September 11, 2023

The Honorable Xavier Becerra
U.S. Department of Health and Human Services
Humphrey Building
200 Independence Ave. SW
Washington, D.C. 20201

The Honorable Janet Yellen
U.S. Department of the Treasury
Treasury Building
1500 Pennsylvania Ave. NW
Washington, D.C. 20220

The Honorable Julie Su
U.S. Department of Labor
200 Constitution Ave. NW
Washington, D.C. 20210

Dear Secretaries Becerra, Yellen, and Su:

The Departments' Notice of Proposed Rulemaking (NPRM) on short-term, limited duration health insurance (STLDI) would effectively cancel all STLDI plans after four months and prohibit renewals of such plans.[1] These changes would reduce consumer protections in the STLDI market. They would strip coverage from sick patients, leaving them uninsured—with all the financial and health risks that follow—for up to 12 months or more in some cases. They would increase by 500,000 the number of uninsured U.S. residents.[2]

The risks of this proposal are so substantial, the Departments propose requiring STLDI marketing and plan materials to warn consumers about them. The Departments are considering a regulatory change so dangerous, they believe it should come with a warning label. The Departments do not propose requiring the warning label to inform consumers that it is the Departments creating those dangers.

The Departments' proposal is unreasonable, unlawful, and cruel. The Departments should rescind it and affirm that their current interpretation of the relevant statute is both consistent with Congress' purpose and can improve the performance of the Patient Protection and Affordable Care Act (ACA).

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[1] Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, "Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance;" and Federal Register 88, no. 132 (July 12, 2023): 44596.

[2] Congressional Budget Office, *H.R. 1010, To Provide That the Rule Entitled "Short-Term, Limited Duration Insurance" Shall Have No Force or Effect.* (Washington: Congressional Budget Office, April 25, 2019).

Background

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which imposed several regulations on the individual health insurance market via the Public Health Service Act (PHSA).[3] At the same time, HIPAA expressly exempted "short-term limited duration insurance" from those regulations. Thanks to this exemption, STLDI plans are an important source of health coverage for millions of consumers. The Departments allowed STLDI plans to have an initial contract period of up to 12 months.[4]

In the intervening 27 years, Congress has clearly manifested its desire to preserve the STLDI exemption and has expressed zero desire to reduce the initial contract term. Congress has repeatedly amended the PHSA. Examples include:[5]

- The Mental Health Parity Act of 1996 (Pub. L. 104–204, September 26, 1996)
- The Newborns' and Mothers' Health Protection Act (Pub. L. 104–204, September 26, 1996)
- The Women's Health and Cancer Rights Act (Pub. L. 105–277, October 21, 1998)
- The Genetic Information Nondiscrimination Act of 2008 (Pub. L. 110–233, May 21, 2008)
- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. 110–343, October 3, 2008)
- Michelle's Law (Pub. L. 110–381, October 9, 2008)
- The Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3, February 4, 2009)
- The Patient Protection and Affordable Care Act (Pub. L. 111– 148, March 23, 2010)
- The No Surprises Act (Division BB of the Consolidated Appropriations Act, Pub. L. 116–260, December 27, 2020)

These laws frequently imposed new requirements on issuers of health insurance. In every case, Congress chose *both* to preserve the STLDI exemption *and* to exempt STLDI plans from the new regulations. It has never curtailed the exemption. It has never sought to shorten the 12-month STLDI contract length. On the contrary, Congresses and Presidents of both political parties have accepted that contract length. Nor has Congress ever sought to prohibit consumers from purchasing multiple consecutive STLDI plans from the same issuer.

The U.S. Court of Appeals for the D.C. Circuit writes that the STLDI exemption allows consumers to use STLDI plans as their primary health insurance:

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[3] Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, August 21, 1996.

[4] Internal Revenue Service, Pension and Welfare Benefits Administration, and Health Care Financing Administration "Interim Rules for Health Insurance Portability for Group Health Plans;" and Federal Register 62, no. 67 (April 8, 1997): 16894.

[5] Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, "Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance." Federal Register 88, no. 132 (July 12, 2023): 44596–7.

> Congress expressly elected *not* to set up a Hobson's choice between purchasing ACA-compliant insurance and forgoing coverage altogether. . . .To be sure, Congress *hoped* that most individuals would purchase ACA-compliant plans as their primary insurance, and it provided incentives to encourage them to do so. . . .But it did not foreclose other options.[6]

The sole instance the Departments cite of Congress imposing burdens on STLDI issuers argues against the changes they propose in the NPRM. In 2020, Congress required issuers of STLDI plans "to disclose the direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage to the enrollees in such coverage as well as to report it annually to HHS."[7] This *de minimis* regulation indicates that Congress knew how to regulate STLDI plans when it wanted and that Congress has repeatedly chosen not to impose the sorts of burdens and penalties the Departments seek to impose without Congress (see below).

For all but two of the 27 years since Congress created the STLDI exemption, a 12-month initial contract term has been the rule. The only exception occurred from 2016 to 2018, when the Departments required STLDI issuers to cancel all STLDI plans after just three months. (More on this change below.)

