

Short-Term Limited Duration Plans and HIV

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Key Findings/Points

- While short-term limited duration (STLD) insurance policies, which provide temporary insurance to those with coverage gaps, have long been available, the Trump Administration is seeking to promote their use and expand their availability.
- STLDs are exempt from ACA requirements prohibiting medical underwriting, pre-existing condition exclusions, and other protections. While not expected to cover someone with HIV, we tested this hypothesis by applying for coverage in 38 STLD plans as someone with HIV. Coverage was denied in all 38 cases.
- We also found that STLD insurance would generally not meet the needs of someone was diagnosed with HIV while enrolled, due to benefit limitations, particularly for prescription drugs, and high out-of-pocket costs. Further, coverage would not be renewed after the term ended.
- To the extent that ACA non-compliant policies, such as STLD plans, are expanded, they could affect the ACA-compliant insurance market, driving up costs for those who rely on them, including people with HIV. Moreover, with pending litigation in Texas now supported by the Trump Justice Department that would eliminate the ACA's pre-existing condition protections, our finding that HIV remains an uninsurable condition without such protections, underscores the implications of such a change.

Introduction

Short-term limited-duration (STLD) health insurance policies, designed to provide temporary coverage to people experiencing coverage gaps, have long been available in the private market, pre-dating the passage of the Affordable Care Act (ACA). Intended primarily for healthy individuals, STLD policies are generally less expensive than traditional policies but limit benefits, including through pre-existing conditions exclusions, exclusion of benefit categories, and high out-of-pocket costs. In addition they are medically underwritten, meaning those with certain health conditions, such as HIV, can be turned down from coverage or charged more. They are exempt from the requirements of the ACA that prohibit many of these practices in more traditional individual coverage. The Trump Administration has moved to promote the use of these plans, proposing to expand their availability and lengthen their coverage periods.¹ (See, [Understanding Short-Term Limited-Duration Health Insurance](#), for more background).

Given this, we wanted to explore what they would mean for people with HIV – both those seeking short term, gap coverage as well as those who are diagnosed with HIV while enrolled. We expected STLD plans to use a similar underwriting process to those employed in the individual market prior to the ACA

and reject people with HIV outright.² We test this hypothesis in this analysis. We also assessed whether such a plan could meet basic HIV care and treatment needs for someone diagnosed once enrolled. While this analysis focuses on people with HIV, these findings may apply to many others with a range of current or past health challenges such as cancer, hepatitis, diabetes and depression.

Methodology

We analyzed data and applied for STLD plans sold on the website, Agile.com, in April 2018. Agile.com was selected for this analysis due to its market prominence, breadth of plan offerings, and because unlike other platforms assessed, it allows consumers to apply for coverage and receive a determination without attesting to the information provided or supplying a social security number and full contact information. We looked at plans in five states that use the Agile.com marketplace and represent the highest HIV prevalence (FL, GA, IL, MD, and TX).³ Together, these states account for one-third of people living with HIV in the U.S.⁴ We applied to the plans with the most and least expensive premiums available by each issuer in a major city in each of the five states: (Miami, FL; Atlanta, GA; Houston, TX; Chicago, IL and Baltimore, MD), totaling 38 plans. In each case, we applied for coverage as a 35-year-old male. Table 1 provides a summary of the states and plans in the sample.

Table 1. States and Plans in Sample			
State	State Share of People with HIV	Issuers with STLD Plans on Agile.com	Number of Plans Reviewed
Maryland	3%	National General (1)	2
Florida	11%	Lifeshield National General Standard Life UnitedHealth One (4)	8
Georgia	5%	Lifeshield Everest Prime National General UnitedHealth One (4)	8
Illinois	4%	Everest Prime LifeShield National General Standard Life UnitedHealth One (5)	10
Texas	8%	Everest Prime LifeShield National General Standard Life UnitedHealth One (5)	10

Source: Share of people with HIV – Kaiser Family Foundation analysis of CDC Atlas data. Available at: <https://www.cdc.gov/nchstp/atlas/index.htm>

