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REPORT

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SHORT-TERM MEDICAL INSURANCE: OPPORTUNITIES AND TRADE-OFFS

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KEY TAKEAWAYS

- The hallmark of short-term medical insurance (STM) plans in the United States is that each term lasts less than a year and offers less coverage than an Affordable Care Act plan, but generally costs dramatically less than comprehensive plans.

- Regulatory action by the Trump Administration has allowed more expansive STM plans to be offered at the state level, with the potential to create a parallel marketplace and greater competition for those who are seeking cheaper and better-tailored insurance options.

- In response to the administration's guidance, Missouri lawmakers should consider expanding the maximum length of STM plans offered in the state to up to a year and reassess state-imposed mandates on health insurance plans of all types.

INTRODUCTION

In 2010, Congress passed the Patient Protection and Affordable Care Act, otherwise known as the PPACA, ACA, or perhaps most often as "Obamacare." While the law significantly shifted regulatory control of medical insurance from states to the federal government, it largely carved out short-term medical insurance (STM) products from its purview. STM plans did not satisfy the ACA's new insurance mandate requirements for individuals, and even as the federal insurance exchanges came online in 2014 states maintained their primary role in insurance regulation for these shorter duration plans.

Nearly a decade has passed since the ACA became law, yet the state of affairs in health care policy in the United States remains in flux, especially for STM plans. At its core, the ACA did not meaningfully change the way Americans receive health care. Rather than reorienting the rules of the game toward greater competition in the sector, the law predominantly reaffirmed a broken status quo that prioritizes third-party payer systems over individual payers, and it fails to address the underlying cost problems inherent in a health care system that disincentivizes competition and price shopping.[1] Some of these policy problems can be resolved through greater liberalization of our health care system, including the promotion of direct primary care,[2] licensure reform,[3] the expansion and protection of volunteer health care services,[4] and the rejection of certificate of need (CON) laws.[5]

The common thread running through these proposals is the promotion of consumer choice in health care. Ensuring that STM insurance plans are available to Americans as an insurance option is an important aspect of this overall initiative toward market-based solutions in health care.

SHORT-TERM MEDICAL INSURANCE PLANS: OVERVIEW

The main feature of STM plans is their limited duration, especially compared to more comprehensive health insurance products. Indeed, the "short-term" in the name refers to their limitation in time. Sometimes referred to as "temporary insurance," STM plans have acted as backstops for individuals with gaps in health care coverage, such as when workers are between jobs and in need of insurance during that period.

Historically, STM plans have escaped heavy federal regulation. According to Health Affairs, this is in no small part because decades of legislation, including the Public Health Service Act of 1944, explicitly excluded STM plans from the federal definition of "individual health insurance coverage."[6] The ACA, passed in 2010, adopted this exclusionary language, and subsequent regulatory action "excluded short-term coverage [from its purview] and cross-referenced the previous HIPAA definition."[7]

Perhaps not surprisingly, STM plans have also typically been cheaper than traditional insurance coverage. There are several reasons why this is the case. First, the term of STM plans is usually shorter than traditional coverage, meaning the probability of an insurer having to pay out on a claim is reduced. Second, STM plans are often exempt from many state insurance mandates which means, depending on the state, preventative care or coverage relating to high risk behaviors might be excluded under an STM plan. Third, STM plans are, generally speaking, high deductible plans, meaning even if a covered event did happen, the insurer's exposure to those costs may be significantly reduced in comparison to traditional comprehensive plans, which could have lower deductibles.

SHORT-TERM MEDICAL INSURANCE AS A FEDERAL RULE-MAKING FOOTBALL

One of the key health care policy changes made by the ACA in 2010 was the establishment of an individual insurance purchase mandate and a tax penalty for noncompliant taxpayers. The intent of these provisions was simple: to compel healthy and younger insurance purchasers to buy comprehensive insurance plans whose services they most likely wouldn't use, as a way to subsidize older and less-healthy policy holders in the newly established federal health insurance pool.

