



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

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May 13, 2019

## Executive Summary

Short-term, limited-duration health plans were originally intended to be a bridge when an individual had a gap in comprehensive coverage – for instance when an individual was between jobs and temporarily without access to an employer plan. Last year the Administration finalized a regulation that would expand access to these products. 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 they can deny coverage to people with pre-existing conditions, can charge more based on a person’s health status, or can 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, we studied 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. Using a nationally-recognized online brokerage site, we created a hypothetical profile of an individual 57-year-old woman, non-smoker, looking for short-term, limited-duration plan availability in one urban and one rural zip code in each of the six states. Our study assumed that the hypothetical woman would be able to pass medical underwriting but then develop breast cancer once she was enrolled in the plan. 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. Some key findings are as follows:

**Pre-existing condition exclusions:** We reviewed the brochures for each issuer examined in this white paper and found that 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 produced symptoms which would have caused a reasonably prudent person to seek diagnosis, care, or treatment. All brochures said the issuer would consider as pre-existing 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 noted that any conditions developed while covered under a previous plan were considered pre-existing under the new plan.

**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 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.

**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 endeavored to assess what kind of coverage an individual who was 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 certain 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.<sup>1</sup>

In our 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.
- **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

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<sup>1</sup> 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. For further details about the scenario used, see Appendix B.

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 eligible to enroll in ACA-compliant coverage until the next ACA open enrollment period.

**Lack of availability and clarity of plan documents:** We discovered that it can be difficult – if not impossible – 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.<sup>2</sup>

## Background

Having adequate and affordable health insurance coverage is a key determinant in surviving cancer. Research from the American Cancer Society shows that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.<sup>3</sup> This not only impacts the nearly 1.8 million Americans who will be diagnosed with cancer this year, but also the 15.5 million Americans living today who have a history of cancer.<sup>4</sup>

Short-term plans were originally intended to provide people who lacked health insurance coverage an opportunity to obtain coverage as their name portends – for a brief period – before more comprehensive coverage became available. These policies traditionally have low premiums but fail to provide the kind of comprehensive coverage an individual undergoing active cancer treatment requires. These plans were carved out from all federal health insurance laws, including the Affordable Care Act’s

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<sup>2</sup> 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*. Available at <http://files.kff.org/attachment/Issue-Brief-Understanding-Short-Term-Limited-Duration-Health-Insurance>.

<sup>3</sup> Ward E, Halpern M, Schrag N, Cokkinides V, DeSantis C, Bandi P, Stewart A, Jemal A. (2007). “Association of Insurance with Cancer Care Utilization and Outcomes.” *CA: A Cancer Journal for Clinicians* 58(1), 9-31. Available at <http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care>.

<sup>4</sup> American Cancer Society. (2019). *Cancer Facts & Figures 2019*. Available at <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2019/cancer-facts-and-figures-2019.pdf>.

(ACA's) patient protections, and thus are permitted to engage in medical underwriting, meaning issuers can deny coverage to people with pre-existing conditions, can charge more for coverage, or can refuse to cover services related to an individual's pre-existing conditions. These plans are also permitted to impose limits on coverage and are not required to provide coverage of the ACA's essential health benefits.<sup>5</sup>

Short-term plans are allowed to engage in post-claims underwriting, meaning that once a person is enrolled in coverage if they submitted claims for an expensive service, the issuer would undertake an investigation to determine whether the enrollee's condition constituted a pre-existing condition. In addition, short-term policies can and will end coverage at the policy's term, even if the policyholder has gotten sick and needs coverage to continue. Individuals whose coverage is rescinded or whose coverage term ends are not generally eligible for a special enrollment period to enroll in comprehensive coverage and thus are exposed to a gap in coverage.

In 2016, the Obama administration finalized a regulation that limited short-term plans to no more than three months in duration (without the ability to extend coverage) and required such plans to display a prominent disclaimer informing consumers that such coverage would not meet the ACA's minimum essential coverage requirements.<sup>6</sup> In doing so, the Obama Administration cited concerns that short-term plans were being sold as primary coverage and were adversely impacting the ACA risk pools.

In 2018, the Department of Health and Human Services (HHS), Department of Treasury, and the Department of Labor (DOL) finalized a rule that changed the previous policy, allowing for expanded access to short-term plans.<sup>7</sup> Under the 2018 final rule, short-term plans were allowed to be sold for a term of up to one year and be renewed, at the issuer's discretion, for up to 36 months (without a prohibition against the sale of back-to-back plans).

Some policymakers and advocates are concerned that the proliferation of short-term plans could undermine the current insurance market by siphoning off younger, healthier individuals who would be swayed by the lower premiums and would be more likely to pass medical underwriting compared to older and sicker individuals. While older and sicker individuals could still seek coverage in the ACA-compliant market, without younger and healthier individuals in the risk pool, the ACA-compliant market would see premium increases to account for an older, sicker pool of enrollees. This effect is among the

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<sup>5</sup> The Affordable Care Act requires health plans to cover 10 Essential Health Benefits (EHBs): ambulatory patient services; emergency services; hospitalizations; maternity care; mental health and substance use disorder services; prescription drugs; laboratory services; habilitative and rehabilitative services; preventive and wellness services; and pediatric oral and dental services.

<sup>6</sup> Department of Health and Human Services, Department of the Treasury, and Department of Labor. Excepted Benefits; Lifetime and Annual Limits; and Short-Term Limited-Duration Insurance. Final Rule. 81 Fed. Reg. 75316 (Oct. 31, 2016).

<sup>7</sup> Department of Health and Human Services, Department of the Treasury, and Department of Labor. Short-Term, Limited-Duration Insurance. Final Rule. 83 Fed. Reg. 38212 (Aug. 3, 2018).

reasons why a coalition of patient advocates and safety net health insurers have challenged the new final rule in court.<sup>8</sup>

The six states -- Florida, Illinois, Maine, Pennsylvania, Texas, and Wisconsin – and cities included in our research were selected in order to provide for geographic diversity, varied overall size, and number of expected cancer diagnoses in 2019. To date at least one state (Illinois) has enacted legislation to limit the availability and duration of STLD policies.<sup>9</sup>

## Pre-Existing Conditions

Prior to the enactment of the Affordable Care Act (ACA), individuals who had a history of cancer were often unable to purchase health insurance coverage on the individual market because plans could refuse to cover an individual who had a pre-existing condition (such as cancer), charge higher premiums to an individual with a pre-existing condition, and/or choose to cover the person with a pre-existing condition but not cover services related to the pre-existing condition. Pre-existing conditions often included serious diseases such as cancer but could also apply to more common conditions such as acne.<sup>10</sup>

A survey conducted before these exclusions were prohibited in ACA-compliant plans found that 36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market were turned down, were charged more, or had a specific health problem excluded from their coverage.<sup>11</sup> The Kaiser Family Foundation estimates that 27 percent of adult Americans under the age of 65 have a “declinable” pre-existing condition,<sup>12</sup> with the prevalence of pre-existing conditions increasing with age.

