DAVID CRAIG
STATE SENATOR

Senate Committee on Insurance, Financial Services Government Oversight and Courts
Public Hearing, February 13, 2020
Senate Bill 793
Senator David Craig, 28th Senate District

Vice-Chairman Stroebel and Committee Members:

Thank you for taking testimony on Senate Bill 793 relating to short-term health care plans. Specifically, SB 793 seeks to provide greater access to health insurance for those in need of short-term health care coverage due to ineligibility for a long-term group health plan and/or inability to afford the more expensive health care plans under the Obamacare system. This bill defines short-term, limited-duration insurance using the federal government's definition, increasing the allowable duration of short-term health plans to 36 months, including renewals and extensions.

In conjunction with the passage of the Affordable Care Act (Obamacare), the eligibility for individuals covered by Short-Term Limited Duration (STLD) health insurance plans was reduced from twelve to three months. While newly limited in duration, these plans were specifically exempted from many of the requirements of Obamacare including hidden taxes, expensive mandates, and onerous regulations. Because these plans now exist outside of the Obamacare framework, they are generally far less expensive, more customizable, and better suited to the individual needs of customers in the private insurance marketplace – especially those who fall ill and need continuity of coverage. The problem, however, is that a three month duration does not provide an effective stop-gap between enrollment periods and thus does not provide adequate, continuous coverage for patients in need.

PO Box 7882 • Madison, WI 53707-7882 • (608) 266-5400
Toll-Free: (800) 334-1442 • Fax: (608) 267-6790 • Sen.Craig@legis.wi.gov • http://legis.wisconsin.gov/senate/28/craig

To remedy this, the federal government instituted a rule in 2018 which returned coverage under STLD plans to the pre-Obamacare duration of twelve months while permitting renewals for up to 36 months. Analyses show these STLD health plans to cost between 70-90 percent less than those available in the Obamacare system. These plans present a lower-cost alternative for not only young, healthy people, but also for sick individuals who require a continuity of coverage in their time of need.

With the increasing cost of health care, combined with the failed Obamacare plan, free market healthcare reforms like SB 793 are necessary now more than ever and further allow customizable plans to fit the needs of the individual or family as opposed to a government-sponsored "one size fits all" health plan.

Thank you for your attention and consideration of my testimony.

Adam Neylon

State Representative • 98th Assembly District

Thank you for your consideration of Senate Bill 793 today, legislation to align Wisconsin with federal standards for Short-Term Limited Duration health insurance plans or STLDs.

This bill, all 14 lines of it, simply aligns Wisconsin standards with federal standards, with respect to the maximum allowable term for STLDs. These plans represent an important option for thousands of families and individuals in Wisconsin. STLDs provide a coverage gap for folks who lack affordable alternatives. Moreover, for consumers who miss annual enrollment periods and are not eligible for a special enrollment, it is the only coverage option available.

These plans cost 70 to 90 percent less than most other plans. The reason they are more affordable is because these plans are customizable and operate outside the mandates of the Affordable Care Act.

Every legislator should be focused on increasing options and expanding access to health insurance. We all want people to have health insurance, and STLD plans are a flexible and affordable option for folks caught in-between more permanent options.

There is no fiscal for this legislation because we are simply extending the maximum allowable term for these plans.

Thank you for your time and take any questions for Committee Members.

Post Office Box 8953 • Madison, Wisconsin 53708 • (608) 266-5120 • Rep.Neylon@legis.wi.gov

Wisconsin Association of Health Plans

The Voice of Wisconsin's Community-Based Health Plans

Senate Bill 793
Senate Committee on Insurance, Financial Services, Government Oversight and Courts
February 13, 2020

Chairman Craig, members of the Committee, thank you for the opportunity to testify today. My name is Tim Lundquist and I am the Director of Government and Public Affairs at the Wisconsin Association of Health Plans. The Association is the voice of 12 Wisconsin community-based health plans that serve employers and individuals across the state in a variety of commercial health insurance markets, including the individual market.

Wisconsin's community-based health plans oppose SB 793 because the bill has the potential to destabilize the individual insurance market and reduce access to affordable, comprehensive health care coverage.

According to the American Academy of Actuaries, "A key to sustainability of the health insurance markets is that health plans competing to enroll the same participants must operate under the same rules." SB 793 would create an even more uneven playing field for an insurance product that already operates under different rules than comprehensive coverage.

