JUMPSTART

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OPPORTUNITIES WITHIN THE SHORT-TERM HEALTH INSURANCE MARKET

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INTRODUCTION

Health insurance is becoming increasingly unaffordable. For example, in the employer-sponsored insurance market, which covers nearly half the US population, the average individual annual premium was $7,188 in 2019. This total is up 4% from 2018, and up 19% since 2014.[1] Additionally, the unaffordable costs of health insurance can be seen in the uninsured population with 9% of the population currently uninsured.[2] Increasing premiums and uninsured rates drive the need for more affordable coverage options.

A more affordable coverage option for some consumers could come through short-term limited-duration insurance (STLDI) plans. STLDI plans are health insurance plans that until recently were only offered to consumers for up to three months to fill temporary gaps in coverage. Recent regulatory changes now allow these plans to be used by consumers for up to 36 months. [3]

STLDI plans typically offer significantly lower monthly premiums in comparison to Qualified Health Plans (QHPs), such as those offered through an employer or the federally-facilitated Marketplaces. STLDI plans can offer lower monthly premiums because they can deny coverage to those with pre-existing conditions, offer less coverage and consumer protections than QHPs, and usually have higher out of pocket maximums than QHPs. [4] Therefore, the lower premiums of STLDI plans can create short-term savings, but the less extensive coverage and financial protections can lead to higher future costs for members. This less extensive coverage and increased financial exposure make consumers wary of enrolling in STLDI plans, as evidenced by the less than 200K people currently enrolled in these types of plans. [5]

Yet STLDI plans do not have to offer such limited coverage and financial protections to be profitable. For example, the top 5 STLDI plans only spent 39% percent of premiums on claims related to care for their members. [5] Comparatively, QHPs are mandated to spend 80% of premiums on care. [6] While high margins are great for a STLDI plan, focusing too aggressively on margin may be a short-sighted strategy for a STLDI plan given the increasingly unaffordable costs of QHPs and the recent regulatory change that enables STLDI plans to keep healthy members enrolled for 36 months.

An alternative STLDI plan strategy could be to reinvest a portion of their collected premiums back into the plan to bulk up the coverage to narrow the coverage and consumer protection differences between QHPs. By eliminating some of the differences that make consumers hesitant to join, a STLDI plan could take advantage of the increasing QHP premiums and begin pulling healthy members from the QHP and uninsured market onto their STLDI plan for up to 36 months. This strategy would cause the SLTDI plan to have lower margins, but the size of their member pool could grow significantly, leading to potentially higher profits for the plan.

To demonstrate how a STLDI plan could be constructed to pull healthy members from the uninsured and QHP markets, we first present the five main challenges that currently prevent STLDI plans from being trusted coverage options. These challenges are:

- STLDI Plans Lack Coverage of All Essential Health Benefits (EHBs)
- STLDI Plans Deny Coverage for Pre-Existing Conditions
- STLDI Plans Have Higher potential out of pocket costs
- STLDI Plans Impose Dollar Limits to their coverage
- STLDI Plans Lack Provider Networks

Next, we outline which of these challenges could be addressed to attract healthy members onto a STLDI plan while still enabling the plan to both maintain a healthy margin and keep premiums lower than QHPs. Following, we provide an outline of a new hypothetical STLDI plan design that could convince healthy individuals to leave the uninsured or QHP market for the STLDI market. Next, we outline an assessment of the new hypothetical plan's strengths and weaknesses. Finally, we offer a conclusion that reiterates why more affordable coverage options are needed.

SECTION 1:

CHALLENGES PREVENTING SLTDI PLANS FROM BEING RELIABLE COVERAGE OPTIONS

CHALLENGE 1: LACKING COVERAGE OF ALL ESSENTIAL HEALTH BENEFITS (EHBS)

The Affordable Care Act (ACA) mandates that QHPs cover ten essential health benefits (EHBs).[7] These benefits include ambulatory services, emergency services, hospitalization, maternity care, behavioral health, prescription drugs, rehabilitative services, prevention and wellness services (including chronic disease management), laboratory services, and pediatric services.