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<sup>8</sup> Litigation has been filed to halt the implementation of the short-term plan final rule. *Association for Community Affiliated Plans v. Treasury*, No. 1:18-cv-02133 (D. D.C. filed Oct. 10, 2018). As of the date of this report that litigation has not been resolved and is currently pending in the United States District Court for the District of Columbia.

<sup>9</sup> Goldberg, S. (2018, Nov. 28). “Illinois legislature overrides veto of short-term health plan limit.” *Crain’s Chicago Business*. Available at <https://www.chicagobusiness.com/health-care/illinois-legislature-overrides-veto-short-term-health-plan-limit>.

<sup>10</sup> Schwab, R. (2016, Dec. 7). “From Acne to EcZema: The Return of Medical Underwriting Puts Millions at Risk for Losing Coverage or Higher Premiums.” *Georgetown University Health Policy Institute Center on Health Insurance Reforms*. Available at <http://chirblog.org/from-acne-to-eczema-the-return-of-medical-underwriting-puts-millions-at-risk-for-losing-coverage-or-higher-premiums/>.

<sup>11</sup> Doty M. M, Collins S. R, Nicholson J. L, and Rustgi S. D. (2009, July). “Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most US Families.” *Commonwealth Fund*. Available at [https://www.commonwealthfund.org/sites/default/files/documents/media\\_files\\_publications\\_issue\\_brief\\_2009\\_jul\\_failure\\_to\\_protect\\_1300\\_doty\\_failure\\_to\\_protect\\_individual\\_ins\\_market\\_ib\\_v2.pdf](https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2009_jul_failure_to_protect_1300_doty_failure_to_protect_individual_ins_market_ib_v2.pdf).

<sup>12</sup> Claxton G, Cox C, Damico A, Levitt L, Pollitz K. (2016, Dec.). “Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA.” *Kaiser Family Foundation*. Available at <http://files.kff.org/attachment/Issue-Brief-Pre-existing-Conditions-and-Medical-Underwriting-in-the-Individual-Insurance-Market-Prior-to-the-ACA>.

Because short-term plans are exempt from the ACA’s consumer protections, they are permitted to deny coverage to individuals with pre-existing conditions. A summary of our analysis of issuer brochures is reflected in Table 1, below:

**Table 1: Pre-Existing Condition Exclusions by Issuer<sup>13</sup>**

	Issuer A	Issuer B	Issuer C	Issuer D	Issuer E	Issuer F
<i>Defined term</i>	No	Yes	Yes	Yes	Yes	Yes
<i>Includes prudent layperson standard</i>	No	Yes	Yes	Yes	Yes	No
<i>Lookback period</i>	60 months	60 months	12 months	60 months	24 months for treatment received; 12-month prudent layperson	None listed
<i>Pre-existing condition protections extending to back-to-back policies</i>	No new medical questions or waiting periods for stacked coverage	Subsequent policies are subject to new pre-existing condition limitations	Subsequent policies only cover conditions covered under a previous plan within 90 days	Unclear	Subsequent policies are subject to new pre-existing condition limitations	Subsequent policies are subject to new pre-existing condition limitations

Based on author review of issuer brochures. In examining plan availability in the six states, we found six distinct issuers offering coverage options.

\* Issuer A’s brochure also noted that enrollees who purchased stacked policies would not be subject to additional medical questions or new waiting periods.

*“Pre-existing condition” definition:* In reviewing the brochures for each issuer examined in this white paper, we found that every issuer’s plan brochure expressly stated that coverage for pre-existing conditions were excluded from coverage under the plan. All but one of the brochures we examined defined the term “pre-existing condition,” though the definitions varied slightly.

<sup>13</sup> Issuers are not identified by name because this paper includes a small illustrative sample of short-term plans; and was not a comprehensive examination of all issuers in a state. Additionally, the report is not intended to provide information about particular plans to consumers, but to discuss trends in the market.

Some of the issuer brochures we examined were intended for products sold in multiple states, and thus contained state-specific terms that varied slightly from the general term used in the brochure.<sup>14</sup> Where state variation existed it usually concerned the period under which an issuer could engage in post-claims underwriting. One issuer's brochure noted that the plan did not cover pre-existing conditions including those not inquired about on the enrollment form. None of the brochures listed specific diseases or conditions that would constitute a pre-existing condition for which the applicant would be denied coverage.

*“Prudent layperson” standard:* Four of the six brochures also included a “prudent layperson” standard – meaning that the issuer considers a pre-existing condition to be something that produced symptoms which would have caused a reasonably prudent person to seek diagnosis, care, or treatment. The “prudent layperson” standard provides issuers with additional flexibility to deny coverage to applicants – or rescind coverage from individuals after they enroll. For example, after enrolling in a short-term plan an individual is diagnosed with brain cancer. If upon investigation the issuer discovers the individual experienced headaches prior to enrolling in the plan, the issuer may determine the brain cancer is a pre-existing condition because a prudent layperson would have sought medical advice to address their headaches and thus refuses to pay for the individual's brain cancer treatments.

*Lookback period:* All issuer brochures examined noted they would employ a lookback period, which is a limit on the amount of time, prior to enrollment, the issuer will look at a person's medical history for evidence of a pre-existing condition that warrants a denial of a person's application or nonpayment of the person's claims related to the condition. The length of the lookback period varied by issuer. Five out of the six brochures specifically noted the length of the look-back period.

*Back-to-back policies:* Depending on state law, short-term plans can now be “stacked”, meaning that an individual could purchase back-to-back plans, thereby extending the period of time during which one is enrolled in a short-term plan. Plan stacking is often confusing to consumers, who frequently assume that issuers will not medically underwrite as long as the individual retains continuous coverage with the same issuer. However, five of the issuers' brochures expressly noted that any pre-existing conditions developed while covered under a previous plan are considered pre-existing under the new plan. Thus, if an individual developed a disease or condition while enrolled in a short-term plan offered by these issuers, she would be unable to purchase another short-term plan because of the ability of plans to deny coverage to individuals with pre-existing conditions. Because the expiration of short-term coverage is not considered a qualifying event, the individual would be unlikely eligible to enroll in other coverage, likely leaving her uninsured until the next open enrollment period.

