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VIA ELECTRONIC TRANSMISSION

September 11, 2023

The Honorable Chiquita Brooks-LaSure
Administrator, Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

RE: RIN 0938–AU67; CMS-9904-P

Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance

Dear Administrator Brooks-LaSure:

The National Women's Law Center appreciates the opportunity to comment on the aforementioned proposed rule.[1] Since 1972, we have striven to protect and advance the progress of women and their families in core aspects of their lives, including health, income security, employment, education, and reproductive rights, with an emphasis on the needs of people experiencing poverty and those who face multiple and intersecting forms of discrimination. To that end, we have long worked to ensure that all people, including women of color, disabled women, low-income women, and LGBTQI+ people, have meaningful access to health care and comprehensive coverage.

Short-term limited-duration insurance (STLDI), fixed indemnity excepted benefits coverage, and other insurance products that do not comply with the Affordable Care Act's protections can open consumers up to substandard coverage and resultant health and financial risks. These harms fall heaviest on those who are more likely to face health disparities and discriminatory practices, including women generally and particularly women of color, LGBTQI+ women, and disabled women. In recent years, the distinction between these insurance products and ACA-compliant plans has become increasingly obscured, especially in the aftermath of the 2018 rule promoting STLDI—exacerbating their risks and leading many consumers to enroll in these products without

[1] 88 Fed. Reg. 44596 (proposed July 12, 2023) (to be codified at 45 C.F.R. pts. 144, 146, and 148).

full knowledge of their exclusions and limitations. Consequently, there is an urgent need for regulation that cabins the harms of these forms of insurance, makes it easier for consumers to differentiate them from ACA-compliant coverage, and restores them to their original limited purposes. We therefore support the proposed rule and offer suggestions to strengthen it.

I. Short-Term Limited-Duration Insurance

Short-term limited-duration insurance (STLDI) was originally intended to fill temporary gaps during a transition from one source of coverage to another, but STLDI plans proliferated far beyond this limited use. Bolstered by the 2018 rule relaxing restrictions on this form of insurance, issuers frequently offer STLDI plans as cheap alternatives to comprehensive coverage, often relying on misleading marketing practices that obscure the nature of these plans. Consumers may seek to enroll in STLDI plans unaware of their risks and harms and without the information they need to assess their value. While exact estimates vary due to lack of consistent data, the number of people enrolled in STLDI plans may reach at least 250,000.[2] The proposed provisions regarding STLDI, including the modified definition of STLDI and the notice language, would help mitigate some of these harms, especially in combination with expanded efforts to regulate aggressive and fraudulent marketing.

(a) STLDI plans expose many consumers to harm.

Unlike comprehensive coverage, STLDI plans do not comply with many of the ACA's critical consumer protections, such as the prohibition on gender rating, protections related to preexisting conditions, and minimum coverage requirements. As a result, STLDI issuers routinely, for example, refuse to enroll some individuals, charge some more than others, and leave those who are able to enroll with inadequate coverage. People who rely on STLDI can find themselves at risk of high uncovered medical bills after a health event, putting their health and economic stability in jeopardy. Some may be forced into medical debt,[3] while others may forgo medically necessary care, leading to poor health outcomes.[4] These harms fall heaviest on women, particularly women of color, LGBTQI+ women, and disabled women, who are more greatly impacted by discriminatory or harmful practices otherwise mitigated by the ACA and have

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[2] *See* National Association of Insurance Commissioners, *2022 Accident and Health Policy Experience Report* 13 (2023), https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf; U.S. House of Representative Committee on Energy and Commerce, *Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk* at 21 (Jun. 2020), https://docs.house.gov/meetings/IF/IF14/20210323/111378/HHRG-117-IF14-20210323-SD023.pdf [hereinafter *Shortchanged*].

[3] Molly Smith, *High-Deductible and Skinny Health Insurance Plans Drive Medical Debt* (Mar. 20, 2023), https://www.aha.org/news/blog/2023-03-20-high-deductible-and-skinny-health-insurance-plans-drive-medical-debt.

