



April 23, 2018

The Honorable Alex Azar
 Secretary
 Department of Health and Human Services
 200 Independence Avenue, SW
 Washington, DC 20201

Mr. David Kautter
 Acting Commissioner, Internal Revenue Service
 Department of the Treasury
 1111 Constitution Avenue, NW
 Washington, DC 20224

Ms. Seema Verma
 Administrator, Centers for Medicare &
 Medicaid Services
 Department of Health and Human Services
 P.O. Box 8010
 Baltimore, MD 21244-8010

Mr. Preston Rutledge
 Assistant Secretary, Employee Benefits Security
 Administration
 Department of Labor
 200 Constitution Avenue, NW
 Washington, DC 20210

Re: Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P)

Dear Secretary Azar, Administrator Verma, Acting Commissioner Kautter, and Assistant Secretary Rutledge:

Thank you for the opportunity to submit comments on your Departments' proposed rule on Short-Term Limited-Duration (STLD or short-term) insurance. The 21 undersigned organizations urge the

Departments to withdraw this proposed rule unless it is heavily revised to meet our standards of accessibility, affordability, and adequacy that appropriately protects patients and consumers.

Our organizations represent millions of patients and consumers across the country facing serious, acute, and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, manage health, and cure illness. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the aforementioned Departments to make the best use of the collective insight and experience that we, and the individuals we represent, offer in response to this proposed rule.

In March 2017, our organizations agreed upon three overarching principles we would use to guide and measure any work to reform and improve the nation’s healthcare system.¹ These principles state that: (1) healthcare must be adequate, meaning that healthcare coverage should cover treatments patients need including all the services in the essential health benefits (EHB) package; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care, the enrollment process should be easy to undertake, and benefits should be clearly defined.

In this proposed rule, your Departments propose to: expand the maximum coverage period of a short-term plan from three months to less than 12 months; revise the consumer notice required within any short-term plan contract and application materials; and implement these changes within 60 days of the publication of a final rule.

Short-Term Insurance is Not a Long-Term Solution

In light of our organizations’ principles, we are deeply concerned about the impact the proposed rule on short-term plans will have on the individuals and families we represent—including those who choose not to purchase STLD plans. While STLD plans can offer cheaper premiums for some consumers, they are not required to adhere to important standards, including coverage for the ten essential health benefit categories, guaranteed issue, age and gender rating, prohibitions on discrimination against people with pre-existing conditions, annual out of pocket maximums, prohibitions on annual and lifetime coverage limits, and many other critical patient and consumer protections.

These plans often require consumers to spend enormous sums during the deductible portion of their benefit design, which can quickly eclipse the premium savings consumers may have while covered by one of these plans.² In addition to the exclusions listed above, short-term plans also frequently exempt themselves from many routine medical services that average consumers may not realize are not covered.^{3,4} This combination of extraordinary financial risk and the lack of basic patient and consumer

¹ Healthcare reform principles. American Heart Association website. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf.

² UnitedHealthcare commercial webpage titled “Short-term Health Plans For Individuals and Families.” <https://www.uhcare.com/insurance/short-term>. Accessed on April 10, 2018.

³ Agile Health Insurance, Everest Prime STM, pg. 11, <http://dah38g2inbo50.cloudfront.net/everest-34d8af6c22f69da36d58184e5954eed5.pdf>. Accessed on April 18, 2018.

⁴ K. Pollitz, *Understanding Short-Term Limited Duration Health Insurance*, Feb. 2018, available at <http://files.kff.org/attachment/Issue-Brief-Understanding-Short-Term-Limited-Duration-Health-Insurance>.

protections led those who sell these plans to acknowledge that such plans are “designed solely to provide temporary insurance during unexpected coverage gaps”⁵ and contribute to their status under federal regulation as separate and distinct from “individual health insurance coverage.”⁶

The connection between access to health insurance and health outcomes is clear for the individuals we represent.^{7,8} For example, Americans with cardiovascular disease or associated risk factors who lack health insurance, or are underinsured, have higher mortality rates⁹ and poorer blood pressure control than their insured counterparts.¹⁰ We are concerned that short-term plans, while less expensive than Affordable Care Act (ACA)-compliant plans, would be woefully inadequate for the majority of our patient populations regardless of age, gender, or health status.