In 2018, the Departments reversed themselves. They re-established an initial contract term of 12 months. For the first time, they gave meaning to the statutory phrase "limited duration" by allowing issuers and consumers to extend the initial contract up to a total of 36 months. The Departments also clarified that nothing in federal law either prevented consumers from purchasing consecutive STLDI plans or prevented issuers from selling standalone renewal guarantees that shielded sick enrollees from medical underwriting when they purchased a new STLDI plan.[8]

Importantly, these features are consumer protections. They shield enrollees who develop expensive medical conditions from coverage denials and coverage loss. The opportunity for renewal guarantees means the STLDI market can reduce ACA premiums by giving patients who develop high-cost conditions an affordable source of health insurance that keeps them out of the ACA's risk pools.

The current rules have withstood a court challenge from private insurance companies that sell ACA plans. Those issuers claimed the current STLDI rules harmed their revenues by providing many consumers a more attractive option than those insurers' ACA plans. The insurers explicitly

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[6] Emphases in original. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, No. 19-5212, 1, 20 (D.C. Circ. 2020).

[7] The law imposing that requirement was the Consolidated Appropriations Act of 2021, Pub. L. 116–260, December 27, 2020. Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, "Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance;" and Federal Register 88, no. 132 (July 12, 2023): 44598.

[8] Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services. "Short-Term, Limited-Duration Insurance;" and Federal Register 83, no. 150 (August 3, 2018): 38212.

petitioned federal courts to reinstate the three-month limit because doing so would increase their revenues by crippling their competitors and punishing their competitors' customers.[9] Both a district court and the U.S. Court of Appeals for the D.C. Circuit upheld the current rules. The D.C. Circuit found the current rules "perfectly reasonable" and that they had "only modest effects on the government Exchanges."[10] It affirmed that "nothing in [federal law] prevents insurers from renewing expired STLDI policies."[11]

Characteristics of STLDI Plans

Short-term plans are comprehensive health insurance. The non-partisan Congressional Budget Office (CBO) writes that—thanks to current STLDI rules—95 percent of STLDI plans are a "comprehensive major medical policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals." In essence, STLDI plans "resemble a typical nongroup insurance plan offered before 2014, when many [ACA] regulations. . .took effect."[12]

On some dimensions, STLDI plans are more comprehensive than ACA plans. The CBO writes that STLDI plans "may exclude some benefits that [ACA] plans must cover [but] may have lower deductibles or wider provider networks" than ACA plans.[13] Figures 1–4 show that STLDI plans in major cities have a wide range of annual out-of-pocket limits, including limits as low as $1,000. In most markets, STLDI plans offer up to $5 million of lifetime coverage.

[9] Michael F. Cannon, "In a Win for Consumers, a Court Ruling Affirms the Legality of Short-Term Health Insurance Plans," *The Hill*, July 4, 2020.

[10] *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.,* No. 19-5212, 1, 20 (D.C. Circ. 2020).

[11] *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, No. 19-5212, 1, 10 (D.C. Circ. 2020).

[12] Congressional Budget Office, *How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans* (Washington: Congressional Budget Office, January 2019), p. 6.

[13] Congressional Budget Office, *How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans* (Washington: Congressional Budget Office, January 2019), p. 6.

Figure 1

ACA marketplace plans vs. short-term health insurance plans in select cities, 27-year-old male

City	Monthly premium for lowest cost bronze marketplace plan (unsubsidized)	Range of monthly premiums for short-term plans	Range of out-of-pocket cost-sharing maximums for short-term plans	Range of policy coverage caps for short-term plans
Phoenix, AZ	$238	$60.98–$353.28	$1,000–$25,000	$100,000–$5 million
Los Angeles, CA	$231	NA	NA	NA
Denver, CO	$205	NA	NA	NA
Miami, FL	$276	$91.21–$588.16	$1,000–$25,000	$100,000–$5 million
Atlanta, GA	$289	$75.54–$582.54	$1,000–$25,000	$100,000–$5 million
Chicago, IL	$226	$71.86–$293.35	$1,000–$25,000	$100,000–$5 million
St. Louis, MO	$262	$54.80–$301.67	$1,000–$25,000	$100,000–$5 million
Columbus, OH	$256	$58.68–$250.07	$1,000–$25,000	$100,000–$2 million
Houston, TX	$256	$86.57–$679.66	$1,000–$25,000	$100,000–$5 million
Virginia Beach, VA	$246	$49.17–$302.20	$1,000–$20,000	$100,000–$5 million

Source: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, accessed August 30, 2023. for ACA-compliant plan premiums; eHealth and Agile Health Insurance for short-term policy premiums and features.

Figure 2

ACA marketplace plans vs. short-term health insurance plans in select cities, 27-year-old female

City	Monthly premium for lowest cost bronze marketplace plan (unsubsidized)	Range of monthly premiums for short-term plans	Range of out-of-pocket cost-sharing maximums for short-term plans	Range of policy coverage caps for short-term plans
Phoenix, AZ	$238	$62.78–$364.85	$1,000–$25,000	$100,000–$5 million
Los Angeles, CA	$231	NA	NA	NA
Denver, CO	$205	NA	NA	NA
Miami, FL	$276	$95.58–$722.53	$1,000–$25,000	$100,000–$5 million
Atlanta, GA	$289	$85.88–$602.00	$1,000–$25,000	$100,000–$5 million
Chicago, IL	$226	$74.05–$302.88	$1,000–$25,000	$100,000–$5 million
St. Louis, MO	$262	$57.25–$312.00	$1,000–$25,000	$100,000–$5 million
Columbus, OH	$256	$61.24–$266.10	$1,000–$25,000	$100,000–$2 million
Houston, TX	$256	$98.96–$702.38	$1,000–$25,000	$100,000–$5 million
Virginia Beach, VA	$246	$54.60–$308.50	$1,000–$20,000	$100,000–$5 million

Source: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, accessed August 30, 2023. for ACA-compliant plan premiums; eHealth and Agile Health Insurance for short-term policy premiums and features.

