

# Bare-Bones Health Plans: Is Something Better than Nothing?

Some states currently allow private insurance companies to sell bare-bones health insurance plans—policies that offer limited benefits and minimal coverage in exchange for less-expensive premiums.<sup>1</sup> While these basic plans do offer individuals some coverage, they also expose plan enrollees to significant levels of health and financial risk. Due to their specific health care needs and patterns of use, women are particularly ill-served by these plans. Health reform that promotes bare-bones health plans as a means of expanding affordable health coverage is a move in the wrong direction and will only increase the number of *underinsured* Americans—individuals who are more likely to go without needed care because of their insurance plan’s inadequate coverage.

## What Are Bare-Bones Health Plans and How Do They Work?

Bare-bones health insurance plans are intended to appeal to individuals who want some insurance coverage, but who cannot afford or do not wish to pay for higher-priced comprehensive plans.<sup>2</sup> Bare-bones plans typically offer limited coverage that excludes many critical services. Bare-bones policies are generally sold at significantly lower prices than traditional plans with more comprehensive health benefits. But in return for lower premiums, individuals covered under these plans will likely find themselves with:

- **Fewer benefits.** Bare-bones health insurance includes fewer benefits than traditional health insurance plans. For example, these plans may exclude coverage for prescription drugs, mental health or substance abuse treatment, maternity services, or cancer care.
- **More limitations on benefits that are covered.** Bare-bones policies often limit the coverage on the benefits that are provided. While even traditional health plans place some limits on coverage, the restrictions that some bare-bones plans impose on benefits are often more severe. For example, many traditional health insurance plans do not limit the number of days a person can be in the hospital, nor do they impose annual coverage limits. In contrast, bare-bones policies often cap hospital coverage at a certain number of days in a year and usually only cover a certain amount of costs incurred during a hospital stay. Individuals enrolled in these plans are thus left to pay, often in full, any costs incurred for longer hospital stays or for treatment expenses above the annual coverage limit. This can leave families with thousands of dollars in medical bills—even though they technically have health insurance.<sup>3</sup>
- **Higher levels of out-of-pocket spending.** Bare-bones plans often have high deductibles, co-pays, and other cost-sharing requirements. Some bare-bones plans, for example, include deductibles of \$1000 or more for an individual, or several thousands of dollars for a family.<sup>4</sup> Because of these high out-of-pocket expenses, individuals may be required to pay large medical bills before their insurance begins to cover costs. Some health plans, often called “high deductible health plans,” also have steep out-of-pocket costs and high deductibles.<sup>5</sup> However, these plans typically do not have the skimpy benefit packages and limits on coverage characteristic of bare-bones policies.

Employers may offer bare-bones health plans to their workers as a lower-cost option alongside more traditional coverage plans, or they may provide bare-bones health coverage

as the only option for employees. This type of health plan may be particularly appealing to small businesses since these businesses have the most difficulty obtaining affordable coverage for their workers. Indeed, many states have enacted laws explicitly allowing insurers to market bare-bones health plans to small businesses—these laws are sometimes called “mandate-lite,” “limited-benefit,” or “mandate-free” laws because the plans are exempt from many of the state’s health benefit mandates (i.e. requirements that insurers include coverage for certain important health benefits in the policies that they sell).<sup>6</sup> Women might also purchase a bare-bones health plan directly from an insurer through the individual insurance market.<sup>7</sup> In general, the health plans that are available through the individual insurance market have more limited benefits and require greater levels of cost-sharing than employer-provided health insurance, though not all individual market plans are bare-bones health plans.

### **Bare-Bones Plans: A Bad Deal for Women and Families**

Due to the lack of coverage for many health benefits and the limited coverage on included benefits, bare-bones plans present women and their families with significant health and financial risks.

#### ■ **The limited benefits offered under bare-bones plans disproportionately affect women’s access to health care, including preventive health care services.**

Bare-bones health plans may fail to cover basic health care services essential to a woman’s health. On average, women have greater health care needs than men.<sup>8</sup> In particular, women have reproductive health needs that require regular medical visits including maternity care and pre- and post-natal care. Additionally, women of all ages are more likely to take prescription drugs on a regular basis, including oral contraceptives. Women also suffer from certain conditions at higher rates than men, including chronic conditions that require regular treatment such as arthritis, asthma, and diabetes.<sup>9</sup>

Because of the unique health needs women have, they require comprehensive health insurance that can adequately cover these needs. But bare-bones health plans often exclude certain benefits that are a critical part of maintaining women’s health, including prescription drug coverage and maternity care. Women may be less likely to access preventive care such as regular primary care visits and annual gynecological exams if these critical preventive services are not covered under bare-bones plans.

