

**America's Health
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April 20, 2018

The Honorable Alex Azar
Secretary
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Submitted via the Federal Regulations Web Portal at <http://www.regulations.gov>

Re: Short-Term Limited-Duration Insurance, File Code CMS-9924-P —AHIP Comments

Dear Secretary Azar:

America's Health Insurance Plans (AHIP) appreciates the opportunity to provide comments in response to the Notice of Proposed Rulemaking (NPRM) on Short-Term, Limited-Duration Health Insurance, published on February 21, 2018.¹

AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public/private partnerships that improve affordability, value, access, and well-being for consumers. Based on this mission, we evaluate potential policy and regulatory changes that would impact the health care system by asking: how will these changes reduce or affect costs, improve consumer satisfaction, and provide better value and health outcomes for everyone?

Improving access to affordable coverage is central to AHIP's mission. We are particularly attuned to the need to improve affordability for middle-class families who lack access to affordable employer-provided insurance and/or do not qualify for premium subsidies through state or federal exchanges. We thank the Centers for Medicare and Medicaid Services (CMS) for the actions already taken to improve the affordability of individual market health insurance, including but not limited to increasing the role of states in regulating their own insurance markets, new flexibility in the review of Qualified Health Plan networks and ongoing work to verify the use of special enrollment periods.

However, we are concerned that substantially expanding access to short-term, limited-duration insurance (short-term plans) will negatively impact conditions in the individual

¹ 88 Fed. Reg. 7437 (2018) (to be codified at 26 CFR Part 54; 29 CFR Part 2590; 45 CFR Parts 144,146, 148).

health insurance market (both on and off exchange), exacerbating problems with access to affordable comprehensive coverage for all individual market consumers. The extent of that impact will depend on the specifics of the final rule and consumer and state reactions to the final federal rule.

Short-term plans are designed to provide coverage for consumers and their families who may have a need for a “bridge” before enrolling in more generous coverage, such as while waiting for coverage to become effective at a new job. Short-term plans are not intended to provide comprehensive, longer-term health insurance coverage and are not treated as “individual market health insurance” under federal law. Because many short-term plans are offered to consumers only after submitting information about their health status or prior medical conditions, we must also recognize that short-term plans will not meet the needs of many Americans with pre-existing health conditions.

As the Departments advance policies to expand access to lower-cost coverage choices for a subgroup of consumers, it is critical to improve the affordability of comprehensive coverage options for all Americans, regardless of health status. These options should help people manage their health and protect them from devastating financial consequences if they get sick.

We recommend that short-term plans should not be offered as a full replacement for comprehensive coverage. Alternatively, we support policies that would improve the individual health insurance market such as: making it easier for states to address issues in their markets through streamlined 1332 waiver processes; continued regulatory streamlining; and adoption of regulations regarding third party payments and improper steering of Medicare and Medicaid eligible consumers into the individual market.

To support a well-functioning, affordable insurance market in which Americans have access to comprehensive individual market health insurance options regardless of health status, we recommend the following:

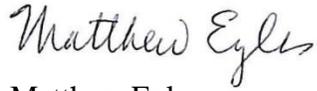
- **Policy Duration and Renewability:** The permissible duration of short-term plans should be limited to six (6) months. Renewals of short-term plans should not be permitted.
- **Disclosure:** Consumers should be provided with meaningful plain-language disclosure about short term plans, including a clear statement that a short-term plan is not comprehensive individual market health insurance. Specific language is recommended in the attachment.
- **States’ Role:** The Departments should re-affirm the right of states to regulate short-term plans in their markets more stringently than they are regulated under federal rules.
- **Effective Date:** The Departments should propose an effective date of any final rule that is no earlier than January 1, 2020.

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Additional detail on our recommendations is provided in the attachment. Again, we appreciate the opportunity to comment on the proposed rule. If you have any questions or feedback about our comments or recommendations, we would welcome the opportunity to discuss them with you or your respective staffs.

Sincerely,

A handwritten signature in cursive script that reads "Matthew Eyles".

Matthew Eyles

Senior Executive Vice President & Chief Operating Officer

Attachment

(1) Short-Term Plan Duration and Renewals

A. Duration

Short-term, limited duration policies are designed to provide coverage for consumers and their families who may have a need for a “bridge” before enrolling in longer-term comprehensive coverage. For example, an individual might need a “bridge” policy when changing jobs and a gap exists between the end date of the coverage provided by the prior employer and the effective date of the coverage provided by the new employer. Although this short-term, limited duration coverage is a type of individual coverage, it is not considered as “individual market health insurance” under the Public Health Services Act.^{2,3} Short-term plans are also not considered HIPAA excepted benefits under federal law. Federal rules adopted in 2016 under the statutory definition excluding short-term, limited-duration coverage from the category of “individual market health insurance” limit such coverage to less than three months.⁴

We agree with the Departments that, in some instances, a three-month limit would prevent appropriate utilization of short-term policies. For some consumers, more than three months may be necessary. For example, it is very common for employers to require new employees to complete 90 days on the job before their eligibility for employer-sponsored health insurance begins. For that reason, it is not unusual for an individual changing jobs to need short-term coverage that lasts through both a gap in employment and then through a 90-day waiting period before becoming eligible for the new employer’s coverage. Individuals who find themselves with a gap of one week or longer between leaving a prior job and starting a new job could find themselves without coverage options for some period of time under the current three-month limit. Consequently, we support updating the rule to allow a short-term policy to be up to six months in duration.

