



American Hospital
Association®

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

April 23, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Short-Term, Limited-Duration Insurance (CMS-9924-P)

Dear Ms. Verma:

On behalf of the American Hospital Association's (AHA) nearly 5,000 member hospitals, health systems and other health care organizations, and our clinical partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, we thank you for the opportunity to comment on the proposed rule amending the definition of short-term, limited-duration health insurance. **While we appreciate the Departments of Treasury, Labor, and Health and Human Services' (collectively, the departments) effort, this rule fails to adequately protect consumers and could contribute to instability in the individual insurance market, ultimately decreasing access to affordable coverage for vulnerable populations.**

The AHA is committed to expanding affordable, high-quality health coverage and looks forward to working with the departments on this shared goal. In [previous comments](#) to the Administration, we have expressed our support for solutions to both lower the cost of coverage and provide greater choice among plans, including by supporting federal and state reinsurance programs, increasing outreach and enrollment assistance, and funding the cost-sharing reduction subsidies. These approaches retain vital consumer protections while supporting greater enrollment and reducing costs by better balancing the marketplace risk pools.

In contrast, short-term, limited-duration insurance products could harm consumers by providing inadequate access to care and subjecting them to much greater out-of-pocket spending when illness or injury occurs. Many primarily young and healthy individuals – by the departments' estimates, 100,000 to 200,000 – would chose a short-term plan over an individual market plan if this proposal were finalized. These individuals may be attracted by the lower cost associated with these plans, without appreciating the high cost they will pay if an illness or injury occurs. Given that the need for health care is often unpredictable, we believe it is critical that all individuals have comprehensive coverage to protect their physical, mental, and financial health.



Enrollment of younger, healthier consumers in short-term, limited duration products in lieu of individual coverage also would drive up the cost of coverage for the millions who rely on the marketplaces. Because these plans are not required to offer coverage to all consumers, they can limit enrollment to healthier individuals. As the Centers for Medicare & Medicaid Services (CMS) notes, this will concentrate the risk of less healthy individuals in the individual market, raising premiums and threatening access to affordable, comprehensive coverage for others.

Given these concerns, the AHA recommends that the departments not finalize this proposed rule and, instead, work with stakeholders on alternative ways to reduce costs and improve health plan choices for individuals. Our more detailed comments follow.

IMPACT OF INSUFFICIENT COVERAGE ON INDIVIDUALS AND COMMUNITIES

Short-term, limited-duration health plans are not required to comply with consumer protection or comprehensive coverage requirements, meaning that plans are free to elect not to cover all essential health benefits, including hospitalizations or maternity care, or services related to a pre-existing condition. They also may impose limits on the amount of benefits that an enrollee receives or impose high levels of cost-sharing, leaving patients liable for higher costs than are allowed in other health insurance products. The departments acknowledge two of the potential outcomes of the proposal: “reduced access to some services and providers for some consumers who switch from [Affordable Care Act (ACA)]-compliant plans” and “increased out-of-pocket costs for some consumers, possibly leading to financial hardships.”¹

Several factors may contribute to significant uptake of these plans. The statutory repeal of the individual mandate for 2019 and the expansion of hardship exemptions for 2018 will remove one of the strongest incentives for individuals to purchase comprehensive coverage. Consumers who may not expect to need comprehensive health care services or who do not understand the level of coverage offered by these plans may be attracted solely to the lower price tag. The departments actually recognize that insufficient coverage could be problematic for individuals who develop unexpected health issues while enrolled in this type of plan, stating that “depending on plan design, consumers who purchase short-term, limited duration insurance policies and then develop chronic conditions could face financial hardship as a result, until they are able to enroll in [ACA]-compliant plans that would provide coverage for such conditions.”²

While these plans may be attractive to patients looking for lower premiums, there are serious drawbacks to using these types of plans as a primary source of coverage. These plans do not offer the level of protection that patients need over the long term, because it is not possible to fully evaluate what one’s health care needs will be in advance. Even well-informed patients who knowingly enroll in these limited plans anticipating very little need for care could find themselves diagnosed with a serious condition or in an accident, with no coverage to help them with their unexpected medical costs. Moreover, many individuals have low health insurance

¹ Short-term, Limited-Duration Insurance Proposed Rule, 83 FR 7437, February 21, 2018. To be codified at 26 CFR 54, 29 CFR 2590, 45 CFR 144, 146, and 148. Table 1.

² Short-term, Limited-Duration Insurance Proposed Rule, 83 FR 7437, February 21, 2018. To be codified at 26 CFR 54, 29 CFR 2590, 45 CFR 144, 146, and 148.

literacy and will lack full awareness about the coverage that they are purchasing. We expect a number of short-term, limited-duration health plan enrollees to seek care that they expect to be covered, only to find out after the fact that their plan does not cover that benefit or they do not qualify for the benefit due to a pre-existing condition determination. Some illustrative examples showcasing our concerns include:

- A couple in their 30s purchased a short-term, limited-duration health plan, anticipating low health care needs for the year given their ages and health status. One morning, a truck turns into their car while they are driving to work. Emergency responders take the couple to the hospital where they are treated in the emergency department before being admitted for several days. Several weeks later, they receive a bill for the hospitalization, which is when they realize that inpatient hospital care is not covered by their policy.
- An entrepreneur in his 50s purchased a short-term, limited-duration health plan anticipating low health care needs. Before choosing the coverage, he had experienced back pain and had seen a chiropractor. During the year, his back pain worsens, and he is eventually diagnosed with cancer. While his health plan covers cancer treatment in theory, his claims are denied, as the pain – which turned out to have been caused by the cancer – was apparent before the insurance was purchased and, therefore, qualifies the cancer as a pre-existing condition.
- A 28-year-old woman works with a broker to find inexpensive health coverage and ends up with a short-term, limited-duration plan. She is a price-sensitive consumer and the lower premium is attractive, and, with low health insurance literacy, she assumes that all basic services she may need are covered. During the year, she becomes pregnant. She goes to the hospital to deliver, which is when she learns that labor and delivery costs are not covered.

