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**Hearing on “Strengthening Our Health Care System: Legislation to Reverse ACA Sabotage and Ensure  
Pre-Existing Conditions Protections”**

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**Committee on Energy & Commerce Subcommittee on Health**  
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Good morning, Chairwoman Eshoo, Ranking Member Burgess, and members of the committee, and thank you for the opportunity to testify today. I am Katie Keith, an Associate Research Professor and Adjunct Professor of Law at Georgetown University, where I study and teach courses on private health insurance and the Affordable Care Act (ACA). I am also the author of the “Following the ACA” blog series for *Health Affairs*, the leading journal of health policy thought and research, where I am responsible for tracking and chronicling ongoing implementation of the ACA at the federal and state levels.

Thank you again for inviting me to testify about three recent actions taken by the Trump administration and their impact on people with pre-existing conditions and state health insurance markets. The views I express today are my own and do not reflect those of Georgetown University or *Health Affairs*.

**Threats to Progress Under the Affordable Care Act**

The ACA has resulted in historic coverage gains: more than 20 million people have gained coverage since the law was enacted in 2010 and the uninsured rate has reached a record low of 8.8%.<sup>1</sup> Millions more Americans—especially those with pre-existing medical conditions—have benefited from ACA protections such as guaranteed availability of coverage, the coverage of preventive services without cost-sharing, the ability of a young adult to remain on their parent’s plan, and the ban on lifetime and annual dollar caps on care.

These historic gains and protections are, however, increasingly at risk due to efforts to undermine the ACA’s protections—in Congress, in court, and by the Trump administration. Even though enrollment through the ACA marketplaces has remained relatively stable over the past two years, recent studies show that progress in insuring more Americans has stalled, if not reversed, since 2016.<sup>2</sup>

The Trump administration has made many policy decisions that threaten the long-term stability of the ACA. This testimony will focus on three of those recent actions to 1) expand access to short-term, limited duration insurance, 2) allow states to potentially skirt ACA requirements, and 3) cut funding for ACA outreach and marketing. Each of these changes has or could leave consumers who become sick without access to the care they need and increase premiums for people with pre-existing conditions, especially middle-income Americans

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<sup>1</sup> Robin A. Cohen et al., [Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-March 2018](#), National Center for Health Statistics (Aug. 2018).

<sup>2</sup> See Katie Keith, [“New Survey Shows Highest Uninsured Rate Since 2014,”](#) *Health Affairs Blog* (Jan. 24, 2019).

with health needs who do not qualify for premium tax credits. Higher ACA premiums also result in higher federal outlays to cover the cost of higher premium tax credits for those who qualify for subsidies.

### **Promoting Expanded Access to Short-Term, Limited Duration Insurance**

Short-term, limited duration insurance (STLDI) is a type of limited insurance product marketed to individuals that was historically used to fill a temporary gap in coverage. Although these policies are meant to be temporary, some insurers offered STLDI that lasted 364 days, just shy of one year. In 2016, the Obama administration reduced the maximum duration of STLDI to no more than three months, citing concerns that these policies were being sold as primary coverage and adversely impacting the ACA risk pool.<sup>3</sup> In August 2018, the Trump administration reversed—and further expanded—the sale of STLDI by allowing these policies to be sold for up to 12 months and renewed or extended for up to 36 months.<sup>4</sup>

Individuals who enroll in STLDI may face significant benefit gaps and high out-of-pocket costs if they become sick. This is because STLDI does not have to comply with the ACA's market reforms. As a result, STLDI insurers in most states can:

- Refuse to offer a policy to an individual with a pre-existing condition;
- Exclude coverage for pre-existing conditions;
- Charge higher monthly premiums based on health status and other factors such as age or gender;
- Impose annual or lifetime dollar limits on care;
- Opt not to cover entire categories of benefits (such as mental health services, prescription drugs, or maternity care);
- Retroactively cancel coverage once care is needed; and/or
- Impose much higher out-of-pocket costs than under the ACA.

