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Centers for Medicare & Medicaid Services
Department of Health and Human Services

Preston Rutledge
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor

Kirsten B. Wielobob
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
Department of Treasury

Re: Comments on Short-Term, Limited Duration Insurance - CMS-9924-P

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

Thank you for the opportunity to comment on the proposed rule, "Short-Term, Limited Duration Insurance."

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On October 12, 2017, President Donald J. Trump signed Executive Order 13813, directing the Departments to reduce regulations and expand consumer choice in health insurance. Specifically, the president urged: "To the extent permitted by law and supported by sound policy, the Secretaries should consider allowing [short-term limited duration] insurance to cover longer periods and be renewed by the consumer."[1] On March 8, 2018, Secretary of Health and Human

[1] Exec. Order No. 13,813, 82 FED. REG. 48385 (Oct. 12, 2017), https://www.federalregister.gov/documents/2017/10/17/2017-22677/promoting-healthcare-choice-and-competition-across-the-united-states.

Services Alex Azar publicly lent his support to allowing short-term plans to offer renewal guarantees: "We'd like to see the ability to give people the option of renewability in whatever form we can have it."[2]

On February 21, 2018, the Departments issued the proposed rule, "Short-Term, Limited-Duration Insurance," which proposes two principal changes to federal regulation of these products: increasing the maximum contract term for short-term limited duration insurance plans to 12 months (from the 3-month limit imposed by regulation in 2016); and allowing short-term plans to offer "renewal guarantees" that allow enrollees who develop expensive medical conditions to continue paying the same premiums as healthy enrollees.[3]

These changes are necessary to protect consumers and consistent with federal law. In brief, these comments make the following points.

- Consumers need relief from the Patient Protection and Affordable Care Act (ACA), which is not working as Congress intended. Allowing short-term plans to offer 12-month contract terms and renewal guarantees would provide protection and relief to millions of consumers struggling with the cost of coverage under the ACA.

- Guaranteed-renewable individual-market plans provide coverage for patients with high-cost medical conditions that is equally or more secure than employer-sponsored coverage.[4]

- Allowing short-term plans to offer 12-month contract terms and renewal guarantees is a reasonable interpretation of the Public Health Service Act (PHSA). Congress and administrations of both political parties accepted 12-month contract terms as a reasonable interpretation for more than 20 years. It is likewise a reasonable interpretation that the PHSA allows short-term plans to offer renewal guarantees, which are a distinct type of insurance that lie outside the definition of "health insurance coverage" the statute authorizes the Departments to regulate.

- Allowing these consumer protections in short-term plans is consistent with the purposes of the PHSA and the ACA, both of which seek to protect consumers from medical underwriting. It would not conflict with or prevent the operation of the ACA or any other federal law. Every provision in the ACA and the PHSA would continue to apply to the plans they regulate.

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[2] Ariel Cohen, *Tweet*, TWITTER (March 8, 2017, 12:21 PM), https://twitter.com/ArielCohen37/status/971843452861321217 (".@SecAzar answers my ? about short-term plan renewability being decided in HHS vs on the hill: 'we'd like to see the ability to give people the option of renewability in whatever form we can have it...'").

[3] Short-Term, Limited-Duration Insurance, 83 FED. REG. 7437 (proposed Feb. 21, 2018), https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-03208.pdf.

[4] Mark V. Pauly and Robert D. Lieberthal, *How Risky Is Individual Health Insurance?* 27 HEALTH AFF. 3, May-June 2008, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.27.3.w242.

- The 2016 final rule that blocks these consumer protections exceeds the Departments' authority.

- It is an economic fallacy to claim that allowing these consumer protections in short-term plans would increase the cost of ACA plans. On the contrary, it would reduce the problem of preexisting conditions and lessen the burden the ACA imposes on taxpayers.

I urge you to allow short-term plans to offer longer contract terms and renewal guarantees that protect enrollees from re-underwriting. Swift action enabling these consumer protections could allow short-term plans to provide a more affordable, a more viable health-insurance option to millions of Americans before the end of this year. The remainder of this comment expands upon the above points.

The Affordable Care Act: Consumers Need Relief

Congress' primary goal when enacting the ACA was to create "Affordable Choices of Health Benefit Plans"[5] and "Affordable Coverage Choices for All Americans,"[6] with various standards and requirements specifying that "Coverage Must Be Affordable"[7]—and, notably, providing relief for "Individuals Who Cannot Afford Coverage."[8] Additional goals included ensuring "Consumer Choices and Insurance Competition Through Health Benefit Exchanges"[9] and ensuring "Quality Health Insurance Coverage for All Americans"[10] by "Rewarding Quality through Market-Based Incentives."[11]

The ACA is not working as Congress intended, and consumers need relief. Rather than deliver an array of quality health-insurance products at reasonable premiums, the ACA is delivering skyrocketing premiums, restricting insurance choices, and eroding the quality of coverage for the sick. Shrinking enrollment in the law's health-insurance Exchanges are further evidence of the law's failure to deliver on its promise, and of the need for relief.

Skyrocketing Premiums

In Executive Order 13813, President Donald J. Trump found the ACA is neither expanding choices nor making coverage more affordable:

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[5] 42 USCS § 18031, Patient Protection and Affordable Care Act § 1311 (2010).

[6] 42 USCS § 18071-18084, Patient Protection and Affordable Care Act (I)(E) (2010).

[7] IRC § 36B(c)(2)(C)(i) (2010), https://www.gpo.gov/fdsys/pkg/USCODE-2010-title26/pdf/USCODE-2010-title26-subtitleA-chap1-subchapA-partIV-subpartC-sec36B.pdf.