[4] *See* Sara R. Collins et al., *U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability* (Aug. 19, 2020), https://www.commonwealthfund.org/publications/issue-briefs/2020/aug/looming-crisis-health-coverage-2020-biennial (finding that underinsured individuals often avoid or delay getting necessary care).

higher rates of preexisting conditions.[5] They also experience higher rates of poverty that make it more difficult for them to absorb high medical costs resulting from limitations in STLDI plans.[6]

Many discriminatory practices described in this subsection of the comment conflict with Section 1557 of the ACA, which bans discrimination based on a range of protected characteristics. We applaud the Department's clarification in its proposed 2022 rule "Nondiscrimination in Health Programs and Activities" that STLDI is subject to Section 1557,[7] and we encourage the Department to incorporate this provision into a final rule with utmost speed. Given the prevalence of these discriminatory practices in STLDI, we recommend that the Department also issue subregulatory guidance outlining the specific practices by STLDI issuers that run afoul of Section 1557's prohibition on discrimination.

(i) Gender rating

Before the passage of the ACA, gender rating was a common practice. According to NWLC's estimates, it once cost women more than $1 billion per year.[8] But STLDI plans do not comply with the ACA's prohibition on gender rating, so they can—and do—charge women more than men for the same health insurance. In July 2023, NWLC compared monthly premiums of short-term insurance plans from three different carriers available in Florida, Georgia, Kentucky, North Carolina, and Texas through an online website.[9] Across all states, all three carriers charged a higher premium for a 30-year-old woman compared to a 30-year-old man, with one plan charging around 25% more for women.[10] All three carriers also charged a higher premium for women compared to men who are 40 years old. Among 20-year-olds, all but one carrier charged women more than men.[11]

Similarly, a 2020 investigation by the U.S. House of Representatives Committee on Energy and Commerce found that gender rating was widespread in STLDI.[12] The Committee found that STLDI issuers charged women up to 1.5 times more for the same coverage. Some charged women between the ages of 30 and 45 up to 30% more than men, with one insurer charging women aged 30–34 up to twice the rate for men.[13]

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[5] *See infra* notes 14–16.
[6] *See, e.g.,* Shengwei Sun, *National Snapshot: Poverty Among Women & Families* (Jan. 2023), https://nwlc.org/wp-content/uploads/2023/02/2023_nwlc_PovertySnapshot-converted-1.pdf; Robin Bleiweis et al., *The Basic Facts About Women in Poverty* (Aug. 3, 2020), https://www.americanprogress.org/article/basic-facts-women-poverty.
[7] Nondiscrimination in Health Programs and Activities, 87 Fed. Reg. 47,824, 47875 (proposed August 4, 2022) (to be codified at 45 C.F.R. pts. 80, 84, 86, 91, 92, 147, 155, and 156).
[8] National Women's Law Center, *Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act* 7 (2012), https://nwlc.org/wp-content/uploads/2022/09/Turning-to-Fairness-Report.pdf.
[9] NWLC calculations are based on short-term health insurance plans found at eHealth, https://www.ehealthinsurance.com/short-term-health-insurance#welcome. Zip codes were chosen based on the most populated cities in each state. The carriers compared were United Healthcare Short Term Medical Value, Companion Life Economy, and Everest Flex. Plans were compared between those with the same demographic information and only difference being sex.
[10] Companion Life Economy charged a 30-year-old woman 24.6% more than a 30-year-old man.
[11] Companion Life Economy and Everest Flex charged a 20-year-old woman more than 20-year-old man.
[12] *Shortchanged*, *supra* note 2 at 74.
[13] *Id*.

(ii) Preexisting conditions

Unlike ACA-compliant plans, STLDI plans frequently discriminate against consumers based on preexisting conditions. For example, they might refuse enrollment to someone with a preexisting condition, charge them higher premiums, deny claims related to conditions that predate the plan, or even rescind coverage. These practices are widespread: A 2020 analysis of STLDI plans with a 12-month duration found that *all* of them denied enrollment in coverage based on health status and excluded preexisting conditions from covered claims.[14]

Discrimination based on preexisting conditions particularly impacts women, who are more likely to have preexisting conditions.[15] Due to persistent health disparities, women of color are especially likely to have preexisting conditions.[16] And since most disabilities are considered to be preexisting conditions under these plans, discrimination based on preexisting conditions has a profound impact on disabled women.[17]