Furthermore, many of the individuals represented by our organizations would be unable to purchase short-term plans due to a pre-existing condition. It is also likely that they would be unwilling to purchase such plans when confronted with the lack of vital patient protections and basic services these plans offer. Unfortunately, patients and consumers who choose to remain in the individual insurance markets would still be negatively impacted if the proposed rule is finalized in its current form. Consumers who choose to purchase ACA-compliant health plans would see their premiums increase and their insurance options decrease as people leave the market to purchase short-term plans.

Extending the period and renewability of short-term plans would significantly and negatively impact the families and individuals we represent. As such, our organizations are extremely concerned that implementing these policies will once again leave patients and consumers in the lurch with insufficient coverage, unpaid medical bills, long-term impacts on their financial wellbeing, and lifelong health implications – just as many of these plans did prior to the enactment of the ACA. If implemented, this proposed rule would have downstream impacts on the individual insurance markets jeopardizing access to affordable and adequate health insurance options for consumers who do not intend to purchase short-term plans. To sum up, short-term plans are an insufficient and inadequate solution to addressing premium and out-of-pocket costs and will have many long-lasting impacts on the entire health insurance market, as well as the health and wellbeing of the individuals we represent.

Accessibility

As mentioned above, a key principle adopted by our organizations is that healthcare must be accessible. All people, regardless of employment, health status or geographic location, should be able to gain coverage without waiting periods or undue barriers to coverage. At the same time, important patient protections in current law should be maintained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender rating, and excessive

⁵ 83 Fed. Reg. at 7443.

⁶ Ibid.

⁷ Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Medical Care Research and Review*. 2005; 62(1): 231-249.

⁸ McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs*. 2004; 23(4): 223-233.

⁹ RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report.

http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf

Accessed June 19, 2017.

¹⁰ McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs* 2004; 23(4): 223-233.

premiums for older adults. Our organizations agree that every individual needs access to quality and affordable healthcare in order to maintain or improve their health and wellbeing.

Discriminatory Plan Design

Because short-term plans are exempt from the ACA's pre-existing condition protections, these plans can deny coverage of specific services based on health status and medical history of an individual, or deny coverage altogether. Insurers who offer short-term plans can also discriminate based on health status by charging higher premiums. By definition, these plans are widely inaccessible to our patient and consumer populations.

Protections included in the ACA prohibit plans from basing premiums on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. Before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating (charging women higher premiums than men). These predatory practices used to cost women approximately \$1 billion a year and are still commonplace among insurers selling short-term plans.¹¹ Health questionnaires are also often used by short-term plans to identify and deny coverage to people with preexisting conditions, a category that can even include pregnancy. The application process often includes language explicitly excluding applicants who are pregnant, or an expectant father. Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services, such as surgery.

Network Adequacy

Short-term plans would also be exempt from any ACA-related network adequacy requirements. While ACA-compliant Qualified Health Plans (QHPs) must meet certain quantitative standards to ensure beneficiary access to varying medical services, such as primary care, oncology, maternity and newborn care, mental health, and emergency services, short-term plans are not required to comply with these standards. This is particularly concerning for our organizations as we represent individuals who are most in need of access to emergency services, outpatient care, and specialty physicians. These physicians and health services are also often the most expensive. Without regulation and oversight of network adequacy within these short-term plans as this proposal would allow, the physicians and services that patients require could be excluded from short-term provider networks altogether. They may also include facilities or specialists in the network that are far too distant from beneficiaries to be accessible.

Affordability

Our organizations' principles also recognize that illness and disease impact individuals across the economic spectrum. We believe that everyone – regardless of their economic situation – should be able to obtain the treatment they require to manage, maintain, or improve their health. This means that care should be affordable to an individual, including reasonable premiums and cost-sharing, and that individuals with pre-existing conditions should be protected from being charged more for their coverage. The proposed rule fails to achieve these goals.