[8] IRC § 5000A(e)(1) (2010), https://www.gpo.gov/fdsys/pkg/USCODE-2010-title26/pdf/USCODE-2010-title26-subtitleD-chap48-sec5000A.pdf.

[9] 42 USCS § 18031-18033, Patient Protection and Affordable Care Act, (I)(D)(II) (2010).

[10] 42 USCS § 18001-18122, Patient Protection and Affordable Care Act, (I)(C) (2010).

[11] 42 USCS § 18031(g), Patient Protection and Affordable Care Act § 1311(g) (2010), https://www.law.cornell.edu/uscode/text/42/18031.

> The Patient Protection and Affordable Care Act (ACA), however, has severely limited the choice of healthcare options available to many Americans and has produced large premium increases in many State individual markets for health insurance. The average exchange premium in the 39 States that are using www.healthcare.gov in 2017 is more than double [105 percent] the average overall individual market premium recorded in 2013. The ACA has also largely failed to provide meaningful choice or competition between insurers, resulting in one-third of America's counties having only one insurer offering coverage on their applicable government-run exchange in 2017.[12]

The Department of Health and Human Services (HHS) reports premiums for benchmark plans increased an additional 37 percent in 2018.[13] California's health-insurance Exchange estimates "the statewide average premium increases in 2019 could range from 12 to 32 percent — with some carriers in certain states having even higher rate increases, depending on state factors."[14]

A report prepared for HHS found the ACA's preexisting-conditions provisions are the driving force behind these premium increases.[15] While those provisions were supposed to protect women from discrimination in health insurance, research indicates they increased premiums for older women more than anyone else:

> Total expected premiums and out of pocket expenses rose by 50 percent for women age 55 to 64 — a much larger increase than for any other group — for policies on the federal exchanges relative to prices that individuals who bought individual insurance before health care reform went into effect…
>
> Premiums for the second-lowest silver policy are 67 percent higher for a 55 to 64-year-old woman than they were pre-ACA.[16]

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[12] Exec. Order No. 13,813, 82 FED. REG., at 48385.

[13] ASPE OFF. OF HEALTH POL'Y, U.S. DEP'T OF HEALTH & HUMAN SERVS., Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange, (2017), https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf.

[14] COVERED CAL., *Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With Wide Variation Among States*, (2018). http://hbex.coveredca.com/data-research/library/CoveredCA_High_Premium_Increases_3-8-18.pdf.

[15] Letter from Ron Johnson, Senator, WI, and Mike Lee, Senator, UT, (July 19, 2017) (on file with Ron Johnson's Senate Office); MCKINSEY & CO., Premium Reconciliation and Pre-ACA Deep Dive, U.S. DEP'T OF HEALTH & HUMAN SERVS. (2017); ASPE, U.S. DEP'T OF HEALTH & HUMAN SERVS., Estimating the Effects of the Consumer Freedom Amendment on the Individual Market, (2017), all available at https://www.ronjohnson.senate.gov/public/_cache/files/2c915f24-f868-4207-85ed-4d0d319c45e8/johnson-and-lee-dear-colleague-july-19a.pdf.

[16] Joann Weiner, *Older Women Bear the Brunt of Higher Insurance Costs under Obamacare*, WASH. POST, June 24, 2014, https://www.washingtonpost.com/blogs/she-the-people/wp/2014/06/24/older-women-bear-the-brunt-of-higher-insurance-costs-under-obamacare/. ("I asked one of the author's [sic] of the study, Mark Pauly, why it seems that older women are bearing the brunt. 'It's likely because they are being averaged in with younger women who have much higher expenses associated with childbearing and with older men who didn't take care of themselves. Community rating redistributes against the relatively healthy,' he explained.").

The fact that most Exchange enrollees receive federal subsidies (nominally, tax credits) toward their premiums merely shifts those rising costs to taxpayers. Those subsidies are also increasing at an accelerating rate. By 2018, the cost to taxpayers of those subsidies increased by 45 percent over 2017, and by 114 percent since 2014.[17]

Increasingly Less Choice

HHS reports the ACA's Exchanges are likewise offering consumers increasingly fewer choices: "Eight states in [2018] will have only one issuer: Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina, and Wyoming…29% of current enrollees will have only one issuer to choose from, up from 20% in [2017]."[18]

This exodus of insurers from the Exchanges is consistent with an adverse selection death spiral. While no Exchange has completely collapsed (yet), there have been periodic and growing fears that in some counties, there will be no Exchange coverage at all.[19]

Eroding Quality

Economic research indicates that in addition to driving up premiums, the ACA's preexisting-conditions provisions penalize high-quality coverage for the sick and have caused Exchange coverage to grow increasingly worse for patients with multiple sclerosis, opioid addiction, and other expensive conditions—a side effect that turns public opinion against those provisions.[20]

Former President Bill Clinton captured the ACA's effects on both premiums and coverage quality when he remarked in 2016: "The people who are out there busting it, sometimes 60 hours a week, wind up with their premiums doubled and their coverage cut in half. It's the craziest thing in the world."[21]

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[17] ASPE OFF. OF HEALTH POL'Y *Supra* note 11.

[18] *Id.*

[19] HENRY J. KAISER FAM. FOUND., *Counties at Risk of Having No Insurers on the Marketplace (Exchange) in 2018*, (Aug. 18, 2017) https://www.kff.org/interactive/counties-at-risk-of-having-no-insurer-on-the-marketplace-exchange-in-2018/.

[20] See Michael F. Cannon, *Is Obamacare Harming Quality? (Part 1)*, HEALTH AFF.: HEALTH AFF. BLOG, January 4, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180103.261091/full/; and Michael F. Cannon, *How to Ensure Quality Health Coverage (Part 2)*, HEALTH AFF.: HEALTH AFF. BLOG, January 5, 2018, https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377/hblog20180103.932096&format=full. See also Michael Geruso, Timothy J Layton, and Daniel Prinz, *Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges*, NBER WORKING PAPER 22832, (2017) http://www.nber.org/papers/w22832.