Findings

Applying as Someone with HIV

We first looked at eligibility determinations for someone with HIV. We found that in all 38 cases, an individual with HIV would be denied coverage in STLD products. The Agile.com marketplace allows users to apply for STLD insurance plans electronically, answering medical, residency, and insurance coverage questions online, after which a real time coverage determination is provided. The number and type of questions asked varies slightly across plans but applicants can typically expect to answer 5-8 questions. All applicants are asked a question about a range of health conditions. For example:

Within the last 5 years has any applicant been diagnosed with, received treatment, abnormal test results, medication, consultation for, or had symptoms of: Insulin or medication dependent diabetes except gestational (diabetes does not apply to residents of DC), stroke, transient ischemic attack (TIA), cancer or tumor except basal cell skin cancer, Crohn's disease, ulcerative colitis, rheumatoid arthritis, systemic lupus, chronic obstructive pulmonary disease (COPD), emphysema, cystic fibrosis, hepatitis C, multiple sclerosis, muscular dystrophy, alcohol or drug abuse; bipolar disorder or schizophrenia; an eating disorder; or any diseases or disorders of the following: liver, kidney, blood, pancreas, lung, brain, heart or circulatory including heart attack or catheterization?

- Lifeshield, GA

In every instance, applicants are also asked a stand-alone question about HIV/AIDS, similar to how HIV was treated in the pre-ACA market. Examples of this question include:

Within the last 5 years has any applicant been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? - National General, IL

Within the last 5 years have you or has anyone listed on the application received treatment advice medication or surgical consultation for HIV infection from a doctor or other licensed clinical professional or had a positive test for HIV infection performed by a doctor or other licensed clinical professional? (The person(s) named will not be covered under the policy.) - UnitedOne, GA

Within the past 5 years, has the Applicant or any Proposed Insured been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? – Lifeshield, FL

In all 38 applications, when the HIV/AIDS question was answered affirmatively, the applicant was rejected from coverage.^{5,6} In some cases, this was explicit in the question wording; in others, the rejection was only provided afterward. By contrast, ACA-compliant policies are prohibited from engaging in medical underwriting, denying coverage on basis of health status, and imposing pre-existing condition exclusions.

Access to HIV Care & Treatment if Diagnosed While Enrolled

In addition to exploring whether someone with HIV would be offered an STLD insurance policy, we assessed whether someone diagnosed with HIV once covered would have meaningful access to HIV care and treatment. In most cases, we found that such access would be fairly limited. In addition, because STLD plans are non-renewable, an enrollee newly diagnosed with HIV while covered by a STLD plan would not be able to renew coverage at the end of the period, currently limited to three months.

We assessed coverage and cost-sharing related to prescription medication, laboratory services, and specialist visits (the most basic and critical elements of HIV care) in each of the 38 plans in our sample. Findings are as follows.

Table 2. States and Plans in Sample		
Service	Plans Offering Coverage	Cost-Sharing
Drug Coverage	13% (5) offer some coverage	Of those offering coverage: <ul style="list-style-type: none"> • Benefit limit in all plans = \$3,000 • All plans require deductible met first (\$1,000 or \$10,000) • All plans require co-insurance (20%-30%)
Specialty Provider Visits	100% (38 plans) offer some coverage	All require cost-sharing, design varies, sometimes including limits: <ul style="list-style-type: none"> • 29% cover prior to deductible with co-payment (\$40 or \$50). • 29% cover after deductible (up to \$10,000) met with co-insurance (20%-50%); 1 plan does not have additional cost-sharing or coinsurance • 18% cover visits 1-3 with flat co-payment; subsequent visits after deductible (\$1,000-\$5,000) with co-insurance (20%- 50%). • 24% utilize limits (1-2) and/or caps (\$2,000)
Laboratory Services	100% (38 plans) offer some coverage	All require cost-sharing: <ul style="list-style-type: none"> • All cover after deductible met (\$250-\$10,000) • 74% require co-insurance (20%-50%), 26% do not

DRUG COVERAGE

Access to comprehensive drug coverage is arguably the most important element of HIV care. The Department of Health and Human Services' (DHHS) national clinical recommendation is now to initiate antiretroviral treatment (ART) as soon as possible after diagnosis.⁷ Doing so improves both individual health outcomes and serves as a preventive measure given that when an HIV-positive individual is engaged in care and treatment and the amount of virus in their body reaches an undetectable level, there is effectively no risk of transmitting HIV to others.⁸

The majority of plans reviewed (33 or 87%) did not offer drug coverage of any kind. However, in four states (IL, TX, FL, and GA), individuals enrolling in STLD plans on Agile.com, had access to at least one plan with drug coverage. Maryland was the only state not to offer any plans with drug coverage on this marketplace in this sample. Some plans mention pharmacy discount cards but do not offer credible drug coverage or guaranteed discounts. A plan without drug coverage would not meet the needs of someone with HIV.