Figure 3

ACA marketplace plans vs. short-term health insurance plans in select cities, 64-year-old female

City	Monthly premium for lowest cost bronze marketplace plan (unsubsidized)	Range of monthly premiums for short-term plans	Range of out-of-pocket cost-sharing maximums for short-term plans	Range of policy coverage caps for short-term plans
Phoenix, AZ	$680	$161.57–$1,281.67	$1,000–$25,000	$100,000–$5 million
Los Angeles, CA	$661	NA	NA	NA
Denver, CO	$588	NA	NA	NA
Miami, FL	$789	$260.64–$1,711.12	$1,000–$25,000	$100,000–$5 million
Atlanta, GA	$828	$214.24–$2,064.42	$1,000–$25,000	$100,000–$5 million
Chicago, IL	$647	$193.92–$1,371.94	$1,000–$25,000	$100,000–$5 million
St. Louis, MO	$750	$165.40–$1,089.34	$1,000–$25,000	$100,000–$5 million
Columbus, OH	$732	$157.15–$1,078.25	$1,000–$25,000	$100,000–$2 million
Houston, TX	$732	$251.03–$2,230.97	$1,000–$25,000	$100,000–$5 million
Virginia Beach, VA	$704	$157.20–$1,213.87	$1,000–$20,000	$100,000–$5 million

Source: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, accessed August 30, 2023. for ACA-compliant plan premiums; eHealth and Agile Health Insurance for short-term policy premiums and features.

Figure 4

ACA marketplace plans vs. short-term health insurance plans in select cities, 64-year-old male

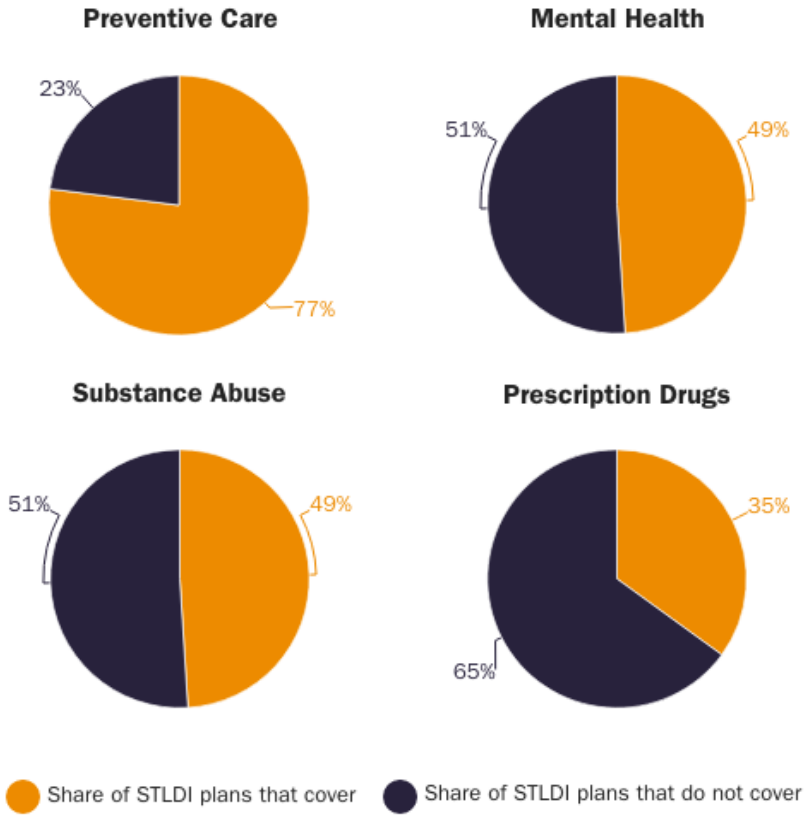
City	Monthly premium for lowest cost bronze marketplace plan (unsubsidized)	Range of monthly premiums for short-term plans	Range of out-of-pocket cost-sharing maximums for short-term plans	Range of policy coverage caps for short-term plans
Phoenix, AZ	$680	$183.36–$1,702.78	$1,000–$25,000	$100,000–$5 million
Los Angeles, CA	$661	NA	NA	NA
Denver, CO	$588	NA	NA	NA
Miami, FL	$789	$279.94–$1,969.20	$1,000–$25,000	$100,000–$5 million
Atlanta, GA	$828	$284.17–$3,182.58	$1,000–$25,000	$100,000–$5 million
Chicago, IL	$647	$220.36–$2,072.66	$1,000–$25,000	$100,000–$5 million
St. Louis, MO	$750	$177.47–$1,667.70	$1,000–$25,000	$100,000–$5 million
Columbus, OH	$732	$178.30–$1,220.58	$1,000–$25,000	$100,000–$2 million
Houston, TX	$732	$269.40–$3,331.20	$1,000–$25,000	$100,000–$5 million
Virginia Beach, VA	$704	$170.12–$1,374.36	$1,000–$20,000	$100,000–$5 million

Source: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, accessed August 30, 2023. for ACA-compliant plan premiums; eHealth and Agile Health Insurance for short-term policy premiums and features.