These limitations mean, first, that STLDI is typically not an option for people with pre-existing conditions and, second, that even healthy people who develop a medical issue while enrolled in STLDI may see their claims denied or their policy cancelled. Such practices have resulted in lawsuits against STLDI insurers and multi-state enforcement actions by state regulators.<sup>5</sup> STLDI is also not subject to the ACA's single risk pool requirement or medical loss ratio standards.

A recent Kaiser Family Foundation analysis of STLDI sold in 2018 shows that 43% did not cover mental health services, 62% did not cover services for substance abuse treatment, and 71% did not cover outpatient

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<sup>3</sup> Departments of the Treasury, Labor, and Health and Human Services, [Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited Duration Insurance](#), 81 Fed. Reg. 75316 (Oct. 31, 2016).

<sup>4</sup> Departments of the Treasury, Labor, and Health and Human Services, [Short-Term, Limited Duration Insurance](#), 83 Fed. Reg. 38212 (Aug. 3, 2018).

<sup>5</sup> See, e.g., California Department of Insurance, ["Investigation into Sale of Short-Term Health Policies Leads to \\$5 Million Settlement with HCC Life Insurance Company."](#) Press Release (Apr. 10, 2018); Declan Harty, ["Tokio Marine HCC, Health Insurance Innovations Facing Class-Action Fraud Lawsuit,"](#) *S&P Global Market Intelligence* (Jan. 3, 2018).

prescription drugs.<sup>6</sup> No plans covered maternity care, and, in seven states, STLDI covered none of these four benefit categories. These policies had out-of-pocket maximums as high as \$30,000 and lifetime limits on care ranging from \$250,000 to \$2 million. A separate study from colleagues at Georgetown University found that the best-selling STLDI policies in five states had out-of-pocket maximums from \$7,000 to \$20,000 for only three months (compared to the maximum of \$7,150 for 12 months for an ACA-compliant plan that year).<sup>7</sup>

Given limitations such as these—and the fact that the policies are medically underwritten—STLDI can be offered at far lower premiums than ACA-compliant coverage. One analysis shows that STLDI policies could have premiums up to 54% lower than ACA-compliant plans due largely to STLDI insurers' ability to exclude people with pre-existing conditions.<sup>8</sup> With lower premiums and far less generous benefits, enrollment in STLDI skews younger and healthier.

Even with lower premiums, STLDI policies are highly profitable. Data from the National Association of Insurance Commissioners (NAIC) shows that STLDI insurers had an average loss ratio of 64.6% in 2017 (compared to 80% for ACA-compliant individual market policies).<sup>9</sup> The three largest insurers offering STLDI had even lower loss ratios of 43.7%, 34.0%, and 52.1%. In other words, the majority of STLDI premium revenue for those insurers went to profit, marketing, and other expenses unrelated to medical care.

***New Rule Expands Access to STLDI and Undermines the ACA's Single Risk Pool.*** The STLDI rule was issued in response to an Executive Order from President Trump that directed the agencies to expand the availability of STLDI as “an appealing and affordable alternative to government-run exchanges.”<sup>10</sup> Consistent with the Executive Order, the rule established a parallel STLDI market that competes with the traditional ACA market and allows STLDI insurers to segment younger, healthier consumers into a risk pool separate from older, less healthy consumers who remain in the ACA risk pool.

Stakeholders such as the American Academy of Actuaries, America's Health Insurance Plans, and the Blue Cross Blue Shield Association raised concerns about this parallel market and the risk of adverse selection. In fact, the vast majority of health care stakeholders who commented—more than 95%—criticized or opposed the STLDI rule.<sup>11</sup> The legality of the rule has also been challenged in court by a coalition of consumer advocates and a safety net health plan association. These organizations argue that the Trump administration has converted a narrow federal exemption for STLDI into a much larger loophole to allow a parallel market of non-ACA-compliant

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<sup>6</sup> Karen Pollitz et al., [Understanding Short-Term Limited Duration Health Insurance](#), Kaiser Family Foundation (Apr. 2018). Even when these benefits are covered by STLDI, they are subject to a number of limitations and exclusions, such as dollar limits on care.

<sup>7</sup> Dania Palanker et al., [New Executive Order: Expanding Access to Short-Term Health Plans is Bad for Consumers and the Individual Market](#), The Commonwealth Fund (Oct. 2017).