While all of the patients in these examples chose short-term, limited-duration plans because they desired lower premiums, they were ultimately left with much higher costs due to limited financial protections. Not only are these scenarios problematic for consumers, they are bad for communities more broadly. Health care coverage is, unsurprisingly, linked to improved access to care, more appropriate utilization of health care services, and improved health outcomes.³ Studies also show that comprehensive coverage supports economically stable communities by reducing individuals' and families' financial burden⁴ and promotes safer communities by reducing both violent and property crimes.⁵

Hospitals work to stretch scarce resources and provide services to everyone who needs them, regardless of ability to pay. However, those resources are not endless. While hospitals provided

³ American Hospital Association, "The Importance of Coverage," April 2018. Accessed at: <https://www.aha.org/guidesreports/report-importance-health-coverage>

⁴ Sommers, Long, and Baicker, "Changes in Mortality after Massachusetts Health Care Reform," *Annals of Internal Medicine*, 2014. Accessed at: <http://annals.org/aim/article-abstract/1867050/changes-mortality-after-massachusetts-health-care-reform-quasi-experimental-study>

⁵ Vogler, "Access to Health Care and Criminal Behavior: Short-Run Evidence from the ACA Medicaid Expansions," University of Illinois at Urbana-Champaign, September 2017. Accessed at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3042267

more than \$38.3 billion in uncompensated care in 2016,⁶ they cannot absorb the full cost of caring for the uninsured and underinsured. Indeed, in light of mounting financial pressure, some hospitals, particularly in rural areas, have had to close altogether. Since 2010, 83 rural hospitals have closed.⁷

EFFECT ON THE INDIVIDUAL AND SMALL GROUP MARKET

The departments estimate that 100,000 to 200,000 younger, healthier individuals would leave the individual market and purchase short-term, limited-duration plans if this proposal is finalized. An independent analysis warns that the churn could be closer to 2 million.⁸ This shift would result in an older and sicker individual market risk pool. As a result, premiums on the individual market would rise and fewer insurers would likely participate, potentially leading to areas of the country without access to subsidy-eligible plans. The departments acknowledge this potential cost of implementing the rule: “worsening of States’ individual market single risk pools and potentially reducing choice for some other individuals remaining in those risk pools.”⁹

While young and healthy individuals may have access to so-called expanded choice under this rule, millions would be explicitly excluded from these new plan options due to their health status. According to the Kaiser Family Foundation, 52 million individuals, or 27 percent of the non-elderly population, had a pre-existing condition in 2015.¹⁰ Those individuals would still need to rely on the individual market but could be priced out of coverage if they are not eligible for a subsidy. A recent analysis by Covered California found that, nationally, rates on the marketplaces could increase by 0.3 –1.3 percent in 2019 and an additional 0.5 – 2.0 percent in both 2020 and 2021 due to this policy change, coupled with the proposal to expand access to association health plans.¹¹ These increases are on top of the anticipated 5 to 24 percent increase in 2019 and 2.5 to 12 percent increases in both 2020 and 2021 as a result of the repeal of the individual mandate, decreased marketing and enrollment supports, and a shorter open-enrollment period.¹²

⁶ American Hospital Association, “Uncompensated Hospital Care Cost Fact Sheet,” December 2017. Accessed at: <https://www.aha.org/system/files/2018-01/2017-uncompensated-care-factsheet.pdf>

⁷ “83 Rural Hospital Closures: January 2010-Present,” Cecil G. Sheps Center for Health Services Research, The University of North Carolina at Chapel Hill. Accessed at: <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/>

⁸ Cohen, Anderson, and Winkelman, “Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market,” Wakely Consulting Group, April 2018. Prepared for the Association for Community Affiliated Plans. Accessed at: <http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf>

⁹ Short-term, Limited-Duration Insurance Proposed Rule, 83 FR 7437, February 21, 2018. To be codified at 26 CFR 54, 29 CFR 2590, 45 CFR 144, 146, and 148. Table 1.

¹⁰ Claxton, Cox, Damico, Levitt, and Pollitz, “Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA,” Kaiser Family Foundation, December 12, 2016. Accessed at: <https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>

¹¹ Covered California, “The Roller Coaster Continues — The Prospect for Individual Health Insurance Markets Nationally for 2019: Risk Factors, Uncertainty and Potential Benefits of Stabilizing Policies,” March 8, 2018. Accessed at: http://hbex.coveredca.com/data-research/library/CoveredCA_High_Premium_Increases_3-8-18.pdf

¹² Ibid.

CONCLUSION

This proposed rule, if finalized, would weaken the individual market, reduce choice for millions of consumers and increase overall costs for patients and the federal government. Hospitals and health systems are committed to ensuring access to coverage and care, but the tradeoffs associated with this proposal are too great.

Instead of finalizing this proposal, we urge the departments to work with stakeholders on other ways to achieve these shared goals while ensuring that critical consumer protections remain in place. Examples of these solutions include, as mentioned above, supporting state and federal reinsurance proposals, fully funding the cost-sharing reductions, and increasing outreach and enrollment assistance to support greater access to coverage and a more stable risk pool. For more information on these and other options, including those that can be pursued by states, please see the [AHA Fact Sheet on Marketplace Stability and Fallback Options](#).

Thank you for the opportunity to comment. Please contact me if you have questions, or feel free to have a member of your team contact Ariel Levin, senior associate director of policy, at (202) 626-2335 or alevin@aha.org.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President
Government Relations and Public Policy