



April 19, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9924-P
P.O. 8010
Baltimore, MD 21244-8010

Re: Short-Term, Limited-Duration Insurance- CMS-9924-P

To Whom It May Concern:

The District of Columbia Health Benefit Exchange Authority (HBX) appreciates your consideration of our comments on the above-cited Notice of Proposed Rulemaking (NPRM).

By way of background, HBX is a private-public partnership established by the District of Columbia (District) Council to develop and operate the District's on-line health insurance marketplace, DC Health Link (DCHealthLink.com). DC Health Link fosters competition and transparency in the private health insurance market, enabling individuals and small businesses to compare health insurance prices and benefits and to purchase affordable, quality health insurance. Leveraging the Affordable Care Act (ACA) and DC Health Link, the District now has the lowest uninsured rate we have ever had. More than 96% of District residents now have health coverage.

We strongly oppose the proposed rule because it will not increase access to comprehensive quality coverage. Instead of strengthening the individual private market, the proposal would destabilize the market putting at risk millions of Americans with individual market health insurance. If the proposal is finalized, it will cause premium increases for people with individual health insurance and millions of Americans will become uninsured or underinsured. For the District of Columbia, actuaries from Oliver Wyman estimate that individual market claims cost will increase by as much as 21.4% and as many as 6,100 people (35% of the individual market) would leave the individual market and either become uninsured or buy short-term, limited-duration plans.

- This proposal will cause premiums to increase for people with individual health insurance coverage in DC and cause the individual private health insurance to shrink by more than 35% -- destabilizing health insurance for thousands of District residents.

Short-Term, Limited-Duration Plans Proposal Will Increase Premiums and will Lead to Higher Uninsured

The Departments propose to reverse the 2016 standards for short-term, limited-duration plans, which currently allow such products to a term of less than 3 months. HBX submitted comments supporting the



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2016 standards. We strongly oppose the proposed new standards to allow such plans to a term of up to 364 days.

Short-term, limited-duration plans are exempt from consumer protections under the ACA applicable to individual health insurance. For example, short-term, limited-duration plans exclude coverage for preexisting condition, use medical underwriting to only cover healthy people and to keep people with medical needs out, cap benefits using annual and lifetime dollar limits, exclude maternity and mental health from coverage, and do not cover all of the benefits considered “essential.” Consequently, these plans do not provide comprehensive health insurance coverage and discriminate against people with pre-existing conditions.

This proposal if finalized will destabilize individual health insurance markets. The Departments noted in the preamble that part of the reason that the regulations were amended in 2016 to restrict coverage to less than three months was due to adverse selection and market segmentation concerns, in other words a concern that such products were destabilizing the market. As the Departments noted in the preamble to the 2016 final regulations, “because these policies can be medically underwritten based on health status, healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for Affordable Care Act-compliant coverage.” (81 F.R. 75316 at 75318.) (October 31, 2016.)

In fact, the record established in 2016 fully supports that concern and the solution adopted in 2016. Without evidence to justify a reversal, the Departments are now intentionally removing standards that help address adverse selection and market segmentation.

- In other words, by the Departments’ admission in the preamble to the final 2016 final regulation, the proposal reversing the 2016 standards will lead to adverse selection and market segmentation causing millions of Americans to experience rate increases and putting millions of Americans at risk of losing their health coverage.

It is undisputed that short-term plans under this proposal will adversely impact the individual health insurance market by cherry picking healthy people and leaving others in the individual market. Even the Departments acknowledge the risk this proposal poses to the individual market risk pool. (83 F.R. at 7441.) These plans are designed to only cover healthy people and only attract healthy people. By using medical underwriting, short-term, limited-duration plans screen and reject people with medical needs. Such plans also don’t cover preexisting conditions, exclude prescription drugs, maternity care and mental health benefits, and have annual and lifetime limits. People with preexisting conditions and people who anticipate needing medical care will choose comprehensive coverage not short-term, limited-duration coverage. And when healthy people leave the individual market, premiums increase for everyone left in the individual market.

Evidence and Data

The Departments also fail to adequately consider data and the negative impact of the proposal on individual private health insurance markets. The proposal if finalized will destabilize private individual markets.

According to Oliver Wyman actuaries, the proposed regulation if finalized will hurt District residents. As noted above, actuaries estimate that combined with the removal of the individual responsibility penalty, in DC there would be an increase in claims costs as much as 21.4% in the individual market and would

result in upwards of 35% of individual market enrollees leaving the individual market.¹ In DC, where fewer than 6% of individual market exchange enrollees receive APTC, these claims cost increases would dramatically impact consumers' ability to afford health insurance.

People who pay full price will be stuck with the increases and some may have to drop coverage because it will be unaffordable. A study by the Urban Institute estimates that, at the national level, this proposal would result in 2.6 million additional people going without minimum essential coverage in 2019, including over 600,000 individuals currently receiving APTC.² This study estimates that a total of 4.3 million people would enroll in short-term, limited-duration plans, a combination of individuals leaving comprehensive coverage and those who did not have comprehensive coverage. This study also estimates that premiums in states that do not prohibit or limit short-term, limited-duration plans would increase 18% on average if this proposal is implemented (this estimate includes the impact of the removal of the penalty under the individual responsibility requirement and the expansion of short-term, limited-duration plans).