Wisconsin health plans support consumer choice and acknowledge that short-term plans can be a necessary product for individuals who are transitioning between coverage sources. But there are consequences to creating an uneven regulatory playing field. Rather than reducing costs in the individual market, SB 793 has the potential to actually raise costs for those who need health care coverage the most.

Because short-term plans do not have to cover essential health benefits or pre-existing conditions, these plans can "cherry pick" healthy individuals by designing coverage options that disadvantage individuals with high health care needs. Increasing the allowable length of short-term policies from 18 months to three years could make individual market coverage more expensive, as individuals with significant health needs are attracted to products that are required to provide more comprehensive coverage.

SB 793 also has the potential to undermine the success of the Wisconsin Healthcare Stability Plan, a state-based reinsurance program with bipartisan support. Thanks in part to the Wisconsin Healthcare Stability Plan, weighted average individual market premiums have decreased two years in a row. In addition, consumers today have more choices of insurers than they did before the reinsurance program was implemented. Legislative action that could lead to a smaller, less healthy individual market risk pool threatens the hard-won, badly-needed stability the individual market is moving toward.

Wisconsin health plans recognize and support efforts to provide greater access to health care at lower costs, but SB 793 does not address health care cost and may actually cause individual market premiums to increase.

We respectfully request your opposition to SB 793.

Children's Wisconsin

TO: **Senate Committee on Insurance, Financial Services, Government Oversight & Courts**
FROM: **Mark Rakowski, Chief Operating Officer, Children's Community Health Plan**
DATE: **Thursday, February 13, 2020**
RE: **Opposition to SB 793 – short term health insurance plans**

Children's Community Health Plan (CCHP), an affiliate of Children's Wisconsin, provides access to high quality health care for more than 140,000 individuals and families across eastern Wisconsin. We offer the second largest BadgerCare plan in the state, as well as offer Together with CCHP, our marketplace plan, and Care4Kids, a partnership with DCF and DHS to provide coverage for kids in out-of-home care. We are proud to offer comprehensive health benefits and innovative services including case management for individuals with complex needs, a 24/7 nurse line and virtual urgent care visits. CCHP also provides health programs to support our members with asthma, depression, pregnant women, new moms, and many other wellness initiatives.

As the chief operating officer of CCHP, I have witnessed many changes in the health insurance industry over the last several years. While the goal of the authors of SB 793 to expand access to health insurance for those in need of short-term health care coverage is laudable, I am concerned the bill could create a gap in access to quality health care. Codifying the 36 month renewal or extension of these type of plans in state law may provide some access, but falls short on access to the type of comprehensive coverage consumers have come to rely on such as access to prescription drugs, wellness check-ups, preventative services like mammograms, mental and behavioral health services and maternity care. Moreover, these plans generally will not cover you if you have a pre-existing condition.

Healthcare reforms have traditionally rested on a foundation often described as a "three-legged stool." The first leg is made up of insurance reforms to ensure that coverage is meaningful. In the context of today's health marketplace, that means essential health benefits are covered and exclusionary practices like lifetime limits and restrictions on pre-existing conditions are ended. The second leg consists of mandates that everyone — young and old, healthy and sick — purchase insurance so that the shared risk of all consumers is as broad and diverse as possible. This contains cost and premium growth. Finally, the third leg of the stool helps bring premiums within reach for people with low incomes including offering subsidies.

Each leg of the stool reinforces the others. The insurance must be useful, the risk pool must be close to universal, and the coverage must be affordable. However, we are now seeing an expansion of short term, limited duration insurance plans. Such plans tend to feature lower premiums but also sparser benefits and fewer consumer protections. These short term plans result in essentially reduced coverage for some and higher premiums for everyone else. Short term plans weaken all three legs of the stool at once, and start to erode the marketplace.

Short term plans were first created to do exactly what the name implies — offer some insurance benefits for a short period of time. HHS defined them as "designed to fill temporary gaps in coverage that may occur when an individual is transitioning from one plan or coverage to another plan or coverage." These plans were originally intended to be temporary stopgaps, not a substitute for coverage.

This proposed legislation would change short term plans from a stopgap into what seems like permanent coverage to individuals because of how they are marketed.

Short term plans undermine some of the most popular recent insurance reforms — including those popular on both sides of the aisle. Short term plans, for instance, can exclude people on the basis of pre-existing conditions. Again, they need not cover essential health benefits, like maternity care or treatment for substance abuse. And short term plans often have deductibles of up to $20,000 for three months of coverage. Some also have annual coverage limits of $1 million.

