CALIFORNIA HOSPITAL ASSOCIATION

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April 23, 2018

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

Subject: Proposed Rule: CMS-9924-P/RIN 0938-AT48: Short-Term, Limited-Duration Insurance; Federal Register (Vol. 83, No. 35, February 21, 2018)

Dear Administrator Verma:

On behalf of our nearly 400 hospital and health system members, the California Hospital Association (CHA) appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) proposed rule that amends the definition of short-term, limited-duration insurance to exclude it from individual health insurance coverage. CMS states this action is being taken to lengthen the maximum period short-term, limited-duration insurance may be used, providing more affordable consumer choices for health coverage. However, CHA is concerned about this proposal's impact on the health insurance marketplace, both in California and nationwide.

Short-Term, Limited-Duration Health Plans

Short-term, limited-duration insurance policies are designed to fill a brief gap when a person is without health insurance. These policies do not comply with Affordable Care Act (ACA) requirements, which reformed the individual health insurance market to improve the availability and quality of coverage issued in that market. Short-term, limited-duration policies can be purchased outside of open and special enrollment periods, are available for fewer than 12 months and are not required to cover essential health benefits.

These policies are not comprehensive coverage, are inexpensive and are, therefore, attractive to relatively young or healthy individuals. CHA is concerned that allowing individuals to purchase policies that do not have many of the ACA's consumer protections may adversely impact the individual's cost-sharing obligations and the individual market single risk pools, subsequently leading to increased individual market premiums. Further, higher cost-sharing often results in the unintended consequence of increasing bad debt borne by hospitals, as patients continue to access care despite being unable to afford their cost-sharing obligations.

Research demonstrates the challenges of these proposed policies:

- The administration's estimate is that in 2019, after the individual shared responsibility payment is eliminated, between 100,000 and 200,000 individuals previously enrolled in exchange coverage would instead purchase short-term, limited-duration insurance policies. This would

cause the average monthly individual market premiums and average monthly premium tax credits to increase, resulting in total annual advance payments of the premium tax credit in the range of $96 million to $168 million.

- A recent issue brief released by the Urban Institute indicates that in 2019, average individual market premiums would increase approximately 18 percent in the states that do not prohibit or limit these plans. This premium increase includes the expansion of short-term, limited-duration plans and the elimination of individual mandate penalties.

- According to a recent Covered California analysis, every state is at risk of significant cumulative premium increases in 2019-21 due to continued federal uncertainty in the individual market. Covered California notes that recent decisions made at the national level — such as the removal of the federal penalty for being uninsured as well as the introduction of association health plans and short-term, limited-duration plans — could promote higher costs and siphon healthy consumers from the risk pool. Covered California's analysis finds that, absent any federal policy action, premium increases for every state could range from 12 to 32 percent in 2019; cumulative increases from 2019-21 could range from 35 to 90 percent. In addition, the report identifies 17 states that — due to their historic risk mix and enrollment — are more likely to have cumulative premium increases of 90 percent or more. Nineteen additional states are at a higher risk of experiencing hikes of 50 percent.

- Under the ACA, California hospitals' bad debt decreased from $1.36 billion in 2013 to $800 million in 2015. According to a recent Kaiser Family Foundation report examining the potential impact of short-term, limited-duration plans, the estimated range of out-of-pocket cost sharing for an individual in Los Angeles who purchases this type of coverage is $2,500-$10,000. Therefore, an individual at 400 percent of the federal poverty level ($48,240) who purchases a plan that costs less than an existing ACA-compliant plan is potentially exposed to out-of-pocket cost-sharing obligations at more than 20 percent of their income. This level of cost sharing is unaffordable to many and would likely lead to increased levels of bad debt for California hospitals.

Impact of Proposed Rule and Other Recent Federal Actions on California

California has made significant strides in decreasing the number of uninsured and keeping health care premiums low. According to a recent survey from the Centers for Disease Control and Prevention, California's uninsurance rate has dropped to 6.8 percent. Prior to the ACA, California's uninsured rate for all ages was higher than the national average — 17 percent compared to 14.4 percent. Since that time, California's uninsured rate has dropped by more than 10 percentage points, while the national average has dropped by 5.4 percentage points.

Since its inception in 2014, Covered California, our state-based exchange, has served more than 3.4 million consumers. A recent report from the California HealthCare Foundation reveals that more than 50 percent of individually purchased insurance in California was purchased through Covered California in 2016.

In addition, a recent analysis of the premium changes for both subsidized and unsubsidized consumers over the past four years reveals that, for the 85 percent of Covered California enrollees who receive subsidies, the cost of coverage dropped 11 percent in 2018, to an average monthly cost of $116. At the same time, the data find that for unsubsidized consumers — buying either through Covered California or directly from the same carriers in the individual market — premiums increased at an average annual rate of 7.2 percent.

Finally, Covered California's risk score dropped from 1.11 in 2016 to 1.09 in 2017, indicating that the current population is healthier, with respect to chronic conditions, than it was a year ago. In addition, new enrollees in 2017 have an approximately 16 percent lower mean risk score than renewing enrollees, an improvement of 4 percent between 2016 and 2017. This suggests that Covered California is successfully attracting healthy enrollees to stabilize the risk pool.

We have made great strides in California and are concerned that our success may be undermined by these new entrants to the market. For the reasons stated above, CHA does not support this proposed rule.

CHA appreciates the opportunity to comment. If you have any questions, please do not hesitate to contact me at akeefe@calhospital.org or (202) 488-4688; or my colleague Amber Kemp, vice president, health care coverage, at akemp@calhospital.org or (916) 552-7543.

Sincerely,

/s/
Alyssa Keefe
Vice President, Federal Regulatory Affairs