Just as pre-ACA plans once commonly did,[18] STLDI policies frequently classify conditions that disproportionately affect women as preexisting, like having had a Caesarean delivery, a current or prior pregnancy, or breast or cervical cancer.[19] For example, in one investigation of STLDI plans, all issuers required women to disclose whether they were pregnant and denied coverage to those who were.[20] Most also required women to disclose whether they were expectant parents, in the process of adoption, or in the process of undergoing fertility treatment.[21]

Even those who are able to enroll in a plan could have claims denied on the grounds that they are related to preexisting conditions. One woman in Texas, for example, was forced to pay thousands of dollars for endometriosis treatment, even though she disclosed her condition prior to enrollment and was assured over the phone by a salesperson that related treatment would be covered.[22] In the case of pregnancy, some issuers require people who learn of their pregnancy while enrolled to disclose the date of their most recent menstrual cycle to determine whether the pregnancy could have started prior to enrollment.[23] In one instance, a woman who had a regular menstrual cycle two days before enrolling in a plan later learned that she was pregnant. Because her last cycle predated her enrollment, the issuer refused to cover claims related to pregnancy on

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[14] Dania Palanker et al., *Limitations of Short-Term Health Plans Persist Despite Predictions That They'd Evolve* (Jul. 22, 2020), https://www.commonwealthfund.org/blog/2020/limitations-short-term-health-plans-persist-despite-predictions-theyd-evolve.
[15] Michelle Long & Alina Salganicoff, *Pre-Existing Condition Prevalence Among Women Under Age 65* (Nov. 4, 2020), https://www.kff.org/womens-health-policy/issue-brief/pre-existing-condition-prevalence-among-women-under-age-65.
[16] *See* Heidi Williamson, *ACA Repeal Would Have Disproportionately Harmed Women of Color* (Aug. 15, 2017), https://www.americanprogress.org/article/aca-repeal-disproportionately-harmed-women-color.
[17] *See, e.g., Shortchanged*, *supra* note 2 at 51–52.
[18] National Women's Law Center, *Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition* 5 (2009), https://nwlc.org/wp-content/uploads/2015/08/stillnowheretoturn.pdf.
[19] *Shortchanged*, *supra* note 2 at 8.
[20] *Id*. at 73.
[21] *Id*.
[22] Leukemia & Lymphoma Society et al., *Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed* 12 (Mar. 2021), https://www.lls.org/sites/default/files/National/undercovered_report.pdf.
[23] *Shortchanged*, *supra* note 2 at 74.

the grounds that it was a preexisting condition, even though she was unlikely to have been pregnant when she enrolled.[24]

In many cases, plans exclude coverage not only for conditions that were diagnosed prior to the plan date, but even conditions that the consumer was not aware of when enrolled. Issuers may categorize a newly diagnosed or newly developed medical condition as preexisting and refuse to cover care.[25] For example, a woman in Georgia who was diagnosed with breast cancer after she bought a short-term plan was left with $400,000 in medical bills, because the insurer claimed that the disease predated the coverage, even though she was unaware of it.[26] Another issuer denied a claim for endometrial ablation on the grounds that the enrollee had a history of heavy menstrual bleeding, despite the fact that the diagnosis occurred after enrollment.[27]

Consumers who develop a condition while on an STLDI plan and renew or enroll in sequential plans may find that the issuer treats conditions that emerged in the initial plan period as preexisting for the purpose of subsequent claims. For example, one issuer denied a claim for a mammogram screening on the grounds that the screening was related to a preexisting condition: The enrollee previously had a mammogram where a mass was found, while enrolled in a previous STLDI plan under the same issuer.[28]

STLDI plan issuers often go so far as to rescind coverage retroactively after a claim is filed, claiming that an enrollee had a preexisting condition that they did not disclose in their application.[29] One issuer, for example, rescinded a consumer's plan on the grounds that she did not disclose her history of sickle cell anemia, even though the claim she filed was unrelated to that condition.[30] Another issuer rescinded a plan because the consumer previously had breast cancer, despite the fact that the diagnosis predated the policy's five-year lookback period. The issuer claimed that the consumer did not indicate she was still on tamoxifen, a medication that helps prevent breast cancer from developing in the future.[31] Yet another issuer rescinded coverage for a consumer who underwent surgery to have her ovary removed. The issuer claimed that the surgery was due to a preexisting condition on the grounds that the consumer had a history of pelvic pain and ovarian cysts.[32] This practice of cancelling a plan in its entirety—often on tenuous grounds and with no prior warning—can leave individuals with an unexpected and potentially catastrophic financial burden, forcing them to scramble to cover the costs at a time when they may be struggling to deal with a medical event.