Recommendation

- **Do not extend the permitted duration of short-term policies beyond six months.** Six months is a sufficient period of time to provide a “bridge” between comprehensive health insurance policies.

B. Renewability

In the proposed rule, the Departments request input on allowing, and even streamlining, renewals of short-term plans. In addition, the Departments go beyond a simple extension to the permitted duration of short-term policies and propose to endorse short-term coverage as a long-term alternative to individual market health insurance. At the same time, however, the Departments acknowledge that due to the limited coverage offered by short-term plans and the use of medical

² 42 U.S.C.A. § 300gg-91(b)(5)

³ Conversely, Department of Labor rules do classify short-term coverage as a type of “health insurance.” See 29 CFR 2590.701-2.

⁴ 45 CFR § 144.103

underwriting, short-term plans are expected to attract a disproportionate number of relatively healthy consumers away from the individual health insurance market.

Any policy that decreases the number of consumers shopping for comprehensive individual market health insurance will necessarily decrease the demand for comprehensive individual market health insurance. As a result, it will also decrease the supply in that market.

Policies that disproportionately draw healthy consumers away from the individual market, like expanding access to short-term plans, will likely have an even more devastating effect on affordability, choice and competition. This will further result in adverse selection, drive up the rate of premium increases, and exacerbate affordability issues for many other people—especially those who are ineligible to buy other kinds of coverage (e.g., short-term plans) because of an existing health condition or who need coverage for services to treat their existing health conditions.

Recommendations

- **Do not allow short-term policies to be renewed beyond a total six-month duration and do not implement a streamlined re-application process.** Allowing renewals or a simple reapplication to extend the coverage period beyond six months nullifies any duration limits by allowing consumers to extend the total duration of the policies. If the federal duration limit for short-term plans remains at three months, we would support the option for one renewal or reapplication for a total period of six months of short-term coverage. We recommend the Departments retain the language in §144.103 that makes it clear short-term plans are not renewable as discussed below.
- **To implement the recommendations above, in the final rule, we recommend these changes to the proposed language for §144.103(1) as noted in brackets:** *“Has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder [with or] without the issuer’s consent) that is less than [6] ~~12~~ months after the original effective date of the contract...”*

As proposed, the language “without the issuers consent” specifies that short term coverage is not guaranteed renewable under HIPAA. Retaining the wording “with or without” would maintain the provision in the current rule that short-term policies are not guaranteed renewable and may not be renewed, even at the option of both the insurer and the consumer.

(2) Disclosures

We agree with the Departments that updates are needed to the required disclosure language specified in the 2016 rule. The current required disclosure is not accurate beginning in 2019 because it references the individual mandate penalty which will not apply in 2019 and beyond.

We support the Department's proposed updates to the disclosure to clarify that federal requirements for individual market health insurance do not apply. However, as proposed, the updated disclosure language lacks enough detail to be helpful to consumers.

We also strongly recommend that the Departments take this opportunity to remove the requirement that the disclosure be written in all capital letters. Studies show that text written in all capital letters is actually harder for people to read and understand and therefore should not be required for important communications like health-insurance-related disclosures.

Consumers who are considering a short-term plan may have correct or incorrect assumptions about what health insurance covers and what is excluded from coverage. Consequently, short-term plan disclosures should be clear that these plans are not required to include the benefits and cost sharing limits that must be included in individual market health insurance under current federal law.

Short-term plans represent a significant change from the types of policies that most Americans have gotten used to since 2014. Americans expect health insurance to cover certain health services such as doctor's appointments, urgent care and prescriptions even if the care is for a condition they had before they got the insurance. Most short-term plans exclude one or more of these categories of services that Americans have come to expect to be covered, such as prescription drugs or mental health treatment. Most short-term plans also exclude some or all care for pre-existing conditions.

It is critical that marketing and application materials for short-term plans are clear that neither federal standards for individual market health insurance nor HIPAA excepted benefits apply and that consumers need to read policy documents carefully before buying a short-term plan. Federal policy and rules should maintain bright-line distinctions between: (1) individual market health insurance products that provide coverage for basic health services regardless of a person's existing health status; (2) HIPAA excepted benefit products designed and sold to supplement comprehensive individual market health insurance; and (3) short-term plans, which cover some health services but are not required to include comprehensive coverage that includes treatment for pre-existing conditions.

We believe disclosure materials should be readable and meaningful and provide consumers with the information that they need to make the best decision for their family. In addition, disclosure materials should not restate all the terms of the policy.