The problem policymakers encountered, however, was a wholly predictable one—that the plans were very expensive, and that potential purchasers were either going without insurance coverage or purchasing lower cost insurance like STM to meet their needs, even if it made them liable to paying the tax penalty for not buying approved coverage.

To drive STM insurance purchasers back into the federal pools, the Obama administration advanced new rules in 2016 that capped STM insurance terms to less than

3 months, including extensions, and imposed other regulations to make the products less attractive both to insurers and the potential insured.[8]

The administration didn't hide its objective, either, as the rule, 81 FR 75316, made crystal clear.

> *In some instances, individuals are purchasing this coverage as their primary form of health coverage and, contrary to the intent of the 12-month coverage limitation in the current definition of short-term, limited-duration insurance, some issuers are providing renewals of the coverage that extend the duration beyond 12 months.… Further, because these policies can be medically underwritten based on health status, healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for Affordable Care Act-compliant coverage.*

Simply put, the administration took away health care choices from American consumers in an attempt to support its own signature legislation.

TRUMP ADMINISTRATION ACTION ON THE STM ISSUE

But something else happened in 2016: an election. And with a new administration came a change in policy for how STM plans were treated by the federal government.

The passage of the Tax Cuts and Jobs Act (TCJA) in December 2017[9] set the stage for STM plans to again become more widely available and last for longer periods of time. The TCJA set the tax penalty for not purchasing qualifying health insurance to $0. By eliminating the penalty for failing or refusing to purchase ACA-approved insurance, the Act freed Americans to more easily purchase insurance that they felt met their needs.

The problem was that the previous administration's STM rules were still in effect, capping how long such plans could last.

Then on August 1, 2018, the Department of Health and Human Services (HHS) issued new guidance on how STM plans would be regulated at the federal level.[10] Rule 83 FR 38212 redefined what constituted an STM plan, allowing STM plans to last up to a year and, including renewals, have a maximum duration of 36 months.[11] Now, STM plans could effectively operate like ACA plans in terms of their length—but without all of the coverage mandates that have inflated the cost of traditional health care plans.

CONSIDERATIONS FOR POLICYMAKERS AND PURCHASERS

Like purchases in other sectors of the economy, consumer decisions to purchase an expensive ACA plan or a cheaper STM plan hinge squarely on the trade-offs each option presents to the purchaser. In this case, ACA insurance plans cover more services but at a greater cost; STM plans are less expensive but cover fewer services.

The mistake that policymakers have made over the last century or so on health care, however, is to treat most of the services provided in the health care sector not as *à la carte* commodities, but generally as highly-regulated bundles provided through employers or directly by government.

Examples in other sectors of the insurance market help to demonstrate why the over-bundling of services in insurance can be problematic. For instance, one of the items that drives the cost of homeowner's insurance is roof coverage, because insurers have an expectation that some percentage of policyholders will try to get the insurer to cover even the most dubious of roof damage. Inflexibly bundled, that expectation boosts the price of homeowner's insurance; unbundle it,[12] however, and insurers can reduce the rate a policyholder would pay for the insurance, with the homeowner predominantly responsible for replacing their own roof when that time inevitably comes.

That assessment of risk—by the purchaser and by the provider—is fundamental to the question of insurance regardless of the sector in question, and empowering consumers to engage in that trade-off calculation is central to achieving the sort of efficiency and cost savings that have been largely absent from the health care sector for the better part of the 20th Century and into the 21st. Moreover, lower health care costs promote greater access to health care services, and to the extent policymakers want to promote the latter objective, greater attention must be paid to addressing the former concern.

Liberalization of regulations allows STM to act as a parallel, alternative marketplace for health care consumers and advances the objectives of choice, lower costs, and greater access to care. Understanding how STM plans operated before, how they operate today, and how they should operate following the HHS's 2018 guidance is fundamental to achieving these goals.