Furthermore, this proposal will also cost the federal government millions of dollars in additional APTC payments. The increased length of short-term, limited-duration plans will make it more attractive for healthy people to choose short-term, limited-duration plans, leaving people with existing medical needs in the individual market. As premiums increase because the individual risk pool will be less healthy, this increased cost will, at least in part, be passed on to the federal government in the form of increased advanced premium tax credit (APTC) payments. The Department's own analysis found that this proposal would result in an increase in APTC payments of between \$96 million and \$168 million in 2019, assuming that between 100,000 and 200,000 individuals drop qualified health plan (QHP) coverage in favor of short-term, limited-duration plans. (83 F.R. 7741, 7742.)

The Proposal Heightens Risks of Misleading Marketing, and the Proposed Disclosure is No Solution

Some who sell short-term, limited-duration plans use abusive marketing practices to mislead consumers into believing that a person is enrolling in comprehensive health insurance. Changing the length of short-term, limited-duration plans from less than 3 months to almost one year will further exacerbate this problem by making it easier to induce unsuspecting consumers into enrolling. Some consumers will falsely believe that a short-term, limited-duration plan that is 364 days long is just like comprehensive health insurance coverage.

We have seen firsthand the devastating impact on consumers who enroll, falsely believing they are enrolling in major medical coverage. For example, one resident was diagnosed with a life threatening condition and learned too late that he purchased a short-term, limited-duration policy that did not cover treatment. The resident told our staff that he thought he was signing up for comprehensive coverage and would have signed up for real coverage during open enrollment had he understood the true nature of the policy he bought. This occurred before the standards for short-term, limited plans changed.

¹ "Potential Impact of Short-Term Limited Duration Plans, Oliver Wyman, April 11, 2018. Available at <https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/OWReview%20of%20Impact%20of%20Short%20Term%20Duration%20Plans%204.11.2018%20%28002%29.pdf>.

² "Updated: Potential Impact of Short-term Limited-Duration Policies in Insurance Coverage, Premiums, and Federal Spending," L. Blumberg, M. Buettgens, and R. Wang, Urban Institute, March 2018. Available at https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf.

The proposal to require short-term, limited-duration plans to include a disclosure that the ACA protections do not apply is inadequate to protect consumers. It is not reasonable to expect consumers to know what rights they are giving up when selecting one of these plans unless those rights are spelled out. The disclosure should list all the ACA consumer protections applicable to individual health insurance that would not apply. The disclosure should also explain the implications of enrolling in a short-term, limited-duration plan, including what happens when the policy ends and a consumer has had medical claims. There should be a clear statement that the consumer may not qualify for another short-term plan because of medical underwriting and if the consumer is able to pass medical underwriting, then his/her medical conditions could be excluded from coverage by the new short-term, limited-duration plan even if claims were paid by the prior short-term, limited-duration plan.

The inadequacy of this notice is further compounded by the fact that the Departments are proposing to remove the statement that this coverage is not minimum essential coverage (MEC) from the required disclosure starting in 2019. This appears to be based on the fact that the IRS will not be imposing penalties for failure to comply with the individual responsibility requirement starting in 2019. However, MEC continues to have meaning outside of enforcement of the individual responsibility requirement. This proposal will particularly harm consumers that are seeking to get back into comprehensive coverage after enrolling in one of these plans. For example, HHS has taken steps to make enrolling through a special enrollment period harder for consumers. One of the new restrictions, HHS recently put in place, requires consumers experiencing certain life events (such as moving or getting married) to have MEC prior to applying for these SEPs in order to be eligible. Consumers that had short-term, limited-duration coverage before applying for one of these SEPs would be ineligible because their prior coverage would not meet MEC. By removing the part of the disclosure that clearly informs consumers that short-term, limited-duration plans are not MEC, the Departments will make it harder for consumers to make informed decisions about what coverage is appropriate for them.

While we oppose this proposal, if the Departments intend to proceed, at minimum the Departments should require carriers to provide meaningful disclosures as outlined above to applicants and enrollees. As the Departments appear to view short-term, limited-duration plans as viable alternatives to comprehensive health insurance, the Departments should also require the Summary of Benefits and Coverage (SBC) standards to apply, which will allow consumers to compare the benefits being offered under these plans to comprehensive health insurance.

Although strong disclosures are important, disclosures alone are not sufficient to protect consumers. The Departments are not proposing strong marketing standards and are not proposing an enforcement plan to protect consumers. The disclosure proposed does not adequately address this risk. Without strong standards and enforced marketing requirements, consumers will be at risk of being duped into enrolling in a short-term, limited-duration plan and missing the opportunity to enroll in comprehensive coverage during open enrollment.

The Departments Failed to Consider Regulatory Alternatives

Departments indicate that the only alternatives to this proposal would be to lengthen the duration of short-term, limited-duration plans to either six or nine months. Without any explanation, they dismiss both options. (See 83 F.R. at 7444.) This suggests that the Departments have not considered other options.

Other options will actually lead to expanded access and will not destabilize the private health insurance market. A well-known option is to fund Cost Sharing Reductions (CSRs). The Administration's decision to not reimburse carriers for CSR caused premiums to increase, resulting in some full pay customers dropping their coverage. Another reasonable option is to take no action since the proposed action will not expand access to comprehensive coverage, will lead to more discrimination against people with preexisting conditions, and will destabilize private health insurance markets.

Conclusion

DCHBX supports real efforts to expand access to affordable quality health insurance. The proposal is a false promise akin to selling a car without an engine – cheap but does not work. We oppose policies, such as this one, that will leave many consumers without real health insurance and will disrupt stable markets putting millions of Americans at risk of losing their existing coverage. Thank you for considering our comments.

Sincerely,



Mila Kofman
Executive Director
DC Health Benefit Exchange Authority