


Short-Term Healthcare Insurance and the Institutionalization of Post-Claims Underwriting

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I. Introduction

Millions of Americans seeking alternatives to the Affordable Care Act's comprehensive health care coverage may be drawn towards short-term health insurance plans, enticed by the plans' availability or price. Because these plans operate outside of the ACA and are not governed by its rules, many times, insureds are surprised to discover that the coverage provided by these plans is not inclusive and often, can be rescinded if the insurer later determines that the insured did not correctly answers policy application questions, even when the supposed incorrect answer has nothing to do with the need for the health care at issue. All too often, the policy is rescinded after a claim has been made—thereby leaving the insured in a vulnerable position and without coverage.

The purpose of this article is to (1) provide a review of short-term health insurance regulation over the last decade, (2) analyze the ways in which the changing regulatory landscape has fostered the institutionalization of post-claim underwriting, and (3) suggest means by which regulators and legal practitioners may address inequities in the current health insurance market.

II. Chronology

A. Pre-Affordable Care Act

Prior to the implementation of the Affordable Care Act (ACA) in 2014, health insurance sold in the individual market was medically underwritten. That is, insurers evaluated the health status, medical history, and other risk factors of applicants to determine whether to issue coverage, and if so, on what terms. Applications for individual market policies included lengthy questionnaires seeking disclosure of information concerning past medical care, pregnancy, medications, lab results, past treatment, diagnosis, and a variety of other issues. Also, applications typically included an authorization that allowed the insurer to obtain and review all of the applicant's medical records.

In this regard, the standard in the health insurance industry was for the insurer to complete a comprehensive investigation prior to agreeing to insure an applicant.[1] The ostensible purpose of medical underwriting is and was to allow the insurer to issue policies to healthier, less-risky applicants and avoid adverse selection. As a result, people with a current or past diagnosis of a "declinable medical condition"—including a variety of mental health disorders, obesity, heart disease, dementia, arthritis, and many, many other conditions—were often denied coverage.[2] It is estimated that approximately 27% of Americans under the age of 65 have health conditions that would likely leave them uninsurable.[3]

B. The Affordable Care Act

In 2014, Congress enacted the Affordable Care Act, which remedied some of the exclusionary effects of medical underwriting. In particular, the ACA required certain plans to include essential health benefits and also mandated that health insurers could not exclude from coverage or charge higher premiums to people with preexisting conditions. Many of the most important protections of the ACA apply to individual and small group plans.

Short-term health insurance, however, is specifically exempted from the ACA's purview. The ACA adopted existing definitions of insurance terms found in the Public Health Service Act. To this end, 42 U.S. Code § 300gg–91 defines "individual health insurance coverage" as "health insurance coverage offered to individuals in the individual market, but [which] does not include short-term limited duration insurance." Neither HIPAA nor the ACA expressly defined exactly how short "short-term" is, but regulations that antedated the ACA required the term of coverage to be less than 12 months.[4]

C. Short-term Health Insurance

Despite the limitations, short-term health insurance policies remain attractive to a percentage of the population because these plans are generally cheaper than ACA-compliant plans and thus appeal to younger, healthier consumers.

Cheaper premiums, however, do not translate to lost profits for insurers. Short-term policies are highly profitable for insurers, as they have significantly lower loss ratios than

ACA-compliant plans. Data from the National Association of Insurance Commissioners (NAIC) shows that short-term plans had an average loss ratio of about 65 percent in 2017 (compared to 80 percent for ACA-compliant individual market policies).[5] The three largest insurers offering short-term coverage had even lower loss ratios of about 44 percent, 34 percent, and 52 percent. The increased profits may fairly be attributed to the fact that short term policies generally offer skimpier coverage and insurers' frequent post-claim recissions result from post-claim underwriting..