The sixth issuer specifically highlighted the benefits of stacked plans by noting that while the cost-sharing responsibilities would restart with a new plan, any medical conditions that arose while covered under the initial short-term plan would be covered under the subsequent policy. But the brochure also said these features were subject to plan limitations as noted in policy documents (which were

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<sup>14</sup> This could be confusing to consumers who would not only have to find information related to policy exclusions among the general exclusions but would also have to look elsewhere in the document to determine if additional exclusions or changes to the brochure were in effect depending on the state in which the applicant resides.

unavailable). On its face this statement suggests the issuer is providing an important consumer protection. However, short-term plans can engage in post-claims underwriting, which would allow the issuer to rescind coverage.

## Premiums and Deductibles

Short-term plans typically have lower premiums relative to ACA-compliant health plans (particularly unsubsidized ACA plans) because short-term plans are not required to provide comprehensive benefits and can exclude individuals with pre-existing conditions or avoid covering their claims. We examined two zip codes within each of the six study states to better understand the extent to which there was premium variation. Health insurance premiums vary for a variety of reasons including, among other things, the value of the benefits covered, health status of the enrollee, and geography. We were unable to ascertain the actuarial value of covered benefits and the premiums listed do not account for any medical underwriting.<sup>15</sup> The summary of our analysis is reflected in Table 2, below:

**Table 2: Average Monthly Premiums for 57-Year-Old Woman in Chosen Zip Code by State**

City	State	Urban/Rural	3-month	6-month	12-month	36-month
Chicago (60639)	IL	Urban		\$349.29	\$498.16	
LaSalle (61301)	IL	Rural		\$271.22	\$384.80	
Houston (77051)	TX	Urban		\$492.84	\$666.70	
Mission (78572)	TX	Rural		\$473.23	\$646.61	
Allagash (04774)	ME	Rural		\$266.15	\$393.86	
Portland (04103)	ME	Urban		\$266.15	\$393.86	
Jackson (32446)	FL	Rural		\$311.26	\$403.93	
Miami-Dade (33172)	FL	Urban		\$393.33	\$506.18	
Milwaukee (53202)	WI	Urban		\$312.93	\$398.65	
Waupaca (54981)	WI	Rural		\$272.38	\$385.48	
Pittsburgh (15286)	PA	Urban	\$290.48	\$416.35	\$576.75	\$386.34
Towanda (18848)	PA	Rural	\$289.74	\$393.79	\$545.16	\$344.65

Source: Analysis of premium provided by online broker. Averages include median premium across all issuers. Premiums do not reflect medical underwriting, meaning actual premiums could be higher than shown here.

The 3-month and 36-month plan options were only available in Pennsylvania.

*Coverage length:* In only one state – Pennsylvania – 3-month and 36-month plans were available.<sup>16</sup> In all of the states that we examined, 6-month and 12-month plans were available. Generally speaking, plan premiums were higher for products with longer coverage periods. One notable exception was that average plan premiums for the 36-month plans were less than premiums for 12-month plans. Average

<sup>15</sup> In general, it was challenging to determine specific information regarding plan coverage and benefits, as discussed further in the “Consumer Disclosure Material” section of this paper.

<sup>16</sup> This could be due to the fact that the data for plan availability in Pennsylvania was gathered in March 2019, rather than November 2018 when the information for the other states was gathered.



monthly premiums for 36-month plans in Pittsburgh, Pennsylvania were \$190.41 less than the average monthly premium for the 12-month plan and \$30.01 less than the average monthly premiums for the 6-month plan. Similarly, in Towanda, Pennsylvania average premiums for 36-month plans were \$200.51 less than average premiums for 12-month plans and \$49.14 less for 6-month plans.

*Urban versus rural:* In a majority of the states examined, premiums were on average less expensive in rural areas compared to urban areas. The notable exception involved products offered in Maine which had the same average premium for both urban and rural areas. Illinois and Florida saw the greatest variation in average premiums between rural and urban areas.

In addition to analyzing the premiums of short-term health plans, we also examined the use of the deductibles for these plans. Short-term plans, like most health insurance coverage, utilize a benefit design that includes a deductible.<sup>17</sup> The summary of our analysis is reflected in Table 3, below:

**Table 3: Most Common Deductibles by State**

City	State	Urban v Rural	3-Month	6-Month	12-Month	36-Month
Chicago (60639)	IL	Urban		\$5,000	\$5,000	
LaSalle (61301)	IL	Rural		\$5,000	\$5,000	
Houston (77051)	TX	Urban		\$5,000	\$5,000	
Mission (78572)	TX	Rural		\$5,000	\$5,000	
Allagash (04774)	ME	Rural		\$10,000	\$10,000	
Portland (04103)	ME	Urban		\$2,500	\$2,500	
Jackson (32446)	FL	Rural		\$5,000	\$5,000	
Miami-Dade (33172)	FL	Urban		\$5,000	\$5,000	
Milwaukee (53202)	WI	Urban		\$5,000	\$5,000	
Waupaca (54981)	WI	Rural		\$10,000	\$5,000	
Pittsburgh (15286)	PA	Urban	\$10,000	\$10,000	\$5,000	N/A
Towanda (18848)	PA	Rural	\$10,000	\$5,000	\$5,000	N/A

Source: Analysis of deductibles provided by online broker.

Some plans use a separate prescription drug deductible, to the extent they provided any drug coverage, which is not reflected in the above data.

The 3-month and 36-month plan options were only available in Pennsylvania. Plan deductibles varied so significantly for the 36-month plan options that it was not possible to ascertain the most commonly utilized deductible.

*Deductibles:* Every state examined offered 6-month and 12-month plan options, and the most widely used deductible for both options was \$5,000 – meaning that the enrollee would have to spend \$5,000 before the plan began covering services. The most common deductible for the plans examined in Allagash, Maine was the only area examined with an average deductible of \$10,000 for both the 6-month and 12-month plan options.

<sup>17</sup> A deductible is the amount an individual pays out of pocket before their health plan starts to cover services.

Individuals who purchased back-to-back policies would have deductible obligations for each new period of coverage. In other words, an individual who purchased four consecutive 3-month plans, would have to meet a new deductible every three months before the plan would begin to cover services.

Plan deductibles varied widely, with every state having plans available with a deductible as low as \$1,000. In every state but Maine, plan deductibles were as high as \$12,500. Plan deductibles in Maine ranged from \$1,000 to \$10,000. As a point of comparison, plans sold on the ACA marketplace are required to cap total annual out-of-pocket costs for in-network services at \$7,900 and provide more robust coverage (including prescription drug coverage).

Finally, we noted that plan availability was relatively robust in each geographic area we examined. The summary of our analysis is included in Table 4, below:

**Table 4: Plan Options and Number of Issuers by State**

City	State	3-Month	6-Month	12-Month	36-Month	Number of Issuers
Chicago (60639)	IL		42	45		5
LaSalle (61301)	IL		42	45		5
Houston (77051)	TX		42	50		5
Mission (78572)	TX		42	50		5
Allagash (04774)	ME		16	16		1
Portland (04103)	ME		16	16		1
Jackson (32446)	FL		42	50		5
Miami-Dade (33172)	FL		42	50		5
Milwaukee (53202)	WI		36	46		4
Waupaca (54981)	WI		41	44		4
Pittsburgh (15286)	PA	26	19	20	4	5
Towanda (18848)	PA	26	19	20	4	5

Source: Analysis of information provided by online broker.

