October 2018 | Fact Sheet

ACA Open Enrollment: For consumers considering short-term policies…

New rules published by the Trump Administration this year may help promote the sale of short-term health insurance policies, which generally have lower premiums compared to ACA-compliant plans. All short-term policies must include a prominent notice to consumers to "check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits…" Short-term policies are different from ACA-compliant plans in several important respects. This fact sheet identifies features of short-term policies consumers may wish to check carefully.

Eligibility based on health status

Except in states that prohibit their sale,[1] short term health insurance policies are medically underwritten. That means consumers can, and likely will, be turned down if they have pre-existing health conditions. Short-term policy applications will ask questions about health – for example, if the applicant is pregnant or planning to get pregnant, of if the applicant has been diagnosed or treated for cancer, hepatitis, mental health or substance use disorders, HIV/AIDS, or other conditions. Insurers will most likely refuse to sell short-term policies to people who answer "yes" to any of those questions.

Duration of coverage and "renewability"

Under new regulations, short-term policies are allowed to provide coverage for up to 364 days. Shorter-term policies – for example, which last for 3 or 6 months – are also for sale. At the end of the policy term, coverage ends. Some policies may now include an option to extend or renew coverage at the end of the policy term. However, it is up to the insurer to decide. People who buy a short-term policy and then get sick most likely will not be able to extend or renew coverage.

Importantly, loss of coverage under a short-term policy during the year does not make people eligible for a special enrollment period (SEP) to switch to an ACA-compliant marketplace policy. They will have to wait until the next Open Enrollment period to buy a plan that cannot turn them down.

Limits on covered benefits

Short-term policies generally cover major-medical benefits, though limits often apply. For example:

- Limits on covered doctor visits - Check to see if the short-term policy limits the number of covered doctor visits, for example, to no more than 3 visits.

[1] So far, California, Hawaii, Massachusetts, New Jersey, New York, and Oregon prohibit the sale of short-term health insurance policies that lack protections for people with pre-existing conditions.

- Dollar limits on covered benefits - Check to see if dollar limits on specific covered benefits apply – such as $1,000 per day in the hospital. If a policy applies dollar limits, actual charges above the limit will not be covered. (For example, according to healthcare.gov, the average cost of a 3-day hospital stay is around $30,000.) Virtually all short-term policies apply an overall dollar cap to all covered benefits, e.g., ranging from $100,000 to $2 million.
- Limits on prescription drug coverage - If prescription drugs are covered, check to see if other limits apply, for example, whether drugs are covered only during an inpatient hospital stay. Some short-term policies might not cover drugs at all but offer a drug discount card instead. A discount card is not the same as insurance coverage; the patient will have to pay the entire discounted price without any insurance reimbursement.
- Excluded benefits – Carefully read information about policy exclusions. Short-term policies typically do not cover maternity care; many will not cover substance use treatment or mental health services.

  Short-term policies exclude pre-existing conditions. If you make a claim under a short-term policy, the insurer can investigate whether your condition existed before you bought the policy. Conditions will be considered pre-existing if you were treated for them before enrolling in the policy. Depending on the policy and state laws where you live, the insurer might also refuse to cover a condition that existed, even if not-yet diagnosed, before you bought the policy. Some short-term policies offer limited coverage for certain pre-existing conditions, such as allergies, if you are otherwise healthy enough to buy the policy.

Cost sharing for covered benefits

Most short-term policies have an out-of-pocket limit on cost sharing. In ACA-compliant policies, the out-of-pocket limit caps what consumers pay in a year for all types of cost sharing: deductibles, co-pays, and coinsurance. For 2019, that limit is $7,900 per year for a single person. In a short-term policy, though, the limit might not include the deductible and co-pays. In addition, cost sharing limits reset at the end of the policy term if coverage is renewed or if a new short-term policy is purchased.

Provider networks

Be sure to check whether the short-term policy offers a network of providers. If so, you will need to seek care in-network to be covered (or, in case of “PPO” plans – to get the highest level of coverage.) Some short-term policies are described as “Indemnity” policies. That means the insurer does not limit coverage to a network of doctors and hospitals. It also means the insurer has not negotiated any limits on what doctors and hospitals can charge you. An indemnity policy will reimburse you up to an amount the insurer allows, and you will be responsible for the difference between that amount and the actual billed amount. This difference is called “balance billing” and can be very expensive.

Other differences from ACA-compliant plans

Short-term policies cannot be sold on HealthCare.gov or state marketplace websites. Consumers eligible for marketplace subsidies cannot use them to buy short-term policies.