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[24] *Id*.
[25] Sarah Lueck, *Key Flaws of Short-Term Health Plans Pose Risks to Consumers* (Sep. 20, 2018), https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers.
[26] *Id.*
[27] *Shortchanged*, *supra* note 2 at 74.
[28] *Id*. at 73.
[29] Dania Palanker & JoAnn Volk, *Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period* 1 (Oct. 2021), https://georgetown.app.box.com/s/mn7kgnhibn4kapb46tqmv6i7putry9gt.
[30] *Shortchanged*, *supra* note 2 at 89.
[31] *Id*. at 91.
[32] *Id.* at 92.

(iii) Inadequate coverage and financial liability

Consumers who are able to enroll in an STLDI plan may find that it fails to cover basic services adequately, if at all, leaving them at significant financial risk if they need access to care.

Plans sold on the ACA individual marketplace are required to cover essential health benefits (EHBs), including maternity and newborn care, preventive and wellness services, mental health services, and prescription drugs. This requirement corrects notable benefit gaps that existed prior to the ACA, where many services that women disproportionately relied on were excluded. For example, NWLC research found that the vast majority of individual market plans excluded maternity care.[33] But STLDI plans are exempt from the ACA's EHB coverage requirement and routinely to fail to cover EHBs. A 2020 analysis in five states found that 100% of plans excluded maternity costs, 73% excluded outpatient prescription drugs, and 64% excluded mental health services,[34] echoing findings from prior studies of STLDI plans.[35] In the same year, a House committee also found that all insurers that were investigated excluded maternity and newborn care.[36] Some also excluded coverage of routine tests or preventive screening procedures like pelvic exams and Pap smears, an exclusion that the committee found especially concerning: It noted that "these services are not even particularly costly, and appear to be driven by risk selection considerations and the desire to avoid enrolling women of childbearing age."[37]

When plans do cover key benefits, they often limit payments to a fraction of the actual costs. For example, one analysis found that the few plans that covered mental health services limited reimbursement to $50 for outpatient services and $100 a day for inpatient services.[38] By contrast, Medicare—where reimbursement rates are significantly lower than ACA-compliant private insurance—reimburses around twice those amounts for outpatient psychotherapy and initial inpatient evaluation, respectively.[39]

STLDI plans leave consumers exposed to high financial liability in a number of other ways. For example, many have high maximum out-of-pocket limits[40] and high deductibles,[41] while capping lifetime and annual dollar value maximums.[42] As a result of such practices, those who are able to enroll in a plan often find that it fails to cover their core needs.

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[33] National Women's Law Center, *supra* note 8 at 11.
[34] Palanker et al., *supra* note 14.
[35] Karen Pollitz, *Understanding Short-Term Limited Duration Health Insurance* (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance; Dania Palanker et al., *Short-Term Health Plan Gaps and Limits Leave People at Risk* (Oct. 30, 2018), https://www.commonwealthfund.org/blog/2018/short-term-health-plan-gaps-and-limits-leave-people-risk.
[36] *Shortchanged*, *supra* note 2 at 8.
[37] *Id*. at 61.
[38] Palanker et al., *supra* note 14.
[39] *Id.*
[40] Dane Hansen & Gabriela Dieguez, *The Impact of Short-Term Limited Duration Policy Expansion on Patients and the ACA Individual Market* 10 (Feb. 2020), https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market.
[41] Palanker et al., *supra* note 14.
[42] Leukemia & Lymphoma Society et al., *supra* note 22 at 5.

(b) Many consumers enroll in STLDI plans with inaccurate and incomplete information about their limitations.