*Plan options:* Every state we examined had robust issuer participation, with the two geographic areas in Maine (Allagash and Portland) having the fewest plan options – only 16 plan choices for both the 6-month and 12-month plan options. The two geographic areas in Texas (Houston and Mission) offered the most robust plan choices with a total of 92 plan options (between both the 6-month and 12-month plans) in each of the geographic areas.

As discussed in more detail in the Consumer Disclosure section below, consumers shopping for coverage were provided with basic information about the plan (premium, deductible, coinsurance), but we were not able to ascertain the actuarial value of the covered benefits. Thus, it would be challenging for a consumer to make an informed decision when choosing a plan.

*Issuer participation:* None of the geographic areas examined provided plan options from all six issuers examined in this report. Most geographic areas – those in Illinois, Texas, Florida, and Pennsylvania –

included plan options from five out of the six issuers examined in the report. Maine was the only state examined that only had one issuer.

Interestingly, in four of the six states examined, one issuer appeared to offer mirror plans. For example, in looking at the index of plan choices in Jackson, Florida this issuer offered a 12-month plan with a monthly premium of \$329.41, a \$10,000 deductible, and 20 percent co-insurance on covered services. In the index of plans, the immediately subsequent plan offering was an identical plan, with the same coverage period, premium, deductible, and cost-sharing. Since this issuer used a standard brochure across all plans, it was impossible to ascertain what, if any, difference existed between these two plan offerings. This duplication of plans appeared in more than one geographic area and often several times per area, which suggested it was a conscious decision by the issuer rather than an error on the part of the online brokerage site.

## Cancer Care Illustrative Examples

Short-term plans are not subject to the patient protections provided under the ACA. As noted, they do not have to offer coverage of essential health benefits and these plans can deny coverage to individuals with pre-existing conditions. Most individuals with cancer (or a personal or family history of cancer) would likely be denied coverage altogether due to the medical underwriting practice employed by these issuers. For those able to pass medical underwriting and enroll in a short-term plan, cancer would likely be treated as a pre-existing condition, and coverage for cancer treatment would be excluded under the policy.

Some cancer patients are diagnosed with cancer after having no prior medical history or symptoms – and therefore it is possible an individual could pass medical underwriting, be enrolled in a short-term plan, and then be diagnosed with cancer. However, short-term plans have been known to rescind coverage, claiming the enrollee had a pre-existing condition that was not adequately disclosed, when faced with a large claim, such as those associated with cancer care.<sup>18</sup>

We wanted to determine what coverage potentially could be provided to a woman who was diagnosed with breast cancer after enrolling in a short-term plan, setting aside the other problems with short-term plans that such a person would likely face in real-life. In 2017, the American Cancer Society Cancer Action Network released *The Cost of Cancer*, a report focusing specifically on the costs of cancer borne by patients in active treatment as well as survivors.<sup>19</sup> To more fully illustrate what cancer patients actually pay for care the *Cost of Cancer* report also presents scenario models for a breast cancer patient. For the purposes of this report, we used cost and utilization information from the *Cost of Cancer*

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<sup>18</sup> Levey, N. N. (2019, April 2). “Skimpy health plans touted by Trump bring back familiar woes for consumers.” *LA Times*. Available at <https://www.latimes.com/politics/la-na-pol-trump-shortterm-health-insurance-consumer-problems-20190402-story.html>.

<sup>19</sup> American Cancer Society Cancer Action Network. (2017, April). *The Costs of Cancer: Addressing Patient Costs*. Available at [www.fightcancer.org/costsofcancer](http://www.fightcancer.org/costsofcancer).

report,<sup>20</sup> and for purposes of the illustration assumed the plan covered all services unless otherwise expressly noted in the plan brochures.

### 3-Month Plan

Three-month policies were only available in one of the states examined (Pennsylvania). Noting that consumers often chose a health plan based on the premium offered, we chose to examine a three-month plan with the lowest premium offered in Pittsburgh, Pennsylvania.<sup>21</sup> For this analysis, we assume a new enrollee who was diagnosed with breast cancer at the beginning of the policy would not have her policy rescinded.

This policy offered coverage for a 57-year old, non-smoking woman as follows:

Monthly Premium	Deductible	Coinsurance	Out-of-Pocket Limit
\$121.30	\$12,500	30%	\$22,500

This particular plan operated an Exclusive Provider Organization (EPO) network, which required the enrollee to use only in-network providers. For purposes of our analysis we assumed all providers were in-network. The brochure noted that policies issued in Pennsylvania would require coverage of one routine mammogram for individuals over 40 years of age.

For purposes of the illustration, total annual costs for a 57-year old woman with breast cancer were estimated to be \$170,229.41.<sup>22,23</sup> The costs of cancer care are highest following diagnosis. The main sources of costs for the enrollee’s treatment during the first three months were physician services, imaging, and surgery.<sup>24</sup> The 3-month plan offered by this issuer did not cover outpatient prescription drugs, though it did offer a discount card. The scenario does not call for the enrollee to incur any outpatient prescription drug costs within the first three months of treatment.

Assuming that the enrollee was able to access all services in-network and further assuming no delays in treatment, the plan would cover a little less than \$60,000 in services during the three months this individual had coverage. She would then become ineligible for coverage for her cancer care in a subsequent short-term policy because her cancer diagnosis would be considered a pre-existing condition. The enrollee’s share of the treatment for the year would amount to over \$111,000 – excluding premiums (which would total \$363.90 for the three months of coverage). This would be

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<sup>20</sup> More information on services contained in the *Cost of Cancer* report is available in Appendix B.

<sup>21</sup> As noted earlier, short-term plan premiums available for this analysis do not reflect medical underwriting, meaning that actual premiums may be higher.

