



Non-ACA-Compliant Plans and the Risk of Market Segmentation

Considerations for State Insurance Regulators

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Preface

This report was commissioned by a group of consumer representatives to the National Association of Insurance Commissioners (NAIC) to assist regulators, lawmakers, and the NAIC during ongoing efforts to promote stable health insurance markets.

The purpose of this analysis is to provide additional background research and information on the risks posed by alternative coverage options that do not comply with all or most of the Affordable Care Act's (ACA's) consumer protections. These alternative coverage options include association health plans, short-term plans, health care sharing ministries, and transitional plans, among others. Some of these plans have proliferated in recent years, and federal regulators have proposed to expand access to this type of coverage. Each of the plans discussed in this report have or will contribute to market segmentation and adverse selection against the traditional individual and small group markets. With the repeal of the individual mandate penalty in 2019, we are concerned that these trends will accelerate.

State insurance departments play a critical role in regulating these types of alternative coverage options. Doing so is increasingly important to promote stability in the individual and small group markets and in light of proposed federal-level policy changes to increase access to non-ACA-compliant plans.

To help inform the perspective of regulators, this report discusses historical data, trends, and the reasons that these alternative coverage options result in market segmentation. Although this analysis does not reflect extensive recommendations for state regulators, the NAIC consumer representatives have or will continue to make recommendations to address these concerns before various NAIC committees, working groups, and task forces. We continue to urge state insurance regulators and the NAIC to regulate and limit the risk of market segmentation caused by non-ACA-compliant plans and to promote market stability.

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Table of Contents

Preface 2

Introduction 4

Association Health Plans 6

- » AHPs can discriminate through rating rules and benefit design. 8
- » AHPs are allowed to offer plans that fail to meet the minimum value standard. 9
- » The proposed AHP rule promotes risk segmentation. 10
- » The proposed rule allows for sales across state lines, which would limit state regulators' ability to assist consumers. 11
- » Fraud, scams, and insolvency: a historical view of AHPs. 12
- » Additional concerns for state insurance regulators: federal preemption, jurisdictional ambiguity, and network inadequacy. 14

Short-Term, Limited Duration Insurance 15

- » Regulator and consumer concerns about short-term plans: higher premiums, unpaid claims, rescissions, and deceptive marketing. 16
- » New proposed rule on short-term plans would exacerbate market segmentation. 18
- » States will play a critical role in regulating short-term plans, especially if the proposed rule is finalized. 19

Health Care Sharing Ministries 20

- » Enrollment in HCSMs continues to grow and consumers face pre-existing condition exclusions and self-pay. 20
- » Courts in some states have found HCSMs to be offering insurance without a license. 22
- » HCSMs raise the potential for market segmentation and may exacerbate the health care cost crisis. 23

Other Non-ACA-Compliant Products 25

- » Transitional plans are a key contributing factor to current risk pool instability in some states. 25
- » Mini-med and excepted benefit plans exacerbate market segmentation. 27

Conclusion 29

References 30

Introduction



Many of the proposals regarding alternative health coverage that have come from Congress and the Trump administration in 2017 and 2018 promote concepts that have been tried in the past. Some of these ideas have now been incorporated into 2018 proposed federal regulations, which loosen existing restrictions on association health plans and short-term health insurance. One of the most prominent protections of the Patient Protection and Affordable Care Act (ACA) is the prohibition of health status discrimination, including the elimination of pre-existing condition exclusions and medical underwriting, and the requirement that all individual and small group insurance be “community-rated.” Each individual or small group insurer must base its premium on the collective health risk of all of its subscribers, combined into a “single risk pool,” which is “central to the notion that insurance spreads risk by pooling lower cost people with higher cost people.”¹

Because association health plans, short-term insurance, health care sharing ministries, and various types of limited benefit health coverage have been available in the health insurance market for decades, there is plenty of evidence demonstrating how these products can segment the risk pool.

Because association health plans, short-term insurance, health care sharing ministries, and various types of limited benefit health coverage have been available in the health insurance market for decades, there is plenty of evidence demonstrating how these products can segment the risk pool. After the passage of the ACA, additional federal restrictions were placed on products sold through associations to employers and on short-term health insurance marketed to individuals because the federal agencies charged with implementing the ACA were aware of the negative effects that these competing products may have on ACA-compliant coverage subject to the single risk pool requirement.