Conversely, SLTDI plans are not held to the same regulations as QHPs and are not mandated to cover EHBs. This lack of mandate leads to many STLDI plans choosing not to cover all EHBs. For example, in a study by the Commonwealth Fund who examined STLDI plans offered across five states, it was found that all researched plans excluded maternity costs as part of their coverage. Additionally, 73% of plans did not include prescription drugs, and 64% excluded mental health services. [8] These numbers are supported by a similar survey by Kaiser. In Kaiser's 2018 survey, it was found that 43% of STLDI plans did not cover mental health services, 71% did not cover outpatient prescription drugs, and no plans covered maternity care.[9]

These coverage differences can leave members on STLDI plans who are unaware of the coverage specifics surprised by their financial obligations after receiving care. For example, a member may be under the assumption their plan covers maternity care as it is always offered by QHPs. Yet if a STLDI plan did not cover maternity care and a member gave birth while on the plan, the plan would not cover the costs. This would result in the patient being left with thousands of dollars of out of pocket costs.

CHALLENGE 2: DENYING COVERAGE FOR PRE-EXISTING CONDITIONS

QHPs must offer coverage for individuals with pre-existing conditions.[10] For example, if a diabetic tries to enroll in a plan on a federally-facilitated marketplace, they can not be denied coverage by the plan for having diabetes. Conversely, STLDI plans can deny coverage for those with pre-existing conditions such as diabetes. In a study by the Commonwealth Fund who examined a sample of all the STLDI plans offered across five states, every plan denied coverage to individuals based on health status. [8]

Additionally, not only can STLDI plans reject coverage to individuals, but they can also rescind the coverage of members who have complications that the plan can tie to a pre-existing condition. This process is called "post-claims underwriting". For example, if a patient has claims that indicate they had diabetes before joining the plan, the plan can then drop the patient from the plan. Depending on when this occurs, it could be nearly a year before the patient is able to gain coverage on a QHP in open enrollment. This can lead to financial devastation for a patient. For example, a study by Milliman found that a condition such as diabetes could cost a patient who has their coverage dropped over $15K before they can enroll in a QHP. [11]

CHALLENGE 3: HIGHER POTENTIAL OUT OF POCKET COSTS

QHPs typically have higher premiums than STLDI plans. For employer-sponsored coverage, the average premium for an individual is $599 a month, with the employee contributing $108 to the total. [1] On the federally facilitated marketplace, the average Bronze plan premium is $331, according to Kaiser, and the average Catastrophic plan premium is $173 a month.[12] While these plans have high monthly premiums; the ACA mandates QHPs cap member's out-of-pocket costs for in-network costs at $8,150. [13] Capping the in-network cost reduces the likelihood of financial devastation if someone were to get seriously sick while under the plan's coverage. For example, if a patient were to have a heart attack, after the out of pocket cap has been met, the plan is liable for the remaining cost as long as it is in-network.

Conversely, STLDI plans usually have lower premiums than QHPs but have higher out of pocket maximums, if any at all. For example, the average premium of a STDI plan is $113, according to eHealth. [14] In regards to out of pocket maximums, STLDI plans are not mandated to have a cap to their out of pocket costs, but many do. [15] In a study conducted by Milliman, over 60% of STLDI plans researched had out of pocket limits above the QHP limit. The study also found the typical out of pocket maximum was $10,000, but popular plans with the lowest monthly premiums can have out of pocket maximums that exceed $20,000 or are uncapped. [11] This could lead to financial devastation for a patient. For example, if a patient has a heart attack while covered by a STLDI plan, they could be on the hook for thousands of dollars more than if they were on a QHP.

CHALLENGE 4: IMPOSING DOLLAR LIMITS TO THEIR COVERAGE

QHPs cannot impose a dollar limit on their coverage for EHBs. [16] For example, if a patient were to have the end-stage renal disease (ESRD) and need a transplant, after the out of pocket maximum has been met, the plan is responsible for the remaining in-network costs no matter how high the costs reach.

