Inadequate Coverage: An ACS CAN Examination of Short-Term Health Plans

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Executive Summary

Last year, the Administration finalized a regulation that expands access to short-term, limited-duration insurance products. Short-term plans were originally intended to bridge gaps in comprehensive coverage – for instance, when an individual was between jobs and temporarily without access to an employer plan. Short-term plans traditionally have low premiums but fail to provide the kind of comprehensive coverage an individual would need if they were diagnosed with a serious and unplanned disease such as cancer. Issuers offering short-term plans are permitted to engage in medical underwriting, meaning issuers can deny coverage to people with pre-existing conditions, charge more based on a person's health status, or refuse to cover services related to an individual's pre-existing conditions. They are also permitted to impose lifetime and annual limits on coverage and are not required to provide coverage of the Affordable Care Act's (ACA's) essential health benefits.

To better understand whether short-term plans would be sold to cancer patients and, if so, what kind of coverage a cancer patient could expect, the paper examined short-term plans in six states: Florida, Illinois, Maine, Pennsylvania, Texas, and Wisconsin. We examined two zip codes within each of the six states to better understand the extent to which premiums and deductibles varied between rural and urban areas. The goal was, in part, to understand how extensively a short-term plan might cover an unexpected and costly condition that was not pre-existing and therefore not excluded outright.

Key Findings

Pre-existing condition exclusions: Brochures for each issuer were examined and each one expressly stated that the plan excluded coverage for pre-existing conditions. The final rule allowing for expansion of short-term plans requires this disclosure. Four of the six brochures also included a "prudent layperson" standard within their definition of a pre-existing condition. A prudent layperson standard includes undiagnosed conditions that produce symptoms which would have caused a reasonably prudent person to seek diagnosis, care, or treatment. All brochures said the issuer would consider as preexisting only those conditions or symptoms that a person experienced within a certain period of time prior to enrollment (i.e., two years or five years), which is known as a lookback period. Depending on state law, some individuals can purchase back-to-back, or "stacked" policies. Five of the six brochures examined expressly note that any conditions developed while covered under a previous plan were considered pre-existing under the new plan.

Hypothetical Patient Profile: Short-term plans can be marketed as a protection against unexpected illness or injury. Given that most cancer diagnoses are unexpected we assessed the kind of coverage an individual diagnosed with breast cancer after enrolling in a short-term plan could potentially be offered.

We used the example of a 57-year-old, non-smoking woman as a hypothetical patient profile. The scenario assumed she would pass medical underwriting and be able to purchase a short-term plan but would then developed breast cancer after enrollment. To keep the scenario simple, we assumed issuers would not raise premiums or rescind coverage for the sample patient, even though individuals diagnosed with cancer and covered under a short-term plan would likely face either higher premiums or cancellation of coverage.[1]

In the hypothetical, the total cost of treating breast cancer for the first year was estimated to be $179,229.41, with health care costs highest in the month following diagnosis. We found the hypothetical patient's out-of-pocket costs would vary by duration of short-term plan as follows:

- **3-month plan**: Assuming the enrollee was able to access all covered services in network and further assuming no delays in treatment, the plan would cover a little less than $60,000 in services. The enrollee's share of the treatment would amount to over $111,000, plus an additional $363.90 in total premiums ($121.30 per month). The enrollee would become ineligible for subsequent coverage of her cancer care in a short-term policy because her cancer diagnosis would be considered a pre-existing condition – and so she would have to pay for the last several months of her cancer treatment as an uninsured patient.
- **6-month plan**: Assuming the enrollee was able to access all covered services, the plan would cover roughly $106,000 worth of the enrollee's treatment. The enrollee would incur more than $63,000 in cost-sharing related to her treatments, and an additional $1,570.56 in total premiums ($261.76 per month).
- **12-month plan**: The 12-month plan provided the most coverage relative to the other plans examined. However, this plan still left the enrollee with over $40,000 in cost-sharing, not including monthly premiums which totaled $31,184.52 ($2,598.78 per month). Taken together, the enrollee's cost-sharing and monthly premiums totaled $71,886.95, which is higher total cost-sharing than that provided under a 6-month plan.

In all cases examined, the individual incurred significantly higher out-of-pocket costs under her short-term plan than had she purchased a plan on the marketplace, which provides more robust coverage of services (including prescription drug coverage) and imposes a yearly cap on in-network cost-sharing of $7,900. In addition, because the expiration of short-term coverage is not considered a qualifying event, the individual would be unlikely to be eligible to enroll in ACA-compliant coverage until the next ACA open enrollment period.

Premium variation: Generally speaking, plan premiums were higher for products with longer coverage periods, with the exception being the 36-month plans offered in Pennsylvania. In a majority of the states

[1] For example, people who are enrolled in short-term plans and then are treated for a serious illness may face "post-claims underwriting," in which the insurer examines their medical history and records for prior signs of the condition, with the aim of deeming it pre-existing and avoiding payment of any related claims. Our scenario assumed that did not happen to the enrollee. The scenario also assumed the insurer would pay the full in-network charge of a given covered service, without any "balance billing," which requires an enrollee to pay extra charges not covered by the plan. More information about the methodology is included in the full report.

examined, average plan premiums were less expensive in rural areas compared to urban areas. We also examined the number of plans offered in each geographic area and found robust issuer participation in most geographic areas.

Lack of availability and clarity of plan documents: It can be difficult for consumers to assess what services a short-term plan covers and does not cover prior to purchasing coverage. Indeed, most of the details about plan coverage were included in the plan's policy documents, which were not made available to individuals shopping for coverage. This was particularly true with respect to plan coverage of prescription drugs. While not all plans offered drug coverage, those that did failed to provide any formulary information. Short-term plans also appeared to provide limited coverage for preventive services.[2]

ACS CAN Recommendations

Proponents of short-term plans often claim these products are not intended for all consumers but rather offer a more affordable option than the robust ACA marketplace plans. While premiums for short-term plans are generally lower relative to ACA plans, our analysis shows that short-term plans actually expose enrollees with serious illnesses to much higher out-of-pocket costs. These costs can be tens of thousands of dollars which is far from "more affordable" for most Americans.

Short-term plans are allowed to deny coverage based on an individual's pre-existing conditions – in many cases whether or not those pre-existing conditions were known at the time coverage was sought. This allows short-term plans to discriminate against individuals with high health care costs. Even if an individual were able to pass medical underwriting and obtain coverage under a short-term plan, the plans examined in this report failed to provide sufficient coverage for the products and services cancer patients need for their treatment. The short-term plans examined in this report also failed to provide the information necessary to determine an enrollee's out-of-pocket costs and coverage of benefits related to an individual's cancer treatment.

Policymakers should consider prohibiting the sale, or at the very least limiting the availability of, short-term plans because of the inadequacy of their coverage, combined with the negative impact on the risk pool and availability of coverage in the ACA-compliant market. Since the Administration's final rule which expanded access to short-term plans went into effect, there has been a significant increase in the length of coverage for short-term plan options, which can be confusing to consumers who may mistake these plans for comprehensive, ACA-compliant coverage.

[2] For purposes of this study, we examined short-term plan issuers' brochures to determine coverage of prescription drugs, preventive services, and any other issues specifically related to cancer care. Other analysis has shown that short-term plans also frequently do not provide coverage of maternity care or mental health and substance use disorder. Pollitz K, Long M, Semanskee A, Kamal R. (2018, April 23). "Understanding short-term limited-duration health insurance." *Kaiser Family Foundation.*