STATE STM LAWS BEFORE AND AFTER THE TRUMP ADMINISTRATION'S ACTION

How STM plans operate in practice has differed dramatically from state to state. This was especially true prior to HHS's 2018 guidance.

In Wyoming, STM plans included plans that were six months or less in duration. STM plans were not only renewable, but they were also exempt from the coverage mandates that attached to plans that were longer than six months.[13]

In Tennessee, STM plans were limited in duration to the federal cap—which prior to August 2018 was six months—and imposed some state insurance mandates on the products. In a wrinkle, insurance products sold by the state's Farm Bureau were not subject to Tennessee's STM regulations thanks to a carveout there for "not-for-profit membership services organizations."[14] In contrast, some states like Texas technically allowed renewable STM plans, but those plans were subject to the coverage mandates imposed on more traditional health insurance products.

Elsewhere, STM plans were banned entirely. Prior to August 2018, several states—including New York, New Jersey, and Massachusetts—prohibited the sale of STM plans and required that only comprehensive coverage plans be available on the individual market. California formerly allowed for STM plans to last 185 days and be renewed once, but in September 2018, California policymakers outlawed the products, as well.[15]

That legislation, SB 910, was a direct response to the Trump Administration's action to liberalize federal regulation of STM plans, which the bill sponsor's characterization of his proposal made abundantly clear[16]:

> *"Trump's team continues to do everything possible to destabilize our insurance market and compromise the healthcare of millions of Californians, but I won't let that happen," [state Sen. Ed] Hernandez said in a written statement.*

Certainly, states that did not permit STM plans prior to the Trump Administration's guidance would have done well to have such products available to their consumers before and should consider allowing them now. Consumers deserve greater choice in their health care decision-making, and STM plans, even when heavily regulated, help to supplement a state's health care offerings.

However, California's decision to actively deny health care choices that had long-existed in the state stands in stark contrast to principles of good governance—denying Californians access to insurance coverage to steer them toward ACA insurance products.

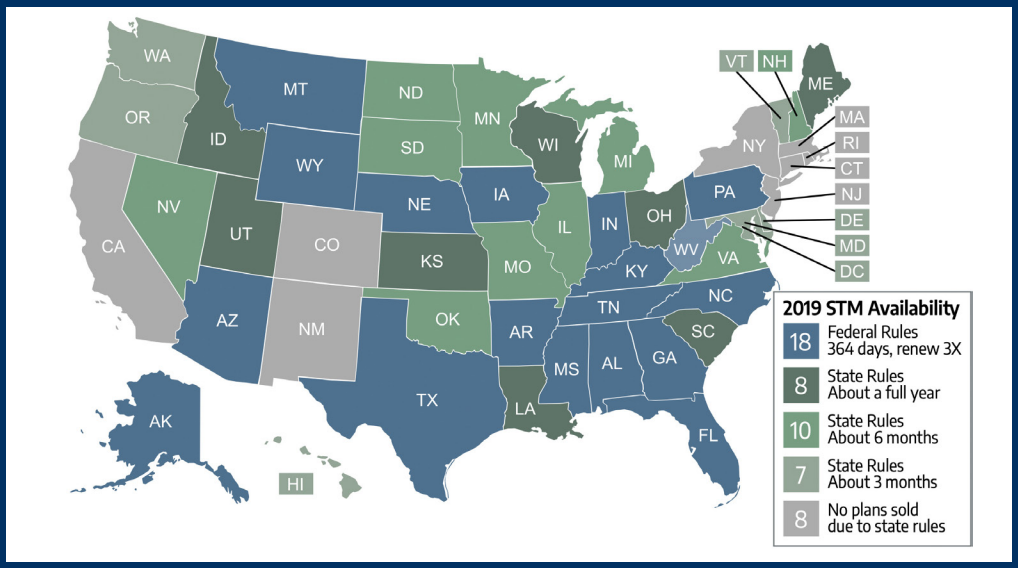
Reactions to the Trump Administration's STM guidance did not typically take the form that California's did. Today, at least sixteen states now have STM laws that hew closely to the Trump Administration's STM guidance—allowing for STM plans to last 364 days per year and to be renewed for a maximum duration of 36 months (Figure 1).[17] An additional eight states allow for STM plans to last up to a year, with most other states allowing coverage to last between 3 and 6 months and subjecting the plans to various levels of regulation. The remaining eight states bar, or effectively bar, STM plans from being offered in their states.[18]