The potential harms of STLDI make it critical that consumers have accurate and complete information about their risks. But consumers are frequently unaware of the limitations of these plans, particularly due to misleading, aggressive, and deceptive marketing practices. Exploiting gaps and disparities in health literacy, issuers often market STLDI as an alternative to long-term, ACA-compliant insurance. Some even claim or imply that their products are ACA-compliant.[43]

In many cases, consumers seeking ACA-compliant insurance are diverted to STLDI. Secret shopper studies have found that consumers searching for health coverage are far more likely to be referred to non-ACA products like STLDI plans, often products that are significantly more expensive despite having less coverage.[44] A 2023 study, for example, found that limited benefit products like STLDI plans dominated online search results, including searches for marketplace plans.[45]

When consumers are directed to these plans, they are often denied basic information. Some marketing brochures or sales representatives fail to disclose major limitations and exclusions, misrepresent coverage, or even falsify information.[46] For example, secret shopper studies have consistently uncovered sales representatives who falsely assure people that they can get coverage for preexisting conditions.[47] Meanwhile, sales representatives frequently misrepresent the availability and cost of ACA marketplace plans. In the 2023 secret shopper study, which focused on the experience of consumers losing Medicaid during the ongoing unwinding, none of the sales representatives informed consumers of their eligibility for $0 premium, $0 deductible marketplace plans. Some sales representatives claimed that the consumer would be ineligible for a marketplace plan until the annual open enrollment period; others suggested that income-based subsidies were unavailable outside of open enrollment or failed to mention those subsidies at all; and several claimed that ACA-compliant plans were much more expensive than the available options actually were.[48]

In many cases, sales representations provide consumers with misleading or false information over the phone and pressure them to buy plans without written information.[49] In one study, most

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[43] Rachel Schwab & JoAnn Volk, *Misleading Marketing of Limited Benefit Products Continues as Millions Losing Medicaid Search for New Coverage* (Aug. 2023), https://georgetown.app.box.com/v/the-perfect-storm-august-2023; Sabrina Corlette et al., *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses* (Jan. 2019), https://www.urban.org/sites/default/files/publication/99708/moni_stldi_final_0.pdf.

[44] Palanker & Volk, *supra* note 29 at 2.

[45] Schwab & Volk, *supra* note 43 at 3.

[46] *Id.* at 4; Palanker & Volk, *supra* note 28 at 1; U.S. Government Accountability Office, *Private Health Coverage: Results of Covert Testing for Selected Offerings* 8–10 (Aug. 24, 2020), https://www.gao.gov/assets/gao-20-634r.pdf; Christen Linke Young & Kathleen Hannick, *Misleading Marketing of Short-Term Health Plans Amid COVID-19* (Mar 24, 2020), https://www.brookings.edu/articles/misleading-marketing-of-short-term-health-plans-amid-covid-19.

[47] *See, e.g.,* Young & Hannick, *supra* note 46.

[48] Schwab & Volk, *supra* note 43 at 4.

[49] Palanker & Volk, *supra* note 29 at 2.

sales representatives refused to provide plan documents when asked.[50] Many urged consumers to commit to plans on the spot and discouraged them from taking time to gather more information, claiming that plans would reach capacity or prices would increase if the consumer would delay.[51]

Brokers who sell STLDI plans may be incentivized to engage in aggressive marketing tactics because they receive far higher compensation for selling these plans—up to ten times the compensation rate that they would earn for ACA-compliant plans.[52] These marketing practices mean that consumers are exposed to risks that they are unable to fully assess prior to purchasing these plans.

These marketing practices have gone relatively unchecked in part due to under-regulation of STLDI plans. State insurance departments often struggle to limit misleading and fraudulent marketing tactics, often because they lack the authority or staff capacity to conduct preemptive oversight to prevent issuers from engaging in these practices.[53] Meanwhile, resolving a complaint after the fact is often challenging because the consumer may have already sustained irreparable harms, as well as because material aspects of the transaction and marketing often occur over the phone rather than in writing.[54] Some states also have limited ability to regulate STLDI when it is offered through out-of-state associations, a rapidly growing practice.[55] Consequently, there is an urgent need for stronger federal regulation to fill in this gap in oversight.

(c) The 2018 rule exacerbated the harms of STLDI plans.