Market Segmentation

Under the proposed rule, the Departments themselves acknowledged that, "consumers who purchase short-term, limited-duration insurance policies and then develop chronic conditions could face financial

¹¹ National Women's Law Center. (2012). Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act. Retrieved 14 December 2016, from http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf

hardship as a result, until they are able to enroll in PPACA-compliant plans that would provide coverage for such conditions”.¹² However, allowing short-term plans to proliferate in the market will not only result in more people buying plans that may not cover the services they need, but will also have a negative impact on the stability and viability of the individual market itself. A recent study conducted by the Urban Institute projects that this proposed rule would result in over 2.5 million younger and healthier consumers across the country moving out of minimum essential coverage plans and into short-term plans, increasing premiums for those consumers who remain in the ACA-compliant nongroup insurance market by an average of 18.3 percent.¹³ These increases in premiums would also likely be accompanied by an exodus of insurers from the marketplaces as their risk pools become older and sicker.

The Departments expect this very same outcome, stating:

Allowing [relatively young and healthy] individuals to purchase policies that do not comply with [ACA], but with term lengths that may be similar to those of [ACA]-compliant plans with 12-month terms, could potentially weaken States’ individual market single risk pools. As a result, individual market issuers could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market.¹⁴

They continue, asserting that, “[i]f individual market single risk pools change as a result, it would result in an increase in premiums for the individuals remaining in those risk pools.”¹⁵

Within this proposed rule, the Departments admit that individuals with chronic conditions, which includes nearly half of the adult population in the United States¹⁶ and the very patients and families that we represent, will be harmed by this rule. Individuals with chronic conditions would be ineligible for short-term insurance, either due to discriminatory plan practices or overt and total benefit exclusions, leaving ACA marketplace plans as their only option. For those in the marketplace, the Departments expect the implementation of this rule, if finalized, to raise their premiums by 10 percent on average.¹⁷

It is clear that the Departments understand the negative impact of the proposed rule. This blatant and intentional segmentation of the individual market will not only harm individuals with chronic, acute or serious health conditions enrolled in short-term plans, but will effectively undermine their ability to obtain affordable comprehensive coverage by exacerbating price increases within the individual market.

Lifetime and Annual Caps

Under current law, the ban on lifetime and annual caps only applies to EHB-covered services. But under this proposal, the Departments would facilitate the proliferation of health insurance options that do not have to comply with EHB coverage requirements. The Departments acknowledge that, “[s]hort-term, limited-duration insurance policies would be unlikely to include all the elements of [ACA]-compliant

¹² 83 Fed. Reg. 7437.

¹³ Blumberg LJ, Buettgens M, Wang R. Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending. Urban Institute. March 2018. Available at: https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf

¹⁴ 83 Fed. Reg. at 7443.

¹⁵ Ibid.

¹⁶ Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. *Prev Chronic Dis.* 2014;11:E62.

¹⁷ 83 Fed. Reg. at 7443.

plans, such as... coverage of essential health benefits without annual or lifetime dollar limits...".¹⁸ Therefore, this proposal would once again subject patients to significant financial insecurity due to medical needs.

In 2007, more than 60 percent of all bankruptcies were the result of serious illness and medical bills.¹⁹ Patients who undergo heart transplants, use specialty medications, have complicated pregnancies, receive a cancer diagnosis, or are diagnosed with rare and complex conditions could easily meet or exceed lifetime and annual caps within a short period of time. For example, prior to the ACA, many children with hemophilia reached the lifetime limit on coverage under both parents' insurance plans before turning 18, leaving them without coverage options.^{20,21} For these reasons, we strongly urge the Departments to consider the financial implications for our patients and secure their financial wellbeing by requiring short-term plans to comply with ACA consumer protections.