SHORT-TERM MEDICAL PLANS IN MISSOURI

Under Missouri law, STM insurance plans can last no longer than 6 months and can also be renewed up to the 36-month limit set by HHS.[19] In both 2018 and 2019, the Missouri House of Representatives considered and passed, by decisive majorities, STM reforms that would have brought Missouri statutes into harmony with HHS's August 2018 rules—mainly by extending the duration of plans in the state to a year. Both times, those efforts failed to receive a vote in the senate.

Of the states that have not fully adopted the Trump Administration's HHS duration and renewal guidance, Missouri is arguably the closest to full implementation. Rather than subjecting policies to two renewals as would occur under the HHS framework, Missouri STM plans can be effectively renewed up to five times to reach the 36-month maximum plan duration. The shortcoming of Missouri's current law is the administrative hassle associated with these short renewal periods.

Figure 1:
Availability of STM Plans by State



Source: healthinsurance.org

WHY MISSOURI SHOULD CONTINUE ITS INSURANCE REFORM PUSH

Pursuing further reforms in Missouri—specifically with regard to STM plans but also in the state's health insurance market generally—is important for several reasons.

First, policymakers need to take a fresh look at the state mandates imposed on health insurance products generally, as the trade-offs imposed by these mandates are rarely reassessed after they've been passed into law. In 2000, the Congressional Budget Office (CBO) estimated that the average cost imposed by state insurance benefit mandates themselves was an additional 5 percent on what state insurance premiums would otherwise be.[20] That is almost certainly a lowball estimate today, given the difference in premiums in Missouri between ACA and short-term plans as of this writing can be the difference between paying a $378 per month premium for an Obamacare plan and a $81 per month premium for STM.[21] The 2000 figure also doesn't include more contemporary state-mandated coverage requirements for more emergent health concerns and treatments, including treatments for autism and addiction, cancer care advances, and more. Table 1 offers some premium and coverage comparisons between ACA and STM plans.

But for the sake of argument, even adding just 5% to the cost of health insurance plans would be nothing to sneeze at. A 1994 Cato Institute study by Robert Krol and Shirley Svorny, recalling research by Jonathan Gruber and Alan Krueger, observes that as state-mandated benefits and costs rise, businesses are disincentivized from hiring.[22] Krol and Svorny conclude: "As with minimum wage legislation, decisionmakers must weigh the benefits of mandated benefits against the costs—a reduction in state employment opportunities."[23] Indeed, insurance coverage mandates bring with them their own trade-offs that policymakers must consider carefully.

Those trade-offs can not only impact whether a Missourian gets hired, but also how a Missourian is compensated for their work. The rising cost of health care crowds out other means of compensation: namely, salaries. To the extent

Table 1:

ACA Marketplace Plans vs. Short-term Health Insurance Plans in Select Cities, 40 year-old Male.

	Premiums and Coverage Gaps			
City	Monthly Premium for Lowest-cost Bronze Marketplace Plan (unsubsidized)	Range of Monthly Premiums for Short-term Plans	Range of Out-of-pocket Cost-sharing Maximums for Short-term Plans	Range of Policy Coverage Caps for Short-term Plans
Phoenix, AZ	$405	$36–$437	$500–$30,000	$250,000–$2M
Los Angeles, CA	$264	$141–$566	$2,500–$10,000	$750,000–$2M
Denver, CO	$338	$35–$262	$2,000–$20,000	$250,000–$1.5M
Miami, FL	$297	$46–$983	$250–$22,500	$250,000–$2M
Atlanta, GA	$371	$47–$503	$1,000–$22,500	$250,000–$2M
Chicago, IL	$305	$55–$573	$250–$22,500	$250,000–$2M
St. Louis, MO	$281	$38–$423	$1,000–$20,000	$250,000–$2M
Columbus, OH	$289	$25–$305	$250–$20,000	$250,000–$2M
Houston, TX	$270	$55–$644	$250–$22,500	$250,000–$2M
Virginia Beach, VA	$479	$44–$583	$250–$20,000	$250,000–$2M