As the ACA's major reforms went into effect, some insurers began selling short-term policies that lasted for 364 days. By offering coverage that extends just one day shy of 12 months, insurers could sell non-ACA compliant policies that met the definition of short-term, limited-duration insurance under federal law and, thus, avoid having to bring these policies into compliance with the ACA.

In 2016, federal regulators concluded that short-term coverage was being sold as primary coverage and was adversely impacting the risk pool for ACA-compliant coverage. It was estimated that enrollment in short-term coverage would reach 1.9 million people by 2022. To combat the move towards short-term policies, the IRS, HHS, and Employee Benefits Security Administration issued a regulation limiting short-term coverage to a period of less than three months, including renewals—the time period that individuals may remain without coverage without having to pay the ACA's individual responsibility penalty.[6]

D. Executive Order 13813 and the New Rules

In October 2017, President Trump signed an executive order directing federal agencies to draft regulations aimed at unraveling the ACA.[7] As related to short term limited duration health insurance, this Order directed the Secretaries of the Treasury, Labor and Health and Human Services to "consider proposing regulations or revising guidance, consistent with law, to expand the availability of" short-term medical plans. This Order urged the Secretaries to "consider allowing such insurance to cover longer periods and be renewed by the consumer."[8]

In response to this Order, the Departments of Health and Human Services, Labor, and Treasury released a proposal in February 2018 that extended the availability of short-term health insurance plans. This proposal, which was finalized in August 2018, changed the maximum duration a consumer could purchase such coverage. Prior to 2018, federal regulations limited the duration of short-term health plans to 90 days. Now, individual plan buyers who are unable or unwilling to by ACA-compliant plans may have the option to purchase a short-term insurance plan for an initial term of up to 364 days, with potential for renewals up to 36 months.[9]

To justify this change, HHS pointed to the coverage's name: "short-term limited duration." HHS reasoned that "short-term" and "limited duration" must mean different things or the name would be redundant. "Short-term", HHS argues, refers to initial term, but "limited duration," allows for multiple renewals.

In the final rule, HHS noted that nothing in the federal statute would prevent a person from enrolling in a new short-term plan after the expiration of the 36-month period. "Nothing in this final rule precludes the purchase of separate insurance contracts that run consecutively, so long as each individual contract is separate and can last no longer than 36 months." As written, a person could purchase multiple short-term plans, potentially linking together short-term coverages for an indefinite period of time.

E. Challenges to the New rule

In September 2018, a group of seven plaintiffs made up of health insurers, physicians, and consumer advocacy organizations, sued the United States Department of Treasury along with multiple other defendants, in the United States District Court for the District of Columbia, challenging the HHS rules. In *Association for Community Affiliated Plans, et. al v. United States Department of Treasury, et. al*,[10] the plaintiffs argued that the new rule violated the plain-English meaning of "short-term" and "limited duration," that it arbitrarily reversed previous limits on these plans to create an alternative to ACA-compliant plans that Congress did not authorize, and that it violated the ACA by effectively undercutting ACA plans, making them increasingly unaffordable and unsustainable for consumers.

In July 2019, however, U.S. District Court Judge Richard J. Leon rejected these claims, finding that Congress had intentionally left the definition of "short-term limited duration insurance" up to HSS and that the Trump Administration had not violated the ACA with the 2018 regulations. Judge Leon found that "any potential negative impact" from the rule would be "minimal," and "its benefits are undeniable."[11]

Nevertheless, HHS made it clear in the final regulations that states may continue to implement more restrictive rules.[12]

III. Post-Claims Underwriting

The proliferation of short-term medical policies has coincided with the institutionalization of a controversial practice known as post-claim underwriting. Post-claim underwriting is an inversion of the established sequence

of underwriting. In other words, the insurer "wait[s] until a claim has been filed to obtain information and make underwriting decisions which should have been made when the application [for insurance] was made, not after the policy was issued."[13]

This practice, which was largely used by health insurers prior to the adoption of the ACA, has been the subject of multiple Congressional investigations. In a June 16, 2009 hearing, Henry Waxman, Democratic Representative from California, stated:

> They scour the policyholder's original insurance application and the person's medical records to find any discrepancy, any omission or any misstatement that could allow them to cancel the policy. They try to find something, anything so they can say that this individual was not truthful in that original application. It doesn't have to even relate to the medical care the person is seeking and often doesn't.