#### ■ **Limited coverage and caps on existing benefits put women at increased financial risk.**

Women are more likely than men to have a chronic condition that requires ongoing treatment, and even healthy women use more health care services than men.<sup>10</sup> Women, therefore, need health insurance that covers their health care needs without leaving them with thousands of dollars of unpaid medical bills.

Bare-bones plans leave women with significant financial risk because these plans may not cover a woman’s full health care costs. For example, while many bare-bones plans purchased on the individual market exclude coverage for maternity care altogether, those plans that do offer coverage often impose severe limits.<sup>11</sup> Under these limitations, even routine pregnancies could leave a woman responsible for significant out-of-pocket

costs. More complicated pregnancies could leave a woman with limited resources in serious debt.

Women who have high health care expenses—such as those with disabilities, chronic conditions, and serious illnesses—are most likely to be negatively affected by the limited coverage and caps on benefits. These individuals generally have higher health care costs, which might exceed the low limits of bare-bones plans. For example, a woman who is admitted into the hospital for multiple days as a result of a severe asthma attack may be left with thousands of dollars in medical bills because her bare-bones plan imposes limits (either in days or dollar amounts) on inpatient hospital stays. Additionally, some plans cover only 5 or 6 visits per year for radiation therapy for cancer.<sup>12</sup> Women who suffer from cancers such as breast cancer and need radiation therapy, however, usually require 5 visits per week over the course of numerous weeks.<sup>13</sup>



### LESSONS FROM THE STATES:

#### “Cover Florida” Creates Bare-Bones Plans to Expand Coverage to the Uninsured

With close to 4 million uninsured residents—one of the highest uninsured rates in the country—Florida faces significant challenges in providing residents with affordable, adequate health care coverage. To address this growing problem, Governor Charlie Crist signed a law in May 2008 that allows insurance companies to offer stripped-down plans to state residents between the ages of 19 and 64 who have been uninsured for six months or longer. All insurance carriers who participate in the program must offer one plan with catastrophic and inpatient coverage and one without these benefits. Neither of the plans will cover important benefits such as treatments for cancer or mental illness.<sup>17</sup> By offering a less valuable, limited benefit package, insurance companies can offer policies for approximately \$150 a month, a cost considerably lower than the average price of a traditional, comprehensive health policy.<sup>18</sup> However, individuals who want coverage for excluded services would have to purchase supplemental insurance.<sup>19</sup> Participating insurers are expected to introduce Cover Florida plans in early 2009.<sup>20</sup>

The “Cover Florida” plan is not the state’s first attempt at introducing bare-bones plans as a solution to its health care problems. In 2002, the state implemented “Health Flex,” a program that allowed insurers to offer limited-benefit plans to low-income residents. Today, only 3 of Florida’s 67 counties offer Health Flex plans, and the program has had very low enrollment rates, an experience shared by other states who have allowed insurers to sell bare-bones policies.<sup>21</sup> Reports have suggested that individuals may not consider these plans to be worth the money.<sup>22</sup> The vast majority of individuals who have Health Flex plans use subsidies provided by counties. In fact, Health Flex’s 2007 annual report acknowledged that the future of the Health Flex Program depended largely on the availability of government or private funding sources to subsidize part of the program’s costs.<sup>23</sup> Unlike Health Flex plans, however, Cover Florida plans will not offer enrollees any subsidies to help pay the \$150 monthly premium.<sup>24</sup> This lack of subsidies, along with the limited benefits, further decrease the chance that Cover Florida will be an affordable, adequate health care option for Florida residents.

■ **High cost-sharing makes bare-bones plans unaffordable for lower-income women and their families.**

On average, women earn less than men. They also typically need and use more health services.<sup>14</sup> It is not surprising, then, that women report more difficulty paying for health care than men. Because of the challenges women face paying for health care costs, affordability is a key component to whether a woman is able to obtain the health care services she needs. The high cost-sharing requirements of bare-bones plans—including premiums, co-pays, and deductibles—leave women with high out-of-pocket expenses for health care. Especially for low-income women, this may be more than they can afford. While premiums for bare-bones health plans may be lower than those for more comprehensive coverage, the money saved on lower premiums of bare-bones plans is often spent on higher deductibles and other forms of cost-sharing involved in bare-bones plans. These cost-sharing mechanisms, such as co-pays and deductibles, may also lead women to avoid needed health care.<sup>15</sup> One study, for example, found that some women decided to forgo mammograms altogether when required to contribute even a small co-pay of \$10 to \$20.<sup>16</sup>

**Bare-Bones Plans Are Not Good Health Reform**

Bare-bones plans are a risky deal for women and their families and fail to offer an effective solution to the growing number of uninsured and underinsured in America.