<sup>8</sup> Larry Levitt et al., [Why Do Short-Term Health Insurance Plans Have Lower Premiums than Plans that Comply with the ACA?](#) Kaiser Family Foundation (Oct. 2018).

<sup>9</sup> National Association of Insurance Commissioners, [2017 Accident and Health Policy Experience Report](#), at 83 (2018).

<sup>10</sup> President Donald J. Trump, [Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States](#) (Oct. 12, 2017). The same Executive Order directed federal agencies to expand the availability of non-ACA-compliant association health plans and the use of health reimbursement arrangements.

<sup>11</sup> Noam N. Levey, [“Trump's New Insurance Rules are Panned by Nearly Every Healthcare Group that Submitted Formal Comments,”](#) *Los Angeles Times* (May 30, 2018).

plans. This will result in higher premiums and out-of-pocket costs that harm those the plaintiffs represent such as individuals with mental health issues, individuals living with HIV, women, and families with children who have complex medical needs and disabilities.

The Trump administration acknowledged that the new rule would raise premiums for ACA-compliant plans and could result in adverse selection against the individual market risk pool.<sup>12</sup> Separately, the independent chief actuary of the Centers for Medicare and Medicaid Services (CMS) estimated that average marketplace premiums would be 3% higher (about \$17 higher per month) in 2019 and 6% higher beginning in 2022 due to the rule.<sup>13</sup> In a separate analysis, the Kaiser Family Foundation estimates that 2019 premiums are an average of 6% higher because of the combined impact of zeroing out of the individual mandate penalty and expansion of STLDI and non-ACA-compliant association health plans.<sup>14</sup>

***Increased STLDI Enrollment in 2019.*** Early data suggest that the rule is achieving its goal of higher enrollment in STLDI, which will likely impact how insurers set their rates for 2020. A November 2018 report from eHealth, a prominent web broker, disclosed that 70% of its customers that do not qualify for marketplace subsidies enrolled in STLDI.<sup>15</sup> This was an increase from 56% of consumers during the same period in 2017.

Increased enrollment in STLDI can also be attributed to the zeroing out of the individual mandate penalty. Prior to 2019, consumers who enrolled only in STLDI may have had to pay the individual mandate penalty because STLDI does not qualify as minimum essential coverage. The possibility of paying the penalty may have discouraged some consumers who would have otherwise enrolled in STLDI from doing so. Now that the penalty has been zeroed out and the new rule offers expanded access to STLDI, more consumers are expected to purchase STLDI over ACA-compliant policies, potentially exposing them to high out-of-pocket costs and resulting in higher premiums in the ACA risk pool.

***Aggressive Marketing of STLDI and Consumer Confusion.*** A recent study further suggests that brokers use aggressive sales tactics for STLDI and that consumers may not be getting information about ACA-compliant coverage.<sup>16</sup> Aggressive marketing is a particular concern because STLDI has been a source of confusion for consumers. Because these policies can mimic (or are deceptively marketed as) major medical coverage, consumers may be unaware that they are enrolling in a policy that will not cover certain medical needs until

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<sup>12</sup> 83 Fed. Reg. at 38234. In the preamble to the rule, the agencies noted that those who purchase STLDI were “likely to be relatively young or relatively healthy” and that the rule “may weaken states’ individual market single risk pools.” The preamble went on to state that individual market insurers “could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market,” and that this rule “may further reduce choices for individuals remaining in those individual market single risk pools.” Although the agencies estimated that the rule would increase premiums by 1% in 2019 and by 5% by 2028, other independent analyses suggest that the agencies underestimated the impact of the rule on ACA premiums.

<sup>13</sup> Chief Actuary Paul Spitalnic, [Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule](#), Office of the Actuary (Apr. 6, 2018). Higher premiums would result in higher premium tax credits and thus higher federal outlays, with federal spending expected to increase by about \$1.2 billion in 2019 and about \$38.7 billion over the next 10 years.

<sup>14</sup> Rabah Kamal et al., [How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums](#), Kaiser Family Foundation (Oct. 2018).