Similarly, Figure 5 shows the broad range of available STLDI plans allows consumers to choose whether and to what extent they will purchase coverage for such items as preventive care, mental health, substance abuse, and prescription drugs. Though apparently no STLDI plans provide coverage for uncomplicated pregnancies, many consumers consider that a feature rather than a drawback (see below).

Figure 5

Short-term health plans let consumers choose common types of coverage



Source: eHealth and Agile Health Insurance for short-term policy premiums and features, August 2023.
Note: Percentages are weighted averages across the 36 states that offer short-term health plans.

The CBO finds that for many consumers, comprehensive STLDI plans carry premiums that are "as much as 60 percent lower than premiums for the lowest-cost bronze [ACA] plan."[14] Figures 1–4 are broadly consistent with the CBO's findings.[15] Figure 6 shows where the lowest-cost bronze ACA plan premium falls in relation to the range of available STLDI premiums. STLDI

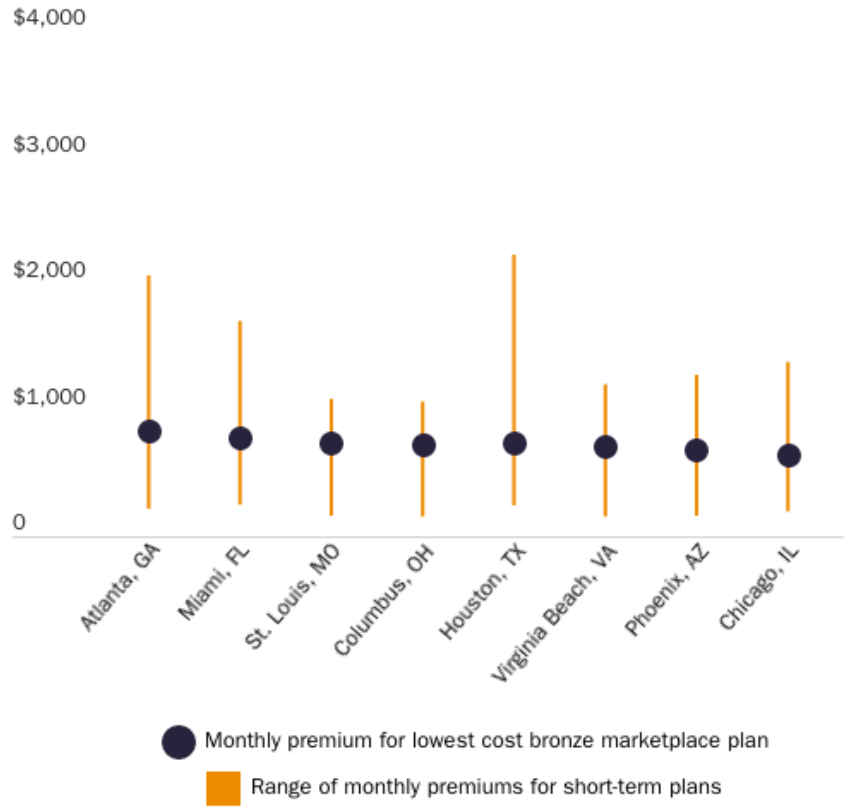
[14] Congressional Budget Office, *How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans* (Washington: Congressional Budget Office, January 2019), p. 6.

[15] Figures 1–4 and 6 figures show that many STLDI plans have premiums that are much more than 60 percent lower than the lowest-cost bronze ACA plan. Presumably, the 5 percent of STLDI plans that have the lowest premiums are not comprehensive coverage. That still leaves plenty of room for comprehensive STLDI plans with dramatically more affordable premiums than ACA plans.

plans even give consumers the choice of paying more than they would pay for the lowest-cost bronze ACA plan.

Figure 6

Short-term plan premiums often lower than lowest-cost bronze ACA plan premium (64-year-old female, select cities)



Source: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, accessed August 30, 2023. for ACA-compliant plan premiums; eHealth and Agile Health Insurance for short-term policy premiums and features.

Finally, under current rules, consumers may purchase consecutive STLDI plans and issuers may sell standalone renewal guarantees that protect enrollees who become ill from medical underwriting at reenrollment.[16]

Who Benefits from STLDI Plans?

STLDI plans provide reasonable temporary and primary health insurance options for many consumers. In contrast to the ACA, which generally bars consumers from purchasing coverage for 9-10 months out of each year, consumers can purchase STLDI plans at any time. STLDI plans can thus be a lifeline to consumers who miss the ACA's restrictive "open" or "special" enrollment periods. They can be particularly attractive to consumers who face high ACA premiums, who receive little assistance with those premiums, or who object to certain types of

[16] Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services. "Short-Term, Limited-Duration Insurance;" and Federal Register 83, no. 150 (August 3, 2018): 38212.

coverage that ACA plans require them to purchase (e.g., religious objections to contraceptives coverage). They provide coverage to undocumented residents who do not qualify for subsidies to purchase ACA plans. When STLDI plans expand coverage to the uninsured, they reduce the problem of uncompensated care.

STLDI plans are especially important as a lifeline in situations that can be difficult for policymakers to foresee. One real-life example is "Maria." In 2023, Maria entered a convent as a postulant, i.e., to study to become a Catholic nun. Maria's only option for health insurance is to purchase it herself. The convent does not sponsor health insurance for postulants. Though her income is low enough to qualify for Medicaid, Maria is an immigrant, which makes her ineligible. She is eligible to purchase an ACA plan. Her income is below the federal poverty line ($14,580), however, which makes her ineligible for a premium subsidy. Were she to purchase an ACA plan, she would have to pay the entire premium herself. The lowest-cost bronze plan available to Maria has an annual premium of $4,821—roughly 33 percent of Maria's household income. That's nearly four times the amount the Departments consider affordable (9.12 percent of household income).

