. 27). Retrieved 7 December 2017 from the National Bureau of Economic Research website: http://www.nber.org/papers/w17922 ("Our main estimates, therefore, imply that 10 percent of the narrowing in the gender gap during the 1980s and 31 percent during the 1990s can be attributed to early access to the Pill . . . . [T]he effects of the Pill may be larger than we find, but it is not clear how much larger. Even these conservative estimates, however, suggest that the Pill's power to transform childbearing from probabilistic to planned shifted women's career decisions and compensation for decades to come.").

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[12] Polliz, Karen. (2018, February 09). *Understanding Short-Term Limited Duration Health Insurance.* Kaiser Family Foundation. Retrieved 26 March, 2018, from https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/

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[16] Blumberg, L., Buettgens, M., Wang, R. (February 2018). *The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending.* Retrieved 26 March, 2018), from https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf

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