April XX, 2018

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Re: **CMS-9923-P-** Short-Term, Limited-Duration Insurance

Dear Deputy Commissioner Wielobob, Assistant Secretary Rutledge, and Administrator Verma:

Thank you for this opportunity to comment on the Proposed Rule entitled "Short-Term, Limited-Duration Insurance."[1] We are writing today to provide support for the Administration's proposal to retract the October 2016 final rule, which reduced the length of coverage under short-term, limited duration insurance policies and deprived consumers of an important, affordable choice in the healthcare marketplace.[2] We applaud efforts by this Administration to loosen the regulatory restrictions on the sale of short-term, limited-duration coverage in order to expand choices for individuals and their families.

As you are well aware, the individual health insurance market is contracting: preliminary numbers show that the total number of people with individual policies fell from 20

[1] 83 Fed. Reg. 7,437 (February 21, 2018).

[2] The final rule scaling back the duration of short-term coverage was published in the Federal Register on October 31, 2016 at 81 Fed. Reg. 75,316.

million in March 2016 to 16 million in September of last year. That is a 20-percent drop in a period of just 18 months. The reasons for this precipitous drop in coverage are numerous: the 2010 Patient Protection and Affordable Care Act (PPACA) introduced wave after wave of distortions into our healthcare sector leading to skyrocketing premiums, states have been deprived of their traditional role in creating unique solutions for their individual populations, and current regulations restrict the offering of important consumer choices including association health plans and short-term, limited-duration coverage. While we believe a broad scale reform of our healthcare system is needed, we also know that granting immediate flexibility in the offering of short-term coverage is an important step in the right direction.

As discussed in detail below, outside of providing a definition for what constitutes "short-term, limited duration" coverage, the plain language of HIPAA exempts these products from federal rulemaking, leaving their regulation to the states. The previous Administration improperly assumed that it had statutory warrant to regulate non-PPACA compliant products that it feared might compete with PPACA-compliant products – but this is simply not the case. We urge the Departments to clarify that, in conformance with the statute, the regulation of short-term coverage is left to the states – and restore to issuers flexibility in designing products that best meet consumers' needs

Supporting Affordable Options for Consumers

American families are currently in the midst of a health insurance crisis. Millions of people now rely on PPACA subsidies for their health coverage, resulting in a chronic state of uncertainty for Americans facing the prospects of changing income or even a new political wind in Washington. For those not qualifying for subsidies, the prospect of obtaining affordable health insurance coverage is bleak. Health costs are rising faster than before: according to a March 2018 survey from the West Health Institute and NORC at the University of Chicago, between a third and a half of people ages 45 to 59 and a quarter of those 60+ went without needed health care in the last year due to its cost.[3] And over the period 2013 through 2017, premiums in the PPACA exchanges increased by 105 percent.

While healthcare costs continue to rise at a rapid pace, choice and competition are disappearing from the marketplace. Competition among health issuers in the PPACA exchanges has collapsed: 52 percent of U.S. counties have only one issuer in 2018. Simply put, Americans now face skyrocketing costs and dwindling choices and many are facing the heartbreaking reality of going without coverage.

These government-subsidized monopolies have priced insurance out of the reach of consumers who do not qualify for premium assistance. As the President's Council of Economic Advisers recently noted:

[3] "Americans' Views of Healthcare Costs, Coverage and Policy," Issuer Brief, West Health Institute and NORC at the University of Chicago (March 2018).

> Issuers remaining in the individual and small group markets seem to have recently accounted for ACA regulations and an older, more costly risk pool than they expected by charging higher premiums that have largely been covered by federal government premium subsidies. Stable year-over-year enrollment, despite large premium increases suggests a distorted market that involves large transfers from taxpayers to issuers.

Issuers of PPACA-compliant policies thus tend to price their most common policies (so-called Silver-level plans) based on the assurance that the federal government will pay 100 percent of the premium increases for most enrollees through income-related premium subsidies. While these large and growing transfers from taxpayer to issuers have made many issuers profitable, they have increasingly made non-group coverage unaffordable for millions of other un-subsidized consumers.