Allowing healthier people to “opt-out” of standard protections in ACA-compliant coverage diverts younger, healthier people to cheaper products that offer less coverage, leaving older, sicker people in health insurance markets that are still protected from health status discrimination. The health coverage options discussed in this paper threaten to “cherry pick” healthier individuals, thereby removing them from the market that is required to maintain a single risk pool. Risk pool segmentation has the obvious effect of driving up premiums in the health plans that protect individuals from health status discrimination.

The repeal of the individual mandate penalty has increased the likelihood that more people will choose products like short-term health insurance coverage and other limited benefit insurance that do not meet the requirements of minimum essential coverage, as defined in the ACA. Current threats to the stability of the ACA-compliant market are discussed in this paper, including a review of the 2018 proposed federal rules on association health plans and short-term health insurance, the effect that transitional health plans have had on the market since 2014, the effect of a resurgence of limited benefit products such as mini-medicals and individual market type association health plans, and the impact of health care sharing ministries.

Beyond market segmentation, these policies will result in higher out-of-pocket costs for consumers and erode access to coverage. Millions of consumers depend on a functional individual insurance market to keep premiums stable, to make cost-sharing affordable, and to cover a range of comprehensive benefits for themselves and their families. Plans that do not cover pre-existing conditions, that allow underwriting, and that do not have to cover essential health benefits may reduce premiums in the short-term but merely shift costs on to patients and consumers in the long-term. The policies discussed in this report are also likely to disproportionately impact individuals with chronic conditions because of necessary treatments that would not be covered under these cheaper, non-ACA-compliant plans, coupled with higher premiums and cost-sharing in the traditional individual and small group markets. In addition, some of these products and concepts also increase other threats to consumers, including discrimination, fraud, and health plan insolvency.

State insurance regulators play a critical role in regulating these products and can take action to protect consumers in their own state from some of these threats. As the leading authorities on insurance regulation, state insurance regulators can limit the risk of market segmentation and help ensure that consumers have continued access to affordable, comprehensive health insurance products. State regulators can also encourage legislators to adopt state laws and rules that will protect the ACA-compliant health insurance market in their state.

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Association Health Plans



On January 4, 2018, in response to the Executive Order issued by President Trump on October 12, 2017, the U.S. Department of Labor (DOL) proposed new regulations governing association health plans and multiple employer welfare associations (MEWAs) marketed to employer groups. Throughout the proposed regulation, the DOL mainly used the term Association Health Plans (AHPs) to refer to both fully insured association health plans and non-fully insured MEWAs. The proposed rule overturns previous regulations on this topic, as well as long-standing “sub-regulatory” guidance and DOL interpretation of existing ERISA statutes and regulations. The stated purpose of these regulations, which is repeated several times during the lengthy preamble, is to make it easier for small employers to join together through an association and receive treatment as a single large employer, thereby avoiding the application of federal ACA and HIPAA regulations that apply to small employer group coverage. The proposed rule eliminates or undermines the following restrictions that were previously placed on the sale of AHP coverage in the employer group market (*Table 1*).

TABLE 1

Proposed Changes to the Regulation of Association Health Plans, 2018

	CURRENT STANDARD	PROPOSED RULE
COMMONALITY OF INTEREST	The group or association must have a sufficiently close economic or representational nexus to the employers and employees that are covered under the plan. This is sometimes interpreted as “same industry.”	Would expand the current test based on two requirements: <ul style="list-style-type: none"> • The employers are in the same industry, line of business or profession, regardless of geographic location, OR • The employers are in geographically limited areas, such as a single state or a certain metropolitan area
SOLE PURPOSE	Associations must: <ul style="list-style-type: none"> • Be in existence for a defined period of time (often 5 years) before offering health coverage, and • Have a purpose that benefits its members, other than offering a health plan 	Would allow associations to form at any time and exist for no other purpose than offering health coverage to its members
SELF-EMPLOYED INDIVIDUALS	AHP coverage is not available to small employers without common-law (unrelated, non-owner) employees. This excludes sole proprietors and certain other small businesses from AHPs because they do not meet the current federal definition of “employer.”	Would allow working business owners, including sole proprietors who have no “common law” employees, earn wages from the business, work at least 120 hours/month or have a certain amount of earned income from the business, to become members of an AHP
FORMAL ORGANIZATIONAL STRUCTURE	AHP must have a formal organizational structure with a governing body that is controlled by the employers who are association members	Would maintain this requirement, requiring participating employers to have control, either directly or indirectly, through the election of directors or other representatives, in the establishment and maintenance of the health plan

