

April 20, 2018

The Honorable Alex Azar, Secretary of Health and Human Services
The Honorable Steven Mnuchin, Secretary of the Treasury
The Honorable R. Alexander Acosta, Secretary of Labor
c/o Centers for Medicare and Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244

RE: Short-Term, Limited-Duration Insurance, File Code CMS-9924-P

Dear Secretaries Azar, Mnuchin, and Acosta:

On behalf of the 54 million adults and nearly 300,000 children in the United States with doctor-diagnosed arthritis, the Arthritis Foundation appreciates the opportunity to offer comments on the notice of proposed rulemaking regarding short-term, limited duration health insurance plans (STLDPs or short-term plans). The proposed rule is in response to Executive Order 13813 issued by the president, which calls for potential regulations or revisions of guidance to expand the availability of short-term plans. As a result, the proposed rule from the Departments would amend the definition of short-term insurance coverage by permitting health insurance issuers to offer a maximum coverage period of 12 months or less compared to the current three-month maximum, among other changes.

Arthritis is a complex, chronic condition and for many in the arthritis community, access to health care can mean the difference between a life of chronic pain and disability and a life of wellness and full mobility. As a patient advocacy organization, we value our role in helping policymakers understand the nuanced nature of treating arthritis and the needs of people who suffer from this disease. The Arthritis Foundation is deeply concerned that revisions to the definition of short-term plans may have consequences for the stability of the individual marketplace and place greater strain on individuals living with chronic conditions like arthritis. For these reasons, we urge you to avoid finalizing the rule as proposed. Below please find our comments.

Short-Term Plans and Market Stability

The advent of short-term health insurance was, by design, intended to be temporary and fill in coverage gaps when an individual moves from one health plan to another, or may be in between jobs. As a result, these types of plans were never meant to be purchased as a primary or comprehensive form of health coverage, let alone be widely eligible for renewability or extension beyond a period of twelve months. As the Departments pointed out in the 2016 notice of proposed rulemaking that scaled back the duration of short-term plans to a period of three months, there were concerns about individuals purchasing these plans as primary coverage as well as issuers offering renewal of these plans. In addition, the Departments noted, “[B]ecause 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 (ACA) compliant coverage.”¹

Many organizations with experience in the dynamics of health insurance markets, including the American Academy of Actuaries (AAA), the National Association of Insurance Commissioners, and Blue Cross Blue Shield Association have all suggested that a balanced risk pool and level playing field are critical for market stability and sustainability. For instance, in a letter to the Commissioner of Insurance in Idaho concerning one of the state’s insurance proposals, the AAA wrote, “Health insurance markets require a stable regulatory environment ... if one set of plans operates under rules that are more advantageous to healthy individuals, then those individuals will migrate to those plans; less-healthy individuals will migrate to plans more advantageous to them.”²

Bolstering this point of view, two recent analyses of the proposed regulatory changes suggest migration of healthier, lower cost individuals from the ACA-compliant market to STLDPs. By one estimate, the Urban Institute finds that the number of individuals without minimum essential coverage would increase by 2.5 million next year, and about 4.2 million individuals would be enrolled in these short-term arrangements overall. The report goes on to estimate premiums in the ACA-compliant individual market (for states where short-term plans are not prohibited) would rise by nearly 20 percent.³

¹ <https://www.regulations.gov/document?D=IRS-2016-0021-0001>

² https://www.actuary.org/files/publications/Idaho_030218.pdf

³ https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf

Additionally, an analysis by Wakely Consulting Group on behalf of the Association for Community Affiliated Plans concurs that enrollment will decrease in the ACA-compliant market when fully implemented, though by a smaller amount at 2 million individuals. In 2019 alone, the study projects enrollment could decline in ACA-compliant plans by nearly 400,000.⁴ This contrasts with the Departments' estimate in the proposed rule, which projects that between 100,000 and 200,000 individuals enrolled in Exchange coverage would migrate to STLDPs.⁵

Short-Term Plans Lack Patient Protections

Although short-term plans may offer cheaper health insurance coverage, the Arthritis Foundation is very concerned that these plans do not need to adhere to important standards and other critical patient protections under current law, which may contribute further to the destabilization of the individual market. Despite the intention of last year's executive order to promote health care choice and competition for consumers, the STLDPs under consideration would actually serve to restrict access to health care. Short-term plans would not be required to include or address a myriad of patient protections:

- **Coverage of essential health benefits, such as prescription drugs and mental health and substance use.** For many people with arthritis, affordability of life changing treatments is interchangeable with access to these treatments. People with arthritis are increasingly subjected to 40 to 50 percent cost-sharing requirements for specialty medications such as biologics, which have greatly improved the lives of patients suffering from arthritis. There are no guarantees that the drugs they need will be on their health plan's formulary. Given the complexities associated with managing the disease, the potential for prescription drugs to fall outside of short-term plan requirements has the very real potential to affect how arthritis patients access appropriate care and treatment and could result in nonadherence and worsening of disease. Further, multiple studies have shown that people with arthritis have higher levels of depression and anxiety; in fact, a Centers for Disease Control and Prevention (CDC) study found that 1 in 3 people with arthritis age 45 years or older suffer from depression

⁴ <http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf>

⁵ <https://www.regulations.gov/document?D=CMS-2018-0015-0002>

and anxiety. However, only half of respondents with mental health issues had sought treatment. Untreated depression and anxiety can have a significant impact on the level of disability and functional limitations among people with arthritis.

- **A ban on excluding coverage for pre-existing conditions.** The return of pre-existing condition exclusions, which would affect people with arthritis and other chronic diseases, is very concerning. Before the passage of the ACA, as many as one-third of adults (about 52 million Americans) under age 65 had a health condition that would leave them uninsurable or paying significantly higher healthcare costs if they sought a policy that was medically underwritten. In fact, all but five states maintained lists of declinable medical conditions in the medically underwritten individual market before the passage of the ACA. Rheumatoid arthritis and other inflammatory forms of the disease were commonly found on such lists, as were many anti-arthritic medications.⁶ As an additional example, pre-ACA young adults with juvenile arthritis who lost health coverage under their parent's insurance policy when they graduated college were frequently denied coverage completely, or coverage was delayed, due to their pre-existing condition. Insurers must not discriminate with respect to health status.
- **A ban on lifetime and annual dollar limits on coverage.** Before the ACA was enacted, health insurers were permitted to impose lifetime and annual dollar limits on certain benefits. A 2012 report from the Office of the Assistant Secretary for Planning and Evaluation estimated that 105 million Americans across large, small, and individually-purchased health plans had lifetime limits prior to the passage of the ACA.⁷ If the proposed rule is finalized, patients who may be diagnosed with a chronic disease such as arthritis while covered by a STLDP would face significant hardship and financial burdens to manage their disease.
- **Limits on out-of-pocket costs like co-payments, co-insurance, and deductibles.** Prior to the ACA, patients often had no limits on out-of-pocket costs to manage their disease. In some cases, patients found payments made toward the

⁶ <https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>

⁷ <https://aspe.hhs.gov/system/files/pdf/76401/ib.pdf>

deductible would not count toward their maximum out-of-pocket costs; higher cost-sharing for certain preventive care services; and/or face a health benefit where total out-of-pocket cost for services and treatments were excluded from coverage. The proposed rule invites these types of practices to return and the allure of a lower premium does not outweigh these significant concerns.

- **Network adequacy requirements.** The Arthritis Foundation is concerned that STLDPs would be exempt from ACA-related network adequacy standards. Many people with arthritis today already face difficulties regarding the availability of doctors, specialists, and hospitals through their health plans. People who do not have access to necessary medical care through their plan network are forced to use out-of-network providers for treatment. Since insurers often do not pay for out-of-network care, patients only have access to care that is specific to their needs by absorbing substantial cost-sharing obligations or by switching doctors. In addition, rheumatologists that may be included in STLDP plan networks may be far too distant from patients to be readily accessible.

The Arthritis Foundation appreciates the opportunity to provide comments and urges the Departments to avoid finalizing the rule as proposed. Health status is dynamic and individuals cannot predict what services they might need in the future; people with arthritis live with uncertainty every day and count on comprehensive health care to appropriately manage their disease. Revising the definition of short-term plans would also not achieve the administration's goal of maintaining the health and well-being of all Americans or assure patients with chronic diseases like arthritis have access to affordable, high-quality care in the individual market. If you have any questions or would like to discuss these comments further, please contact Vincent Pacileo, Director of Federal Affairs, at vpacileo@arthritis.org or 202-843-0114.

Sincerely,



Anna Hyde
Vice President, Advocacy and Access
Arthritis Foundation