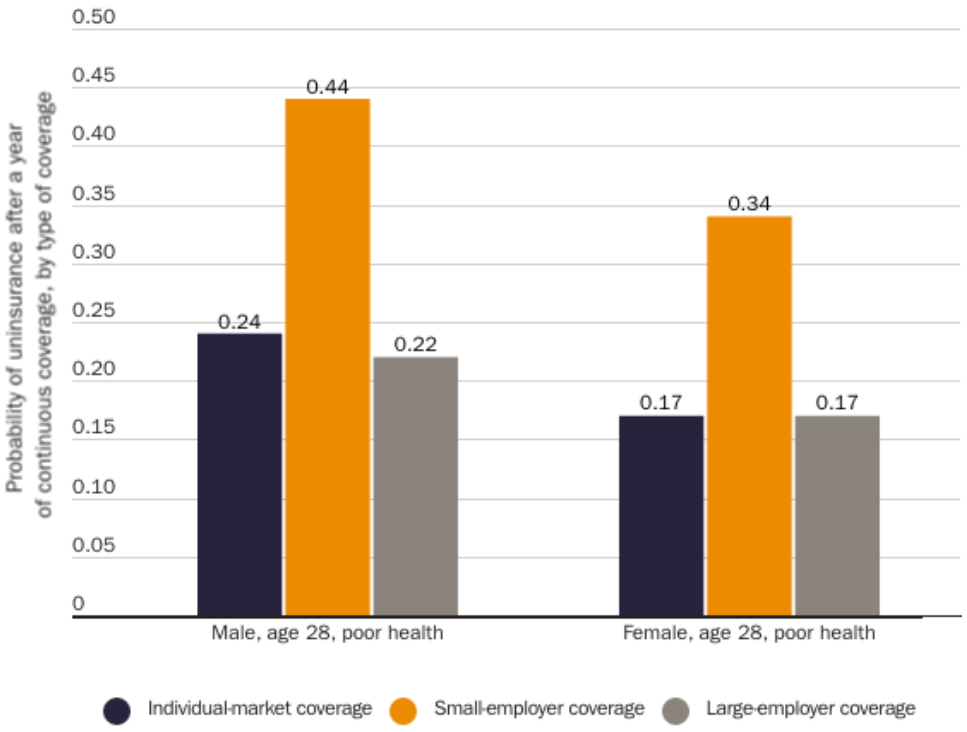
An STLDI plan is the only affordable option Maria has. She can choose from STLDI plans with annual premiums ranging from $1,100 to $5,300 and deductibles ranging from $1,000 to $10,000. Importantly for Maria, an STLDI plan would allow her to avoid both maternity coverage and contraceptives coverage, one of which violates her religious beliefs and neither of which she needs.[17]

Other potential beneficiaries of STLDI plans are enrollees in ACA plans. If STLDI issuers have the certainty of knowing that the Departments will allow them to sell renewal guarantees that protect STLDI enrollees from medical underwriting at re-enrollment, the STLDI market can give enrollees who fall ill a lower-cost insurance option than ACA plans. Giving high-cost STLDI enrollees that option could help reduce ACA premiums by keeping high-cost patients out of the ACA risk pools. Figure 7 shows that due to renewal guarantees, the pre-ACA individual market did a better job of providing secure health insurance—and thereby reducing the problem of preexisting conditions—than employer-sponsored insurance.

[17] Michael F. Cannon, "How Do You Solve a Problem Like Maria's? Rescind Biden's Short-Term Plans Proposal," *Cato at Liberty* (blog), August 4, 2023.

Figure 7

For enrollees in poor health, individual-market coverage is similarly or more secure than employer coverage, 2000–2004



Source: Mark V. Pauly and Robert D. Lieberthal, "How Risky Is Individual Health Insurance?," *Health Affairs* 27, no. 1 (2008), https://doi.org/10.1377/hlthaff.27.3.w242.
Notes: Assumes family income of $50,000 annually, expecting a 4 percent increase in income.

Proposal to Cancel New STLDI Plans after Four Months

The Departments propose to cancel all new STLDI plans after four months. They propose to prohibit renewals by prohibiting insurers to sell two STLDI plans to the same customer within a 12-month period. These proposals would strip away the protections that longer contract terms, renewals, and renewal guarantees provide consumers. They would have little effect on healthy STLDI enrollees but catastrophic effects for STLDI enrollees who fall ill.

Consider these changes from the perspective of Maria. So long as she remains healthy, Maria could continue to use STLDI plans as her primary source of insurance. As she can today, Maria could keep purchasing a series of consecutive STLDI plans, albeit from different insurers. Her premiums would be higher and her plans' medical loss ratios lower, though, because insurers would have to underwrite enrollees more frequently.

Were she to fall ill, however, Maria could not continue to use STLDI plans as her primary source of insurance. Within four months of falling ill, the Departments' proposal would strip her of her current STLDI plan and any hope of enrolling in a subsequent STLDI plan. At the same time canceling Maria's STLDI plan would turn her otherwise *insured* medical condition into an uninsured *preexisting* condition, it would also expose her to medical underwriting in that market.