Short-term, limited duration coverage is one important option that can give a lifeline to some individuals and families looking for either an affordable option amidst rising insurance premiums in the individual marketplace or a stop-gap in periods of coverage loss or financial distress. As this Administration works to bring consumer choice back to the marketplaces, reviving the ability of individuals to purchase short-term coverage is important. Not only would expanded short-term coverage offer many consumers a significantly more affordable option for coverage, as the Departments note in the preamble to the proposed rule, expanding short-term coverage could also offer consumers broader access to health care providers compared to the PPACA plans which are plagued by narrow-networks.

While we certainly don't think that revising the rules around short-term coverage will solve the health insurance crisis overnight, we believe this is one important and immediate step the Administration can take to inject competition and affordability into the marketplace today. We urge the Departments to remove the inappropriate limits placed on short-term coverage by the Obama Administration and restore to issuers flexibility in offering and administering these plans.

Revising the Restrictions on Short-Term Coverage is Required by Statute

Before turning to the issues of the length of contract and renewability, it is important to understand the statutory scheme that Congress has adopted for purposes of regulating short-term coverage. Of note, this scheme protects short-term, limited duration policies from federal regulation.

Congress originally created the exemption for these policies in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[4] In HIPAA, Congress for the first time imposed certain federal requirements on non-group health insurance policies. These policies had previously been regulated almost exclusively by the states. By exempting

[4] Pub. L. 104-191 § 102, codified at 42 U.S.C. § 300gg-91 (adding new section 2791 to the Public Health Service Act).

short-term, limited duration policies from HIPAA, Congress preserved state regulation of these products and excluded federal regulation.[5]

Congress subsequently enacted the PPACA,[6] which established a far more sweeping federal regulatory regime on non-group policies. Significantly, PPACA did not amend the definition of 'individual health insurance coverage' in the Public Health Service Act and thus did not subject short-term coverage to this new federal regulatory regime. As a result, CMS initially saw no need to issue new regulations pertaining to short-term coverage as a result of PPACA's enactment. It did, however, reverse this position in late 2016[7] and decide to issue rules that were not only not required by PPACA but, we will argue, should be rescinded, in part because they exceed the Departments' statutory authority.

The effect of the two statutes was to create a safe harbor from federal regulation for short-term coverage. Unlike insurance products sold in the non-group market, these plans are exempt from federal regulation and subject only to state regulation. The extent of CMS's statutory authority is to define what short-term coverage is; it has no legal warrant to impose regulatory burdens or limitations on these policies. To define them is to exempt them from federal regulation. The Departments must take care not to use its authority to define short-term coverage as a means of imposing federal regulation on these products or of pre-empting state regulation. The definition must allow room for states to devise regulatory schemes best suited to their respective markets.

The Departments erred in their rulemaking by subjecting these plans to new federal regulation. In their June 10, 2016 NPRM,[8] the Departments opined that short-term coverage provided "an important means for individuals to obtain health coverage when transitioning from one job to another." They no longer are needed, the Departments continued, because of PPACA's "guaranteed availability of coverage and special enrollment requirements."

The Departments were alarmed by a *Wall Street Journal* article indicating that the policies were "being sold to address situations other than the situations that the exception was initially intended to address."[9] Some individuals, according to the Departments' interpretation of the article, "are purchasing this coverage as their primary form of health

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[5] *See* 42 U.S.C. § 300gg-91(b)(5) ("The term 'individual health insurance coverage' means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.")

[6] Pub. L. No. 111-148, 124 State. 119, as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 State. 1029.

[7] 81 Fed. Reg. 75,316 (October 31, 2016)

[8] 81 Fed. Reg. 38,020, 38,032 (July 10, 2016).

[9] "Sale of Short-Term health Policies Surge," Anna Wilde Matthews, Wall Street Journal (April 10, 2016).

coverage." This raised concern at the Departments because short-term coverage is "exempt from market reforms, may have significant limitations, such as lifetime and annual dollar limits on EHBs and pre-existing condition exclusions, and therefore may not provide meaningful health coverage." The Departments also speculated that "healthier individuals might be targeted for this type of coverage, thus adversely impacting the risk pool for PPACA-compliant coverage."