[21] Fox 10 Phoenix, *FNN: Bill Clinton Campaigns in Flint, Michigan*, YOUTUBE (Oct. 3, 2016), at 25:43 https://www.youtube.com/watch?v=Rva2kLSBAWY.

Falling Enrollment

Skyrocketing premiums and eroding coverage are affecting Exchange enrollment, which has consistently failed to meet expectations, and is now falling. Plan selections fell by 4 percent from 2016 to 2017, and by 3 percent in 2018.[22]

And while plan selections numbered 11.8 million for 2018, actual enrollment—i.e., consumers who both select a plan and pay their premiums—will likely prove substantially less. There were originally 12.2 million plan selections for 2017, but 16 percent of those individuals never made a premium payment, reducing actual enrollment to 10.3 million.[23] If that trend persists, peak Exchange enrollment could fall below 10 million in 2018, a lower number than any year since 2014.[24]

The Benefits and Promise of Short-Term Limited Duration Insurance

In the PHSA, however, Congress explicitly exempts "short-term limited duration insurance" from the costly regulations (including ACA regulations) it imposes on other individual-market coverage.[25] As a result, short-term plans have been providing relief for a growing number of consumers.

Premiums for short-term plans are often 70 percent lower than Exchange premiums,[26] and have not been subject to the same (or any) premium inflation that Exchange coverage has.[27] This is due in part to the fact that federal law allows underwriting in short-term plans, but also to the fact that consumers may select only those benefits they want. If researchers are correct that women

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[22] CTRS. FOR MEDICARE AND MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., *Health Insurance Exchanges 2018 Open Enrollment Period Final Report* (April 3, 2018) https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html.

[23] CTRS. FOR MEDICARE AND MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., *2017 Effectuated Enrollment Snapshot* (June 12, 2017), https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf.

[24] CTRS. FOR MEDICARE AND MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., *Total Effectuated Enrollment and Financial Assistance by State* (Aug. 3, 2017), https://data.cms.gov/Marketplace-Qualified-Health-Plan-QHP-/Total-Effectuated-Enrollment-and-Financial-Assista/v9jz-riug/data.

[25] 42 U.S.C. §300gg–91(b)(5) (2016), https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/html/USCODE-2016-title42-chap6A-subchapXXV-partC-sec300gg-91.htm.

[26] Michelle Andrews, *Sales Of Short-Term Insurance Plans Could Surge If Health Law Is Relaxed*, NPR.ORG: SHOTS, January 31, 2017, https://www.npr.org/sections/health-shots/2017/01/31/512518502/sales-of-short-term-insurance-plans-could-surge-if-health-law-is-relaxed ("In the fourth quarter of 2016, the average monthly premium a shopper would pay for a short-term plan sold through eHealth.com was $124, compared with $393 for someone who bought a regular Obamacare plan and didn't qualify for premium subsidies.").

[27] EHEALTH, *Short-Term Health Insurance: Value, Benefits and Cost*, (Mar. 2018), https://news.ehealthinsurance.com/_ir/68/20182/Short-Term%20Health%20Insurance%20-%20Value%20Benefits%20and%20Cost.pdf ("The average premium for individual short-term coverage in 2017 was unchanged from 2016 ($110 per month) and decreased by 3 percent for families during the same period (from $276 to $267 per month), a stark contrast to the premium inflation seen among major medical plans.").

age 55-64 have seen the largest premium increases under the ACA,[28] short-term plans would offer the greatest premium savings to women in this age group. Unlike Exchange coverage, consumers can enroll in short-term plans at any time of year—an option that a majority of voters support.[29] Access to providers is often broader than in Exchange plans.[30] Due to these factors, consumers have sought relief from the ACA in short-term plans, demand for which has been growing.[31]

Relief for Victims of the ACA

With longer contract terms and renewal guarantees, short-term plans could provide relief to potentially millions more consumers and reduce the burden the ACA imposes on taxpayers. The National Association of Insurance Commissioners (NAIC) explains the current 3-month maximum contract term exposes consumers to "the risk of losing their coverage after three months if they become sick."[32] By contrast, a 12-month contract term would give short-term plan enrollees the additional peace of mind that comes from knowing their current plan will cover them, and protect them from medical underwriting, for an entire year.

Renewal Guarantees Can Increase Health Security, Reduce the Burden of the ACA

Renewal guarantees, as offered in the individual market prior to the ACA (and under existing "grandmothered" plans[33]) offer even greater protection. They guarantee both that enrollees may renew their coverage at the end of the contract term (i.e., when they form a new contract with the issuer) *and* that the issuer will not subject the enrollee to re-underwriting at renewal. A renewal guarantee thus guarantees that if a consumer develops an expensive medical condition, she will continue to pay the same premium as healthy enrollees. Research indicates renewal guarantees

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[28] Weiner, *supra* note 16.

[29] Foundation for Government Accountability, *34-State Poll Confirms Voters Don't Want State-Run Obamacare Exchanges* (March 26, 2015), https://thefga.org/news/for-immediate-release-34-state-poll-confirms-voters-dont-want-state-run-obamacare-exchanges/ ("77 percent of voters want to buy health insurance coverage at any time during the year, not just during 3-month windows of open enrollment").

[30] Anna Wilde Mathews, *Sales of Short-Term Health Policies Surge*, WALL ST. J., April 10, 2016, https://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539 ("A recent promotional email to insurance brokers from UnitedHealth Group Inc. touted its short-term policies' broad access to doctors, compared with limits found in 'most major medical plans.'").

[31] EHealth, *supra* note 27.