For its part, the Mississippi Supreme Court has strongly admonished insurers that engage in post-claims underwriting.

> It is patently unfair for a claimant to obtain a policy, pay his premiums and operate under the assumption that he is insured against a specified risk, only to learn *after* he submits a claim that he is *not* insured, and, therefore, cannot obtain any other policy to cover the loss…[14]

An insurer engaged in post claim underwriting does not attempt to reduce risk or adverse selection. Instead, the insurer performs no underwriting and endeavors to generate the greatest amount of premium revenue possible. The result is that the insurer will have issued at least some policies to individuals that would not have been able to secure coverage had underwriting been performed. Yet, the insurer has reduced costs across the board by disposing with underwriting. Further, to the extent that a traditionally uninsurable individual never makes a claim during the short pendency of the policy, the insurer still recognizes a profit that would not have been recognized had underwriting been performed. Finally, to the extent that the traditionally uninsurable individual *does* make a claim, an insurer engaging in post-claim underwriting then takes the opportunity to conduct an exhaustive underwriting process in an attempt to deny claims based upon application misrepresentations or pre-existing condition exclusions.

Examples of the real-world consequences of these "junk" plans, which were cited in the *Association for Community Affiliated Plans, et al. v. United States Department of Treasury, et al.*,[15] complaint 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 man in Washington, D.C., 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, however, he was paid only $11,780, in part due to a denial of coverage based on his *father's* medical history.

Post-claim underwriting allows carriers to transform an uncertain event—the loss— into an event that is certain. "This manipulation of the odds is possible only because of the postponement in performance occasioned by the sequential character of the insurance contract."[16] The insurance industry argues that post-claims underwriting and rescission are necessary to defend against fraud and keep insurance affordable. "In some cases, an applicant may have an incentive to conceal information about her health or risk status from an insurer in order to obtain coverage or terms of coverage that might otherwise not be issued. At the same time, an applicant might inadvertently fail to disclose information—for example, about health history in the distant past or concerning seemingly minor and unimportant health conditions or symptoms."[17]

For their part, consumer advocates argue that insurers have a strong financial incentive to rescind coverage for individuals with high-value claims. This is evidenced by the lower amount paid out by short-term carriers.[18] Additionally, information discovered during the investigation process may or may not be related to the claim that triggered the investigation.[19] Critics also argue that the industry uses vague questions in applications that are difficult for applicants to answer accurately and completely, thereby leaving the door open for future rescission.

Finally, in the event that an insured's policy is rescinded after a post-claim investigation, the insured does not merely lose the benefits of their short-term policy—they are without the ability to purchase a new or different policy that would cover their pending claim. To combat the risk of this outcome, certain states, including Connecticut in Connecticut General Statute Sec. 38a-477b, require pre-approval of coverage cancellation or rescission.

IV. Colorado's Regulation on Short-Term Policies

The Colorado Division of Insurance (DOI), which is part of the Department

of Regulatory Agencies (DORA), amended the regulations governing short-term limited duration health benefit plans to require these plans provide many of the protections afforded by ACA qualified plans. As provided by amended regulation 4-2-59, short-term health plans must comply with multiple rules:

- Because short-term plans meet the state definition of health benefit plans, they must cover essential health benefits mandated by Colorado law, such as preventive services, prescription drugs, hospitalization and maternity and newborn care.
- Premiums for such plans can vary only due to the same factors as ACA-qualified plans: family (individual vs. family plan), geographic rating area, age (with premiums for the oldest to be no more than three times the cost of the youngest, a 3:1 ratio), tobacco use and the benefits of the plans themselves.
- The health status of enrollees, and their claims history, cannot be used to calculate or vary premiums.
- Policies are guaranteed-issue, meaning that anyone who applies must be accepted. Pre-existing conditions may be excluded from coverage.
- Short-term plans must spend at least $0.80 of every dollar collected in premiums on health care claims. This is known as a medical loss ratio (MLR) of 80%.