Annual Out-of-Pocket Maximums

The ACA also implemented a requirement for QHPs to include an annual out-of-pocket maximum set each year by the Department of Health and Human Services (HHS). For 2018, the annual out-of-pocket limit for an individual is \$7,350, and for a family plan is \$14,700.²² Similar to the ban on annual and lifetime caps, the out-of-pocket maximums only apply to EHB-covered services. If the Departments move forward with this proposed dramatic expansion of non-EHB compliant short-term plans, it will also be subjecting consumers and patients with complex and chronic conditions in these plans to unaffordable cost-sharing for medically necessary services.

Adequacy

In our third principle, we assert that healthcare coverage must be adequate, covering the services and treatments patients need, including patients with unique and complex health care needs. It is paramount that protections including EHB packages, the ban on annual and lifetime caps, and restrictions on premium rating all be preserved in all health care plans, whether they are considered short-term policies or not.

As we have already stated, we are deeply concerned that the short-term plans created by this proposed rule could offer entirely inadequate, even discriminatory, coverage to the communities we represent. Our organizations emphatically urge the Departments not to finalize the rule or, if unwilling to do so, modify the proposed rule to fully protect consumers and patients against harm by requiring that all short-term plans that are allowed to operate for longer than the currently permitted three-month limit adhere to the patient protection standards that apply to plans sold on the individual marketplace.

¹⁸ Ibid

¹⁹ Himmelstein DU, Throne D, Warren E, Woolhandler S, Medical bankruptcy in the United States, 2007: results of a national study. *Am J Med* 2009 Aug; 122(8): 741-6. Doi.

²⁰ Economic Costs of Hemophilia and the Impact of Prophylactic Treatment on Patient Management," *AJMC* (4.18.2016), <http://www.ajmc.com/journals/supplement/2016/incorporating-emerging-innovation-hemophilia-ab-tailoring-prophylaxis-management-strategies-managed-care-environment/incorporating-emerging-innovation-hemophilia-ab-tailoring-prophylaxis-management-strategies-managed-care-environment-economic-costs?p=1>

²¹ National Hemophilia Foundation: Strategic Summit Report" (October 2012), at 11:

<https://www.hemophilia.org/sites/default/files/article/documents/HemophiliaSummitFinalReportOct2012.pdf>

²² Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, Final Rule, 81 Fed. Reg. 94058 (Dec. 22, 2016).

Essential Health Benefits (EHBs)

One of the most troubling characteristics of short-term health insurance plans is that they are not required to comply with EHB coverage requirements that apply to health plans offered on the individual market.

The individuals we represent rely on the current law's coverage requirements for access to medically necessary care. Prior to the creation of the ten EHB categories, patients and consumers frequently found themselves enrolled in plans that failed to provide coverage for the care they routinely relied upon to maintain their health or treat illnesses. Patients with serious illnesses would discover they were not covered for new and innovative treatments, some individuals could not get coverage for emergency room services, and patients with chronic illnesses were often denied coverage for life-improving, sometimes even life-saving, medication. Many of these individuals did not realize at the time of their enrollment that they had selected a plan that did not meet their health care needs, let alone provide adequate coverage for a new diagnosis. Individuals with and without pre-existing conditions have come to rely upon the foundation that EHBs provide for adequate health insurance, and they expect those services to be covered by their insurance.

Short-term plans are allowed to categorically exclude certain benefits, such as maternity and newborn care, prescription drugs, mental health care, substance use services, and preventive services like birth control and tobacco cessation. We are very concerned that healthy individuals may enroll in a short-term health plan that they believe meets their limited needs, but then not have access to necessary and medically appropriate care, including preventive care, as well as unpredictable but necessary health services such as prescription drugs or emergency room services.

Preventive Services

Short-term plans also would not be required to cover preventive services with no cost-sharing. Current law requires most private health plans to cover preventive services without cost-sharing, including co-pays, co-insurance and deductibles. The defined preventive services are any treatment receiving an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and any immunization having a recommendation from the Advisory Committee on Immunization Practices. They include services like cancer screenings, preventive treatments for cardiovascular disease, screenings for pregnant women, and tobacco cessation. These preventive services save both money and lives and are an important component of healthcare coverage for our patients.