She would be unable to obtain STLDI coverage and would then face up to 12 months of uninsurance—with all the financial and health risks that entails—before she would be eligible to enroll in ACA plan. Such is the situation that most STLDI enrollees would face. But since Maria is ineligible for ACA premium subsidies, she would also either need to devote at least 33 percent of her income to purchase an ACA plan or face *more* than 12 months without insurance.

These risks are entirely foreseeable. The National Association of Insurance Commissioners (NAIC), which represents state insurance regulators, warned the Departments about the dangers of limiting STLDI plans to less than one year when the Departments were contemplating a three-month limit in 2016. The NAIC wrote:

> Short term, limited duration insurance has long been defined as a policy of less than 12 months both by the states and the federal government. The proposed rule provides no data to support the premise that a three-month limit would protect consumers or markets.
>
> In fact, state regulators believe the arbitrary limit proposed in the rule could harm some consumers. For example, if an individual misses the open enrollment period and applies for short-term, limited duration coverage in February, a 3-month policy would not provide coverage until the next policy year (which will start on January 1). The only option would be to buy another short-term policy at the end of the three months, but since the short-term health plans nearly always exclude pre-existing conditions, if the person develops a new condition while covered under the first policy, the condition would be denied as a preexisting condition under the next short-term policy. In other words, only the healthy consumers would have coverage options available to them; unhealthy consumers would not.
>
> This is why we do not believe this proposal will actually solve the problem it is intended to address. If the concern is that healthy individuals will stay out of the general pool by buying short-term, limited duration coverage there is nothing in this proposal that would stop that. If consumers are healthy they can continue buying a new policy every three months. Only those who become unhealthy will be unable to afford care, and that is not good for the risk pools in the long run.[18]

The D.C. Circuit noted that canceling STLDI plans after just a few months would lead consumers "to be denied a new policy based on preexisting medical conditions."[19]

These risks are not hypothetical. They already befell STLDI enrollees from 2016 to 2018 after the Departments unwisely adopted a proposal to cancel all STLDI plans after three months. *Consumer Reports* tells the story of 61-year-old Arizona resident Jeanne Balvin. In 2017, the lowest-cost ACA plan Balvin could find had a monthly premium of $744 and a $6,000 deductible. Balvin instead enrolled in an STLDI plan from UnitedHealthcare that had a monthly premium of $274 and a $2,500 deductible. When Balvin required emergency surgery and

[18] John M. Huff et al. to Internal Revenue Service, August 9, 2016.

[19] *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.,* No. 19-5212, 1, 20 (D.C. Circ. 2020).

hospitalization for diverticulitis, her STLDI plan paid its share of her bills promptly and in full. In July 2017, however, the Departments' three-month rule cancelled Balvin's STLDI plan. Had the Departments not implemented the three-month limit, Balvin's diverticulitis would have continued to be an *insured* condition. Instead, the Departments canceled her plan, which exposed her to medical underwriting. Balvin lost coverage for diverticulitis and was not eligible to enroll in an ACA plan until January 2018. A rule that is functionally identical to the one the Departments are considering today left Jeanne Balvin with $97,000 in unpaid medical bills.[20]

The risks of canceling STLDI plans after four months are so substantial, the Departments propose to warn consumers about those risks. The proposed "Notice to Consumers" would require all STLDI marketing and plan materials to state, in part:

> When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.[21]

From one perspective, it is noble that the Departments have compassion enough to warn would-be STLDI enrollees about what will happen to them after the Departments throw them, sick and vulnerable, out of their health plans. From another perspective, a good rule of thumb is that if a product feature is so dangerous that it requires a 14-point-type warning label, regulators should not mandate it.

Misleading Descriptions of STLDI Plans vs. ACA Plans

The NPRM expresses the Departments' desire to protect consumers from "misleading or aggressive sales and marketing tactics that obscure the differences between comprehensive coverage and STLDI," tactics to which "underserved populations may be particularly vulnerable."[22] The NPRM directly conflicts with these goals by aggressively misleading consumers and the public at large about the merits of STLDI plans versus ACA plans, as well as the Departments' own proposal.

It is false and misleading to tell the public, and to propose requiring STLDI issuers to notify consumers, that STLDI plans are categorically "not comprehensive coverage." Non-partisan authorities such as the CBO affirm that 95 percent of STLDI plans provide comprehensive coverage. On some dimensions, STLDI plans demonstrably provide *more* comprehensive coverage than ACA plans (see below).

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[20] Donna Rosato, "Short-Term Health Insurance Isn't as Cheap as You Think," *Consumer Reports*, October 2, 2018.

[21] Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, "Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance;" and Federal Register 88, no. 132 (July 12, 2023): 44596.

[22] Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, "Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance;" and Federal Register 88, no. 132 (July 12, 2023): 44608.

In certain circumstances, indeed for most of the year, STLDI plans offer more comprehensive coverage than *all* ACA plans. Consumers are generally free to purchase STLDI throughout the year and coverage can take effect as early as one day after an enrollee applies. By contrast, federal law generally prevents consumers from enrolling in ACA plans for 9-10 months of the year.[23] Consumers may purchase ACA plans only during narrow "open" or "special" enrollment periods. Even then, there can be a lag of up to two months before ACA coverage takes effect. Outside of those narrow enrollment windows and lagged start dates, ACA plans offer consumers *zero* coverage: no essential health benefits, an annual coverage limit of $0, and unlimited out-of-pocket exposure.

