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Thwarting the Short-Term Health Care Crisis

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I. The Calm before the Storm

Short term health care policies have existed for decades. Traditionally they have been considered to be "gap-filler policies" and have been used to obtain short-term health care for individuals who were between jobs. [1] Until fairly recently, they occupied a small niche in the insurance marketplace and did not appeal to the mainstream.

Compared to group health insurance policies, these policies contain severe limitations. For instance, these policies are underwritten on an individual basis, which means that the insurer examines the health of the individual policyholder. Less healthy individuals either receive no insurance or pay more for the insurance they receive. Furthermore, these policies exclude coverage for pre-existing conditions, contain limits on the amount of benefits paid, and exclude coverage for services like maternity and mental health care.[2] In short, they suffer from many of the limitations that the Obama administration sought to address with promotion and passage of the Patient Protection and Affordable Health Care Act.

II. The Storm Hits

[1] *Novak v. Am. Community Mut. Ins. Co.*, 718 N.E.2d 958, 959 n. 1 (Ohio Ct. App. 1998)(stating "A policy which is called "short term" is essentially a gap filler, or a policy which provides a person with health insurance for a short period until a primary policy begins."); *Miller v. Fidelity Security Life Insurance Company*, 294 F.3d 762, 765 (6th Cir. 2002)(stating "The policies at issue here were obtained by Miller as "gap fillers," presumably to serve until he could obtain insurance through an employer."); Sabrina Corlette, Kevin Lucia et al., "The Marketing of Short Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses" at p. 3, January 2019 Report by Robert Wood Johnson Foundation and Urban Institute.
[2] Karen Pollitz, Michael Long et al., "Understanding Short-Term Limited Duration Insurance", April 2018 Issue Brief, Henry J. Kaiser Family Foundation at p. 2.

Ironically, certain companies viewed the passage of the ACA as an opportunity to repackage and re-brand short term health care policies as viable alternatives to ACA compliant policies. Companies like Health Insurance Innovations and E-Health gambled that the Affordable Care Act would cause insurance premiums to rise. They also realized that short-term health care policies had been exempted from the types of policies that had to comply with the ACA. As a result, they set up sophisticated mechanisms to develop, sell, and administer short term health care policies which would be underwritten by different insurers.[3] When the individual mandate requirements of Obamacare became effective in 2014, the sale of these policies took off.

Unfortunately, the mechanisms that these companies developed to promote these policies not only confuse consumers, but seem deliberately designed to do so. One way they have done this is by using call centers to solicit individuals and to field calls regarding short term policies. The individuals selling these policies frequently misrepresent the coverage available and whether or not pre-existing conditions are covered.[4] Phone salesmen also have been reluctant to provide sample policies until after consummation of the sale.[5] In addition, these companies have developed extensive Internet presences to directly market to individuals. Not only do they have large sophisticated websites that aggregate health insurance policies from many different insurance companies, but they also optimize SEO to target individuals looking for ACA compliant policies. In fact, a search for an Obamacare of policy or an ACA policy is much more likely to lead a consumer to a short-term non-ACA compliant policy[6]. Furthermore, printed materials and representations on the websites often exaggerate the coverage available while avoiding discussion of exclusions for pre-existing conditions.[7]

Depending on the insurer involved, a third-party like Health Insurance Innovations may have an agreement with the insurer to collect premiums and issue policies. Insurers who sell short term policies may also outsource other parts of the process. For instance, HCC Life Insurance

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[3] Health Insurance Innovations 2014 10K at p. 3.

[4] Reed Abelson, "Without Obamacare Mandate 'You Open the Floodgates' for Skimpy Health Plans", November 30, 2017, New York Times; "Health Insurance Innovations: A Close Look at Relationship with Third-Party Call Centers; Company Could Potentially Be Held Liable for Actions of Centers, The Capitol Forum, Vol. 5, No. 407, December 4, 2017.

[5] Sabrina Corlette, Kevin Lucia et al., "The Marketing of Short Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses" at pp. 6-8, January 2019 Report by Robert Wood Johnson Foundation and Urban Institute;

[6] Sabrina Corlette, Kevin Lucia et al., "The Marketing of Short Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses" at pp. 4-7, January 2019 Report by Robert Wood Johnson Foundation and Urban Institute; "The Marketing of Short-Term Health Plans: Industry Practices Create Consumer Confusion," Georgetown University Health Policy Institute, Center on Health Insurance Reforms, Jan. 31, 2019.