<sup>15</sup> eHealth, [Half-Time Report – The ACA Open Enrollment Period for 2019 Coverage](#) (Nov. 2018).

<sup>16</sup> Sabrina Corlette et al., [The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses](#) (Jan. 2019).

after they are sick. This confusion led a number of state insurance departments to issue alerts or warnings to inform consumers about the limitations of short-term policies and deceptive marketing practices.<sup>17</sup>

**State Regulation of STLDI.** States have the authority to regulate STLDI, but fewer than half have adopted stricter limits than the federal government.<sup>18</sup> Some states and the NAIC had asked for a delay in the effective date of the new rule to 2020 to provide states with time to review their rules and seek changes to protect consumers and state markets. The Trump administration ignored this request, and the new rule went into effect on October 2, 2018 (less than one month before the 2019 open enrollment period began). This prevented many states from being able to consider new regulation of STLDI before the 2019 open enrollment period. Further, many state insurance departments lack the authority or capacity to prevent deceptive STLDI marketing before it occurs.<sup>19</sup> State regulators may be further limited in their ability to regulate STLDI because many of these products are being marketed through out-of-state associations that are exempt from state regulation.<sup>20</sup>

### **New Guidance on Section 1332 Waivers**

The Trump administration did not stop at the STLDI rule. In new guidance issued in October 2018, the Departments of Health and Human Services and Treasury signaled a willingness to allow states to potentially subsidize the purchase of STLDI, and other non-ACA-compliant plans, using federal funds under a Section 1332 waiver.<sup>21</sup> The new guidance also outlined the Departments' interpretation of Section 1332's "guardrails."

Section 1332 of the ACA allows states, with approval from the federal government, to waive certain provisions of the ACA in the interest of pursuing alternative coverage approaches that are consistent with the goals of the ACA.<sup>22</sup> To help fund these efforts, the federal government can "pass through" to a state the funds that it would have otherwise spent on premium tax credits, cost-sharing reductions, and small employer tax credits for residents.

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<sup>17</sup> See Rachel Schwab & Maanasa Kona, [State Insurance Department Consumer Alerts on Short-Term Plans Come Up Short](#), CHIR Blog (Dec. 17, 2018).

<sup>18</sup> Justin Giovannelli et al., [What is Your State Doing to Affect Access to Adequate Health Insurance?](#), The Commonwealth Fund (Feb. 2019).

<sup>19</sup> Corlette et al., *supra* note 17.

<sup>20</sup> Emily Curran et al., [Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections](#), The Commonwealth Fund (Jan. 2019).

<sup>21</sup> Departments of the Treasury and Health and Human Services, [State Relief and Empowerment Waivers](#), 83 Fed. Reg. 53575 (Oct. 24, 2018). Federal officials also hinted at this possibility in the final rule on STLDI. See 83 Fed. Reg. at 38218.

<sup>22</sup> Section 1332 does not allow states to waive all or any provisions of the ACA. States are limited to waiving provisions in Parts I and II of subtitle D of Title I of the ACA (the rules regarding the regulation of qualified health plans); Section 1402 of the ACA (cost-sharing reductions); and Sections 36B, 4980H, and 5000A of the Internal Revenue Code (premium tax credits and the individual and employer mandates). Section 1332 does not allow a state to waive key market-wide provisions, such as the ACA's ban on preexisting condition exclusions or underwriting based on health status.

Even where ACA provisions can be waived, a state must meet certain procedural and substantive “guardrails” to be granted a waiver.<sup>23</sup> Federal officials can approve a Section 1332 waiver only if a state’s waiver proposal will:

1. Provide coverage that is at least as comprehensive as the coverage offered through the marketplaces;
2. Provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the ACA would provide;
3. Provide coverage to at least a comparable number of its residents as the ACA would provide; and
4. Not increase the federal deficit.