Since the implementation of this regulation, insurers no longer offer short-term medical plans in Colorado.

V. Other States' Approaches

Other states have also joined Colorado in restricting the sale of short-term plans:

- **California** enacted SB910 in 2018 that prohibits the sale of short-term plans in the state as of January 1, 2019.[20]
- **Hawaii** passed HB1520, which was signed it into law in July 2018. The legislation prohibits the sale of a short-term plan to anyone who was eligible to purchase a plan in the exchange during the previous calendar year, either during open enrollment or during a special enrollment period. The only people who aren't eligible to purchase coverage in the exchange are undocumented immigrants, incarcerated individuals, and people who are eligible for premium-free Medicare Part A.[21]
- **Maryland** enacted HB1782 in 2018, which limits short-term plans to three months and prohibits renewal.
- **Vermont** also enacted H.892 to limit short-term plans to three months and prohibit renewal. Currently, no short-term plans are for sale in Vermont.
- Lawmakers in **Illinois** approved HB2624, which limits short-term plans to durations of less than 181 days, prohibits renewals, and prevents an enrollee from purchasing a new short-term plan from the same issuer within 60 days of the termination of a previous short-term plan. Governor Rauner vetoed HB2624, but lawmakers overrode his veto in November 2018 and the bill became law.
- **Washington** has limited short-term plans to three months, prevents renewals, and prohibits insurers from selling short-term coverage in the prior 12 months. The new rule also prohibits the sale of short-term plans during open enrollment, if the short-term coverage is to take effect in the coming year.
- **Delaware** and **New Mexico** have both implemented regulations that limit short-term plans to three-month durations and prohibit renewals.[22]
- **Maine** enacted legislation, LD1260, that requires short-term plans to terminate no later than December 31st of the year in which the plan was issued. The new law also imposes various other requirements, including a ban on the sale of short-term plans during the ACA's open enrollment period (unless the plan is slated to start and end prior to the start of the new year) and a requirement that the applicant be informed about the availability and cost of ACA-compliant options.
- **South Carolina**: In *Mitchell Jr. v. Fortis Insurance*, the defendant insurer argued that "as a general matter, post-claim underwriting is 'perfectly lawful' in South Carolina." The Supreme Court of South Carolina, however, held "Fortis's post-claim underwriting practices played a pivotal role in the harm inflicted upon Mitchell in South Carolina. This evidence was probative of Fortis's bad faith conduct, and was properly submitted to the jury.[23]

Other states have worked to **expand** access to short-term plans, including:

- **Indiana** enacted legislation HB1631 that allows short-term plan durations to conform with the new federal rules for plans issued on or after July 1, 2019. The legislation also added a new requirement that short-term plans have benefit maximums of at least $2 million, and took effect in July 2019.[24]

- **Oklahoma** enacted legislation SB993 that allows short-term plans to mirror the same maximum durations as the federal rules.[25]
- **Arizona** enacted legislation SB1109 that allows short-term plans to mirror the same maximum durations as the federal rules.[26]
- **Missouri** lawmakers considered HB165 (it passed the House in 2018, but not the Senate), which would have defined short-term coverage as a policy with a duration of less than one year.[27] The House passed the bill, but it didn't reach a full vote on the Senate floor.
- In **Minnesota**, current rules restrict short-term plans to no more than 185 days in duration, and residents are limited to having short-term insurance for no more than 365 days out of a 555-day period. But HF3138 would have redefined a short-term plan as being less than a year in duration and eliminated the 365 out of 555 days cap.[28] The bill passed the House, but did not advance to a vote on the Senate floor.
- In **Virginia**, lawmakers passed SB844 in 2018, to allow short-term plans to have a term of up to 364 days, however, Governor Northam vetoed this bill in May 2018.[29]