Not only do short term plans *not* cover pre-existing conditions, but what was covered when you bought the plan can be excluded later when you try to renew the plan. Rescissions are rampant in the short term market, leading to retroactive cancellation of policies that stick patients with enormous medical bills.

Just a couple of examples of the real-world consequences of these plans include:

– A woman in Illinois went to the hospital with heavy vaginal bleeding resulting in a five-day hospital stay and a hysterectomy, only to be denied coverage under her short-term plan on the ground that her menstrual cycle constituted a pre-existing condition.

-A husband and wife in Arizona who purchased a short-term plan believing it was comprehensive coverage were left with over $200,000 in medical bills after the husband suffered a heart attack. The listed maximum total payout of $750,000 was misleading after the deductible was paid. It instead meant they could have a number of procedures totaling up to $750,000, but only covered up to $5,000 maximum per procedure.

Short term plans are inadequate as health insurance but are still being marketed as an alternative to actual health insurance plans – that is, Qualified Health Plans in the Marketplace. State regulators have been receiving increased complaints about these plans related to their marketing and coverage. The Federal Trade Commission has received numerous cases of customers buying health insurance they believed was comprehensive, then having their claims rejected or barely paid out. We thought we had solved the problem of insurance companies pocketing premium rather than spending it on medical care for their members. Short term plans bring that problem back—in a big way. Some don't spend even half their premiums on medical care.

Short-term plans also do not have to meet market-wide standards such as ensuring most premium dollars are used for health benefits or that sufficient doctors and hospitals are in the plan's network. Short term plans are not subject to rules around mental health parity, or other non-discrimination rules that protect people with conditions like HIV/AIDS.

These plans can be effective stopgaps. But that is all they should be. Short term plans are not functional as full-time health coverage products and Wisconsin would be wise not to allow the extension of these up to three years.

Children's Community Health Plan is glad to serve as a resource. If you have any questions, comments or concerns, please contact me mrakowski@chw.org, 414-266-6328.

Wisconsin Medical Society

TO: Senate Committee on Insurance, Financial Services, Government Oversight and Courts

FROM: HJ Waukau, Director of Policy

DATE: February 13, 2020

RE: Opposition to Senate Bill 793 – Short-term Health Coverage

Adopting the federal definition of short-term limited duration insurance plans (STLDI) as defined under SB 793 present two concerns for the Society. First, the coverage provided by STLDI plans does not maintain the patient protections as codified by the Affordable Care Act (ACA). Second, expansion of STLDI plans could undermine and destabilize the ACA marketplace threatening coverage for Wisconsin's residents. It is the mission of the Wisconsin Medical Society (Society) to improve the health of the people of Wisconsin by supporting and strengthening physicians' ability to practice high-quality patient care in a changing environment. We are also committed to achieving universal coverage for patients through both public and private means.

To help guard against any potential market instability the Society ardently supported the Wisconsin Healthcare Stability Plan (WIHSP) that was created by Governor Walker in 2018. WIHSP was a reinsurance plan that buttressed Wisconsin's insurance markets and lowered premiums, enabling Wisconsin's residents to seek and maintain adequate health coverage.

STLDI plans do not adhere to all of the ACA's guidelines and requirements. They are intended to serve as stopgap for those who lose coverage, but still want to maintain a major medical policy for a variety of personal reasons. By design, STLDI plans are allowed to be underwritten, and not cover preexisting conditions. Under STLDI plans patients can be denied coverage based on any preexisting conditions, lose coverage if they are diagnosed with a new condition, or be subject to coverage caps.

The issue of insurance affordability is one that the Society takes very seriously but exposing patients to unnecessary risk is not a remedy. Further, the Society does not support insurance plans that do not cover essential health benefits as defined under the ACA or patient protections such: as guaranteed issue of insurance, no caps on coverage, and no exclusions for preexisting conditions. By definition, STLDI plans do not meet this standard.

An additional concern is that the enrollees most apt to select an STLDI plan are younger and healthier than those who need the coverage provided by a qualified ACA plan. Increased utilization of STLDI plans could siphon off younger, healthier members who are a key component of a financially sustainable insurance exchange.

The Society appreciates any and all efforts to increase access to robust insurance coverage for Wisconsin's residents and welcomes future conversations on the subject.