In the 2018 guidance, the Departments shifted away from the Obama-era approach in which the guardrails were considered collectively in assessing a waiver proposal (i.e., coverage under a state waiver must meet all four guardrails: comprehensiveness, affordability, number of people covered, *and* deficit neutrality). Instead, the Departments will essentially consider the guardrails separately. This means the Departments may approve waivers even if only *some* coverage under the waiver is as comprehensive, as affordable, and as available as coverage provided under the ACA. In a further shift, waivers will be evaluated based on whether residents have *access to* comprehensive and affordable coverage (even if they do not enroll in this coverage), and the Departments will assess a waiver’s aggregate effects instead of the effect on vulnerable individuals (such as those who are elderly, low-income, or with serious health issues).<sup>24</sup>

The new guidance encourages states to consider waivers for less comprehensive coverage that likely would not meet the needs of those with pre-existing conditions.<sup>25</sup> In particular, the 2018 guidance encourages states to propose waivers that could:

- Define “coverage” to include plans that do not comply with the ACA, including STLDI and association health plans, that exclude coverage for pre-existing conditions and other key benefits;
- Increase the number of people with less comprehensive coverage relative to the ACA;
- Increase the number of consumers exposed to higher out-of-pocket costs relative to the ACA; or
- Impose coverage losses or higher out-of-pocket costs on vulnerable populations, such as older adults or low-income people.

It will be challenging to reconcile approval of these types of waivers with the text of Section 1332 or the ACA as a whole, and approval of a waiver that fails to meet the statutory guardrails is likely to face a legal challenge.<sup>26</sup>

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<sup>23</sup> Section 1332 requires states to have a law in place to authorize a waiver application and outlines certain procedural requirements that must be followed, such as opportunities for public comment. The 2018 guidance would no longer require states to adopt new legislation to authorize a Section 1332 waiver application. Instead, states may be able to rely on existing legislative and executive authority to authorize a waiver application. This may make it easier for at least some states to pursue Section 1332 waivers.

<sup>24</sup> States must still explain how their waiver will impact those with low incomes and high health care costs but these populations are no longer a focal point of the waiver approval analysis.

<sup>25</sup> See Jennifer Tolbert & Karen Pollitz, [New Rules for Section 1332 Waivers: Changes and Implications](#), Kaiser Family Foundation (Dec. 2018).

<sup>26</sup> See Joel McElvain, [“The Administration’s Recent Guidance on State Innovation Waivers under the Affordable Care Act Likely Violates the Act’s Statutory Guardrails,”](#) Take Care Blog (Dec. 7, 2018); Christen Linke Young, [“The Trump Administration Side-Stepped Rulemaking Processes on the ACA’s State Innovation Waivers—and It Could Make Their New Section 1332 Guidance Invalid,”](#) Brookings (Nov. 28, 2018); Katie Keith, [“Feds Dramatically Relax Section 1332 Waiver Guardrails,”](#) *Health Affairs Blog* (Oct. 23, 2018).

This is in part because the new guidance sets up the potential for an end-run around Section 1332 itself. Section 1332 cannot be used to waive every ACA provision. Yet, the new guidance opens up the possibility for states to waive non-waivable provisions by allowing (and potentially directing federal pass-through funding for) coverage options that do not cover pre-existing conditions and allow health status underwriting and gender rating.

The 2018 guidance went into effect immediately, meaning these criteria will be used by federal officials from now on in analyzing future waiver applications from states. Since then, the Trump administration has continued to encourage the use of Section 1332 waivers by releasing four new “waiver concepts” for states to consider.<sup>27</sup> These waiver concepts include components of bills to repeal the ACA that were considered in Congress in 2017, such as flat tax credits that would result in higher premiums for older and lower-income Americans. To my knowledge, no state has yet submitted a new waiver application under the 2018 guidance.

### **Cuts to ACA Marketing and Outreach**

Beyond expanding access to STLDI and other non-ACA-compliant plans, the Trump administration has made dramatic cuts to funding for ACA marketing and outreach since 2017. Almost immediately, the Trump administration moved to cut outreach and advertising funding for the final week of the 2017 open enrollment period; this contributed to an estimated 500,000 fewer enrollees that week.<sup>28</sup>

In August 2017, CMS reduced its ACA advertising budget by 90% from \$100 million for 2017 to about \$10 million for 2018.<sup>29</sup> This cut in advertising coincided with a reduction in the length of the 2018 open enrollment period, which was cut from 90 days to 45 days. CMS invested a similar \$10 million in advertising for the 2019 open enrollment period and has reduced funding for the navigator program—which provides unbiased, in-person outreach and enrollment assistance to consumers—by 84% since January 2017.<sup>30</sup>

In justifying these cuts, the Trump administration asserted that the Obama administration spent too much on advertising and that robust outreach efforts are less needed because the public is more aware of options for private coverage. While this may be true relative to the initial open enrollment period that began in 2013, awareness of the timing of open enrollment itself remains low, particularly among the uninsured.