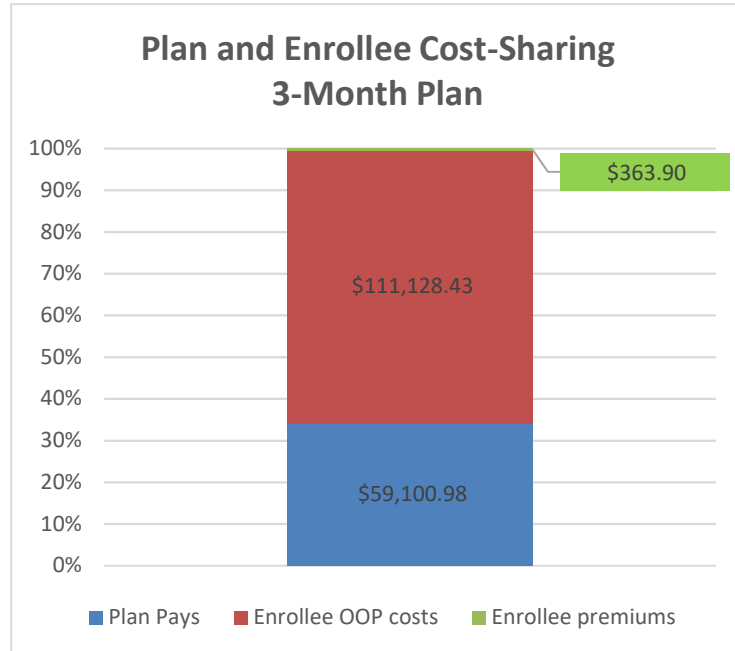
<sup>22</sup> For purposes of this illustration, the “costs” referred to estimated costs for services used for ACS CAN’s *Cost of Cancer* report. More information is available at Appendix B.

<sup>23</sup> Unless otherwise stated, the term “costs” refers to total annual costs.

<sup>24</sup> For purposes of this illustration it is assumed that surgical procedures would include prescription drugs, which would be covered as part of the bundled payment for the surgical procedure. It is not possible from publicly available documents to determine whether surgical procedures would be billed as a bundled payment.

unaffordable for most Americans. Nearly half of all American adults report being unable to cover an emergency expense costing \$400 without having to borrow or sell something to do so.<sup>25</sup>

In the first month of coverage the plan paid less than \$200, leaving the enrollee to pay more than \$8,000, which was still less than her \$12,500 deductible. This 3-month plan covered only 35 percent of the enrollee’s costs, mostly due to the fact that the plan did not provide any services beyond the first three months.



After three months the enrollee could not obtain coverage for her cancer treatment from the same issuer. The issuer’s brochure said it will not cover benefits for a health condition discovered under a prior plan. Because the end of the three months of short-term coverage is not considered a qualifying event, the person would unlikely be eligible to enroll in ACA-compliant coverage, likely leaving her uninsured—while in active cancer treatment—until the next ACA open enrollment period.

As a point of comparison, if the individual enrolled in an ACA plan, her plan would provide coverage for benefits not covered by the short-term plan (such as prescription drugs). The ACA plan would be required to cap her in-network cost sharing each year at \$7,900.

	3-month plan	ACA Plan Annual Limit	Savings by choosing an ACA Plan
Total out-of-pocket costs (excluding premiums)	\$111,128.43	\$7,900	\$103,228.43

The phrase “ACA plan annual limit” refers to the Affordable Care Act’s annual limit total out-of-pocket expenses an enrollee would incur for in-network covered services.

<sup>25</sup> Board of Governors of the Federal Reserve. (2016, May). *Report on the Economic Well-Being of U.S. Households in 2015*. Available at <https://www.federalreserve.gov/2015-report-economic-well-being-us-households-201605.pdf>.

## 6-Month Plan

We chose to examine a 6-month plan in Florida given that the state has the highest incidence of breast cancer (among the states examined in this report).<sup>26</sup> The online brokerage site we used gave consumers several options in which to sort plans. We chose the first 6-month plan that appeared in the “recommended” sorting option (which is also the default option) offered in Miami-Dade, Florida.

This policy offered coverage for a 57-year old, non-smoking woman as follows:

Monthly Premium	Deductible	Coinsurance	Out-of-Pocket Limit
\$261.76	\$10,000	20%	\$20,000

This product was an indemnity product, meaning there was no plan network available and that consumers are responsible for seeking reimbursement directly from the health plan (rather than having the provider submit claims). More importantly, indemnity plans can expose consumers to additional costs because the plan will provide limited reimbursement based on a set formula, regardless of the actual amount billed. In many situations this means the patient’s doctor will bill the patient for the amount the insurer did not pay (called balance billing).<sup>27</sup> Because we could not quantify the amount of any balance billed services, for purposes of this illustration we assumed the enrollee would not incur any additional costs as a result, even though in reality she probably would.

The issuer’s brochure specifically noted that enrollees would not be entitled to receive any benefits for cancer during the first 30-days of coverage (it was the only issuer examined that had a 30-day waiting period for cancer-related services). The enrollee incurred over \$8,000 in costs in the first month.

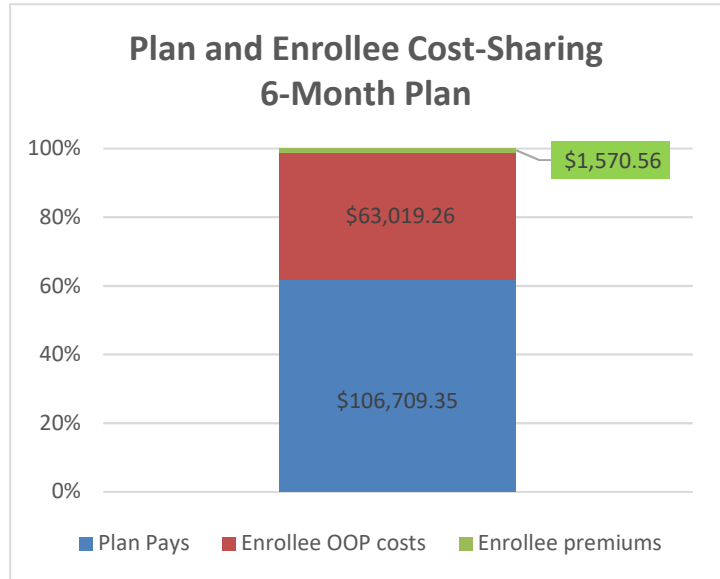
The issuer offers consumers the choice of back-to-back policies (e.g., stacked policies), as long as they are purchased together. According to the brochure, any medical conditions that may arise under the initial policy would be covered under new certificates, subject to plan limitations (including a higher premium). For purposes of this illustration we assumed the consumer chose to purchase one 6-month policy and at the time of purchasing her initial coverage did not purchase a second (stacked) 6-month policy. As with the example under the 3-month plan, she may not qualify for a special enrollment period to enroll in ACA coverage until the next open enrollment period, leaving her potentially uninsured until that time.

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<sup>26</sup> In 2019, the estimated number of new cases of female breast cancer among the states examined in this report are as follows: Florida (19,130), Illinois (11,560), Maine (1,390), Pennsylvania (12,070), Texas (18,750) and Wisconsin (5,270). American Cancer Society. (2019). *Cancer Facts & Figures 2019*. 5. Available at <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2019/cancer-facts-and-figures-2019.pdf>.