These changes would expand access to AHP coverage. The proposed rule would expressly allow AHPs to market to employers in the same industry and profession across state lines. The second part of the commonality test limits sales of the AHP products to a single state or metropolitan area (even one that crosses state lines) but eliminates all requirements of same trade or profession. The changes to the “sole purpose” standards are likely to result in the proliferation of “air breather” associations even though the DOL asserts in the preamble that AHPs will maintain the characteristics and accompanying fiduciary duties of a plan sponsor and will not become “mere sellers of commercial insurance.”

AHPs can discriminate through rating rules and benefit design.

The proposed rule states that non-discrimination on the basis of health status will apply to AHPs. AHPs may not base eligibility, premiums, or contributions to premium on any health status-related factors. The proposed rule clarifies that both fully insured AHPs and non-fully insured MEWAs may not treat employer members of the association as distinct groups of similarly situated individuals. The examples in the regulation illustrate that AHPs cannot rate-up the employees of an employer because of the collective health status of the employees of that particular employer. Premiums must be set as if the AHP is in fact, a single large employer. This part of the rule is an attempt to level the playing field between MEWA and AHP coverage and other types of employer coverage. However, the rule also states that rating factors such as age, geographic location, industry, and other “employment based” classifications (such as part-time/full-time) may be applied to the rates charged to individuals within the group.²

Permissible AHP Rating Factors

- age
- gender
- geographic location
- industry
- employment-based classifications

The justification for allowing large employers to use these “non-health status” rating factors cannot easily be applied to an AHP that consists of many small employers, especially small employers that do not share the commonality of “same trade or profession.” AHPs can use these rating factors to charge higher rates to smaller businesses and businesses in certain industries, to charge women higher rates than men, and to charge older employees higher rates, without limit. This creates a clear opportunity to cherry-pick the better risks, despite the non-discrimination provisions that are included in the proposed rule. In addition, the changes to the commonality of interest rule clearly allow AHPs to define their membership in any way that they choose, including in ways that exclude businesses involved in higher risk trades or businesses that typically have older employees. The proposed rule allows AHPs to pick and choose geographic areas, thereby allowing AHPs to “redline” areas where there are known health risks.

An AHP is exempt from the requirement to cover essential health benefits (EHB), and therefore by using benefit design, may attract healthier groups by marketing health plans that are cheaper because they offer fewer benefits. For example, many responsible small employers who have employees with medical needs that require high cost drugs will avoid plans without prescription drug coverage.

If AHPs take advantage of the proposed rule to sell coverage that is not comprehensive and does not meet minimum value, their premiums will be lower. However, the primary way they will achieve lower pricing will be by avoiding higher risk individuals. Avoiding even just the top 1% of medical spenders can save almost 25% of total costs in any given health risk pool.³ Even though the proposed rules do not allow this obvious type of rating discrimination, AHPs may still gain this advantage by using other allowed rating factors to avoid risk.

AHPs are allowed to offer plans that fail to meet the minimum value standard.

The ACA requires small group and individual market health insurers to offer only plans that meet EHB requirements, with “metal levels” that have specific actuarial values (AV). However, the ACA does not apply these EHB and AV requirements to plans offered to large employer groups with more than 50 employees. Instead, the tax code requires that large employers offer coverage that achieves a 60% actuarial value as measured against EHB, or be at risk of paying a penalty of up to \$3,000 per employee.⁴ Large employers have flexibility in determining which benefits to cover, but they still must offer coverage that has a minimum actuarial value (MV) of 60%, as determined by a federal calculator. If a large employer plan excludes too many benefits that are part of the EHB package, especially the more expensive benefits, such as prescription drugs, hospitalization, physician services, mental health, substance use disorder, and maternity care, it will fail the MV test, and the employer will be exposed to significant penalties. In this way, the ACA incents large employers to offer comprehensive coverage. However, this standard is achieved by imposing a requirement on the large employer, not the group health plan or the health insurance issuer.