Just 5 plans, all from a single issuer, provide some drug coverage but come with significant limitations related to cost sharing and dollar caps (See Table 2). For example, all 5 plans have a \$3,000 limit on prescription spending for the three month term period, a limitation that might prohibit someone with HIV from filling a prescription each month. The plans also require patients to pay out-of-pocket for prescriptions at the point of sale, at the lowest price available, and then submit a claim to the plan, something that could be burdensome and financially out of reach for many.

For the one issuer offering drug coverage, obtaining information on those benefits was difficult. There were no links to formularies on Agile.com, in the plan documents provided, and we were unable to locate links on the issuer's website. Upon calling the issuer's 800 number, the agent we first spoke with was unable to provide details on the drug benefit, unaware of where to find formulary information or if one existed at all. After being transferred to a manager, we were directed to the correct location of the formulary for the 5 plans offering a drug benefit in this study. We were told that an enrollee would receive the formulary document only after enrollment in coverage was complete. The manager also emphasized that drug coverage excludes treatment for pre-existing conditions.

Reviewing the formulary, we found that while not all approved HIV medications were included, it did cover all drugs identified in the recommended initial regimens for treatment naïve patients by the DHHS HIV Treatment Guidelines.⁹

ACA compliant plans, by contrast, are required to provide a Summary of Benefits and Coverage (SBC), which offer specific information on how essential benefits (including prescription drugs, provider visits, and laboratory services) are covered. The plans must also display clear links with up-to-date formularies, which, along with the SBC, can be used to assess which drugs are covered and how cost-sharing is applied. These documents are provided on both issuer websites and on state Marketplaces.

SPECIALIST PROVIDER VISITS

Many people with HIV get their care from a specialty provider, such as an infectious disease physician. We assessed coverage of specialty providers visits among the plans in the sample and found that all 38 plans cover these services to some degree, though some use dollar and quantity caps to substantially limit coverage. For example, 24% of plans cap specialty visits to 1 or 2 or impose dollar caps. Cost-sharing related to coverage varied but in some cases could be quite significant (see Table 2). For instance, some plans do not cover visits until the deductible has been met, which in one case was \$10,000.

In addition to utilization management and cost-sharing, another aspect of provider access is network scope. While STLD plans permit enrollees to seek care out-of-network, a feature emphasized by issuers, better pricing is often available to enrollees using an in-network provider, a detail de-emphasized in plan materials. For instance, one plan says up front, “Choose your own doctors and hospitals with no network restrictions” but does not clarify that the plan does indeed have a network where care can be delivered with lower out-of-pocket costs until much deeper in the plan information. Several plans reviewed use the networks of parent insurance companies and seem to provide significant choice, including among infectious disease specialists. Others contracted with an outside vendor to create a provider network and also seemed to have reasonable access to specialists. However, it was very hard to find provider network information and at times, it was unclear which network was related to what plan.

For ACA-compliant policies, the SBC would provide information on coverage of specialist visits and links to provider networks in their online materials. These documents are also provided on both issuer websites and state Marketplace websites.

LABORATORY SERVICES

Another important element of HIV care delivery is laboratory services, particularly to test for CD4 counts, viral load, and drug resistance. As with specialty provider visits, all 38 plans offered laboratory services. Unlike the other areas examined, however, laboratory services generally included few limitations – none impose dollar or quantity caps, for example, though all require cost-sharing (see Table 2).

Discussion

The Trump administration’s proposals to expand STLDs could make them a more mainstream insurance option that offers some consumers less-expensive coverage while they are healthy. However, for those with a past or pre-existing condition or who become sick while enrolled, such plans are, by design, either unavailable or limited in the covered benefits they offer. As we find here, people with HIV would be denied STLD coverage in all cases because they are HIV positive. Moreover, if an STLD enrollee was diagnosed with HIV, they would not have access to needed services, such as prescription drugs, or face limits and prohibitive costs if the service was covered. Further, since STLD policies are non-renewable, at the end of the coverage period an enrollee diagnosed with HIV would not be able to enroll in a new policy.