<sup>27</sup> Short-term plans that do not use a provider network increase the risk of enrollees being faces with significant balance billing charges. Goe, C. L. (2019, April 30). “Short-term plans: no provider networks lead to large bills for consumers.” *Commonwealth Fund*. Available at <https://www.commonwealthfund.org/blog/2019/short-term-plans-large-bills-consumers>.

For purposes of the illustration, total annual estimated costs for a 57-year old woman with breast cancer were \$170,229.41. Assuming that the enrollee was able to access all services without being subject to balance billing, the plan would cover roughly \$107,000 of the enrollee’s yearly treatment. The enrollee would incur more than \$63,000 in cost-sharing related to her treatments, and an additional \$1,570.56 in premiums.



While the 6-month plan would cover more of the enrollee’s expected costs than the 3-month plan discussed above, it is important to note that even under this scenario, the enrollee would still be responsible for cost-sharing (including premiums) of approximately \$65,000 – a cost well out of the reach of most Americans.

As a point of comparison, if the individual enrolled in an ACA plan, her plan would provide coverage for benefits not covered by the short-term plan (such as prescription drugs). The ACA plan would be required to cap her in-network cost sharing each year at \$7,900.

	6-month plan	ACA Plan Annual Limit	Savings by choosing an ACA Plan
Total out-of-pocket costs (excluding premiums)	\$63,019.26	\$7,900	\$55,119.26

The phrase “ACA plan annual limit” refers to the Affordable Care Act’s annual limit total out-of-pocket expenses an enrollee would incur for in-network covered services.

### 12-Month Plan

We chose a 12-month plan offered in Houston, Texas because this plan required the highest premium (\$2,598.78 per month) among all 12 areas examined. We wanted to ascertain whether purchasing a plan with a higher premium provided an enrollee with more robust coverage.

This policy offered coverage for a 57-year old, non-smoking woman as follows:

Monthly Premium	Deductible	Coinsurance	Out-of-Pocket Limit
\$2,598.78	\$1,000	50%	\$6,000

This plan also had features of an indemnity plan which exposes enrollees to additional cost-sharing for balance billing which was not quantifiable for purposes of this analysis. This policy stated that enrollees would incur a \$50 copayment for physician services (for both primary care and specialists), though the

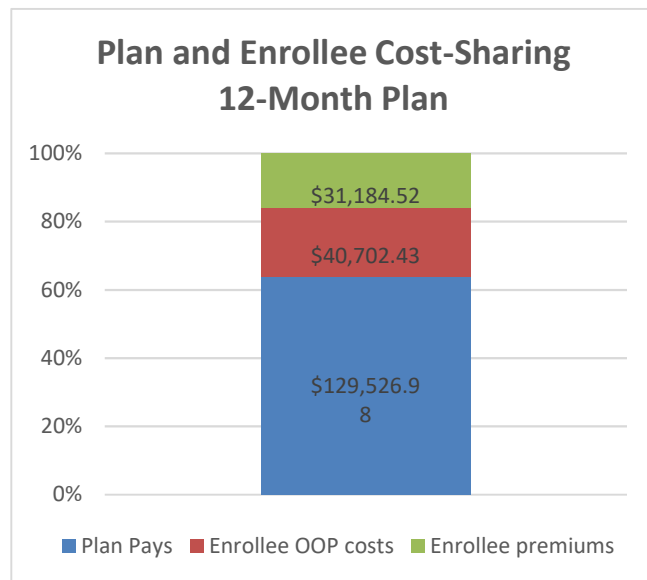
brochure indicated subsequent visits would be subject to the plan deductible and coinsurance, without specifically defining a coinsurance related to physician services. Given the relatively low out-of-pocket limit, under the illustration the enrollee would have only had one physician visit before hitting the cap.

While this policy had a lower out-of-pocket cap compared to other short-term plans examined, the brochure noted that the cap did not include the deductible. Also, while the premiums were significant, the plan only covered prescription drugs when prescribed on an inpatient basis for a covered disease or sickness. The plan did, however, indicate that it offered an outpatient prescription drug discount program, though provided no information regarding the program or its formulary.

Of the three plans examined, the 12-month plan provided the most coverage.<sup>28</sup> However, this plan still left the enrollee with over \$40,000 in cost-sharing, not including monthly premiums which totaled \$31,184.52

over the 12-month period. Taken together, the enrollee’s cost-sharing and monthly premiums totaled \$71,886.95, which is actually higher than what the illustrative patient would pay under a 6-month plan scenario.

As a point of comparison, if the individual enrolled in an ACA plan, her plan would provide coverage for benefits not covered by the short-term plan (such as prescription drugs). The ACA plan would be required to cap her in-network cost sharing each year at \$7,900.



	12-month plan	ACA Plan Annual Limit	Savings by choosing an ACA Plan
Total out-of-pocket costs (excluding premiums)	\$40,702.43	\$7,900	\$32,802.43

The phrase “ACA plan annual limit” refers to the Affordable Care Act’s annual limit total out-of-pocket expenses an enrollee would incur for in-network covered services.

<sup>28</sup> This statement is predicated on the assumption that the 12-month plan provided robust coverage of physician services. The authors are unable to verify this claim given the lack of transparency regarding the plan’s coverage of services.



## Consumer Disclosure Materials

In order to assess coverage options, consumers need information regarding what the policy does and does not cover, as well as any expected cost-sharing for covered services. Insurance concepts can be challenging for consumers to understand, and thus any information intended for consumers should be presented in a clear and concise manner so consumers can assess their coverage options and make an apples-to-apples comparison. One recent study suggests that consumers are confused by the limitations of short-term plans because they have been shaped by their experiences and expectations of the insurance market since the enactment of the ACA and expect all insurance coverage to contain important patient protections.<sup>29</sup>

*Lack of Summary of Benefits and Coverage:* Under the ACA, plans – including grandfathered plans<sup>30</sup> – are required to provide enrollees (and potential enrollees) with a Summary of Benefits and Coverage (SBC) that provides an easy-to-understand, standardized summary of the benefits provided under the plan, including prescription drug formulary information.<sup>31</sup>

Short-term plans do not have to comply with this requirement, which makes it harder for consumers to assess materials that describe what services are, and are not, covered under the plan prior to purchasing coverage. Indeed, most of the details about plan coverage were said to be included in the plan’s policy documents, which were not made available to individuals shopping for coverage.

*Lack of formulary information:* Qualified Health Plans (QHPs) – ACA-compliant plans in the individual and small group markets – are required to provide consumers with prescription drug coverage as well as information regarding a plan’s prescription drug formulary (i.e., list of covered drugs). Three of the issuers examined in this report did not provide any coverage of outpatient prescription drugs. One issuer noted under its excluded benefits page that outpatient prescription drugs were not covered unless shown as included in the Schedule of Benefits, which was not available to consumers shopping for coverage.