[7] Contact me for a copy written materials used to promote HCC life's short term health care policies and filed publicly in the United States District Court for the Southern District of Alabama.

Company outsources its customer service functions to call centers operated by Global Response, a Florida company with call centers in Michigan and Florida. Insurers may use other companies to handle claims functions. Insurers may even hire yet another company to handle medical records requests and indexing.

This patchwork of third-party providers can have negative consequences for the policyholder. These consequences can include the failure to consider information submitted by the policyholder, miscommunication with the policyholder, and the failure to thoroughly and accurately evaluate claims. In addition, since these insurers nearly always conduct pre-existing condition investigations before paying any significant benefit, claims decisions are extremely slow. These delays can conflict with prompt payment laws, which generally require that the insurers pay claims within 30 to 45 days of submission of a properly completed claim form.[8]

In response to many of these abuses, the Obama administration revised the definition of "short-term, limited-duration health insurance policies" to limit them to a period of three months and require clear disclosures that they did not meet the requirements of the ACA and included exclusions for pre-existing conditions.[9] This limitation survived only briefly though. Industry lobbying and a change in the political winds brought in another revision to the regulation allowing these types of policies to be sold for up to one year at a time and renewed for up to three years.[10] In the face of this regulatory change and active promotion by the current administration, preliminary signs indicate that the sale of these policies is on the rise.

III. Addressing the Challenges That Short Term Policyholders Face

Rescission

Because they do not have the protections of the ACA or of a group policy, short-term health insurance policyholders face unique challenges. One such challenge relates to efforts by the insurer to rescind the coverage. While these insurers do only minimal health underwriting on the sale of the policy, they actively engage in post-claim underwriting when faced with major claims. Because of this, an insured may face a rescission challenged by the company claiming that the insured misrepresented their health on the application.

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[8] *See e.g.* Ala. Code §21-1-17.

[9] "Excepted Benefits; Lifetime and Annual Benefits; and Short-Term, Limited-Duration Insurance," 81 Fed. Reg. 210 (Oct. 31, 2016)(stating "The departments have become aware that short-term, limited-duration insurance policies are being sold in situations other than those that the exception from the definition of individual health insurance was originally intended to address.")

[10] "Short-Term, Limited-Duration Insurance," 83 Fed. Reg. 150 (Aug. 3, 2018); 26 C.F.R. § 54-9801-2.

King v. Golden Rule Insurance Company[11] demonstrates how short-term insurers may use rescission to deny coverage. Mr. King filled out an insurance application in which he denied having cancer, diabetes, or circulatory problems[12]. His medical records revealed that he had been treated for diabetes, a tumor on his spine, and chronic vein insufficiency[13]. Golden Rule unilaterally rescinded his policy after his wife filed a claim on his behalf and Mrs. King challenged Golden rule's actions in rescinding the policy without first seeking a court ruling[14]. The court noted that Pennsylvania law prevented insurers from denying benefits on the basis of a misrepresentation unless the insured made the misrepresentations "with actual intent to deceive, or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer[15]." Because of this language, the insurer did not have to prove actual intent to deceive[16]. The court then dismissed Mrs. King's complaint finding that Golden rule act in accordance with the law[17]. Many states have similar laws.

Other states have laws requiring that the insurer show that the insured knew of the health condition when he or she made the misrepresentation. For instance, in *HCC Life Insurance Company v. Conroy*[18], the court observed that California law required an insurer to prove that an insured knew that he or she made a misrepresentation and denied HCC life's motion for summary judgment on the grounds that issues of material fact remain on whether the Conroys knew of the misrepresentation.[19]

Even in states that allow rescission on the basis of an innocent misrepresentation, a few avenues exist for attacking rescission. For instance, some applications contain the phrase "to the best of my knowledge and belief." This language can be construed to require an insured to have knowledge that he or she is making a misrepresentation[20]. Also, an insurer may not be able to rescind if the insurer knows of facts before issuing the policy that put it on notice of the need to further investigate[21].

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[11] 2016 WL 7338771 (E.D. Pa. Dec. 19, 2016).
[12] *Id*. at *1.
[13] *Id.*
[14] *Id.*
[15] *Id.* at 2.
[16] *Id.* at 3.
[17] *Id.* at 4.
[18] 2017 WL 1080742 at *6 (S.D. Cal. March 22, 2017).
[19] *Id.* at *5-*6.
[20] *William Penn Life Ins. Co. v. Sands*, 912 F. 2d 1359, 1362-63 (11th Cir. 1990)
[21] *Bankers Life & Cas. Co. v. Long*, 345 So. 2d 1321, 1323 (Ala. 1977)(indication of treatment for hepatitis and name of doctor sufficient to induce inquiry that would have let to discovery of cirrhosis of the liver)

The Successive Coverage Trap

An insurer may attempt to use the successive coverage trap to deny coverage. This situation can occur when an insured develops a condition during a first policy period which continues over to a second policy. Absent language continuing coverage for the condition, an insurer may attempt to deny coverage on the basis that the condition preexisted the second policy[22].