Under the proposed rule, an AHP will not be a large employer for the purposes of the tax code. Therefore, there is no “minimum value” requirement that would apply to plans offered by AHPs or MEWAs that cover small employers and sole proprietors. Employees of small employers who purchase these plans could find themselves covered by a plan with a 25% actuarial value, with no penalties to the small employer. The provisions of the ACA are structured to avoid this outcome, but this proposed rule would allow it, contravening the intent of the ACA. Employees who are not offered an employer health plan that meets MV may purchase an individual marketplace plan, with premium tax credits, if they are otherwise eligible. However, this opportunity may result in additional adverse risk selection because only employees and their family members who are facing significant health care costs are likely to purchase individual coverage. Many consumers, especially those with less familiarity with insurance design, may not be fully aware of all of the different coverage options available to them and may not seek a marketplace plan until after they incur unexpected medical costs and realize their AHP coverage is inadequate.

When a health plan is allowed to eliminate benefits without consequence, the value of the ACA’s maximum out-of-pocket (MOOP) limit is also undermined. The MOOP is required in all health plans, fully insured and self-funded across all market segments, but only applies to EHB. If an AHP is allowed to offer a plan that covers very few EHB requirements, the MOOP protection may become meaningless if the majority of health care costs would not be covered and would not be applied to the MOOP.

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The proposed AHP rule promotes risk segmentation.

The proposed rule threatens the small employer and the individual market single risk pools by allowing small employers and individuals who claim they are self-employed to exit their assigned risk pool and move to an AHP. As noted above, the rule provides many opportunities for AHPs to design their coverage and membership criteria to attract better risks and avoid worse risks. The DOL claims that the AHP rule will not cause risk segmentation because unhealthy people will also be attracted to the cheaper rates of AHPs. However, because AHPs can design their plans to avoid higher-risk people, as discussed above, the diversification of the AHP risk pool is unlikely to occur.

While some people with pre-existing conditions and disabilities could be healthy enough to consider AHPs, they will often require some kind of health service, drug, device, or therapy that is not covered by AHPs. These individuals or families may be forced to somehow predict their health care needs, further fragmenting the market and jumping from product to product as they juggle affordability and significant or potentially devastating out-of-pocket costs.

The DOL also alleges that in general, large employers do not offer “skimpy” plans to their employees, so AHPs will not either. This is a deeply flawed comparison because an AHP is not an employer. Even though employer members are supposed to control the AHP, past experience shows that in many cases, that will not happen, especially after so many other guardrails have been removed, such as same trade or profession and having a purpose other than selling insurance. Actual large employers are usually concerned about keeping their employees happy in order to retain better employees, but it is unlikely that an AHP will share that concern. Some small employers joining these AHPs will shop based primarily on price, and they may not have the time to devote to comparing plan benefits or managing the structure of the AHP. Actual large employers also have the motivation of the MV requirement, as discussed above, to avoid the penalty and AHPs will not.

The proposed rule will allow AHPs to offer less comprehensive coverage with impunity. Employers, employees, individuals, and dependents with health concerns that could lead to even moderate health costs generally will not choose less comprehensive coverage that does not include EHBs. Younger, healthier individuals will be drawn to cheaper coverage with fewer benefits. Older individuals can be rated up without limit by AHPs so they will not be attracted to less comprehensive coverage, if it has a higher price tag resulting from broader age bands. DOL’s assertion that AHPs will not cause risk segmentation cannot be genuine. Despite the proposal to apply non-discrimination rules to the premium rates of AHPs, the proposed rule has left the door open for numerous other ways to avoid less desirable health risks by using “employment-based” rating factors.