The Departments then set out to write a rule with the express purpose of "address[ing] the issue of short-term coverage being sold as a type of primary coverage." In addition to limiting their duration to 90 days, they stipulated that such contracts could not be extended "with or without the issuer's consent." The Departments argued that this limitation was needed "to address the Departments' concern that some issuers are taking liberty with the current definition of short-term, limited duration insurance either by automatically renewing such policies or having a simplified reapplication process."

Selling a state-licensed product that is exempt from federal regulation is not "taking liberty" in any nefarious sense. The Departments, however, are inappropriately "taking liberty" with their definitional authority, transmuting it into a regulatory authority that is not authorized by statute. The regulation's intent was not to define the law's terms but to impose a revised definition that is not a definition at all, but a transparent effort to federally regulate a product that the statute exempts from federal regulation.

PPACA's combination of federal regulations and subsidies have often created perverse consequences, by pushing issuers to price products beyond the reach of millions of Americans and enhancing the market power of government-subsidized monopolies and duopolies throughout most of the individual insurance market. The sale of short-term coverage threatened these anti-competitive arrangements, allowing other issuers to offer different types of coverage consumers may prefer at prices they are willing to pay. The Departments under the previous Administration sought to stamp out this competitive threat to PPACA-compliant policies through the artifice of a definitional change to short-term, limited-duration insurance.

However, the plain language of HIPAA exempts these products from federal rulemaking, leaving their regulation to the states. The Departments improperly assumed that they had statutory warrant to conduct search and destroy missions against non-PPACA compliant products that they feared might compete with PPACA-compliant products.

The Departments have no such warrant. The statutory reference to "short-term, limited duration" polices expressly prevents the federal government from regulating them. By excluding these policies from the definition of "individual health insurance coverage," the statute preserves the pre-existing arrangement under which states, not the federal government, regulate these plans. The Department's belated discovery that these policies are exempt from HIPAA and PPACA regulation (which is both the purpose and effect of their lone mention in the United States Code) and a newspaper article suggesting that some people may rely on them "as a type of primary coverage," does not create a regulatory authority that the statute excludes.

By leaving the term undefined, the statute invites the Departments to *define* short-term coverage. It *does not* authorize the Departments to use this authority to define as a pretext to regulate. The existing regulation, by the Departments' own admission, is an effort to limit the sale of these policies, constrain consumer choice and impose federal regulations on a product whose regulation the statute reserves to the states. As such, it is an exercise in regulatory overreach and must be amended to make it consistent with the statute.

Loosening the Restrictions on Short-Term Coverage

Given these limitations, we will turn to the three general provisions of the October 2016 rule that the Departments now propose to revise:

1. Requiring a disclaimer that short-term, limited duration coverage does not satisfy the requirement that everyone lawfully present in the United States have "minimum essential coverage."
2. The limitation of these policies to 90 days.
3. The prohibition of extensions "with or without the issuer's consent."

Changes to the Required Disclaimer

While we find the proposed disclaimer unobjectionable, we are unaware of any legal basis for imposing it on products that are exempt from federal regulation. It is understandable that the Departments want consumers to be notified that these products are not PPACA-compliant. It is not clear that the Departments have the statutory authority to require such notification. State insurance commissioners regulate short-term policies pursuant to state law. Some ban their sale; others may impose notice requirements or otherwise provide that consumers be informed of the difference between these plans and PPACA-compliant policies. It is not clear that the Departments have the authority to require these disclaimers. If the Departments move forward with requiring such disclaimers in the final rule, they should explicitly set forth the legal basis for that requirement.

Extending the Duration of Short-Term Coverage

The Departments' proposal to change the duration of these policies from 90 days to "less than 12 months" is a good one. First, 90 days is an inadequate length of time for transitional coverage. The preamble to the June 2016 proposed regulation improperly and in a manner contrary to the statute declared that short-term limited duration policies may only be sold for the purpose of "fill[ing] in temporary gaps in coverage when an individual is transitioning from one plan or coverage to another plan or coverage."[10] As we have seen, the Departments have no authority to limit short-term coverage in this way.

[10] 81 Fed. Reg. 38,025 (June 10, 2016).

In any event, limiting their duration to 90 days prevents them from fulfilling even this inappropriately narrow purpose.