Ambiguous Pre-Existing Condition Exclusions

Insurers may also attempt to use ambiguous pre-existing condition causes to deny coverage for claims. Many short-term health care policies contain very broad definitions of pre-existing conditions and these insurers broadly interpret them once claims had been made. For example, *DeMatteis v. American Community Mutual Insurance Company* interpreted an exclusion defining a pre-existing condition as "an illness, disease, accidental bodily damage or loss that first appears (makes itself known) before the Effective Date.[23]" In that case, the court rejected an insurer's attempt to argue that the insured's atherosclerotic cardiovascular disease was a pre-existing condition to the plaintiff's myocardial infarction.[24]

In *Jones v. Golden Rule Insurance Company*, the short-term policy defined a pre-existing condition as "a condition for which medical advice, diagnosis, cure, or treatment was recommended or received within the 60 months immediately preceding the date.[25]" Golden Rule attempted to use this exclusion to argue that a mammogram performed before the date of the policy was a "diagnosis," even though the insured did not receive her cancer diagnosis until after the effective date of the policy.[26] The 11th circuit rejected this argument, reversing and remanding in favor of the insured[27].

Bad Faith Claims Practices

Finally, short-term insurance policies can give rise to bad faith claims. With short-term policies, insurers have a special incentive to place their interests above those of their policyholders. These policies are not subject to the loss ratio requirements of the ACA. As result, companies issuing these policies commonly show loss ratios under 50%. In addition, they use third parties to gather information for them which can lead to communication problems. In addition, due to

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[22] *See e.g. Novak v. American Community Mut. Ins. Co.,* 718 N.E.2d 958, 963 (Ohio Ct. App. 1998); *Miller v. Fidelity Security Life Ins. Co.*, 294 F.3d 762, 767 (2002)(finding that continuation language in policy afforded coverage).
[23] 616 N.E.2d 1208, 1209 (Ohio Ct. App. 1992).
[24] *Id*. at 1211-12.
[25] 2018 WL 4043229 at *2 (11th Cir. 2018).
[26] *Id.* at *1.
[27] *Id.* at *9.

the pre-existing condition exclusions, they perform background medical analysis going back as far as five years every time a policyholder files a significant claim. Due to these dynamics, these claims can exhibit the following bad faith claims practices:

> (1) the insurer looks only for reasons to deny the claim and does not look for reasons to pay the claim[28],
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> (2) the insurer ignores proofs submitted by the insured[29],
>
> (3) the insurer does not conduct a thorough and adequate investigation[30], and
>
> (4) the insurer does not timely evaluate and pay claims[31].

Accordingly, be sure to seek pattern and practice discovery, other similar incidents, and financial incentives in discovery. In addition, you will want to make sure that you identify any third- party vendors and seek copies of the applicable contracts. Feel free to contact me if you would like to discuss discovery in greater detail.

IV. The Storm Clears

Because of misleading marketing practices, high health costs, and aggressive denial of claims these policies can leave policyholders devastated. As lawyers protecting the vulnerable people that these policies target, we have an obligation to educate people about the dangers of these policies and to fight these dangerous claims practices aggressively. In response to reckless positions taken by the current administration, easing of the federal regulations and rising insurance premiums, sales of these policies are rising. We have the opportunity to positively impact our clients and to hold the wrongdoers in this industry accountable. With our efforts, we can reform this industry these products can bring responsible insurance practices to the short-term health insurance area. As trial lawyers, we do not like to back down from a just fight; let us not back down from this one.

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[28] *See Wilson v. 21st Century Ins. Co.*, 171 P.3d 1082, 1087 (Cal. 2007).
[29] *See id.*
[30] *See id.; State Farm Fire & Cas. Co. v. Slade*, 747 So. 2d 293, 315-316 (Ala. 1999)(duty to marshall all of the facts before making a determination on coverage).
[31] *See Acceptance Ins. Co. v. Brown*, 832 So. 2d 1, 16 (Ala. 2001)(quoting *Thomas v. Principal Fin. Group*, 566 So. 2d 735, 742-43)