The proposed rule creates an unlevel playing field that allows AHPs to proliferate by exempting them from rules that apply to licensed health insurers in the small group and individual markets. In an issue brief published in February 2017, the American Academy of Actuaries stated that if AHPs are allowed to operate under different rules than the traditional health insurance market, they could create adverse selection concerns.⁵ “AHPs

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could result in unintended consequences such as market segmentation that could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage.” This type of market fragmentation could threaten the viability of the insured market. AHP members will think they have a bargain until they get sick and then discover that comprehensive coverage is truly unaffordable or no longer available in their geographic area.

“AHPs could result in unintended consequences such as market segmentation that could threaten non-AHP viability and make it more difficult for high-cost individuals and groups to obtain coverage.”

— American Academy of Actuaries, 2017

The proposed rule allows for sales across state lines, which would limit state regulators’ ability to assist consumers.

AHPs that represent employers and individuals in the “same trade or profession” have no geographic restrictions and would be allowed to sell across state lines under the proposed rule. The proposed rule does not attempt to address the jurisdictional issues that will arise for state regulators and consumers. The nation’s insurance regulators, through the NAIC, have expressed their opinion on the topic of selling across state lines many times—most recently in a bulletin entitled Interstate Health Insurance Sales: Myth vs. Reality.⁶

The NAIC’s bulletin states that interstate sales will start a race to the bottom by allowing insurers (and non-fully insured AHPs) to choose a state with the fewest regulations and bypass the state regulation in other states where they sell products. Interstate sales will actually reduce options available to consumers by cherry-picking the healthier risks in the market. Insurance with comprehensive benefits will be left with a sicker risk pool and will have to price products so high that most individuals will not be able to afford them. Allowing insurance to be sold across state lines would eliminate the ability of insurance regulators to assist consumers: the NAIC noted that “consumers will have to hope that the regulator in a distant jurisdiction has the ability and resources to assist consumers nationwide.”⁷

Many other stakeholders, such as the National Conference of Insurance Legislators, have also opposed the sale of insurance across state lines, citing similar concerns about “domicile state shopping and cherry picking risks.”⁸ Further, evidence suggests that such proposals do not work: in states that have already pursued across state lines legislation or tried to form interstate compacts, none resulted in a single insurer entering a new market or the sale of a single new insurance product.⁹

Health insurance and health care is local.¹⁰ Out-of-state insurers often have difficulty negotiating with local health care providers. Most insurance experts disagree with DOL’s assertion that AHPs will have “market power” that will allow them to negotiate better discounts. The American Academy of Actuaries asserts that allowing AHPs to sell across state lines will not lower premiums or the cost of health care. “Out-of-state insurers ... could have difficulty developing provider networks and negotiating provider payment discounts ... Any cost savings resulting from differences in benefit coverage requirements among states can be small compared to cost savings that can be accomplished through negotiating strong provider contracts.”¹¹

The DOL asserts that “administrative savings” will result in lower premiums for AHPs. However, they provide no real evidence to support that claim, and in any case, administrative costs are not the primary reason for higher premiums, and AHPs would actually add to administrative costs for health care providers by adding a new payor with additional payment rules. Also, AHPs selling across state lines are unlikely to manage care in the way that many local health insurers do. Many local health insurers utilize care management techniques that benefit patients and help lower costs by focusing on primary care and coordinated care and services.

Rates in the small group market actually have not increased dramatically since the ACA was passed. A recent article in Forbes cites Kaiser Family Foundation and CMS studies demonstrating that rate increases for small employers were actually higher pre-2010.¹² Currently, small employer group coverage prices have remained stable and are not higher than large group coverage. The coverage is comprehensive and the employers are protected from large price increases if their employees get sick. Encouraging AHPs may destabilize the small group market and cause prices to spiral upward.

Fraud, scams, and insolvency: a historical view of AHPs.