While many states have led the charge to combat the abuses of post-claim underwriting, Congress continues to fight as well. A 2009 Congressional Investigation led by the House of Representatives Committee On Energy and Commerce determined that, "Over the past 5 years almost 20,000 individual insurance policyholders have had their policies rescinded by three insurance companies who will testify today: Assurant, United Health Group and WellPoint."[30]

Although this 2009 investigation did not specifically pertain to short-term health insurance policies because short-term policies operate outside of the ACA, the same problems have arose again.

In a March 13, 2019 letter to National General CEO Barry Karfunkel, the Committee states,

> The Committee's initial examination of these plans has yielded disturbing information about how insurance companies that sell STLDI discriminate against individuals with pre-existing conditions and put consumers at significant financial risk. Additionally, we are troubled that consumers who sign up for these plans are being misled about the nature of the coverage they are purchasing.

VI. Conclusion

Based on the recent federal court ruling upholding the 2018 HHS regulations directed by the Trump Administration, for the time being it seems that any broadside attack on the rules face an uphill battle. However, state regulators remain generally resistant to short-term coverage that misleads consumers and institutionalizes of post-claim underwriting. Insurers are already unwilling to write short-term coverage in a number of states, and this is a trend that may well continue.

Nevertheless, many consumers have already fallen victim to post-claim underwriting. Fortunately, Colorado insurance law provides multiple avenues through which consumers can seek recourse. Colorado's Unfair and Deceptive Trade Practices Act, C.R.S. § 10-3-1104(1)(h), sets forth certain standards, the violation of which can be used as evidence of bad faith conduct. Where an insurer has engaged in post-claims underwriting, its actions could result in numerous violations of this Act, including but not limited to the following:

- Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue;
- Failing to acknowledge and act reasonably promptly upon communications with respect to claims arising under insurance policies;
- Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies;
- Refusing to pay claims without conducting a reasonable investigation based upon all available information;
- Not attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear; and
- Compelling an insured to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by an insured.

In addition, if the insurer delays payment or denies a claim for medical benefits owed, the insured may also have a claim against the insurer under C.R.S. § 10-3-1115 as well as Colorado's Prompt Pay Statute, C.R.S. §10-16-106.5. Colorado's Prompt Pay Statute mandates payment or denial of all claims within 90 days after receipt; the only exception to this 90-day rule is if the insured engaged in fraud. Notably, depending on the facts of each case, additional remedies may be available. ▲▲▲

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Endnotes:

[1] Thomas C. Cady & Georgia L. Gates, *Post Claim Underwriting*, 102 W. Va. L. Rev. (2000), *available at* https://researchrepository.wvu.edu/wvlr/vol102/iss4/5.

[2] Garu Claxton et al., *Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA*, The Henry J. Kaiser Family Foundation (Dec. 2016), http://files.kff.org/attachment/Issue-Brief-Pre-existing-Conditions-and-Medical-Underwriting-in-the-Individual-Insurance-Market-Prior-to-the-ACA

[3] *See id.*

[4] 26 CFR 54.9801-2.

[5] https://www.naic.org/prod_serv/AHP-LR-18.pdf

[6] 26 CFR 54.9801-2.

[7] Executive Order 13813, Executive Order Promoting Healthcare Choice and Competition Across the United States, 82 F.R. 48385 (October 12, 2017), *available at* https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/.

[8] *Id*. at sec. 3.

[9] Short-Term, Limited Duration Insurance, 83 F.R. 38212, *available at* https://www.govinfo.gov/content/pkg/FR-2018-08-03/pdf/2018-16568.pdf.