[32] Letter from John M. Huff, President, National Association of Insurance Commisioners, et al., to the Internal Revenue Service (Aug. 9, 2016) (on file with the National Association of Insurance Commissioners), http://www.naic.org/documents/government_relations_160809_hhs_reg_short_term_dur_plans.pdf [hereinafter Letter from NAIC] (comments on the proposed rule Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 FED. REG. 38019, (June 10, 2016) https://www.federalregister.gov/documents/2016/06/10/2016-13583/expatriate-health-plans-expatriate-health-plan-issuers-and-qualified-expatriates-excepted-benefits).

[33] Michael Cohen et al., *Effects of Short-term Limited Duration Plans on the ACA-Compliant Individual Market* WAKELY CONSULTING GRP., (2018), http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf.

create sustainable, incentive-compatible insurance pools that offer more secure coverage to patients with high-cost conditions than even employer-sponsored plans.[34]

Allowing short-term plans to offer renewal guarantees could reduce the problem of preexisting conditions, and thus reduce the burden the ACA places on taxpayers, by providing greater protection to both the uninsured and individuals with employer-sponsored insurance.

Here's how. While renewal guarantees are insurance, they are distinct from health insurance and insure against a distinct risk. Health insurance—i.e., insurance that pays one's medical bills—insures against the risk that one will need expensive medical services during the contract term. Renewal guarantees insure consumers against the risk that *developing an expensive medical condition* during the contract term will increase their premiums.[35] Since renewal guarantees insure against a distinct risk, insurers can sell them as a separate product that protects consumers against the risk that developing an expensive medical condition will leave them with an uninsurable preexisting condition.

Indeed, one insurer has sold renewal guarantees as a separate product. In 2009, UnitedHealth Group received regulatory approval from 25 states to offer renewal guarantees as a standalone product.[36] Consumers could purchase the guarantees for an annual premium equal to 20 percent of the cost of a guaranteed-renewable health insurance policy. Purchasing the standalone renewal guarantee—what we might call "preexisting-conditions insurance"—gave consumers the right to enrolling in a health insurance policy, at a healthy-person premium, no matter how sick they became in the meantime. UnitedHealth had planned to offer this product, which reduced the cost of insurance protection by *80 percent*, in an additional 15 states. Yet the ACA made the products economically unviable everywhere but the short-term market.

Allowing short-term plans to offer renewal guarantees would allow insurers to offer them once again as standalone products to both the uninsured and individuals with employer-sponsored insurance. This approach would make coverage more secure for workers by building on an approach that is already proven to make coverage equally or more secure for patients with high-cost conditions than employer-sponsored insurance does.[37]

It would also reduce the burden the ACA imposes on taxpayers by enabling individuals with expensive medical conditions, even if they lose employer-sponsored coverage, to obtain secure coverage that does not depend on taxpayer subsidies. By contrast, prohibiting short-term plans from offering renewal guarantees effectively forces short-term plan enrollees who fall ill, the

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[34] See Bradley Herring & Mark V. Pauly, *Incentive-Compatible Guaranteed Renewable Health Insurance Premiums*, 25 J. OF HEALTH ECON. 3, May 2006, at 395-417, http://www.nber.org/papers/w9888.pdf; and Mark V. Pauly & Robert D. Lieberthal, *How Risky Is Individual Health Insurance?*, 27 HEALTH AFF. 3, May-June 2008, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.27.3.w242.

[35] See generally John H. Cochrane, *Health-Status Insurance: How Markets Can Provide Real Health Security*, CATO INST. POL'Y ANALYSIS no. 633, February 18, 2009, https://object.cato.org/sites/cato.org/files/pubs/pdf/pa-633.pdf.

[36] Reed Abelson, *UnitedHealth to Insure the Right to Insurance*, NEW YORK TIMES, Dec. 2, 2008, https://www.nytimes.com/2008/12/03/business/03insure.html.

[37] Pauly & Lieberthal, *supra* note 4

uninsured who fall ill, and workers who fall ill and lose their employer-sponsored coverage, to enroll in Exchange plans where they become a burden on taxpayers.

Unfortunately, ill-conceived federal rules are blocking these consumer protections.

The 2016 Rule Blocks Consumer Protections

Though health-insurance regulation has traditionally been the responsibility of states, in 1996 Congress imposed a set of federal regulations on the individual market. At the same time, it exempted "short-term limited duration insurance" from those regulations. The rules governing short-term plans were settled for two decades before the Departments issued an ill-advised rule that misread federal law and congressional intent, and arbitrarily blocked important consumer protections in that market.

From 1996 to 2016, interim and final rules defined "short-term limited duration insurance" as:

> health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract.[38]

In 2010, the ACA imposed significant new regulations on health insurance markets, but did not alter the exemption for short-term plans or the Departments' rules interpreting that exemption.

The 2016 Rule

In 2016, however, the Departments finalized a rule that imposed arbitrary limits on short-term plans.[39] In relevant part, the 2016 rule redefined "short-term limited duration insurance" as (changes in *italics*):

> health insurance coverage provided pursuant to a contract with an issuer that [h]as an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder *with or* without the issuer's consent) that is less than *3 months* after the original effective date of the contract…

The new language shortened the maximum duration of short-term plan contracts from 12 months to 3 months and prohibited short-term plans from offering renewal guarantees. The stated reason

[38] See Health Insurance Portability for Group Health Plans; Interim Rules and Proposed Rule, 62 FED. REG. 16,893-16,975 (Apr. 8, 1997), https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/InterimRulesforHIPAA.pdf; and Final Regulations for Health Coverage Portability; Final Rule Notice of Proposed Rulemaking for Health Coverage Portability and Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I & IV; Proposed Rules, 69 FED. REG. 78,720-78,790 n.250 (Dec. 30, 2004), https://www.gpo.gov/fdsys/pkg/FR-2004-12-30/pdf/04-28112.pdf.