2450 Rimrock Rd. Suite • Madison, WI 53713-1109 • wisconsinmedicalsociety.org • Phone 608.442.3800 • Toll Free 86.442.3800 • Fax 608.442.3802

COMMON GROUND

HEALTHCARE COOPERATIVE

Testimony Opposing Senate Bill 793
Relating to Short-Term Health Coverage

Senate Committee on Insurance, Financial Services, Government Oversight and Courts
February 13, 2020

Chairman Craig and members of the committee, we appreciate the opportunity to submit written testimony regarding Senate Bill 793, which would allow short-term limited duration insurance (STLDI) policies to be sold for a consecutive 36 months in Wisconsin.

Common Ground Healthcare Cooperative (CGHC) was created by business and healthcare leaders to bring value, accountability and honesty to the individual and small group health insurance markets. Anyone that is familiar with our story knows that we faced many challenges with the startup of the Affordable Care Act. We fought for the privilege of serving consumers in the individual market, and we were the only carrier on the exchange in several Wisconsin counties in 2018 and 2019. Today, there is more competition in those counties because the market is stabilizing.

Our mission, defined by the insurance consumers that govern our Board of Directors, dictates that we provide education and advocacy for our members who need support and assistance in understanding their health care choices and decisions. Today, we advocate for our members by opposing Senate Bill 793. Yes, there are problems with the Affordable Care Act that need fixing – we know those very well. And we also recognize that the authors of this legislation have good intentions to lower costs for consumers. Unfortunately, SB 793 is not compatible with consumer protections such as pre-existing condition coverage have been embraced by the majority of Americans and politicians on both sides of the aisle. We hope the remainder of this testimony illustrates why.

What is Short-Term Insurance?

STLDI plans were created as a stopgap measure before the federal government passed laws related to portability of health coverage, and they played an important role of providing coverage to workers that were subject to coverage waiting periods. A short-term carrier can deny coverage, charge more based on age or health status, and exclude services like prescription drug coverage, mental health care and maternity care. Short-term plans are not required to cover pre-existing conditions (even if they are not yet diagnosed) and can impose annual and lifetime limits on benefits. STLDI plans are typically not renewed for enrollees who become sick while covered by one.

In other words, short-term plans play a role in providing continuity of coverage. They are not, and were never intended to be, a replacement for long-term coverage that meets all insurance consumer protections and regulations. Like undersized spare tires in a car, they get the job done for short periods of time but have severe limitations. Using them long term will bring trouble.

How SB 793 Hurts Consumers

Any consumers that decline comprehensive coverage during the annual open enrollment period and opts to purchase an STLDI plan is taking a gamble. If they get sick, their health claims will certainly be investigated to determine if there is a tie to a pre-existing condition. In fact, in-depth claims investigations are a key component of STLDI from a carrier perspective. Some egregious examples cited in a recent federal lawsuit currently pending on short-term plans include:

- A woman who went to the hospital with heavy vaginal bleeding resulting in a five-day hospital stay and a hysterectomy, only to be denied coverage under her short-term plan on the ground that her menstrual cycle constituted a pre-existing condition.

- A man in Washington, D.C. who purchased a short-term plan with a stated maximum payout of $750,000; when he sought coverage for a $211,000 bill resulting from a hospitalization, he was paid only $11,780. He was denied coverage in part based on his father's medical history.

Many short-term plan consumers are not aware of what they are buying. A simple google search for "affordable health insurance" or "Obamacare plans" will result in numerous top-of-page returns that links the consumer to STLDI plans without disclosing it to the consumer. One marketing scan conducted by the Georgetown University Center on Health Insurance Reforms (CHIR) found that in every state, over half of all results from websites that suggest ACA-compliant health insurance products to consumers directed them to STLDI or other insurance products that don't meet the standards for comprehensive insurance.

It demonstrates that while consumers are looking to purchase more comprehensive coverage, they may be duped into purchasing STLDI coverage when they need something more comprehensive. Or, a consumer may not fully understand the potential impact of purchasing an SLTDI product, particularly consumers that don't realize they have a pre-existing condition or what an STLDI plan might deem a pre-existing condition.

The math alone is telling. While other types of regulated health insurance are required to spend at least 80% of premium dollars on medical care as opposed to administrative costs or profits, STLDI plans only spend about 50% according to a Milliman study. The percentage is not regulated at all, and it is not unheard of for companies to spend as little as 35% on medical care in a successful year. The attached policy paper from the Center on Budget and Policy Priorities goes into greater detail about how STLDI plans achieve their low medical loss ratio and high profit margins.