There are legitimate trade associations that have offered good health plans in the past, in conjunction with many other valuable services to their members. However, the AHP market also has a long history of attracting bad actors whose purpose is to make a quick profit and take advantage of consumers looking for a bargain. There have been several documented cycles of large-scale scams involving entities purporting to be AHPs or MEWAs. According to the GAO, between 1988 and 1991, multiple employer entities left 400,000 consumers with medical bills exceeding \$123 million. The most recent cycle was between 2000 and 2002, when 144 entities left 200,000 policyholders and providers with \$252 million in unpaid medical bills.¹³ Today’s health care prices would multiply that number by ten times or more, and the scam entities would become insolvent even faster because of the high health care costs.¹⁴ Self-employed individuals were often targeted. Promoters of scams set up fake associations, but also sell through established professional and trade associations that are looking for cheaper coverage.

The preamble to the proposed rule discusses the fraud of the past, but still proposes to eliminate safeguards that discouraged the proliferation of scams. Because the proposed rule expressly authorizes selling across state lines, it creates additional ambiguity about preemption and the jurisdiction of state insurance departments, especially jurisdiction to license and monitor solvency, handle complaints, and pursue enforcement actions. The DOL does not license or certify MEWAs or AHPs and does not even do the basic criminal background checks that a state insurance department would do. The DOL likely does not have the regulatory framework or capacity that would keep bad actors out, and the regulation creates new jurisdictional problems for states that would otherwise do that job.

AHPs and Unpaid Medical Bills

- **1988 to 1991: 400,000 policyholders left with \$123 million in unpaid bills**
- **2000 to 2002: 200,000 policyholders left with \$252 million in unpaid bills**

Source: U.S. General Accounting Office

The DOL likely does not have the regulatory framework or capacity that would keep bad actors out, and the regulation creates new jurisdictional problems for states that would otherwise do that job.

Further, even the most well-intentioned AHP or MEWA may encounter issues with solvency. If a non-fully insured AHP offers comprehensive health plans—and in many cases, their membership will demand that—the financial risks are great due to rising health care costs. This is especially true if their membership risk pool is small and their financial reserves slim. Despite these grave risks, the proposed rule does not impose any solvency standards on these entities.

AHPs have a long, well-documented history of insolvencies.¹⁵ Approximately 20 states have special licensing standards for self-insured AHPs, and all other states reported requiring AHPs to be licensed the same as any other health insurer. Many states with specific licensing laws for MEWAs impose lower solvency standards than health insurers. AHPs do not participate in guaranty associations, and therefore, if they become insolvent, policyholders may be left with millions of dollars in unpaid claims. If there is joint and several liability with the AHP, participating employers are assessed and are responsible for any unpaid claims. Many employers do not understand the significant risk of this financial exposure when they sign up. If state laws concerning insurance company receivership do not apply to these AHPs, the entity will end up in bankruptcy court and consumers and providers will have to get in line with other creditors, because their outstanding medical bills may not receive priority. State departments of insurance that license or certify self-funded AHPs or MEWAs invest significant time and resources to prevent and detect problems early.

The preamble to the proposed rule states that its purpose is to encourage the growth of AHPs, which will mean more insolvencies. An AHP created for the sole purpose of offering a health plan is the equivalent of setting up an insurance company without any of the standards and consumer protections that are applied to insurance companies. DOL proposes no standards that protect consumers from the risk of insolvency of these plans. Even though the proposed rule sets forth a requirement that the participating employers have some level of control over the AHP, the truth is that small employers and sole proprietors are not generally in the position to provide adequate oversight of the complicated operations of a health plan. This may be a key area for states to adopt regulations to help minimize the harm of insolvency to consumers.

Additional concerns for state insurance regulators: federal preemption, jurisdictional ambiguity, and network inadequacy.

In 1982, Congress clarified ERISA preemption provisions and gave states full authority over MEWAs and AHPs. The 1982 amendment was intended to remove ambiguity concerning ERISA preemption of state authority over these entities. In this proposed rule, the DOL has included a Request for Information that suggests it is considering creating broad exemptions from state regulation for AHPs and MEWAs. Further erosion of state authority in this area would leave state regulators with no ability to help consumers in their state who become victims of an AHP that is unscrupulous, and the DOL does not have the resources to adequately regulate the activity of these entities across the whole country.

The proposal to allow AHP coverage to be sold across state lines will create jurisdictional ambiguity for state departments of insurance, making their regulation less effective also.