[39] Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 FED. REG. 75316, 75318 (Dec. 30, 2016), https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance#citation-17-p75318.

for the changes was that "the Departments are concerned that these policies may have significant limitations…may not provide meaningful health coverage…[and may] adversely impact[] the risk pool for Affordable Care Act-compliant coverage."[40] The stated purpose of the changes was "to address the Departments' concern that some issuers are taking liberty with the current definition…either by automatically renewing such policies or having a simplified reapplication process with the result being that such coverage…lasts longer than 12 months and serves as an individual's primary health coverage."[41] In reality, the changes were arbitrary, exceeded the Departments' authority, and harmed consumers by stripping important consumer protections from short-term plan enrollees.

Since the PHSA does not define the phrase "short-term limited duration," it falls to the Departments to define that term.[42] That task requires only that the Departments fix a period of time within which a health insurance contract must expire in order to qualify for this exemption. The PHSA grants the Departments no authority to decide that consumers are purchasing short-term plans in the wrong quantities or for the wrong reasons—much less to alter the established maximum contract term to prevent consumers from entering these contracts in quantities and for reasons that Congress never declared to be wrong. If Congress wanted to restrict the availability of short-term plans, it could have done so in the ACA or other bills it passed before or since. It did not, and the Departments lacked the authority to do so.

Just as these changes are unsupported by the statute, they are unsupported by data, and are harming consumers rather than helping them. As the NAIC explained in comments on the proposed 2016 rule:

> 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.[43]

In other words, the 3-month limit reduces consumer protections by exposing enrollees who develop expensive illnesses to medical underwriting and cancelled coverage. The NAIC further

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[40] Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 FED. REG. at 75317-75318.

[41] Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 FED. REG. at 75,318.

[42] The PHSA does define the term "insurance," which undercuts the 2016 rule's prohibition on renewal guarantees (see below).

[43] Letter from NAIC, *supra* note 32.

explained the 3-month limit would not make the ACA's risk pools healthier and could even make them sicker:

> [W]e 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.[44]

The 2016 rule exceeds the Departments' authority because the changes are not supported or required by statute, and indeed run counter to congressional intent. Congress has never enacted or sought any such restrictions on short-term plans. At no time before or after it enacted the ACA in 2010 has Congress given any indication it wished to restrict the ability to purchase short-term plans under the rules that had been in place since 1996. With the ACA, Congress created a regulatory scheme it hoped would "improve health insurance markets, not…destroy them."[45] Yet it left consumers the choice of enrolling in short-term plans under the rules that existed at the time.

As the NAIC's comments highlight, the Departments' rationale for the 2016 rule rests on a perverse and counter-historical interpretation of congressional intent. Congress has never, in any health-insurance market, sought to block renewal guarantees or expose consumers to medical underwriting. On the contrary, at every turn, Congress has sought to expand renewal guarantees—even to the point of mandating them[46]—and to shield consumers from medical underwriting.

The 2016 rule flouts congressional intent by blocking these consumer protections and exposing short-term plan enrollees to medical underwriting—even after they fall ill. Just as a 12-month maximum contract term gives enrollees the additional peace of mind that comes from knowing their current plan will cover them, and protect them from medical underwriting, for an entire year, renewal guarantees further protect enrollees who develop an expensive medical condition by guaranteeing their premiums will not spike when they enroll in a new plan. The 2016 rule, and those who wish to preserve it,[47] are literally blocking valuable consumer protections.

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[44] *Id.*

[45] King v. Burwell, 135 S. Ct. 2480, 2496 (2015), https://advance.lexis.com/api/document/collection/cases/id/5G97-H4P1-F04K-F071-00000-00?cite=135%20S.%20Ct.%202480&context=1000516.

[46] Since 1996, Congress has mandated that all issuers of health insurance in the individual or group market "must renew or continue in force such coverage at the option of the plan sponsor or the individual." Many issuers in the individual market offered stronger consumer protections than the law required, including renewal guarantees that protected enrollees from underwriting after initial enrollment. 42 U.S.C. §300gg–2 (2014), https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/html/USCODE-2016-title42-chap6A-subchapXXV-partA-subpartI-sec300gg-2.htm.

[47] See Letter from Frank Pallone, Jr., Ranking Member, House Committee on Energy and Commerce, et al., to Steven Mnuchin, Secretary, U.S. Department of the Treasury, et al., (Apr. 12, 2018) (on file with the House Committee on Energy and Commerce Democrats), https://democrats-

Recent congressional action provides further evidence that the 2016 rule's interpretation of federal law and congressional intent is flawed. The 2016 rule inadvertently contradicts itself when it complains "individuals are purchasing this coverage as their primary form of health coverage" even as it explains the ACA's "individual shared responsibility provision…provides sufficient incentive to discourage consumers from purchasing multiple successive short-term, limited-duration insurance policies."[48]

Despite the contradiction, the Departments apparently believed that Congress intended the individual mandate to discourage consumers from purchasing multiple successive short-term plans. It is therefore significant that earlier this year, Congress eliminated that disincentive by eliminating the penalty for failing to purchase minimum essential coverage beginning in 2019.[49] The fact that Congress enacted legislation facilitating consumers' ability to use short-term plans in a manner the 2016 rule assumes is counter to congressional intent casts doubt on that rule's claim that it effectuates congressional intent.