The current regulation, promulgated in 2018, exposed more consumers to the harms of STLDI. It upended prior restrictions on STLDI plans that kept them temporary in nature and that helped consumers distinguish between them and comprehensive coverage. In particular, the 2018 rule allowed these plans to last 12 months, with renewals or extensions up to 36 months. This has made them seem more comparable to comprehensive insurance and has led more consumers to rely on them for long-term needs. Indeed, the promulgation of the rule was followed by an increase in STLDI being marketed to consumers as comprehensive insurance.[56] An investigation of large issuers found that enrollment in their STLDI plans rose approximately 27% in 2019 compared to 2018.[57]

The likely harms of this rule may have been amplified in recent months, when many individuals lost coverage due to a chaotic Medicaid unwinding process.[58] The repercussions of this mass loss

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[50] Schwab & Volk, *supra* note 43 at 5.
[51] *Id*.
[52] *Shortchanged*, *supra* note 2 at 43.
[53] Corlette et al., *supra* note 43 at 2.
[54] *Id*.
[55] *Shortchanged*, *supra* note 2 at 25–26.
[56] Leukemia & Lymphoma Society et al., *supra* note 22 at 8. *See also* Zeke Faux et al., *Health Insurance that Doesn't Cover the Bills Has Flooded the Market Under Trump*, BLOOMBERG (Sep. 17, 2019), https://www.bloomberg.com/news/features/2019-09-17/under-trump-health-insurance-with-less-coverage-floods-market.
[57] *Shortchanged*, *supra* note 2 at 20.
[58] *See* Schwab & Volk, *supra* note 43.

of coverage, which may persist for years, makes it all the more urgent that the current rule be replaced—both to protect consumers navigating the insurance market in the aftermath of the current unwinding period and to ensure that if a similar loss of coverage occurs in the future, those affected will be better protected against the risks of STLDI plans.

(d) The proposed rule would help mitigate many of the harms of STLDI, but it can be strengthened.

We generally support the Department's efforts to limit STLDI plans. The new definition of STLDI and the revised notice language will help mitigate potential harms and make it easier for consumers to distinguish them from comprehensive coverage. We offer recommendations to improve these provisions.

(i) Definition of STLDI

We support modifying the definition of STLDI. Specifically, we support limiting the length of the initial contract period to no more than three months, with a maximum duration of 4 months if renewed or extended. This can help ensure that STLDI plans are truly temporary in nature, making it less likely that people will rely on them for long-term needs and be exposed to their risks over time. It also will allow consumers to more easily distinguish these plans from ACA-compliant coverage.

We also support the clarification that a company may not issue multiple STLDI policies to the same policyholder within a 12-month period. Closing this "stacking" loophole is necessary to ensure that issuers do not evade duration limits.

(ii) Notice language

Clear notice language helps consumers understand the limitations of an STLDI product, the available alternatives, and opportunities to redress harms. We therefore support revising the notice language to make it more consumer-friendly. We recommend adopting the alternative language presented in the preamble rather than the language in the proposed rule, because it is more accessible and easier to follow.

We support having this notice displayed prominently in 14-point font on the first page of marketing, enrollment, reenrollment, and application materials. We recommend that the Department require that the presentation of the notice be made accessible to people with a range of disabilities. We also recommend that the notice be available in the most commonly spoken languages in each state in order to ensure that people with limited English proficiency can benefit from it.

We recommend requiring the notice to be tailored to each state. This should include specifying the phone number and website link for state exchanges in states that do not use HealthCare.gov. It should also include providing the name and phone number for state departments of insurance. We do not recommend adding the language about the notice being required by federal law, since this language adds length and is not critical for consumers' understanding of their rights.

(iii) Marketing tactics

In partnership with the Federal Trade Commission, the Department should adopt additional strategies to address misleading, aggressive, and fraudulent marketing practices. Among other measures, it should prohibit the sale of STLDI over the phone. This measure is warranted given the prevalence of salespeople making oral misrepresentations and pressuring consumers to purchase plans without written documentation, as well as the challenges in resolving complaints for transactions that occurred primarily over the phone. Further, the Department should also prohibit the sale of STLDI over the internet. As noted above, STLDI plans dominate internet searches for affordable health insurance, leading many consumers seeking comprehensive insurance to be misdirected to these plans, and the information issuers provide over the internet is frequently misleading or false. Limiting online sales of STLDI is an effective way to address these tactics.

Additionally, the Department should prohibit the sale of STLDI during the open enrollment period. STLDI plans are aggressively marketed during open enrollment, when companies can more easily divert consumers seeking ACA-compliant plans. One investigation found a significant uptick in STLDI enrollment by brokers during the 2018–2019 open enrollment period: Compared to November 2018, there was a 60% increase in STLDI enrollment in December 2018 and a 120% increase in January 2019.[59]

Finally, the Department should require issuers and brokers to report STLDI enrollment and plan data, including the number of enrollees, their medical loss ratio, broker commissions, and details related to covered services, exclusions, and limitations. Incomplete data on STLDI has frustrated oversight,[60] and more robust information is needed to document and address the harms of these products.