**Pursuing bare-bones health plans as a reform strategy will do little to reduce the number of uninsured Americans.** Instead, these plans will increase the number of underinsured Americans. Historically, limited-benefit products have not sold well.<sup>25</sup> Many insurers are reluctant to sell bare-bones policies, and consumers—aware of the many problems with this type of coverage—are uninterested in buying them. Those that do purchase these plans will join the ranks of the 25 million underinsured Americans—individuals who have health coverage that does not adequately protect them from high medical expenses.<sup>26</sup> According to a recent study, more than half of the underinsured go without needed care—including not seeing a doctor when sick, not filling prescriptions, and not following up on recommended tests or treatment.<sup>27</sup>

**Bare-bones plans will further segment the health insurance market and will not help control rising health care costs.** Bare-bones plans are intended for those individuals in good health who think they won't need comprehensive coverage. Therefore, these plans will lead healthy, low-cost enrollees away from plans with comprehensive coverage and leave sicker and poorer Americans concentrated in traditional, comprehensive insurance plans.<sup>28</sup> This division of the pool of insured people fails to spread medical risk between those with high and low medical expenses. As a result, the premiums for those in traditional plans may significantly increase.

The high out-of-pocket costs that accompany bare-bones plan may compel financially-concerned individuals to delay or forgo preventive care. This may lead to the development or worsening of illnesses, which the health care system will have to address at a later stage. Treatment for these advanced conditions will likely be far more expensive than the cost of preventing the illness in the first place.



## What Can Women's Advocates Do?

***Women's advocates can spread awareness about the risks and dangers of bare-bones health plans, and explain why these plans will not help solve America's health care problems.***

Bare-bones health plans lack coverage for important health benefits and place limits on the benefits that are covered. Consequently, these health plans present women and their families with significant health and financial risks. Promoting bare-bones health plans will not lead to reductions in America's overall health care costs, but will lead to an increase in the number of underinsured Americans.



## For further reading, see:

Isabel Friedenjohn, The Commonwealth Fund, *Limited-Benefit Policies: Public and Private-Sector Experiences* (July 2004), <http://statecoverage.net/pdf/issuebrief704.pdf>.

Sherry Glied et al., The Commonwealth Fund, *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002), [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=221524](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221524).

Judith Solomon, Center on Budget and Policy Priorities, *New Georgia and Florida Plans Unlikely to Reduce Ranks of Uninsured* (July 2008), <http://www.cbpp.org/7-1-08health.htm>.