Agencies Have Repeatedly Reinterpreted the ACA to Provide Relief to Consumers

Fortunately, there is ample precedent for reversing the 2016 rule. On several occasions, the Departments have altered their interpretation of the PHSA and the ACA to provide relief to victims of the latter. Relief efforts have included delaying provisions limiting out-of-pocket exposure in health plans; multiple delays in implementing the employer mandate; and allowing consumers to remain in non-ACA-compliant "grandmothered" health plans for four years (and counting[50]) after the ACA prohibited them.[51]

Since 2013, HHS has allowed hundreds of thousands of consumers to remain in so-called "grandmothered" plans that neither comply with, nor qualify for exemptions from, the ACA's health-insurance regulations.[52] As one ACA supporter describes the policy, HHS "prospectively

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energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/HHS.2018.4.11.%20Short%20Term%20Plans%20proposed%20rule%20comment.%20HE.pdf.

[48] Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 FED. REG., at 75316, 75318.

[49] 115 P.L. 97, 131 Stat. 2054, 2017 Enacted H.R. 1, 115 Enacted H.R. 1 (2017), https://www.congress.gov/115/bills/hr1/BILLS-115hr1enr.pdf.

[50] Timothy Jost, *Administration Allows States To Extend Transitional Policies Again*, HEALTH AFF.: HEALTH AFF. BLOG (Feb. 23, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170223.058912/full/; Louise Norris, *Should I Keep My Grandmothered Health Plan?*, HEALTHINSURANCE.ORG (Dec. 19, 2017), https://www.healthinsurance.org/obamacare-enrollment-guide/should-i-keep-my-grandmothered-health-plan/.

[51] Nicholas Bagley, *Legal Limits and the Implementation of the Affordable Care Act*, 164 U. PA. L. REV. 1715, 1723 (2016), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=9550&context=penn_law_review.

[52] Timothy Jost, *Administration Allows States To Extend Transitional Policies Again*, HEALTH AFF.: HEALTH AFF. BLOG (Feb. 23, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170223.058912/full/; Louise Norris, *Should I Keep My Grandmothered Health Plan?*, HEALTHINSURANCE.ORG (Dec. 19, 2017), https://www.healthinsurance.org/obamacare-enrollment-guide/should-i-keep-my-grandmothered-health-plan/. On the legality of "grandmothered" plans, see Nicholas Bagley, *The Legality of Delaying Key Elements of the ACA*, 370;21 NEW ENG. J. MED. 1965, 1967-1969 (2014), http://www.nejm.org/doi/full/10.1056/NEJMp1402641.

licens[ed] large groups of people to violate a congressional statute."[53] Under this policy, HHS has allowed these non-compliant plans to continue offering renewal guarantees that protect enrollees from re-underwriting at renewal.[54] If HHS can allow renewal guarantees in health insurance plans federal law clearly forbids, it can certainly allow renewal guarantees where federal law does not forbid them.

Most analogous to the current situation is HHS's decision to reinterpret the ACA to exempt U.S. territories from the law's core regulations. From 2010 through 2013, HHS maintained "that the insurance market reforms in title XXVIII of the Public Health Service Act (PHS Act), as amended by title I of the Affordable Care Act, apply to health insurance issuers in the territories because the definition of 'State' in the PHS Act includes territories."[55] In 2013, the NAIC described the likely impact of that interpretation and those regulations on U.S. territories:

> Without some action to prevent a cycle of adverse selection in the territories, implementation of the ACA's market reforms is likely to lead to a result that is the opposite of what the ACA intended—higher premiums, less competition, and more Americans without health insurance coverage.[56]

After being confronted with the consequences of its interpretation, HHS reversed its interpretation in 2014:

> We have been informed by representatives of the territories that this interpretation is undermining the stability of the territories' health insurance markets. After a careful review of this situation and the relevant statutory language, HHS has determined that the new provisions of the PHS Act enacted in title I are appropriately governed by the definition of "state" set forth in that title, and therefore that these new provisions do not apply to the territories.[57]

HHS reversed its interpretation of the ACA to provide relief from unintended harms that law caused—i.e., higher premiums, less competition, and a destabilized health-insurance market.

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[53] Nicholas Bagley, *Legal Limits and the Implementation of the Affordable Care Act*, 164 U. PA. L. REV. 1715, 1723 (2016), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=9550&context=penn_law_review.

[54] "[I]ndividuals in transitional plans did not undergo underwriting." Michael Cohen et al., *supra* note 33, at 13.

[55] Letter from Gary Cohen, Director, Center for Consumer Information and Insurance Oversight, to Sixto K. Igisomar, Secretary of Commerce, Commonwealth of the Northern Mariana Islands, (July 12, 2013) (on file with the Department of Labor) https://www.doi.gov/sites/doi.gov/files/migrated/oia/igia/upload/12-3-HHS-CMS-CNMI-Letter-igisomar7-12-13.pdf.

[56] HEALTH INS. AND MANAGED CARE (B) COMM., NAT'L ASS'N OF INS. COMM'R, *Implementation of the Affordable Care Act in the U.S. Territories*, (October 7, 2013) at 9, http://www.naic.org/documents/index_health_reform_comments_140501_naic_letter_us_territories_paper_final.pdf .

[57] Letter from Marilyn Tavenner, Administrator, U.S. Department of Health and Human Services, to Gregory R. Francis, Commissioner, Office of the Lieutenant Governor, (July 16, 2014) https://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Francis.pdf.

On the mainland, consumers are suffering those very harms with no relief in sight. Reversing the Departments' interpretation of federal law with respect to short-term plans can provide relief to millions of those consumers. As explained below, unlike delays in the employer mandate and exemptions for "grandmothered" plans, allowing short-term plans to offer longer contract terms and renewal guarantees is consistent with federal law.