The proposal to allow AHP coverage to be sold across state lines will create jurisdictional ambiguity for state departments of insurance, making their regulation less effective also. This rule places a burden on state insurance regulators, who will still have the duty to protect consumers in their state, even though the jurisdictional ambiguity may make that impossible.

Also, network adequacy issues arising from the challenge of establishing contractual relationships with local providers will present significant issues for state regulators and covered individuals. An insufficient network, without contracted providers who are obligated to hold consumers harmless from balance billing, will severely reduce the value of the coverage, and consumers will not discover this until they have claims. If the AHP purchases access to a sufficient, approved network, the cost of their product will rise significantly. State regulators will not be able to review networks of out-of-state AHPs.

Short-Term, Limited Duration Insurance



Short-term, limited duration health insurance was originally developed to fill temporary gaps in coverage when an individual is transitioning from one health plan to another. Short-term coverage is not an “excepted benefit,” like accident-only or specified disease plans, but it is exempted from the definition of individual health insurance in the Public Health Service Act (PHS).¹⁶ The definition that exempts short-term health insurance from individual market health insurance requirements was adopted by most states when HIPAA definitions were adopted into state law. Before 2016 federal regulations became effective for policy years beginning on or after January 1, 2017, short-term insurance was generally defined as a health insurance contract that has an expiration date specified in the contract (including any extensions that may be elected by the policyholder without the issuer’s consent) that is less than 12 months after the original effective date of the contract.¹⁷

Prior to the passage of the ACA, short-term insurance was a means for individuals to keep coverage and protect against catastrophic costs, albeit with exclusions and limits for those with pre-existing conditions, while someone transitioned between jobs and in other circumstances. However, the guaranteed availability of coverage and special enrollment periods available in the individual market beginning in 2014 substantially reduced the need for short-term insurance. Therefore, in 2016, the Departments of Health and Human Services, Labor, and Treasury (Departments) proposed new short-term insurance regulations. In the preamble to the 2016 regulations, the Departments state that they “have become aware that short-term, limited duration insurance is being sold in situations other than those that the exception from the definition of individual health insurance coverage was initially intended to address. In some instances, individuals are purchasing this coverage as a primary form of health coverage and contrary to the intent of the 12-month coverage limitation in the current definition of short-term, limited duration insurance, some issuers are providing renewals of the coverage that extend the duration beyond 12 months.”¹⁸

In 2016, the Departments explained their concern about the limitations of these policies, including the fact that they usually include lifetime and annual limits and pre-existing condition exclusions, which would prevent these policies from providing “meaningful health coverage.” As a result of these observations, the Departments revised the definition of short-term coverage, limiting the duration to less than three months, including any period

“Because these policies can be medically underwritten based on health status, healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for ACA compliant coverage.”¹⁹

— *Tri-Agencies, 2016*

for which the policy may be renewed or extended, with or without the issuer’s consent, meaning that the product cannot be renewed by the insurer or policyholder. In addition, insurers had to include a prominent notice on the contract and on the application stating that the short-term plan does not qualify as minimum essential coverage and thus an individual may face the individual mandate penalty.²⁰

Regulator and consumer concerns about short-term plans: higher premiums, unpaid claims, rescissions, and deceptive marketing.

Short-term coverage lacks protections that are otherwise required in ACA-compliant individual health insurance, including, but not limited to: guaranteed issue, guaranteed renewability, ban on pre-existing condition exclusions, limitation on rescissions, ban on lifetime or annual limits on EHBs, MOOP restrictions, required EHBs coverage, preventive benefits coverage with no cost-sharing, and the elimination of rating based on health status. Without these protections, short-term health insurance is considerably cheaper than individual market insurance. Even if the product appears to provide comprehensive benefits, it is medically underwritten, so that all individuals who have known health risks can be rejected or rated up. Short-term plans also have considerably higher MOOPs and deductibles relative to ACA plans (*Table 2*). In this way, short-term health insurers, if left unchecked, will siphon off the healthier individuals in the market, leaving the ACA-compliant market with the higher risk individuals.