To these points, it is critical to include the following information in the required disclosure associated with the application materials for any short-term plan:

- Does the plan cover treatment for pre-existing conditions, preventive care, prescription drugs, or mental health care?
- Does the plan include lifetime or annual maximums?
- Are any of the categories of essential health benefits (EHBs) required for individual market health insurance excluded from this plan?

- Can the plan be renewed, and if so, will renewal require refreshed medical underwriting?

Recommendations

- **The disclosure should not be required to be written in all capital letters.**
- **In consumer disclosure requirements and future rulemaking, bright-line distinctions should be maintained between individual market health insurance, HIPAA excepted benefits, and short-term plans.**
- **The required disclosure should be updated to describe the meaning of “This coverage is not required to comply with federal requirements...”** At a minimum, the disclosure should address: how pre-existing conditions are treated; the possibility that preventive care or some essential health benefits may not be covered; spending caps may apply; renewal of the policy may not be offered; and, the end of a short-term policy is not a qualifying life event to enroll in individual market health insurance outside open enrollment.

Proposed Revised Disclosure for All Short-Term Plans

Our recommendation to further improve on the proposed disclosure language is provided in the text box below.

This plan is “short-term” coverage and is not comprehensive individual market health insurance under federal law. Read short-term plan policy documents carefully to make sure you understand what’s covered. You can find out if you qualify for discounted comprehensive health insurance by visiting www.healthcare.gov. Before buying a short-term plan, you should know that:

- This plan only covers the services listed in the policy and may not cover some of the things typically covered by health insurance. For example, this plan might not cover prescription drugs, preventive care, or mental health care.
- This plan may not cover treatment for health issues you had before you bought the plan, even if you had coverage with this company before.
- The premium may take into account your age, gender and your health conditions.
- This plan may have benefit caps, which are maximum limits on how much the plan will pay for care during your life, during the calendar year, or during the term of the policy, or during a single day. You may have to pay any medical bills you get after you reach any maximums specified in the policy.
- You might not be able to renew your short-term plan when the policy ends. When this plan ends, you may have to wait until an open enrollment period to

sign up for comprehensive health insurance coverage. The open enrollment period for buying your own insurance is [November 1-December 15 for coverage that starts on January 1]. If your employer offers insurance, they may have a different open enrollment period.

(3) The Role of Agents and Brokers

Agents and brokers are trained and licensed professionals who play a critical role in providing consumers with the information they need to choose the best coverage for their family. CMS sets standards for agents and brokers who are authorized to sell individual market health insurance offered on the Federally Facilitated Exchange (FFE).

Consumers looking to purchase comprehensive individual market health insurance in FFE states are directed to agents and brokers who serve a vital role in helping them to understand their coverage options and enroll in a plan. These agents are charged with the responsibility of making sure their clients understand if they are eligible for discounted exchange insurance, possibly with lower cost sharing.

Most certified FFE agents and brokers also sell other health-related products and are well-positioned to help consumers understand the risks and benefits of expanded short-term options. In some cases, a short-term plan may be an appropriate option, such as when a consumer comes to the agent or broker outside of an open enrollment period and does not qualify for a special enrollment period.

Recommendation

- **CMS should review and update existing FFE agent and broker standards and training materials, including standards for web brokers, to ensure that agents and brokers accurately describe to consumers the coverage provided under a short-term plan and how it differs from the coverage offered under an FFE qualified health plan.**

(4) The Role of States

We support the Departments' acknowledgement that the federal rule does not prevent states from specifying state requirements for short-term plans sold in the state. We also encourage states to review existing state regulations for short-term plans and update them if necessary in light of any changes to the federal rule. For example, some states currently require disclosure language for short-term plans that references the individual mandate penalty and those state requirements should be updated to reflect the elimination of that penalty starting in 2019.

Specifically, we recommend that states should review any state requirements for the short-term plans sold through associations. Many short-term plans are offered through associations, and we

encourage states to ensure that all short-term plans sold to their residents are subject to the same laws and regulations. Short-term plans offered through associations should not follow different rules than other short-term plans sold in the state. To support a level playing field for all short-term plans sold in a state, state regulators should ensure that they capture data on all short-term policies sold to the residents of each state, regardless of whether it is sold through an association or directly to the consumer.

Recommendation

- **The Departments should re-affirm the right of states to regulate short-term plans in their markets more stringently than they are regulated under federal rules.**

(5) Effective Dates of Final Rule

The effective date of the final rule should allow for sufficient time to adapt to the new rules and for states to ensure that laws and systems are in place for additional short-term plans. State rate review deadlines are quickly approaching for 2019 comprehensive individual market health insurance. Due to the potential impact of the final short-term rule on those markets, the effective date of the rule should allow states to factor in its effects. Additionally, in some states, legislation will be required to make updates to state rules on short-term plans in light of the updated federal rule.

Recommendation

- **This effective date should be no sooner than January 1, 2020, or no sooner than eighteen (18) months after the date of issue of the final rule.**