Legal Analysis: A Reasonable Interpretation of the PHSA

Even if one considers the 2016 rule a reasonable interpretation of the PHSA, it is not the only reasonable interpretation. It is clearly reasonable to interpret the PHSA to allow short-term plans to offer contract terms of up to 12 months. That rule was in place for 20 years, accepted by administrations of both political parties, and has never been altered by Congress. It is likewise reasonable to interpret the PHSA as allowing short-term plans to offer renewal guarantees.

The undefined phrase "short-term, limited duration" allows the Secretary to define the length of time within which short-term plan contracts must expire. It creates no authority for the Secretary to limit how many such contracts consumers enter. Nor does it create any authority for the Secretary to regulate renewal guarantees.

On the contrary, renewal guarantees are a form of insurance that lies completely outside those that the PHSA authorizes the Secretary to regulate. The PHSA authorizes the Secretary to regulate "health insurance coverage," including "individual health insurance coverage," but exempts "short-term limited duration insurance" from regulation.

The proposed rule is incorrect when it states, "The PHS Act does not define short-term, limited-duration insurance."[58] The statute does indeed fail to define the phrase *short-term, limited duration*. The task of defining that ambiguous term therefore falls to the Secretary. As noted above, this ambiguity authorizes the Departments to do no more than to fix a period of time within which health insurance contracts must expire to qualify for this exemption.

Yet the PHSA does define *insurance* as used that phrase. The PHSA specifies[59] and the Departments affirm[60] that the word *insurance* in the phrase *short-term, limited duration*

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[58] Short-Term, Limited-Duration Insurance, 83 FED. REG. 7437.

[59] 42 U.S.C. §300gg–91(b)(1) ("The term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.").

[60] See Final Regulations for Health Coverage Portability; Final Rule Notice of Proposed Rulemaking for Health Coverage Portability and Request for Information on Benefit-Specific Waiting Periods Under HIPAA Titles I & IV; Proposed Rules, 69 FED. REG. 78,747 2nd column n.250 (Dec. 30, 2004), https://www.gpo.gov/fdsys/pkg/FR-2004-12-30/pdf/04-28112.pdf ("*Health insurance coverage* means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance. However, benefits described in § 54.9831(c)(2) are not treated as benefits consisting of medical care.").

insurance means "health insurance coverage," which the statute defines as a "policy or certificate [or] contract" that provides "benefits consisting of medical care."[61] To qualify for this exemption, therefore, a policy/certificate/contract must provide benefits consisting of medical care and must expire within the timeframe specified in regulation.

Renewal Guarantees Are Not "Health Insurance Coverage"

Importantly, renewal guarantees are not "health insurance coverage." They provide no benefits consisting of items and services paid for as medical care. They are a form of insurance, but a different one that protects against a different risk (the risk of one's health insurance premiums increasing due to a change in health status) and provide a different benefit (lower premiums). As evidence that renewal guarantees are a separate and distinct product from health insurance coverage, in 2009, 25 states had approved renewal guarantees for sale as a standalone product, separate from health insurance and providing no medical benefits. [62]

When the PHSA creates an exemption from regulation for short-term limited duration *insurance* and specifies that only *insurance* of limited duration qualifies for that exemption, it creates no authority for the Departments to regulate or prohibit something that does not meet the definition of *insurance*. The only authority the PHSA creates for the Secretary to deny the "short-term, limited duration insurance" exemption to health insurance contracts is if those contracts fail to expire within the specified time period. It creates no authority to prohibit short-term plans from offering renewal guarantees that govern the relationships between issuers and consumers when they renew—i.e., form a new short-term health insurance contract. In sum, the Secretary has no authority to interpret "short-term limited duration insurance" in a manner that regulates insurance products whose benefits do not consist of medical care. In this way, renewal guarantees are akin to the "excepted benefits" insurance products the PHSA exempts from many of the same regulations.[63]

Since renewal guarantees are not "health insurance coverage," it is reasonable to interpret the statute as not counting renewal guarantees against the time limit HHS sets for the legally relevant contract for medical benefits. Even if there are other reasonable interpretations of the statute, it is implausible to argue the law precludes HHS from adopting this one. This interpretation is sufficiently reasonable that the 2016 rule could prompt a legal challenge from insurers and/or consumers who would wish to buy and sell short-term plans with renewal guarantees.

Finally, ending the ban would not conflict with or prevent the operation of any federal law. Congress never prohibited renewal guarantees. Every provision in the PHSA and the ACA would continue to apply to the plans they regulate.

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[61] 42 U.S.C. §300gg–91(b)(1) (Emphasis added).

[62] Reed Abelson, *UnitedHealth to Insure the Right to Insurance*, NEW YORK TIMES, Dec. 2, 2008, https://www.nytimes.com/2008/12/03/business/03insure.html.

[63] 42 U.S.C. §300gg–21(b)-(c) (2016), https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/html/USCODE-2016-title42-chap6A-subchapXXV-partA-subpart2-sec300gg-21.htm.

Economic Impacts of Allowing Consumer Protections

The proposed rule and various observers miscategorize the economic impact of these changes. Allowing these consumer protections would not increase the cost of Exchange coverage by one penny. If anything, they would reduce the cost of Exchange coverage. Nor would they transfer resources from the sick to the healthy.