Even if the Departments define "comprehensive coverage" as plans that provide the same benefits as ACA plans, it is still misleading to state, and require STLDI issuers to state, that STLDI plans are categorically "not comprehensive coverage." Were consumers to demand plans that cover the same benefits as ACA plans with the same cost-sharing structure, STLDI issuers could provide those features—and still with broader provider networks and lower premiums than ACA plans. In that case, STLDI plans would be more comprehensive than ACA plans across all dimensions, all year round. The only obstacle to STLDI issuers selling such plans is a lack of consumer demand. Unless the Departments believe consumers would never voluntarily choose ACA coverage and cost-sharing—not even alongside broader networks and lower premiums—the Departments should not categorically state that STLDI plans are "not comprehensive coverage."

It is further misleading for the Departments to describe ACA plans as categorically providing "comprehensive health insurance." Some ACA requirements have the effect of making ACA plans more comprehensive. Other ACA requirements have the effect of making ACA plans less comprehensive. The net result is that on many dimensions, ACA plans are less comprehensive than many STLDI plans.

The centerpiece of the ACA's regulatory scheme is its community-rating price controls. This set of requirements makes coverage less comprehensive by effectively penalizing issuers unless they "avoid enrolling people who are in worse health" by designing plans to be "unattractive to people with expensive health conditions."[24] At the same time the ACA purports to end discrimination against the sick, its centerpiece penalizes issuers unless they engage in "backdoor discrimination" against the sick that "undoes intended protections for preexisting conditions."[25]

One example is network breadth. The ACA's community-rating price controls effectively penalize ACA plans unless they make their networks narrower than their competitors' networks. "Narrow networks existed before the implementation of the ACA, but they have grown more

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[23] *Guaranteed Availability of Coverage, U.S. Code 42* (2010), § 300gg–1.; and *Initial and Annual Open Enrollment Periods, CFR 45* (2021), § 155.410.

[24] Cynthia Cox et al., "Explaining Health Care Reform: Risk Adjustment, Reinsurances, and Risk Corridors," Kaiser Family Foundation, August 17, 2016.

[25] Michael Geruso, "Screening in Exchanges: Some Facts and Findings from Geruso, Layton, Prinz (2016)," Lecture, Penn LDI HIX Conference, September 2017, p. 3.

common as a result of it."[26] According to surveys, broad provider networks accounted for 80 percent of individual-market plans in 2013, when networks reflected consumer preferences, but only 21 percent of Exchange plans in 2020.[27] The CBO confirms that ACA provider networks are often less comprehensive than STLDI provider networks.

Another example is prescription drug coverage. The ACA's community-rating price controls penalize issuers unless they make drug coverage less comprehensive than their competitors' drug coverage. These "protections" thus ration care for patients with costly chronic illnesses including multiple sclerosis, infertility, substance abuse disorders, hemophilia, severe acne, and nerve pain.[28] The "I Am Essential" coalition of 150 patient groups identified numerous examples of such discrimination against patients with cancer, cystic fibrosis, hepatitis, HIV, and other illnesses.[29]

Rather than guarantee comprehensive coverage, these provisions create a race to the bottom by ceaselessly penalizing any ACA plan that is more comprehensive than its competitors. The resulting gaps coverage harm patients. Excessively narrow networks "jeopardize the ability of consumers to obtain needed care in a timely manner."[30] The ACA's drug-coverage gaps cost patients thousands of dollars per year.[31] The "I Am Essential" coalition writes that such discrimination "completely undermines the goal of the ACA."[32] Even "currently healthy consumers cannot be adequately insured."[33] It is false and misleading for the Departments to describe ACA plans as providing "comprehensive coverage" when the centerpiece of the ACA's regulatory scheme is actively eroding coverage for all enrollees.

Finally, it is highly misleading for the Departments to propose to cancel STLDI plans after four months, and to require STLDI issuers to warn their potential customers about these risks, without

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[26] The National Academies of Sciences, Engineering, and Medicine, *Health-Care Utilization as a Proxy in Disability Determination* (Washington: The National Academies Press, 2018): 47–48.

[27] Noam Bauman et al., "Hospital Networks: Updated National View of Configurations on the Exchanges," McKinsey & Company, June 1, 2014, p. 5; and Avalere, "2020 Exchange Plan Networks Are the Most Restrictive since 2014," December 11, 2019.

[28] Michael Geruso, Timothy Layton, and Daniel Prinz, "Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges," *American Economic Journal: Economic Policy* 11, no. 2 (May 2019): 64–107.

[29] Beatriz Duque Long, Carl Schmid, and Andrew Sperling, email to Sylvia Mathews Burwell, "Re: 2017 Qualified Health Plan Review and 2018 *Notice of Benefit and Payment Parameters* Rule & Letter to Issuers," August 24, 2016.

[30] The National Academies of Sciences, Engineering, and Medicine, *Health-Care Utilization as a Proxy in Disability Determination* (Washington: The National Academies Press, 2018): 47–48.

[31] Michael Geruso, Timothy Layton, and Daniel Prinz, "Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges," *American Economic Journal: Economic Policy* 11, no. 2 (May 2019): 64–107.

[32] Beatriz Duque Long, Carl Schmid, and Andrew Sperling, email to Sylvia Mathews Burwell, "Re: 2017 Qualified Health Plan Review and 2018 *Notice of Benefit and Payment Parameters* Rule & Letter to Issuers," August 24, 2016.

[33] Michael Geruso, Timothy Layton, and Daniel Prinz, "Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges," *American Economic Journal: Economic Policy* 11, no. 2 (May 2019): 64–107.

also informing consumers that is the Departments themselves that are responsible for creating those risks.