How SB 793 Damages the Wisconsin Market

In a free-market health insurance system, all competitors must play by the same rules. If certain competitors can play by different rules by calling their long-term plans "short-term," then it will be a race to the bottom for insurance coverage. Individuals with pre-existing conditions, who cannot go without comprehensive coverage and would be denied by a short-term carrier will be the ones that will pay the highest price, as will consumers who simply want high quality, comprehensive health insurance coverage.

If STLDI plans proliferate in Wisconsin, they will only accept Wisconsin's healthier consumers. This will have a detrimental impact on the risk pool and the stability of Wisconsin's individual health insurance market. The risk profile for plans that cover pre-existing conditions will only worsen, driving prices up. As more people leave, the more expensive comprehensive coverage will become.

The Association for Community Associated Plans (ACAP) recently commissioned an actuarial study done by Wakely Consulting Group to model the impact of three-year short-term plans on the individual market. Wakely estimated that after an initial ramp-up period, the impacts of adverse selection would begin to take effect and decreased enrollment in individual market would result in higher premiums. They modeled two scenarios, high and low enrollment, to produce a range of estimates. We are happy to share the entire study if you are interested, but we provide an excerpt below. The figures are based on national data.

Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market
(Wakely Consulting Group for ACAP, used with permission)

Scenario	Near-term, after initial ramp-up	Near-term, after initial ramp-up
Method	Low 80% of unsubsidized market drops comprehensive coverage	High 100% of unsubsidized and a portion of subsidized
Year of Impact	**4-5 years**	**4-5 years**
Estimate Performed By?	Wakely	Wakely
Off-Exchange Population Included?	Yes	Yes
Increase in Premiums	2.2%	6.6%
Decrease in Enrollment	-8.2%	-15.0%

Should long-term STLDI plans proliferate as modeled above, the landscape will become hostile to Wisconsin plans offering comprehensive coverage that covers pre-existing conditions. If comprehensive plans once again exit the Marketplaces then fewer affordable, comprehensive health insurance options will remain. Keep in mind most consumers in ACA-compliant plans today are enrolled in Wisconsin-based community health plans. By contrast, most STDLI policies are sold by companies headquartered outside of Wisconsin that emphasize profit over service (as evidenced by their low MLR/high profit margin).

Conclusion

As you consider SB 793, please keep in mind that STLDI plans cost less only because they offer less coverage and pay for much less care. While this may appear to be a solution for individuals that don't currently receive tax credits to lower the cost of their coverage, it would do more damage than good. Instead, we hope to work with policymakers on solutions that will improve the individual market through smart reforms that may require federal action or approval. While this may be not be politically popular or expedient, it is what is needed to best serve the people of Wisconsin.

Thank you to the members of the Senate Insurance Committee for reading through this testimony. If you agree that protecting Wisconsin's insurance market and consumers (especially those with pre-existing conditions) is the priority, then we ask that you not move SB 793 forward and begin to work with us on other solutions. Please contact Melissa Duffy at (608) 334-0624 if you have any questions about this testimony.

Enclosure: Attachment 1

Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

September 20, 2018

Key Flaws of Short-Term Health Plans Pose Risks to Consumers

By Sarah Lueck

Federal rule changes to short-term health plans are set to take effect on October 2, newly allowing insurers to offer them to consumers for up to one year (instead of three months) and renew or extend them even longer. This is likely to make short-term plans seem, at least on the surface, more similar to traditional individual-market health coverage. But that's far from true: in most states, short-term plans are exempt from pre-existing-condition protections and benefit standards that individual-market plans must meet. This new parallel market for skimpy plans will expose consumers buying these plans to new risks and raise premiums for those seeking comprehensive coverage, especially middle-income consumers with pre-existing conditions.

Short-term plans do not have to cover all of the Affordable Care Act's (ACA) essential health benefits, such as maternity and mental health care, substance use disorder treatment, and prescription drugs — and they often don't.[1] Short-term plans can deny coverage or charge higher prices to people with pre-existing conditions, and they typically do not cover medical services related to a pre-existing condition.