Note: Monthly premiums for Marketplace plans do not reflect discounts for premium tax credits. Monthly premiums for short-term plans reflect prices posted online; these rates are not guaranteed and may be adjusted after medical underwriting. Short-term monthly premiums also do not all reflect association membership fees often required for purchase. Out-of-pocket cost-sharing maximum for short-term plans applies to a 3-month term of coverage; by contrast, out-of-pocket cost-sharing maximum for an ACA-compliant plan in 2018 was $7,350 for the calendar year.

Source: Kaiser Family Foundation Subsidy Calculator for ACA-compliant plan premiums; eHealth and Agile Health Insurance for short-term policy premiums and features. https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

compensation packages are intended to insulate salaries from the pressures of health insurance costs, those cost reductions often are realized through significant increases in deductibles. As with roofs for homeowners, the higher the deductible for health insurance, the lower premiums can be—but only by transferring greater risk to the beneficiary.

Second, expanding the duration of STM plans in Missouri from six months to 364 days would bring the state in line with a plurality of its peers and reduce paperwork imposed on consumers and insurers. Adopting the increasingly common 364-day renewal rubric would likely ease the transition of potential new insurance providers to the state and simplify the renewal process for purchasers, providing both supply and demand benefits to the STM marketplace.

Lastly, passage of an STM expansion bill like those that have passed the state house in recent years would serve practical and legal functions for educating the public writ large. Practically, Missourians may not currently have a good understanding about what STM insurance is and how they might benefit from it; the public debate about it

and attendant news coverage would help to bring greater awareness to the issue. Legally, both of the bills that would have expanded STM coverage in the state—HCS HB 1685 (2018) and HB 83 (2019)—would also inform potential beneficiaries of the sorts of coverage that they can and cannot expect with an STM plan. Language that would have been included in the plan documents, per these bills, would read as such:

> *This policy may not cover preexisting conditions, including conditions you may currently have and are unaware of but are not diagnosed until the policy's term. This policy may not cover certain essential health benefits, including prescription drugs, preventative care, and emergency services. Before you realize benefits under this policy, you may be responsible for a deductible and/or coinsurance. Be sure to discuss these items with your insurance broker before purchasing a short-term medical policy.*[24]

Again, the objective of expanding STM plans is not to simply have more Missourians on the plans for the sake of the plans. For some, these lighter plans may be a bad choice compared to more comprehensive plans elsewhere. Instead, the objective of STM plan liberalization is to ensure that Missourians have a wide variety of *choices* to meet their particular health care and financial needs – needs that may not be met under the ACA today.

CONCLUSION

The expansion of STM plans across the country is an incremental reform that advances health care choice. As Missouri policymakers assess the opportunities embedded in recent STM regulatory revisions, they should also consider other market-based and competition-promoting reforms and reconsider the mandated coverage requirements imposed on insurance products of all sorts that currently fall under state oversight. Greater competition should lead to lower prices for consumers; and as to health insurance, liberalized STM plans play an important role in promoting that end and deserve continued attention from the legislature.

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12. "Unbundled" here could simply mean a substantial increase in the deductible for roof coverage. Policyholders with a $500 deductible for their roof can expect to pay much more in premiums to account for roof repairs that could cost thousands of dollars. Meanwhile, policyholders with a $10,000 deductible can expect to pay much less because the insurer's exposure is greatly reduced; indeed, a roof replacement could cost less than $10,000, and the insurer might not be on the hook at all to fix a homeowner's roof damage.

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