Revealing the Full Cost of the ACA

The proposed rule estimates these consumer protections could induce as many as 200,000 low-risk individuals to leave Exchange plans for short-term plans in 2019, and that their exit could increase nominal Exchange premiums by less than 1 percent, which would cause spending on Exchange subsidies to rise by up to $168 million.[64] Other estimates predict greater impacts. The Urban Institute projects as many as 2.1 million people could leave Exchange plans, which when combined with the effect of eliminating the individual-mandate penalty, could increase nominal ACA premiums by 18 percent.[65]

While the proposed consumer protections would make short-term plans differentially attractive to healthy consumers who would otherwise enroll in Exchange plans, and while this dynamic could cause *nominal* Exchange premiums to rise, it would not cause *actual* Exchange premiums to rise. The full or actual premium for Exchange coverage is equal to the total cost of the coverage the ACA requires participating insurers to provide. When adverse selection causes nominal Exchange premiums to rise, it means those nominal premiums are more closely reflecting the actual cost of the coverage the ACA requires participating insurers to provide. When those higher nominal premiums cause federal spending on Exchange subsidies to rise, it is because the ACA is replacing *hidden* transfers (from low-risk Exchange enrollees in the form of higher premiums) with *explicit, on-budget* transfers (from taxpayers). Making those transfers explicit is desirable because it increases transparency in government and provides voters and policymakers with better information about the cost of the ACA.

Enhancing Short-Term Plans Could Reduce Exchange Spending

Allowing short-term plans to offer longer contract periods and renewal guarantees could reduce the cost of the ACA. As noted above, guaranteed-renewable individual coverage can provide sustainable access to care for people who develop expensive conditions without taxpayer

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[64] Short-Term, Limited-Duration Insurance, 83 FED. REG. 7,437.

[65] Linda Blumberg et al., *The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending*, URBAN INST. (2018), https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf. See also Letter from Ryan Shultz, Oliver Wyman, to Mila Kofman, Executive Director, DC Health Benefit Exchange Authority, (Apr. 11, 2018) (on file with the DC Health Benefit Exchange Authority), https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/OWReview%20of%20Impact%20of%20Short%20Term%20Duration%20Plans%204.11.2018%20%28002%29.pdf; and Michael Cohen et al., *Effects of Short-term Limited Duration Plans on the ACA-Compliant Individual Market* WAKELY CONSULTING GRP., (2018), http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf.

subsidies. It can do so not only for consumers who are currently in (or sitting out) the individual market. It can also do so for workers in employer-sponsored plans through innovations like standalone renewal guarantees (i.e., preexisting-conditions insurance).

Every individual who develops an expensive condition and would have enrolled in Exchange coverage but instead obtains secure coverage through a short-term plan with a renewal guarantee reduces the cost of the ACA both to taxpayers and to other Exchange enrollees. Given the ACA's current struggles, ACA supporters should reconsider their opposition to allowing these consumer protections in short-term plans.

It Is Not a "Transfer" When You Get to Keep Your Own Money

The proposed rule further miscategorizes the economic effects of these consumer protections when it claims they would "transfer [resources] from enrollees in individual market plans who experience increase in premiums to individuals who switch to lower premium short-term, limited-duration insurance."[66]

As noted above, the ACA currently effects hidden transfers from healthy people to sick people by increasing premiums on low-risk Exchange enrollees (a hidden tax) in order to reduce premiums for high-risk enrollees (a hidden subsidy). When healthy Exchange enrollees switch to short-term plans with lower premiums, the money they save is not a *transfer* that they receive from sick consumers. The money they save was theirs in the first place. It is not a transfer when consumers get to keep their own money. Allowing greater consumer protections in short-term plans no more transfers resources from sick to healthy than the ACA itself does when its skyrocketing premiums spur healthy consumers to withdraw from the market.

Concerns with the Rulemaking Process

With the caveat that one ought not to believe everything one reads, in late March the health-policy trade press attributed the following troubling comments to HHS officials:

> The Trump administration told state insurance commissioners and officials that they will not include guaranteed renewability in the final version of short-term plans, according to insurance officials exiting a closed door meeting…
>
> "The response from the 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.

[66] Short-Term, Limited-Duration Insurance, 83 FED. REG. 7,437.

> Three additional meeting attendees confirmed that CCIIO officials declared that short-term plans and guaranteed renewability are incompatible.[67]

Such reports raise concerns about the rulemaking process. First, these remarks are not consistent with a careful understanding of the authority Congress has granted the Departments. Second, they suggest agency officials are not asking the right questions. The question is not, "Do the Departments have the authority to *permit* guaranteed renewability?" It is, "Do the Departments have the authority to *prohibit* guaranteed renewability?" As detailed here, that authority is lacking.

Most troubling, these remarks suggest agency officials have made their decision prior to reviewing public comments. If so, there would be little point to soliciting public comments. I trust instead agency officials will approach public comments with an open mind.

Conclusion

Consumers need immediate relief from the ACA's skyrocketing premiums, dwindling choices, and eroding coverage. Allowing short-term plans to offer 12-month contract terms and renewal guarantees can provide that relief. It is consistent with federal law, and with Congress' manifest support for renewal guarantees and desire to shield patients from medical underwriting. The 2016 rule that bars these consumer protections is a clear example of executive overreach. Commenters who defend the 2016 rule or ask the Departments to "withdraw the proposed rule in its entirety" are quite literally asking the Departments to deny consumer protections to individuals seeking relief from the ACA.[68] If the Departments act swiftly, they can provide that relief before the ACA's next open enrollment season.

I am happy to answer any questions the Departments may have.

Sincerely,

Michael F. Cannon
Director of Health Policy Studies

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[67] Ariel Cohen, *Sources: CMS Will Not Allow Guaranteed Renewability in Short-Term Plans*, INSIDE HEALTH POL'Y, (Mar. 26, 2018), https://insidehealthpolicy.com/daily-news/sources-cms-will-not-allow-guaranteed-renewability-short-term-plans.

[68] See Letter from Frank Pallone, Jr., Ranking Member, House Committee on Energy and Commerce, et al., to Steven Mnuchin, Secretary, U.S. Department of the Treasury, et al., (Apr. 12, 2018) (on file with the House Committee on Energy and Commerce Democrats), https://democrats-energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/HHS.2018.4.11.%20Short%20Term%20Plans%20proposed%20rule%20comment.%20HE.pdf.