Conversely, STLDI plans can impose dollar limits to their coverage. According to Milliman's study in which they examined 96 STLDI plans offered in the Atlanta, GA area, the typical STLDI plan offered a coverage limit of $2M dollars. Having dollar limits to coverage could lead to financial devastation for a member. [11] For example, if someone receives a cancer diagnosis and has costs upwards of $2M, the plan would stop paying at $2M, which would leave the patient with the remaining costs until they could enroll in a QHP to cap their expenses.

CHALLENGE 5: LACKING PROVIDER NETWORKS

QHPs have networks of providers that the plan has contracted with that determine what services are reimbursed and the rate the service will be reimbursed. Having a provider network benefits the patient because the provider must bill the patient according to the rate negotiated between the provider and plan. Additionally, having a provider network enables the plan to ensure their members are being seen by high-quality providers, which can control costs for the plan by catching complications early. [17]

Conversely, many STLDI plans frequently lack provider networks. For example, in a study by the Commonwealth Fund who looked at the STLDI plans in five states, only 57% of STLDI plans had provider networks. Not having a provider network can lead to what is known as "balanced billing." [8]

Balanced billing is when a provider sends a patient a bill for the remaining balance of the care they received after the payer pays a "usual, customary rate" (UCR). [18] Insurers own the databases that determine the UCRs they payout, and therefore the providers and consumers do not know how much the payer will reimburse. Oftentimes the UCR is well below what the provider charges. Therefore, the provider will then bill the patient for the remaining balance, leaving the patient with an unpredictable, surprise bill. [19] For example, if a patient has already hit their out of pocket maximum and then has a $10K surgery according to the provider, but the plan only pays $5K as that is what they deem the UCR, the provider could still come after the patient for the remaining $5K because there was not an agreed upon rate between the provider and plan.

SECTION 2:

APPROACHES TO MITIGATING CHALLENGES OF STLDIS

Suppose an STLDI plan wants to attract healthy members to join from the QHP or uninsured market. In that case, it must close the gaps that exist between traditional STLDI plan coverage and QHP coverage while still maintaining lower monthly premiums. To close the gaps without substantially raising premiums, the plan must cut into its existing margin. Many STLDI plans can afford to do this. For example, the top 5 STLDI plans only spent 39% percent of premiums on care for their members. [5]

As every challenge the plan addresses increases the plan's financial exposure or adds to administrative costs, not every challenge can be addressed while keeping margins and retaining lower premiums than QHPs. For example, if a plan did not deny coverage for pre-existing conditions, they would be exposed to nearly the same member risk profile of a QHP. The plan would then have to offer premiums to match the risk level or be unviable. Therefore, the STLDI plan designers must carefully decide which challenges to address to provide enough coverage to convince people to join while keeping their financial risk and administrative costs low enough to still offer cheaper premiums than QHPs and maintain a viable margin. Below we explain which challenges a STLDI plan can choose to address while maintaining a viable margin and offering lower premiums that QHPs.

CHALLENGE 1: LACKING COVERAGE OF ALL EHBS

Choosing to Address: Providing coverage for all EHBs would increase premiums or force the plan to cut into margin because each benefit a plan covers increases the claims a plan should expect to pay. Each EHB has a different expected cost of coverage, with some EHBs being more expensive than others to cover. For example, according to Kaiser Health, females have an average cost of $3,360 and males have an average cost of $1,746 in the 19-34 age group. [20] This difference is primarily due to maternal health costs. Costs for EHBs such as maternal health make it hard, but probably not impossible to offer coverage for all EHBs. A plan's ability to cover all EHBs depends in part on what other challenges are addressed.