Another issuer provided prescription drug coverage for some plan options but not for others. While the brochure supplied by the issuer noted that outpatient prescription drugs would be subject to a separate prescription drug deductible, it did not provide access to any formulary information. However, the brochure noted that no specialty drugs were covered under any plan offered by the issuer. Many cancer drugs are considered specialty drugs.<sup>32</sup>

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<sup>29</sup> Consumer Representatives to the National Association of Insurance Commissioners. (2019, Mar. 15). *New Consumer Testing Shows Limited Consumer Understanding of Short-Term Plans and Need for Continued State and NAIC Action*. Available [https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report\\_NAIC-Consumer-Reps.pdf](https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf).

<sup>30</sup> A “grandfathered health plan” is a policy that was purchased before March 23, 2010. These plans are exempt from many of the protections provided under the Affordable Care Act.

<sup>31</sup> 45 C.F.R. § 147.200.

<sup>32</sup> Most cancer drugs (such as chemotherapy) are considered specialty drugs because they often require special handling, administration, and/or monitoring. Depending on the insurer and the type of chemotherapy, these drugs can be covered under a plan’s medical benefit, not the plan’s prescription drug benefit.

Finally, another provided confusing information regarding prescription drug coverage. The brochure seemed to indicate that one out of the four plan options does not cover prescription drugs – offering only a discount card. The remaining three plan options seemed to indicate the plan provided some drug coverage, though the brochure did not mention any formulary information. Consumers were told to pay for their prescriptions at the point of sale “at the lowest price available” and to then submit a claim to the plan for reimbursement. Even then, the brochure indicated that the issuer imposed a maximum \$3,000 benefit for prescription drugs. However, in the exclusions section of the brochure, the issuer explicitly stated, “no benefits are payable for expenses ... for outpatient prescription drugs, except as provided for in the policy/certificate.” Neither the policy nor the certificate was made available to individuals shopping for coverage.

*Disclaimer:* All of the examined issuer brochures included a disclaimer of some kind. These disclaimers all noted that the coverage provided does not qualify as minimum essential coverage as required under the Affordable Care Act. Four issuers’ disclaimers noted that not having minimum essential coverage could result in a federal tax penalty.

One issuer included a disclaimer noting that short-term plan coverage does not constitute minimum essential coverage, followed by a statement that the plan “can, however, offer financial protection in the event of an unexpected injury or illness when you are waiting for coverage to begin under an ACA-compliant plan.” Most cancer diagnoses are unexpected. The disclaimer offered by this issuer implies that the policy would provide coverage for an unexpected illness, yet as our analysis demonstrated, the coverage proved inadequate with respect to a diagnosis of breast cancer. The 12-month plan discussed in detail above, offered by this issuer would leave a patient with over \$40,000 in out-of-pocket costs (excluding premiums).

## Preventive Services

Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.<sup>33</sup> Providing access to high quality primary medical care and preventive services is one of the most effective ways to prevent or detect cancer at an earlier, more curable, and less expensive stage. ACA-compliant plans are required to cover without cost-sharing clinical preventive services that receive an “A” or a “B” rating from the United States Preventive Services Task Force (USPSTF) as well as vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). These services include breast, cervical colorectal, and lung cancer screenings, tobacco cessation treatment, weight loss interventions to reduce obesity, and a vaccine that prevents cervical and other cancers.

*Cancer screenings:* It was very hard to ascertain whether the issuers covered routine cancer screenings of any kind. Only two issuers noted in their plan brochures that they offered coverage for any cancer screenings. Neither of these issuers offered coverage for all the cancer screenings recommended by the USPSTF. Of the two issuers who provided any cancer screening coverage, one issuer’s brochure notes

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<sup>33</sup> American Cancer Society. (2017). *Cancer Prevention & Early Detection Facts & Figures 2016-2017*.

that it covers mammography, pap smear, and prostate antigen test, though did not provide additional information regarding the intervals at which these services would be covered<sup>34</sup> and whether any cost-sharing would be imposed. The other issuer's brochure noted that it covered colorectal cancer screening examinations, prostate specific antigen testing, and any preventive services required by the state.<sup>35</sup>

*Tobacco cessation products:* Quitting tobacco use can often require multiple quit attempts and treatment is more likely to be successful with the use of scientifically-effective treatments including prescription medications. Four of the six issuer brochures explicitly note they do not provide coverage for tobacco cessation products. While the remaining two issuer brochures did not specifically mention coverage for tobacco cessation products, neither of these issuers provide coverage for out-patient prescription drugs.

*Wellness exams:* Short-term plans are not required to cover physical exams. In reviewing plan brochures, only one issuer explicitly noted that "wellness exams" were covered for a \$50 copayment. However, with respect to the other issuers there were inconsistencies between the information provided in the plan brochures and the information available in the "details" page displayed by the online broker. For example, another issuer's brochure exclusions and limitations section expressly states that it does not cover costs for routine physical exams or other services not needed for medical treatment, but the "details" page provided by the online broker states that preventive health exams are covered on a limited basis.

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<sup>34</sup> The USPSTF screening recommendations provide specific screening intervals. For example, the USPSTF recommends screening for cervical cancer in women age 21 to 65 every three years. U.S. Preventive Services Task Force. Cervical Cancer: Screening. Release date Aug. 2018.

<sup>35</sup> This issuer used a multi-state brochure which made it confusing for consumers to gain a better understanding of what is covered under a specific plan option.

## 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 higher out-of-pocket cost. These costs can be tens of thousands of dollars which is far beyond the financial means of most Americans.

Research suggests that consumers generally do not understand short-term plans' limitation on covered benefits,<sup>36</sup> particularly given that they have become accustomed to, and now expect the patient protections provided under the ACA (such as the prohibition of medical underwriting). Some of this confusion may be due to how these plans are marketed. As noted earlier, one issuer's disclaimer specifically noted that the product was intended to offer financial protection for an unexpected illness. Yet our analysis showed the short-term plans included in this report exposed the enrollee to significant out-of-pocket costs associated with an unexpected diagnosis of breast cancer.

We also note that the short-term plans examined in this report failed to provide information necessary to determine an enrollee's out-of-pocket costs and coverage of benefits related to an individual's cancer treatment. For example, we were not able to ascertain the exact premiums an individual would pay if she enrolled in a short-term plan because the premiums made available to those shopping for coverage did not reflect medical underwriting.