In February 2018, the average duration of unemployment was 22.9 weeks (160 days), which far exceeds the arbitrary and capricious 90-day standard established in the existing regulation.[11] The unemployment rate in that month was 4.1 percent, which is low by historic standards.[12] During the most recent recession, that average at one point reached 40.7 weeks (285 days), more than three times the 90-day limitation. Moreover, even once an individual found work, her new employer could impose a waiting period of up to 90 days before allowing her to participate in group coverage.[13] That 90 days is in addition to the spell of unemployment.

The Obama Administration's 90-day limitation is thus inconsistent with the Departments' stated purpose which, in any event, exceeds its statutory authority.

Second, the proposed rule restores a duration limit that defines the universe of products broadly, while leaving further regulatory discretion to the states, as the federal statute requires.

Third, as a matter of policy, health insurance issuers should be able to offer short-term policies with a wide variety of durations. The market will ultimately control which types of policies are demanded – and we find that by giving health issuers the flexibility to design policies that meet consumers' needs, prices will go down and options will flourish.

Permitting Renewability of Short-Term Coverage

We also strongly support the Departments' proposal to amend the regulatory definition of "Short-term, limited-duration insurance" at 26 C.F.R. § 54.9801–2 to permit carriers, at their discretion, to offer renewable short-term policies. In particular, we support the removal of the language "with or" from the definition of short-term coverage, so as to permit an issuer to option to offer renewable short-term coverage. Consumers may need to renew a policy for a variety of reasons – including a gap in other coverage that lasts longer than anticipated or simply a desire to obtain and retain coverage they can afford, rather than become uninsured.

The current rule exceeds the Departments' statutory authority by prohibiting extensions "with or without the issuer's consent." Congress, as we have seen, excluded these products from federal regulation. The existing rule imposes a stultifying regulatory

[11] "Table A-12. Unemployed persons by duration of unemployment," Economic News Release, Bureau of Labor Statistics, United States Department of Labor (accessed April 6, 2018).

[12] "Unemployment rate at 4.1 percent in February 2018," TED: The Economics Daily, Bureau of Labor Statistics, United States Department of Labor (March 14, 2018).

[13] *See* 42 C.F.R. § 147.116.

scheme that, in effect, deprives states of the regulatory authority that the statute preserves. A policy can only last for 90 days and neither the consumer nor the issuer can extend or renew it. This is regulation designed to limit consumer choice, remove desired products from the insurance marketplace, and improperly curtail regulatory authority that the federal statute reserves to the states.

The current proposal, by contrast, would return to the pre-existing regulatory standard, which prohibits consumers from extending their coverage "without the issuer's consent."

The administration has made clear that its intent is to allow for these products to be renewed. In his executive order, the President stated:

> "Within 60 days of the date of this order, the Secretaries of the Treasury, Labor, and Health and Human Services shall consider proposing regulations or revising guidance, consistent with law, to expand the availability of [short-term, limited-duration insurance]. To the extent permitted by law and supported by sound policy, the Secretaries should consider allowing such insurance to cover longer periods and be renewed by the consumer."

Consistent with the executive order, HHS Secretary Alex Azar has stated, "We'd like to see the ability to give people the option of renewability in whatever form we can have it," Azar made the statement, quoted in the March 9 issue of *Inside Health Policy,* and added that his department has solicited public comments as to his authority to allow for such renewability. It was somewhat jarring, then, to read reports that CCIIO officials have told state insurance regulators that they have already decided not to allow the plans to be renewable.

> "The response from the [CCIIO] deputy, with his boss sitting at the table with him, who last week said we could [make these plans guaranteed renewable], was 'well if we allowed you to make these guaranteed renewable they wouldn't be short term plans anymore'," a state insurance commissioner told *Inside Health Policy*, referring to Center for Consumer Information and Insurance Oversight officials.

This view is contrary to statutory and regulatory history. Under the rules in place prior to January 1, 2017, the federal government did not prohibit issuers from renewing short-term coverage. So long as the length of each contract was less than 12 months (including extensions without the issuer's consent), the policy fell within the Departments' longstanding definition of "short term limited duration coverage.".

The Departments should restore the previous definition and not seek to constrain renewals for several reasons.