As people with HIV and other significant health conditions will not gain access to the lower cost STLD plan market, those without group coverage will likely remain in ACA-compliant plans (if not eligible for Medicaid, Medicare, or other coverage). To the extent that migration of younger healthier individuals to the non-compliant market destabilizes the individual market risk pool, people with HIV and other less healthy individuals could face higher costs in the future. Subsidies would protect low-income individuals from dramatic premium increases but the cost would increase the federal deficit and those who are not eligible, could face financial strain.¹⁰ In the context of HIV, this could strain the Ryan White program which currently helps with premium and other cost-sharing assistance. Additionally, pending litigation in Texas now supported by the Trump Justice Department, the prohibition against pre-existing condition exclusions could be reversed, eliminating access for those with HIV and other health conditions. Given this potential dynamic, it will be important to continue to monitor the status of the case as well as the impact of proposed changes to STLD plans, and other non-ACA compliant products, on people with HIV (and others with significant health conditions) along with the ACA-compliant marketplace that serves them.¹¹

Endnotes

1 President Donald Trump. Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States. October 12, 2017. Available at: <https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/>; U.S. Department of Treasury, Department of Labor and Health and Human Services. Proposed Rule. Short-Term, Limited-Duration Insurance. 83 Fed. Reg. 55 (February 21, 2018). <https://www.gpo.gov/fdsys/pkg/FR-2018-02-21/pdf/2018-03208.pdf>

2 The Kaiser Family Foundation. (2001). How Accessible is Individual Health Insurance for Consumer in Less-Than-Perfect Health? Available at: <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf>.

3 While CA and NY rank higher than IL and MD in terms of HIV prevalence, neither state sells products on Agile.com.

4 Kaiser Family Foundation analysis of CDC Atlas data, U.S. HIV prevalence. Available at: <https://www.cdc.gov/nchhstp/atlas/index.htm>

5 While HIV is highlighted as a condition plans are specifically seeking to avoid in selecting enrollees, many other past or current health conditions would be grounds for rejection from coverage. In addition, to HIV, answering affirmatively to any of the health condition related application questions would result in rejection.

6 In several circumstances, the HIV/AIDS application question mentions that, by law, residents of Wisconsin (WI) do not need to disclose their HIV status. To test this we also applied for plans in WI. Despite this disclaimer, the HIV/AIDS question is asked in the WI plan applications and the applicant must answer the question to move on in the process and ultimately, receive a coverage determination. If the applicant says they have been diagnosed with HIV, they are rejected from coverage. If they say they have not been, they are accepted but the applicant has then lied on their application, which could be grounds for rejecting claims or rescinding coverage. Online at least, there seems to be no way to avoid responding to this question despite the statement that WI residents need not answer it.

7 INSIGHT START Study Group. Initiation of antiretroviral therapy in early asymptomatic HIV infection. N Engl J Med. Jul 20 2015. Available at <http://www.ncbi.nlm.nih.gov/pubmed/26192873>; .S. Department of Health and Human Services. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Available at <http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf>. Accessed 6/7/2018.

8 Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. N Engl J Med 2011;365:493-505.; Cohen MS, Chen YQ, McCauley M, et al. Antiretroviral therapy for the prevention of HIV-1 transmission. N Engl J Med 2016;375:830-9.;CDC. [HIV Treatment as Prevention](https://www.cdc.gov/hiv/risk/art/index.html); updated November 2017. <https://www.cdc.gov/hiv/risk/art/index.html>

9 U.S. Department of Health and Human Services. Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Available at [http://www.aidsinfo.nih.gov/ContentFiles/ AdultandAdolescentGL.pdf](http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf). Accessed 6/7/2018.

¹⁰ U.S. Department of Health and Human Services. Centers for Medicare & Medicaid Services, Office of the Actuary. *Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule*. April 6, 2018. https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf?elq_mid=11771&elq_cid=1094384

¹¹ Pollitz, K., et al. (2018). Kaiser Family Foundation. Understanding Short-Term Limited Duration Health Insurance. Available at: <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>