CHALLENGE 2: DENYING COVERAGE FOR PRE-EXISTING CONDITIONS

Choosing to Address: Providing coverage for those with pre-existing conditions would increase premiums or force the plan to cut into margin because pre-existing conditions significantly increase the member population's risk profile. For example, in 2010, 86% of healthcare spending was associated with patients with at least one chronic condition. [21] Additionally, according to the Milken Institute, chronic disease costs over one trillion dollars a year. [22] Considering these costs and the evidence in a study by The Commonwealth Fund that found no plans covering pre-existing conditions, covering pre-existing conditions would most likely render a STLDI plan unviable. [8]

CHALLENGE 3: HIGHER POTENTIAL OUT OF POCKET COSTS:

Choosing to Address: Providing lower limits to out of pocket costs would increase premiums or force plans to cut into margin because it shifts more cost responsibility onto the STLDI plan. For example, QHPs begin covering all in-network costs after $8,150. A STLDI plan could choose to drop their out of pocket limits and have them be as low or lower than QHPs, but to do so would require cutting into their margin or raising premiums in proportion to the increased risk. A STLDI plan should have out of pocket maximums more in line with QHPs, but it ultimately depends on what other challenges the plan chooses to address.

CHALLENGE 4: IMPOSING DOLLAR LIMITS TO THEIR COVERAGE:

Choosing to Address: Eliminating dollar limits would increase premiums or force plans to cut into margin because the dollar limits shift lots of financial risk onto the plan. For example, if a member is diagnosed with cancer and has bills of $3M in a year, yet the plan capped the dollar limit at $2M, the plan saves $1M by capping coverage. With the ability to deny coverage for pre-existing conditions, these situations should be rare, and a plan could choose to address this challenge. Still, ultimately it depends on what other challenges the plan chooses to address.

CHALLENGE 5: LACKING PROVIDER NETWORKS

Choosing to Address: Creating a provider network would increase premiums or force plans to cut into margin because it increases administrative costs to set up and maintain and does not allow for the plan to pass as much financial risk to the member. For example, by treating every claim as out of network and reimbursing a UCR rate well below what they would have had to pay if they created a network, the plan can limit its financial exposure. With plans able to keep patients for 36 months, it may be beneficial to the plan to build a network to make sure members are seeing quality physicians to lower the chances of high future claims. This challenge could be alleviated, but ultimately it depends on what other challenges the plan chooses to address.

SECTION 3:

SUMMARY OF A NEW PLAN DESIGN

There are multiple different ways the above challenges could be addressed in a new STLDI plan to create an appealing plan for healthy consumers. For example, a plan could determine that it may be feasible and worth the investment to address all the challenges except for coverage of pre-existing conditions. Another plan could argue that including all EHBs in coverage is the only challenge they want to address to attract healthy members while still maintaining viable margins.

While there are various plan design strategies that could work, to more concretely demonstrate how a STLDI plan could offer a viable plan capable of attracting healthy individuals from the QHP and uninsured market, below is a high-level outline of a new hypothetical STLDI plan.

The goal of the new plan is to attract healthy members with very low expected claims costs. In this new plan overview, whether a challenge is addressed or not is posed In the "Important Questions" column. Next, whether the typical STLDI challenge design is changed in the new plan or kept the same is answered in the "Answers" column. Then, an explanation of why a challenge is unchanged or changed is then provided in the "Explanation" column.

IMPORTANT QUESTIONS	ANSWERS	EXPLANATION
Challenge 1: Are EHBs covered?	All EHBs included except Maternity Health	According to Kaiser Health, females have an average cost of $3,360 and males have an average cost of $1746 in the 19-34 age group. This difference is largely due to maternal health costs. [20] To keep premiums low, maternity care will be excluded.
Challenge 2: Are pre-existing conditions covered?	Pre-existing conditions are excluded from coverage. Enrollment in plan can be for 12 months, renewed for up to 36 months.	By excluding those with pre-existing conditions, this plan can lower the risk profile of our population and offer lower premiums. By enabling enrollment for 12 months, if a person were to enroll during open enrollment one year, they would then be eligible for a QHP the following year. Therefore if they were to develop a serious illness, they would continue to have coverage until being able to enroll in a QHP during open enrollment.