Specific Solicited Feedback

Under the proposed rule, the Departments also solicited specific feedback regarding commenters' perspectives on (1) the appropriate duration of short-term plans; (2) existing regulations, policies, or guidance that limit or create barriers to entry into the short-term plan market; (3) conditions under which issuers should be allowed to incorporate renewability of these plans beyond 12 months; (4) the accuracy of the Departments' estimates of the increase in both premiums and federal spending that would result from this proposal; and (5) the impact of the proposed effective date.

Duration

The Departments ask what the appropriate duration of a STLD plan should be. The proposed rule suggests that the duration should increase from three months (90 days) to under 12 months (presumably 364 days). Our organizations believe this shift is unwarranted and will threaten the accessibility, affordability, and adequacy of health care for patients, as has been previously detailed. The

short-term plans are transitional coverage for people to access some coverage between jobs or other extenuating circumstances but are not considered healthcare coverage as defined by the Affordable Care Act, the Congressional Budget Office (CBO), and our organizations. Since short-term plans are not true health insurance, our organizations believe the duration of the plans should not exceed the current three-month threshold.

Renewability

Unlike insurance plans sold on the individual market, short-term plans also do not have to offer continued coverage once the policy term expires. This means that individuals who purchase these policies and then develop a health condition almost certainly will not have the option to renew their coverage, resulting in an effective rescission of coverage due to health status. This would disproportionately affect the individuals who develop acute, chronic, and serious health conditions while enrolled in short-term plans and cause significant, potentially dangerous disruption to their care.

As such, our organizations do not believe these plans should be renewable or allowed to continue for more than three months. The renewability of plans should be reserved for health insurance that meet the definition of minimum essential coverage (MEC). Under the proposed rule, the STLD plans do not meet that definition. Further, allowing for short-term plans to be renewed will create confusion in the marketplace. Our organizations strongly object to the renewability of the short-term plans.

Effective Date

As proposed, the final rule will become effective 60 days after the publication of the final rule, and any plans sold on or after the 60th day would need to meet the definition contained in that final rule to be considered short-term, limited-duration insurance. Our groups are deeply concerned that this timeline could threaten the stability of the individual market as it will allow for plans to be sold in 2018, after the rate filing process for 2019 is well underway or even complete in some states.

Issuers, state insurance commissioners, and other stakeholders need ample time to address the significant effects that the final rule will have on the individual marketplace. Issuers are already developing rates for the 2019 plan year. The Department of Health and Human Services' guidelines indicate that issuers' deadline for submitting plans in the exchange is less than two months after comments are due.²³ Setting the effective and applicability dates just 60 days after the release of the final rule will not provide enough time to prepare for this major disruption to the health care of millions of Americans purchasing insurance in the individual marketplace.

Moreover, some state legislatures might desire to pass laws that would address the STLD plans sold in their state. As of May 31, however, at least 30 states' regular legislative sessions will have ended. The effective date denies those states the ability to consider the impact of STLD plans on their individual market and to make changes that might compensate or mitigate that effect.

Departmental Estimates

The Departments estimate that the impact of this policy would be minimal, resulting in 100,000-200,000 individuals exiting the individual insurance markets in favor of enrolling in a short-term plan. We are concerned that this estimate is excessively conservative. An analysis conducted by the Urban Institute

²³ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Proposed-Key-Dates-for-Calendar-Year-2018.pdf>

estimates that more than 4 million individuals would exit the exchanges to purchase a STLD plan.²⁴ The significant discrepancy between these two estimates suggests that the Department's estimations may be low and should be recalculated.

Other Concerns

Guided by the real experiences and needs of people with high health care needs that we represent, many of our groups have additional concerns with the proposed rule put forward by your Departments.