(iv) Effective date

The Department proposes to allow consumers to renew existing coverage for the full duration permitted under current rules. We recommend that while it should allow consumers to keep existing coverage (lasting up to 12 months), it should not allow further renewals of coverage (which may extend up to 36 months). This would strike a better balance between avoiding disruptions of current plans and prolonging the harms of the current rule.

II. Fixed Indemnity Excepted Benefits Coverage

(a) Fixed indemnity policies can expose consumers to harms, particularly when offered as an alternative to comprehensive insurance.

Fixed indemnity plans were originally intended as a form of income replacement, rather than a source of medical coverage. Issuers, however, are increasingly marketing these policies as

[59] *Shortchanged*, *supra* note 2 at 22.
[60] U.S. Government Accountability Office, *Limited Data Hinders Understanding of Short-Term Plans' Role and Value During the COVID-19 Pandemic* (May 2022), https://www.gao.gov/assets/730/720774.pdf.

alternatives to comprehensive insurance. When consumers use fixed indemnity policies in this manner, they are subject to risks similar to those posed by STLDI plans. Fixed indemnity policies typically offer coverage that falls far short of the actual cost of medical care. And as excepted benefits, fixed indemnity policies are typically not subject to ACA consumer protections. For example, they may deny enrollment based on health status or refuse to cover services that they deem to be associated with a preexisting condition, and they can impose annual or lifetime benefit maximums.[61]

Increasingly, issuers offering fixed indemnity policies are mimicking the characteristics of comprehensive coverage, creating confusion about the purpose and function of these policies.[62] For example, instead of paying a fixed amount per day or period of illness or hospitalization—as fixed indemnity policies traditionally have done—many fixed indemnity plans pay on a per service basis, though generally with payments far below actual costs.[63] Some maintain a more complex benefit design modeled after traditional insurance, like by requiring that enrollees meet a deductible before payout begins or making payments directly to providers, sometimes with a network of providers given discounted rates.[64]

Misleading marketing practices may further obscure the differences between fixed indemnity policies and health insurance, with some brokers leading consumers to believe that the product is ACA-compliant or a form of comprehensive coverage.[65] In a 2023 secret shopper study, model consumers seeking ACA marketplace plans were often pressured into purchasing fixed indemnity products, sometimes tacked onto other forms of coverage.[66] Sales representatives selling these products concealed their coverage restrictions, and some made misleading or deceptive statements about their features. One representative, for example, claimed that the fixed indemnity plan would have no copayments, even though copayments are not applicable to such a plan; another claimed that the fixed indemnity plan would pay the consumer more than the cost of care and leave her with a surplus, despite the fact that fixed indemnity plans typically offer payments that fall far below actual costs of health services.[67] Representatives also suggested that fixed indemnity plans have the same attributes as marketplace plans or offer similar levels of protections.[68] When asked for written plan documents, most sales representatives refused to provide them, with one saying that complete details about the plan would be unavailable until the consumer enrolled.[69]

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[61] Leukemia & Lymphoma Society et al., *supra* note 22 at 5.
[62] Christen Linke Young & Kathleen Hannick, *Fixed Indemnity Health Coverage Is a Problematic Form of "Junk Insurance"* (Aug. 4, 2020), https://www.brookings.edu/articles/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance.
[63] *Id*.
[64] *Id*.
[65] *Id*.
[66] Schwab & Volk, *supra* note 43 at 4.
[67] *Id.* at 4–5
[68] *Id*.
[69] *Id*. at 5.

(b) The proposed rule can help mitigate some of the harms of fixed indemnity policies as commonly designed.

We support the provisions of the proposed rule related to fixed indemnity excepted benefits coverage, which can help limit the potential harms of these policies as they are commonly designed, particularly when marketed or used as an alternative to comprehensive coverage.