First, if the Departments were to decide that short-term coverage cannot be renewed, then the change they propose to the regulation would be meaningless. The current regulation improperly prohibits extensions "with or without the issuer's consent." The proposed

rule says that customers cannot renew coverage "without the issuer's consent." The unavoidable inference of that change is to permit them "with the issuer's consent." Any other reading would be nonsensical. As a result, the proposed rule can only mean that short-term policies are renewable "with the issuer's consent."

Second, it is important to understand why this phrase was needed in the original regulation. Congress had just enacted HIPAA, which for the first time established a federal requirement that issuers renew non-group policies[14] In other words, the federal government was requiring renewal of coverage at the option of the customer and "without the issuer's consent."[15] The statute, as we have seen, excluded short-term coverage from this mandate. The regulation thus properly clarified that there was no federal requirement that these policies be extended "without the issuer's consent" beyond the initial period of "less than 12 months."

But that does not mean that such policies cannot be renewed at all, much less that allowing renewals "with the issuer's consent" would somehow mean that "they wouldn't be short-term plans anymore." The length of the initial contract is "less than 12 months." A consumer is free to purchase a new contract from the issuer, but may be subject to re-underwriting. However, nothing in the regulatory language would prevent an issuer from selling a customer a "guaranteed renewal" rider, enabling the customer to buy a new policy without being subject to medical underwriting. That separate guaranteed renewable contract or rider would not change the nature of the policy. The initial insurance contract and any of its successors still each would be less than 12 months. The offering of the rider would constitute the "issuer's consent" to issue a new insurance contract once the initial one expired. The Departments have no statutory authority to prohibit or otherwise regulate such arrangements.

Other arrangements are possible so long as they are consistent with state regulation. Indeed, robust state regulation of short-term policies already exists – a clear signal of the traditional role reserved to the states in regulating these types of policies.[16] Under current statutory law, the federal government can neither impose a "guaranteed renewal" requirement on issuers, nor prevent them from renewing coverage or entering into contracts with their insured customers that guarantee renewal without re-underwriting. The federal government lacks statutory authority to prohibit such arrangements.

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[14] Pub. L. 104-191 § 111, codified at 42 U.S.C. § 300gg-41 (adding new section 2741 to the Public Health Service Act).

[15] 69 Fed. Reg. 78,748, 78,720 (December 30, 2004).

[16] *See* Blumberg L, Buettgens M, and Wang R. "The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending," Urban Institute (February 2018). The Urban Institute study notes that six states (MA, NJ, NY, OR, VT, and WA) already have in place laws that would prevent an expansion of short-term coverage; two other states (MI and NV) have laws that would limit short-term coverage policy expansion.

We expect that given the appropriate flexibilities, carriers will be able to offer consumers two different types of products (of varying length) – (1) a traditional non-renewable short-term policy; and (2) a short-term policy with a renewability rider attached. While the latter will certainly cost a consumer more than a tradition short-term policy, it will permit consumers looking for traditional pre-PPACA coverage an important and much needed choice. Once again, we believe the offering of short-term policies with renewability riders is fully within the discretion of the Departments to implement given the wide latitude granted in defining what constitutes short-term coverage within the individual market.[17] In the final rule, we ask that the Departments clarify that health issuers are permitted to sell short-term policies with renewability waivers attached.

Providing for an Efficient Implementation

As a final note, we urge the Departments to expeditiously review the comments from this proposed rule and issue a final rule as soon as practicable, but well in advance of the 2019 Open Enrollment period. Given the approaching deadline of Open Enrollment in the PPACA exchanges, we believe that consumers must be given affordable choices well in advance of being forced to make the decision of whether to enroll in an exchange plan that may place their family under severe financial distress. We strongly urge the Departments to make the Final Rule effective at the date of publication – and to expedite the publication of the Final Rule.

Thank you for your attention to our comments. We would be pleased to answer any questions that you may have.

[17] As the Departments note in the preamble to the proposed rule, "rule, "Sections 733(a)(1) of ERISA and 2791(a)(1) of the PHS Act provide that a group health plan is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents (as defined under the terms of the plan) directly, or through insurance, reimbursement, or otherwise. *There is no corresponding provision excluding short-term, limited-duration insurance from the definition of group health insurance coverage*." (Emphasis added).