[10] *Ass'n for Cmty. Affiliated Plans, et al. v. U.S. Dep't of Treasury*, Case No. 18-2133 (RJL) (D.D.C. Jul. 19, 2015).

[11] *Id.*

[12] Short-Term, Limited Duration Insurance, 83 F.R. 38212, 38232 "This final rule has no federalism implications to the extent that current state law requirements for short-term, limited-duration insurance are the same as or more restrictive than the Federal standard in this final rule."

[13] *Lewis v. Equity Nat. Life Ins. Co.*, 637 So.2d 183 (Miss. 1994).

[14] *Id*. at 188-89 (emphasis added).

[15] *Ass'n for Community Affiliated Plans*, Case No. 18-2133.

[16] *See* Cady & Gates, *supra* note 1, at 819.

[17] Peter Harbage & Hilary Haycock, Primer on Post-Claims Underwriting (Robert Wood Johnson Foundation 2016), available at https://harbagecon sulting.com/wp-content/uploads/2016/08/Primer-on-Post-Claims-Underwriting.pdf.

[18] According to the National Association of Insurance Commissioners' 2018 *Accident and Health Policy Experience Report*, the average loss ratio of the top five short-term plan insurers by total premiums was 39.2% in 2018 (compared to 80% from ACA-compliant policies). In other words, these short-term carriers only paid 39 cents out of every dollar collected in premium on medical care.

[19] While many states do not require the condition investigated be related to the conditions requiring medical treatment, there are exceptions to the rule. *See* Tenn. Code Ann. 56-7-103: "No written or oral misrepresentation or warranty made in the negotiations of a contract or policy of insurance, or in the application for contract or policy of insurance, by the insured or in the insured's behalf, shall be deemed material or defeat or void the policy or prevent its attaching, unless the misrepresentation or warranty is made with actual intent to deceive, or unless the matter represented increases the risk of loss."

[20] *See* CA Ins. Code Section 10123.61 ("Commencing January 1, 2019, a health insurer shall not issue, amend, sell, renew, or offer a policy of short-term limited duration health insurance in this state.").

[21] *See* HB1520, Relating to Insurance, "No insurer shall issue, renew, or re-enroll an individual in a short-term, limited-duration health insurance policy or contract if the individual was eligible to purchase health insurance through the federal health insurance marketplace during an open enrollment period…" *available at* https://www.capitol.hawaii.gov/session2018/bills/HB1520_CD1_.htm.

[22] *See* HB285, Section 2.I., *available at* https://www.nmlegis.gov/Sessions/19%20Regular/final/HB0285.pdf (limiting short-term plans to three months.).

[23] *Mitchell v. Fortis Ins. Co.*, 385 S.C. 570, 595, 686 S.E.2d 176, 189 (2009).

[24] HB1631 (2019), *available at* http://iga.in.gov/legislative/2019/bills/house/1631/#document-2a4d294a.

[25] SB993 (2019), *available at* http://webserver1.lsb.state.ok.us/cf_pdf/2019-20%20ENR/SB/SB993%20ENR.PDF.

[26] SB1109 (2019), *available at* https://legiscan.com/AZ/text/SB1109/id/1962211/Arizona-2019-SB1109-Chaptered.html.

[27] HB1685 (2018), *available at* https://www.house.mo.gov/billtracking/bills181/hlrbillspdf/5383H.02P.pdf.

[28] HF3138 (2018), *available at* https://www.revisor.mn.gov/bills/text.php?number=HF3138&type=bill&version=3&session=ls90&session_year=2018&session_number=0&format=pdf.

[29] SB844, An Act relating to individual health insurance coverage; short-term policies (2018), *available at* http://lis.virginia.gov/cgi-bin/legp604.exe?181+ful+SB844ER+pdf.

[30] Statement of Congressman Bart Stupak, Hearing Before Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, June 16, 2009.