In October 2017, about 81% of uninsured adults were unaware of the deadline to enroll.<sup>31</sup> A separate survey found that 40% of uninsured adults were still unaware of the marketplaces in 2017.<sup>32</sup> A November 2018

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<sup>27</sup> See Chris Fleming & Katie Keith, “[CMS Releases New 1332 Waiver Concepts: A Summary](#),” *Health Affairs Blog* (Nov. 29, 2018); Katie Keith & Chris Fleming, “[CMS Releases New 1332 Waiver Concepts: Implications](#),” *Health Affairs Blog* (Nov. 29, 2018). These waiver concepts are account-based subsidies, state-specific premium assistance, adjusted plan options, and risk stabilization strategies.

<sup>28</sup> Joshua Peck, “[Trump Blocked Nearly 500,000 People from Getting Coverage](#),” *Medium* (Feb. 2, 2017).

<sup>29</sup> Timothy Jost, “[CMS Cuts ACA Advertising by 90% Amid Other Cuts to Enrollment Outreach](#),” *Health Affairs Blog* (Aug. 31, 2017).

<sup>30</sup> Karen Pollitz et al., [Data Note: Further Reductions in Navigator Funding for Federal Marketplace States](#), Kaiser Family Foundation (Sep. 2018).

<sup>31</sup> Ashley Kirzinger et al., [Kaiser Health Tracking Poll—October 2017: Experiences of the Non-Group Marketplace Enrollees](#), Kaiser Family Foundation (Oct. 18, 2017).

poll further confirmed that 61% of adults who are uninsured or purchase their own coverage were unaware of the December 15 enrollment deadline; another 8% offered the wrong date.<sup>33</sup> Only about 31% reported hearing or seeing information or ads about how to enroll in health insurance under the ACA.

Marketing and outreach is critical to helping ensure a balanced ACA risk pool and keeping premiums stable. While enrollment in the 39 states that use HealthCare.gov is down slightly, enrollment of new consumers is down by about 50% since 2016.<sup>34</sup> This is a troubling trend because new enrollees tend to be younger and healthier. Younger and healthier consumers are also more likely to benefit from marketing and outreach with reminders of the deadline and the availability of subsidies. In recent testimony before the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies, the former chief marketing officer for HealthCare.gov estimated that there have been at least 2.3 million fewer new enrollments due solely to cuts to outreach and advertising.

### Conclusion

In conclusion, the ACA's historic coverage gains and protections, especially for those with pre-existing medical conditions, are increasingly at risk. The Trump administration's new rule to expand access to STLDI poses a significant risk to the individuals who enroll but are left without coverage for services they need when they become sick. The rule also undermines the ACA's single risk pool requirement and has had the demonstrated effect of increasing premiums for ACA plans that millions of people with pre-existing conditions rely on. In new guidance on Section 1332, the Trump administration has encouraged states to consider waivers for less comprehensive coverage that will not meet the needs of those with pre-existing conditions. And cuts to outreach and marketing are leaving consumers, especially younger and healthier consumers, behind when it comes to enrolling in ACA coverage.

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<sup>32</sup> Sara R. Collins et al., [Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?](#) The Commonwealth Fund (Sep. 2017).

<sup>33</sup> Ashley Kirzinger et al., [KFF Health Tracking Poll—November 2018: Priorities for New Congress and the Future of the ACA and Medicaid Expansion](#), Kaiser Family Foundation (Nov. 28, 2018).

<sup>34</sup> Joshua Peck, "[Week 7: Demand for Quality, Comprehensive Health Coverage Once Again Overcomes Trump Administration](#)," *Medium* (Dec. 19, 2018).