Notification to Consumers

Under the proposed rule, the Departments propose modifying the notice to consumers that the plan they are purchasing is not minimum essential coverage (MEC). We appreciate the language that clarifies the plan does not meet federal standards. However, as proposed, the notice is not sufficient to inform consumers that the coverage offered by these plans is frequently inadequate or substandard. Our organizations believe the notice on short-term limited-duration plans, including all plan documents and those that advertise the plans, must clearly articulate that these plans do not meet ACA protections, including those regarding preexisting conditions and essential health benefits.

Medical Loss Ratio

Additionally, as these plans are not ACA-compliant, they are not subject to the ACA's medical loss ratio (MLR) requirements under federal law. The MLR requirement, or so-called '80-20 rule', compels individual and small group health plans to spend at least 80 percent of premium income on health care and quality improvement activities, or rebate amounts in excess of this payout requirement back to the policyholder. Since 2011, insurance companies have paid out \$3.2 billion in rebates under the medical-loss-ratio requirement.²⁵ As such, the MLR requirement represents a major advance in the transparency and value of health insurance coverage, and places a curb on insurers' marketing and overhead expenditures.

Absent this requirement for STLD products, insurers choosing to issue them will be more likely to spend more resources on marketing short-term products and offering higher commissions to their brokers compared to comprehensive ACA-compliant plans. This creates a perverse incentive for brokers to aggressively market these plans, and consumers may purchase them without understanding what they are buying. For patients with pre-existing conditions, unintentionally signing up for a short-term plan can limit access to life-sustaining treatment or leave them with no insurance at all if they are denied coverage – and with no recourse. Without a clear explanation of the basic elements of health insurance that may not be covered by these plans, consumers may not understand the comprehensiveness (or lack thereof) of their coverage. This creates a dangerous situation for patients who may unknowingly purchase plans that do not include the providers, medications, treatments, or services that they need to manage their conditions and stay healthy. As a result, patients may end up being surprised with massive medical bills for treatment that they believed to be covered, likely when they attempt to use their plan and need care most.

²⁴ Blumberg, L, Buettgens, M, & Wang, R. The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending, The Urban Institute, February 2018. Available at https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf

²⁵ Health Insurance.org, '[Billions in ACA rebates show 80/20 Rule's impact](#)'. online April 16, 2017.

Concerns with the Public Comment Process

Finally, our groups are concerned with the Departments' comments regarding the finalization of the rule prior to the comment period closure. In a letter to the Governor and Director of the Department of Insurance of Idaho about the enforcement of the Affordable Care Act, Administrator Verma stated that CMS believed that Idaho could modify a proposal to sell state-based plans to comply with the new short-term, limited-duration plan rule so that the state could legally offer them.²⁶ We are concerned that CMS and other federal agencies and departments would offer guidance to states regarding the implementation of a regulation that is not yet finalized prior to taking into account the opinions and recommendations of all stakeholders who wish to comment.

Conclusion

Our organizations represent millions of patients, individuals, caregivers, and families who need access to quality and affordable healthcare regardless of their income or geographic location. We appreciate the opportunity to provide our recommendations on the proposed rule. However, given the history of discrimination and inadequate coverage within short-term limited-duration plans, we are deeply concerned that the proposed rule could seriously undermine the key principles of access, adequacy, and affordability that are the underpinnings of current law – and put those we represent at enormous risk.

We urge the Departments to withdraw the proposed rule until the needs of our populations are met and instead, to focus on stabilizing the individual insurance markets and lowering premiums for QHPs.

As leaders in the healthcare and research communities and staunch patient and consumer advocates, we look forward to working with the Departments of the Treasury, Labor, and Health and Human Services' leadership and staff on the direction of such important public policy. Thank you for the opportunity to submit comments on this rule. If you have any questions or would like to discuss these comments further, please contact Katie Berge, American Heart Association Government Relations Manager, at katie.berge@heart.org or 202-785-7909.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
Autism Speaks
Chron's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes

²⁶ <https://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Otter.pdf>

Mended Little Hearts
NAMI
National Health Council
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocacy Foundation
National Psoriasis Foundation