## References

- 1 Isabel Friedenjohn, The Commonwealth Fund, *Limited-Benefit Policies: Public and Private-Sector Experience* (July 2004), <http://statecoverage.net/pdf/issuebrief704.pdf>; and Sherry Glied et al., The Commonwealth Fund, *Bare-Bones Health Plans: Are They Worth the Money?* (May 2002), [http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=221524](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221524).
- 2 Comprehensive health insurance plans cover the services that women need to stay healthy and to treat physical and mental illnesses at all stages of life. Comprehensive plans include coverage for all necessary care, including preventive care and a full range of reproductive health services. See: "Women and Health Reform: An Introduction to the Issues" section of the *Reform Matters Toolkit* for a discussion of comprehensive benefits.
- 3 Kyung Song, *Bare-Bones Health Plan Left Family Swimming in Debts*, The Seattle Times, February 28, 2008.
- 4 *Id.*
- 5 See: "Health Savings Accounts and High-Deductible Health Plans: The Wrong Answer to Women's Health Care Needs" section of the *Reform Matters Toolkit* for detailed information on high-deductible health plans.
- 6 See: "Mandated Insurance Benefits: Important Health Protections for Women and Their Families" section of the *Reform Matters Toolkit* for detailed information on mandated benefits.
- 7 For a discussion on the challenges women face obtaining health insurance coverage in the individual market see: National Women's Law Center, *Nowhere to Turn: How the Individual Health Insurance Market Fails Women* (2008), <http://action.nwlc.org/site/PageServer?pagename=nowheretoturn&JServSessionId.001=kn5chpapp1.app1>.
- 8 Elizabeth Patchias and Judy Waxman, National Women's Law Center and The Commonwealth Fund, *Women and Health Coverage: The Affordability Gap* (2007), <http://www.nwlc.org/pdf/NWLCCommonwealthHealthInsuranceIssueBrief2007.pdf>.
- 9 Alina Salganicoff et al., Kaiser Family Foundation, *Women and Health Care: A National Profile* (July 2005), <http://www.kff.org/womenshealth/whp070705pkg.cfm>.
- 10 *Women and Health Coverage*, *supra* note 8; Also: A Harvard Medical School analysis of 2003 Medical Expenditure Panel Survey (MEPS) data found that women's median health expenditures are \$997 higher than men's. While only one third of insured men under 45 spent \$1,050 or more each year in medical costs, over half of insured women reached this figure. See: Steffie Woolhandler and David U. Himmelstein, *Consumer Directed Healthcare: Except for the Healthy and Wealthy It's Unwise*, *Society of General Internal Medicine*, 22(6): 879-881 (June 2007), <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=2071952>.
- 11 For a discussion of the challenges women face obtaining maternity coverage in the individual market see *Nowhere to Turn*, *supra* note 7.
- 12 BlueCross BlueShield of Tennessee, *CoverTN Plan A Schedule of Benefits*, <http://www.bcbst.com/health-plans/cover-tennessee/covertnt/PlanA.pdf> (last visited Nov. 3, 2008); BlueCross BlueShield of Tennessee, *CoverTN Plan B Schedule of Benefits*, <http://www.bcbst.com/health-plans/cover-tennessee/covertnt/PlanB.pdf> (last visited Nov. 3, 2008), cited by Families USA, *Limited-Benefit Plans: Expanding Coverage or Holding Your State Back?* (October 2008), <http://www.familiesusa.org/assets/pdfs/limited-benefit-plans.pdf>.

- 13 National Comprehensive Cancer Network and American Cancer Society, *Breast Cancer Treatment*, 2007; National Comprehensive Cancer Network and American Cancer Society, *Prostate Cancer Treatment*, 2007 (as cited by *Limited-Benefit Plans*, *supra* note 12).
- 14 *The Affordability Gap*, *supra* note 8.
- 15 *Id.*
- 16 Irfan Dhalla, et al. *Effect of Cost Sharing on Screening Mammography*, *New England Journal of Medicine* 358(22): 2411-2412 (May 29, 2008).
- 17 Anika Myers Palm, *New low-cost-health plans to be offered to uninsured*, *The Orlando Sentinel*, October 18, 2008.
- 18 Judith Solomon, Center on Budget and Policy Priorities, *New Georgia and Florida Plans Unlikely to Reduce Ranks of Uninsured* (July 2008), <http://www.cbpp.org/7-1-08health.htm>.
- 19 Press Office of Governor Charlie Crist, *Governor Crist Signs Cover Florida Legislation to Provide Health Insurance Options to Florida's 3.8 Million Uninsured* (May 21, 2008), <http://www.flgov.com/release/10024>.
- 20 Josh Hafenbrack, *Six Health Insurance Companies to Offer Bare-Bones Plans*, *South Florida Sun-Sentinel*, October 16, 2008.
- 21 *Limited-Benefit Policies*, *supra* note 1 .
- 22 Kevin Sack, *New Florida Law Allows Low-Cost Health Policies*, *The New York Times*, May 22, 2008.
- 23 Agency for Health Care Administration, *Health Flex Plan Program: Annual Report 2008* (Jan. 2008), [http://www.fdhc.state.fl.us/mchq/managed\\_health\\_care/health\\_flex/annual\\_report-final\\_2008.pdf](http://www.fdhc.state.fl.us/mchq/managed_health_care/health_flex/annual_report-final_2008.pdf).
- 24 *New Georgia and Florida Plans*, *supra* note 18.
- 25 Philip J. Hiltz, *Bare-Bones Health Plans Are Found to Attract Few*, *The New York Times*, July 23, 1993.
- 26 Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, *Health Affairs Web Exclusive*, w298–w309 (June 10, 2008).
- 27 *Id.*
- 28 Paul Fronstin and Sara R Collins, The Employee Benefits Research Institute, *Issue Brief No. 315: Findings From the 2007 EBRI/Commonwealth Fund Consumerism in Health Care Survey* (March 2008), [http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content\\_id=3897](http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3897).

2008