Short-term plans are likely to offer some healthier people lower premiums (because the plans include reduced benefits and cover less costly populations), and thus will lure healthy enrollees away from the individual and small-group markets and leave a costlier group behind. This dynamic, known as adverse selection, raises premiums for traditional, more comprehensive health coverage and undermines ACA protections for people with pre-existing conditions. Meanwhile, healthy people who enroll in these plans may find themselves facing gaps in coverage and exposed to catastrophic costs if they get sick and need care.

Short-term health plans can be sold all year, but the companies that sell them are already gearing up to use the six-week open enrollment period for ACA plans that begins November 1 as a focal

[1] Karen Pollitz *et al.*, "Understanding Short-Term Limited Duration Health Insurance," Kaiser Family Foundation, April 23, 2018, https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

point for their own, often aggressive marketing efforts.[2] And even as the Trump Administration scales back its efforts to inform people about more comprehensive ACA plans, it is promoting short-term plans as a viable alternative with often-lower premiums.

Recent short-term plan documents filed with state regulators show that the plans' major shortcomings will persist for consumers as these plans expand.[3]

Short-term plans' major problems include:

1. **Invasive and complex applications.** Applicants for short-term plans typically must answer numerous questions about their health status, illnesses, and prior medical treatments. For example, the application for short-term coverage from Independence American Insurance Company, as submitted to North Dakota insurance regulators early this year, asks more than a dozen health-related questions, such as whether the applicant received medical tests or advice related to cancer, stroke, diabetes, or alcohol abuse within the last five years; whether the person weighs more than 300 pounds (if male) or 250 pounds (if female); and whether the applicant is waiting for test results or has been advised to have treatment or testing for any of the listed health conditions.[4] In an application for short-term coverage submitted to Arkansas regulators, United Security Health and Casualty Insurance Company asks applicants to grant access for two and a half years to medical records related to matters such as: alcohol or drug abuse treatment, mental health diagnosis, HIV testing, pharmacy prescriptions, lab data, and genetic testing.[5]
2. **Higher premiums based on personal characteristics such as gender and age**. Unlike ACA plans, short-term health plans charge higher premiums to people based on their gender and can charge far higher premiums to older people based on their age than the ACA allows. For example, a National Health Insurance Company short-term plan with a $5,000 deductible would cost $109 per month for a 40-year-old woman, compared to $90 per month for a 40-year-old man, according to data submitted to Wisconsin insurance regulators. The same plan would cost a 60-year-old man $297 per month, while a 60-year-old woman would pay $270 per month.[6]

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[2] "IHC's HealtheDeals.com to Greatly Expand its Owned Sales Distribution Capabilities," PRWeb, September 5, 2018, https://www.prweb.com/releases/ihcs_healthedeals_com_to_greatly_expand_its_owned_sales_distribution_capabilities/prweb15737057.htm.

[3] Notably, in many states, short-term plans that were filed with regulators many years ago could be newly or more actively marketed again without being subject to new filing or approval requirements, making it hard to get a complete picture of most states' short-term markets. See Emily Curran *et al.*, "Do States Know the Status of Their Short-Term Health Plan Markets?" Commonwealth Fund, August 3, 2018, https://www.commonwealthfund.org/blog/2018/do-states-know-short-term-health-plan-markets.

[4] "Application for Individual Limited Short Term Medical Expense Insurance," Independence American Insurance Company, submitted January 2018 in North Dakota, accessed via SERFF Filing Access, September 18, 2018.

[5] "Arkansas Short-Term Medical Insurance Application," United Security Health and Casualty Insurance Company, submitted August 30, 2018, accessed via SERFF Filing Access, September 18, 2018.

[6] "National Health Insurance Company Rate Manual," submitted to Wisconsin, April 6, 2018, accessed via SERFF Filing Access, September 18, 2018.

3. **Denials of coverage for pre-existing conditions.** Short-term insurers use various tactics to avoid paying out large amounts for people's pre-existing conditions. As noted, they may simply deny coverage to people who report having a health condition. In addition, short-term plan contracts typically include a broad exclusion for any care related to a pre-existing condition, so that if a person has a condition the application didn't ask about (or that the enrollee didn't know about), care related to that condition may not be covered. In addition, after a short-term plan enrollee receives medical care, the insurer may investigate their medical history for evidence that the care they already received is related to a pre-existing condition, a practice known as "post-claims underwriting."[7] That's what seems to have happened to a Pennsylvania man who was hospitalized for an abnormal heartbeat but had his medical claims denied because of a previous doctor visit for high blood pressure.[8] A similar issue arose for a Georgia woman who was diagnosed with breast cancer *after* she bought a short-term plan and was then left with $400,000 in medical bills because the insurer said the disease pre-dated the coverage.[9]

4. **High out-of-pocket costs for people who need care.** Short-term plans can — and often do — fail to cover ACA essential health benefits. An April 2018 study of the short-term plans available through two major online broker sites found that 43 percent of plans didn't cover mental health services, 62 percent didn't cover substance use disorder treatment, 71 percent didn't cover outpatient prescription drugs, and none covered maternity care.[10] People who enroll in a short-term plan and then need one of these missing benefits have to foot the bill on their own.