IMPORTANT QUESTIONS	ANSWERS	EXPLANATION
Challenge 3: What is the out of pocket limit?	Deductible and out of pocket maximum for all in-network covered costs of $8,150 Supplemental Hospitalization Insurance included at $2,000 a day for inpatient hospitalization, maximum 7 day	A study by Kaiser indicated many people on plans with high deductibles often do not have savings up to their deductible. [20] Therefore, if they are hospitalized or have any large healthcare expense, they are at risk of medical debt. Supplemental hospitalization insurance can help reduce this burden, but oftentimes it is not utilized by consumers due to the additional cost. Yet there are 45 visits to EDs per 100 people in the 25-44 age bracket in the US. [23] Additionally, the average inpatient visit is over $2,000 dollars. [24] With the reduced risk in the member population due to the ability to exclude coverage of pre-existing conditions, Supplemental Hospitalization insurance can be added to this plan while still keeping the premium costs lower than many Catastrophic or HDHPs.
Challenge 3: What is the monthly premium?	Premiums will be roughly $100 a month for those below 30 and increase heavily for those above 30	According to a report by Kaiser, the uninsured millennial spends about $850 a year in healthcare spend, or $70.83 a month. [20] Using this as a proxy for necessary spend, and including supplemental insurance, maintaining a positive margin with $100 monthly premiums seems possible. Keeping the premium payment low enough to attract the uninsured while also being able to add the supplemental option to attract those on marketplace bronze plans or Catastrophic plans is the intent of this design
Challenge 4 Are there dollar limits?	No coverage dollar limit	This plan is designed to protect members from financial devastation. There is not a coverage dollar limit to any care covered by the plan.
Challenge 5: Is there a provider network?	In person, transparently priced Provider Network for primary and urgent care. Additionally, there is a virtual network of primary care, specialists, and behavioral health providers	Many STLDI plans do not build out provider networks. The lack of provider networks can lead to balanced billing. One of the ways to counter this lack of trust would be to build a small network of providers in the major cities this plan is offered in. This network of providers could offer transparently priced services for plan members so that plan members can shop for care. Supplementing these limited in-person providers, the plan could build a narrow, virtual-first, cost-effective network for care that can be done virtually.

SECTION 4:

ASSESSMENT OF HYPOTHETICAL NEW PLAN DESIGN

The above plan is designed for the healthy, 26-30 year old male demographic that are either uninsured or currently on a HDHP or Catastrophic plan from the federally facilitated marketplaces. It's designed to keep premium costs as low as possible while controlling for an unlikely health event in healthy consumers who are low utilizers of healthcare. Given that over a third of patients report having difficulty paying up to their deductible, saving members from medical debt from unforeseen medical events with the supplemental benefit should interest this demographic. [25]

One of the largest weaknesses of this plan would be the ability to pull people from the employer-sponsored section of the QHP market. With employee contributions being only $108 a month on average, the $100 a month premiums of this proposed plan may not be enough in premium savings to convince people to forego their employer-sponsored option. Additionally, marketing this plan and getting enrollment could be difficult for this plan as STLDI plans are not allowed to be listed on the federally facilitated Marketplaces and are banned in eleven states.[26,27] Therefore, plans would have to spend considerably on marketing and brokers to push the plan in the limited states they are allowed, which would cut into the plan's margin considerably.

CONCLUSION

There is research indicating that market utilization of STLDI plans will increase marketplace premiums. While this is not positive for the market, 16% of millennials (11.5M people) are currently uninsured. In a survey by Transamerica Center For Health Studies, it was found that 60% of those who are uninsured lack coverage due to costs. This indicates that more affordable options are needed. Many current STLDI plans poorly protect consumers, leading consumers to be rightfully hesitant to enroll. This does not have to be the case. Consumers aged 19-34 make up 22% of the population but comprise only 11% of healthcare spending. There is an opportunity to create more affordable options for these younger, healthier individuals by using the lack of regulations surrounding SLTDI plans to exclude those with pre-existing conditions and use the lower risk within the member population to lower monthly premiums and provide reasonable out of pocket maximums.

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