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. Indeed, many of the short-term plans failed to provide comprehensive access to preventive services, which are key to diagnosing cancer at an earlier stage when an individual has a greater likelihood of a successful outcome. Half of the short-term plans examined in this report did not provide any coverage of outpatient prescription drugs. Of the plans that indicated there was some prescription drug coverage, none of the plans provided information on the plan's formulary. The issuers' brochures would often refer to a Schedule of Benefits or other policy documents, which were not provided to individuals shopping for coverage.

Short-term plans also have a negative impact on the risk pool for ACA-compliant plans. Short-term plans tend to attract younger, healthier individuals who are lured by the plans' lower premiums and more likely to be approved for coverage given their health status. As a result, older and sicker individuals are left in the ACA-compliant plan risk pool, which results in increased premiums for those plans. As

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<sup>36</sup> Consumer Representatives to the National Association of Insurance Commissioners. *New Consumer Testing Shows Limited Consumer Understanding of Short-Term Plans and Need for Continued State and NAIC Action.*

premiums become more expensive, individuals, particularly those who do not qualify for subsidies, are more likely to forego coverage due to cost.

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.

While the federal government finalized a rule expanding access to these plans, there are a number of states that have taken action to address the concerns raised by the proliferation of short-term plans.<sup>37</sup> Some states have enacted policies that prohibit short-term plans from engaging in medical underwriting, and other states have enacted limits on the length of time a consumer could be enrolled in a short-term plan.<sup>38</sup> Action taken by states to strengthen their markets should be encouraged but ultimately result in a patchwork of consumer protections. Strong federal protections limiting the duration and availability of short-term plans are needed to ensure that all consumers are protected.

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<sup>37</sup> Palanker D, Kona M, Curran E. (2019, May 2). "States step up to protect insurance markets and consumers from short term health plans." *Commonwealth Fund*. Available at <https://www.commonwealthfund.org/publications/issue-briefs/2019/may/states-step-up-protect-markets-consumers-short-term-plans>.

<sup>38</sup> Giovannelli J, Lucia K, Corlette S. (2019, Feb). "What is Your State Doing to Affect Access to Adequate Health Insurance?" *The Commonwealth Fund*. Available at [https://www.commonwealthfund.org/publications/maps-and-interactives/2019/mar/what-your-state-doing-affect-access-adequate-health?redirect\\_source=/publications/maps-and-interactives/2019/feb/what-your-state-doing-affect-access-adequate-health](https://www.commonwealthfund.org/publications/maps-and-interactives/2019/mar/what-your-state-doing-affect-access-adequate-health?redirect_source=/publications/maps-and-interactives/2019/feb/what-your-state-doing-affect-access-adequate-health).

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## Appendix A

For purposes of this report, the author visited a well-known online brokerage website and searched for short-term, limited-duration health plans using the patient profile of a 57-year-old woman, who indicated she was a non-smoker. Plan information was sought using the following zip codes:

City	State	Zip Code	Urban/Rural
Chicago	IL	60639	Urban
LaSalle	IL	61301	Rural
Houston	TX	77051	Urban
Mission	TX	78572	Rural
Portland	ME	04103	Urban
Allagash	ME	04774	Rural
Miami-Dade	FL	33172	Urban
Jackson	FL	32446	Rural
Milwaukee	WI	53202	Urban
Waupaca	WI	54981	Rural
Pittsburgh	PA	15286	Urban
Towanda	PA	18848	Rural

Plan information was solicited in November 2018 for five states. Plan information for Pennsylvania was solicited in March 2019.

Information regarding premiums, deductibles, and plan duration was based on the index provided by the online broker. In addition, the authors selected specific plans – including the least expensive and most expensive plans in each of the zip codes examined. The author recorded the online broker’s summary information regarding the plan. The broker’s summary information also contained direct links to the issuer’s plan brochure and plan exclusions and exceptions. For all but one issuer included its plan’s exclusions within the plan brochure. This issuer provided plan exclusion information as a separate document, accessible via a separate link.

## Appendix B

In September-December 2016, experts at Avalere Health, LLC, the American Cancer Society and the American Cancer Society Cancer Action Network (ACS CAN) created three profiles of cancer patients and treatment regimens. Avalere analysts ran each patient profile through three insurance scenarios and calculated patient out-of-pocket costs and total healthcare costs. These profiles can be found at <https://www.fightcancer.org/policy-resources/costs-cancer>. Following is detailed methodology for the breast cancer patient profile, Mary.

Mary had Stage I breast cancer. She had one tumor that measured 1 cm in size. Her breast cancer was hormone-receptive positive and HER2 negative. Her RT-PCR score was 20, which meant that her cancer might come back, so Mary chose to have adjuvant chemotherapy. Her oncologist also recommended radiation treatment to stop her cancer from returning. Mary was assumed to be diagnosed in the first month of coverage of each of the plans examined in this report. Mary's treatment regimen was based on National Comprehensive Cancer Network (NCCN) Guidelines for patients with Mary's profile. The treatment regimen included:

- Mammogram
- Ultrasound
- CBC and liver function tests
- Breast MRI
- Core needle biopsy
- Lumpectomy (surgery)
- Sentinel lymph node biopsy
- Hormone receptor and oncotype tests
- Chemotherapy – dose-dense AC and paclitaxel
- Supportive care drugs – filgrastim, aprepitant, dexamethasone, ondansetron
- Monitoring blood tests
- EBRT (radiation)
- Adjuvant hormone therapy – letrozole
- Multiple primary care provider visits
- Multiple specialist visits with a medical oncologist, radiation oncologist, breast surgeon

### Individual Market Insurance Scenario

The treatment costs used in this model were average commercial costs across private payers taken from [MEPS](#) and [HCUP](#) data sets. 2014 was the most recent year available for these data sets at the time of the analysis of the Cost of Cancer report. In instances where commercial rates were not available, 100 percent of published 2016 Medicare rates from the following fee schedules were used: Medicare Physician Fee Schedule, Outpatient Prospective Payment System, Inpatient Prospective Payment Systems, and Clinical Lab Fee Schedule.



The costs used in this model for pharmacological treatments are as follows. For intravenous drugs, average sales price (ASP) data from the [Centers for Medicare and Medicaid Services \(CMS\) October 2016 pricing file](#) were used, reflecting ASP plus 6 percent. Though some plans may reimburse based on other methodologies, their methodologies are not always made publicly available, which creates challenges in estimating precise payment amounts; using the Medicare rate should serve as a reasonable estimate for most payers. For oral drugs, prices were obtained from the [Medicare Plan Finder](#), assuming the patient lived in Texas zip code 77025. These data were used to represent negotiated prices similar to those negotiated by an insurance plan.

It was assumed that all treatment received was in-network and covered – note that patient costs would likely increase with out-of-network or non-covered treatments.

The Costs of Cancer: Addressing Patient Costs report and accompanying materials can be found at <https://www.fightcancer.org/policy-resources/costs-cancer>.