The Departments' Proposal Is Not Reasonable

The Departments have authority to interpret (and reinterpret) ambiguous statutes so long as their interpretation is reasonable. The interpretation of "short-term, limited duration insurance" that the Departments propose in this NPRM is not reasonable. An interpretation that cancels all STLDI plans after four months and prohibits renewals directly and starkly conflicts with and undermines Congress' express goals, as well as the Departments' stated goals.

Congress has not given the Departments explicit guidance as to the meaning of the statutory phrase "short-term, limited duration." Yet decades of congressional legislation clearly evince:

1. Congress wants consumers to have access to STLDI plans that are exempt from federal health insurance regulation.

2. Congress' primary goals with respect to health insurance regulation are to reduce gaps in health insurance, to reduce the number of uninsured, and to shield the sick from medical underwriting.

3. Since the enactment of the ACA, Congress has moved away from negative incentives (i.e., penalties) to induce consumers to enroll in ACA plans in favor of positive incentives (subsidies).

Canceling STLDI plans after four months and prohibiting renewals conflicts with each of these elements of Congress' plan.

The Departments' proposal conflicts with Congress' regulatory scheme by treating the STLDI exemption as an aberration or a lesser part of federal law. The STLDI exemption stands on an equal footing with all other provisions of federal law. The same lawmaking process that created the ACA and the remainder of the PHSA also created the STLDI exemption. Indeed, the STLDI exemption predates most federal health insurance regulations, including the ACA. The D.C. Circuit held that the STLDI exception is "[an] exception *Congress* created" and "Congress expressly elected *not* to set up a Hobson's choice between purchasing ACA-compliant insurance and forgoing coverage altogether. . .it did not foreclose other options."[34] Congress has never once sought to shorten STLDI plan durations. It has never expressed any dissatisfaction with the 12-month initial contract terms that have prevailed for all but two years of the STLDI exemption's 27-year history. It has never demonstrated any desire to prohibit consumers from renewing STLDI plans. The Departments have no warrant to favor other provisions of federal law over the STLDI exemption, nor to favor other health insurance over STLDI plans, as this proposal would do.

[34] Emphases in original. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, No. 19-5212, 1, 20 (D.C. Circ. 2020).

The Departments' proposal conflicts with Congress' regulatory scheme by taking the opposite of the consistent approach to health insurance coverage that Congress has. Decades of legislation clearly show that Congress' goal in this area of health reform has been to reduce gaps in health insurance; to reduce the number of uninsured; and to reduce discrimination against the sick, in particular by shielding the sick from medical underwriting. Canceling STLDI plans after four months and prohibiting renewals would increase gaps in health insurance, increase the number of uninsured by 500,000 individuals according to the CBO, and increase discrimination against the sick, including by exposing patients with preexisting conditions to medical underwriting.[35] The NPRM would mandate the very practice of stripping coverage from the sick that the Departments said the ACA would end.

Finally, the Departments' proposal conflicts with Congress' regulatory scheme by employing a tactic that Congress disfavors. The Departments propose to encourage consumers to enroll in ACA plans by exposing them to greater financial and health risks if they enroll in the "wrong" health plans (and then requiring issuers of those health plans to advertise those penalties). Since 2010, Congress has moved away from negative incentives (i.e., penalties) to induce consumers to enroll in ACA plans in favor of positive incentives (subsidies). In 2017, Congress eliminated the financial penalties it had previously imposed on taxpayers who fail to enroll in "minimum essential coverage." In 2021 and 2022, Congress opted for subsidies rather than penalties to induce consumers to enroll in ACA plans.

Even if Congress still favored penalizing consumers who do not enroll in ACA plans, the Departments have identified no statutory authority or support for their proposal to impose these burdens on STLDI enrollees. Nowhere does Congress grant the Departments such warrant. The Departments' depiction of Congress' intent leans heavily into the passive voice: STLDI "is primarily designed," "was not intended," "was initially intended," etc..[36] Yet the Departments supply no evidence of these designs or intentions. Just as the passive voice presents a verb without an actor, the Departments present a claim about congressional intent without any support.

Conclusion

This proposal is not an attempt to protect consumers. Quite the contrary: it would expose consumers to greater risk by reducing the consumer protections available in the STLDI market. It would increase the number of uninsured by 500,000 and expose sick patients to canceled coverage, uninsurance, and avoidable financial and health risks.

The problem that the Departments seek to redress is not that STLDI plans offer inadequate coverage but that they offer many consumers a perfectly reasonable alternative to ACA plans,

[35] Congressional Budget Office, *H.R. 1010, To Provide That the Rule Entitled "Short-Term, Limited Duration Insurance" Shall Have No Force or Effect.* (Washington: Congressional Budget Office, April 25, 2019).

[36] Internal Revenue Service, Employee Benefits Security Administration, and Department of Health and Human Services, "Short-Term, Limited Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance;"and Federal Register 88, no. 132 (July 12, 2023): 44598, 44610–44611.

and consumers are choosing the alternative that is better for them. For better or worse, Congress leaves STLDI plans free to compete with ACA plans. The Departments should respect Congress' handiwork.

I respectfully request that the Departments adhere to Congress' goals, set aside this NPRM, reaffirm the current rules regarding STLDI plans, and affirm that the PHSA grants the Departments no authority to regulate standalone renewal guarantees.

Thank you for your time and attention.

Cordially,

Michael F. Cannon
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