(i) Conditions for excepted benefits

We support modifying the conditions for fixed indemnity coverage to be considered an excepted benefit. Specifically, we support prohibiting fixed indemnity excepted benefits coverage from paying on a per-service basis in individual markets. This would limit the practice of designing fee-for-service plans that mimic comprehensive insurance, as well as realigning the individual market with the group market. We also support the clarification that these policies must pay benefits without regard to factors like the services or items received, the expenses incurred, or the severity of the illness or injury. Such a policy would help prevent fixed indemnity plans from designing complex reimbursement structures that are only nominally fixed benefits. Finally, we support the assessment that policies that make payment directly to providers generally do not meet the conditions for excepted benefits.

(ii) Independent, non-coordinated coverage

We support the clarification regarding the requirement that these policies be offered as independent, non-coordinated coverage. Employers are increasingly offering fixed indemnity excepted benefits coverage to employees in combination with a bare-bones or "minimum essential coverage" plan, as an alternative to more robust comprehensive employer-provided health coverage.[70] Some have interpreted the non-coordination requirement to allow this combination as long as there is no formal coordination-of-benefits arrangement, even when the fixed indemnity policy reduces its payments based on the benefits covered by the health plan.

The Department proposes to clarify through an added illustrative example that fixed indemnity excepted benefits must be paid "without regard" to whether benefits are provided for the medical event under the group plan maintained by the same sponsor. When fixed indemnity insurance is coordinated with an exclusion of benefits under a group health plan maintained by the same plan sponsor, that arrangement fails to satisfy the non-coordination requirement. We agree with this clarification.

(iii) Notice language

We appreciate the new notice language, and we recommend adopting the alternative version for greater accessibility. We support the requirement that the notice be prominently displayed in 14-point font on the first page of marketing, application, or enrollment materials. Like with the notice for STLDI plans, we recommend that the Department require the formatting to be

[70] Dania Palanker & Kevin Lucia, *Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk* (Sep. 10, 2021), https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk.

accessible to people with a range of disabilities and that it be made available in the most commonly spoken languages in each state. Additionally, we recommend that the notice be tailored to the state by including state-specific details.

III. Level-Funded Plan Arrangements

Level-funded plans combine self-insured employer-sponsored coverage with a stop-loss insurance policy purchased from an insurance provider. They are regulated as self-funded plans, exempted from health status rating prohibitions and minimum essential health benefit coverage requirements under the ACA, as well as from most state insurance laws.[71] Additionally, stop-loss insurance is not required to be ACA-compliant, meaning that employers who maintain low attachment points can offer many or most of the health benefits in a manner that does not comport with the ACA's requirements, such as the prohibition on discrimination based on preexisting conditions.[72]

Because insurers can use medical underwriting when issuing stop-loss insurance, we are concerned that an increased prevalence of level-funded plans may disadvantage women, particularly women of color and disabled women. A 2021 study of the impact of level-funded plans on Pennsylvania's Small Group ACA market demonstrated that aggressive underwriting of level-funded plans shrinks the fully insured market, leading to market instability and increased premiums due to the greater likelihood of adverse selection.[73] As women, women of color, and disabled women tend to have higher rates of preexisting conditions, employers that hire more people from these groups may not pass a stop-loss issuer's underwriting. These employers and employees would therefore be subject to higher premiums and other indirect costs of remaining in the fully insured group market.

We recommend that the Department investigate concerns and study the key features and characteristics of level-funded plan arrangements. Specifically, we recommend that the Department consider the effect of increased proliferation of level-funded plans on ACA market participant demographics, enrollment, and premium levels.

IV. Conclusion

We appreciate the opportunity to comment on this proposed rule. We request that the supporting documentation we have made available through direct links in our citations be considered part of the formal administrative record for purposes of the Administrative Procedure Act. For further

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[71] Georgetown University McCourt School of Public Policy Center on Health Insurance Reforms, *Proposed Expansion of Self-Funding for Small Employers Would Roll Back Affordable Care Act Protections, Pre-empt State Insurance Oversight* (Jun. 9, 2023), https://ccf.georgetown.edu/2023/06/09/proposed-expansion-of-self-funding-for-small-employers-would-roll-back-affordable-care-act-protections-pre-empt-state-insurance-oversight.

[72] *Id.*

[73] Ryan Schultz et al., *Study of the Impact of Level Funded Plans on Pennsylvania's Small Group ACA Market* (Jun. 17, 2021), https://www.insurance.pa.gov/Coverage/Documents/Health/PAImpactLevelFundedPlansonSmallGroupACAmarket.pdf.

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