   Some benefit gaps may be subtle, found only in the policy's fine print. For example, a Golden Rule short-term plan submitted in Arizona in August (but sold in multiple states via the United Business Association) excludes coverage of expenses for such events as: illnesses resulting from being intoxicated or under the influence of illegal drugs, charges incurred as a result of "intentionally self-inflicted bodily harm (whether the covered person is sane or insane)," and injuries related to professional or intercollegiate sports, hang-gliding, SCUBA diving, riding a motorcycle, riding a horse, rock climbing, and skiing.[11] One odd provision found in short-term plans from Golden Rule (part of health insurer UnitedHealthcare) bars

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[7] Gary Claxton *et al.*, "Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA," Kaiser Family Foundation, December 12, 2016, https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

[8] Sarah Lueck, "Health Care Executive Order Would Destabilize Insurance Markets, Weaken Coverage," Center on Budget and Policy Priorities, November 29, 2017, https://www.cbpp.org/research/health/health-care-executive-order-would-destabilize-insurance-markets-weaken-coverage.

[9] Erik Larson and Zachary Tracer, "The Health Plans Trump Backs Have a Long History of Disputes," Bloomberg, October 16, 2017, https://www.bloomberg.com/news/articles/2017-10-16/trump-s-insurance-directive-renews-preexisting-conditions-fight.

[10] Pollitz *et al.*, *op cit.*

[11] "Short Term Medical Expense Certificate," Golden Rule Insurance, submitted to Arizona August 6, 2018, accessed via SERFF Filing Access, September 18, 2018.

coverage of costs of room and board and nursing care when someone begins a hospital stay on a Friday or Saturday.[12]

Short-term plans also can charge high deductibles and cost-sharing for the benefits they do cover (i.e., a $5,000 deductible for a policy that lasts three or six months), leaving patients responsible for the rest. Or, the plans include dollar limits on how much they will pay out for a given service or in total for benefits over the life of the policy, or during the life of the enrollee. A recent review of select short-term health plans available in Philadelphia concluded that even when people experience unanticipated illnesses, unrelated to a pre-existing condition, the coverage available under short-term health plans is so sparse that enrollees would face large out-of-pocket charges. For example, one Philadelphia plan limited coverage of hospitalization to no more than $1,000 per day, far less than the U.S. average cost of more than $5,000 per day. Another Philadelphia plan limited benefits for an appendectomy to $2,500, when the average cost of that procedure is nearly $14,000.[13]

5. **High premiums relative to the value of the benefits they provide**. Even with seemingly low premiums, enrollees in short-term plans may still pay too much for the coverage these plans offer. Much of the money that consumers pay to insurers offering short-term plans actually goes toward plan administration, marketing, and profits — and little toward enrollees' health care. For example, the top three companies selling short-term health plans (based on premiums earned) paid 43 percent, 34 percent, and 52 percent of the premiums they collected from short-term plan enrollees for medical claims (known as the loss ratio), according to data from the National Association of Insurance Commissioners.[14] By comparison, the ACA requires individual-market insurance plans to pay *at least 80 percent* of premiums on medical claims or health quality improvement. The requirement is meant to ensure that consumers receive decent value for the money they spend on health insurance, but it doesn't apply to short-term plans.

Short-term health plans raise risks for the consumers who enroll in them and raise premiums for comprehensive coverage in the traditional ACA market. While some states have banned or limited these plans to protect consumers,[15] in most states, consumers who buy their own health insurance are likely to face a proliferation of substandard, short-term health plans.

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[12] Michael Hiltzik, "The fine print of those short-term health plans favored by Trump: Don't get sick on a weekend," *Los Angeles Times*, April 26, 2018, http://www.latimes.com/business/hiltzik/la-fi-hiltzik-short-term-insurance-20180426-story.html.

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