TABLE 2
Examples of Out-of-Pocket Maximums and Deductibles by Best-Selling Short-Term Plan Per State

STATE	3 MONTH OUT-OF-POCKET MAXIMUM	OUT-OF-POCKET MAXIMUM INCLUDES DEDUCTIBLE	DEDUCTIBLE	EFFECTIVE 3 MONTH OUT-OF-POCKET MAXIMUM
GEORGIA	\$10,000	No	\$10,000	\$20,000
IDAHO	\$5,000	No	\$2,500	\$7,500
KENTUCKY	\$2,000	No	\$5,000	\$7,000
NORTH CAROLINA	\$5,000	No	\$5,000	\$10,000
PENNSYLVANIA	\$7,000	Yes	\$5,000	\$7,000

Source: D. Palanker, K. Lucia, and E. Curran, "New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market," *To the Point, The Commonwealth Fund*, Oct.11, 2017.

A recent study suggests that the proposed rule, if implemented, would increase the number of people without minimum essential coverage by 2.5 million in 2019, with enrollment of about 4.2 million people in expanded short-term, limited-duration plans.²¹ The combined effect of eliminating the individual mandate penalty and the expansion of short-term coverage would, on average, increase premiums in the ACA-compliant individual market by 18.2 percent in the 43 states that do not currently prohibit or limit this type of coverage.²² This analysis also includes estimated impacts on a state-by-state basis.

State regulators have handled complaints from consumers about short-term health insurance products. For example, in Montana in 2015 and 2016, there were complaints from consumers regarding short-term insurance that they purchased because it was represented as ACA-compliant individual health insurance coverage. In some cases, the consumer did not discover this mistake until claims were denied on the basis of a pre-existing condition exclusion. Those consumers were sometimes left with many tens of thousands of dollars in unpaid claims. In other cases, when a large claim was received, the insurer rescinded the coverage retroactive to the start date, claiming that the insured had “misrepresented” some aspect their health history.

Some state insurance departments took actions against certain companies and agents that were alleged to have sold short-term insurance in a deceptive manner and other states issued bulletins to warn consumers.²³ Also, multi-state class action lawsuits have been filed alleging fraud and misrepresentation, not only in the manner in which this insurance was marketed, but also because of the failure to pay claims.²⁴ The lawsuits allege that the named defendant short-term health insurers hired outside brokers, who used dishonest sales tactics, falsely claimed to be licensed insurance agents, and preyed on the most vulnerable consumers. These broker/marketers are earning much higher commissions than licensed producers selling legitimate health insurance products earn, and the insurers have much larger profit margins, with often about 50% of every dollar paid in premium staying in the insurer’s pocket.²⁵

Not all health insurers who market short-term insurance are bad actors. Nevertheless, the provisions of the 2016 federal rules—that limit the duration of short-term health coverage, eliminate its renewability, and provide for a clear notice to consumers warning that short-term insurance is not meant to take the place of actual individual health insurance—are important to protect consumers from deceptive practices and to prevent further erosion of the individual market risk pool.

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New proposed rule on short-term plans would exacerbate market segmentation.

In response to an October 2017 executive order, the Departments issued proposed amendments to the short-term rule. The proposed rule, issued in February 2018, allows the “term” of a short-term health insurance policy to be as long as 364 days. In addition, the insurer is allowed to renew or reissue the policy, so individuals can continue this coverage indefinitely—at least until their health deteriorates and/or they experience a large claim so that the insurer refuses to continue coverage. If the non-renewal occurs outside of an open or special enrollment period for individual health insurance, that person may not have access to coverage until the next open enrollment period. The proposed rule does require a consumer notice and prescribes two different versions: one warns that a tax penalty may be assessed because short-term insurance is not minimum essential coverage and the second notice removes the tax penalty warning for policies issued on or after January 1, 2019.

The 2018 preamble continues to assert that short-term health insurance was designed to fill in temporary gaps in coverage. However, the proposed amendment that allows the coverage to be renewed or reissued indefinitely appears to belie that stated purpose. Despite concerns raised just two years earlier that short-term coverage did not provide “meaningful health coverage,” the Departments are newly focused on providing access to cheap coverage that avoids ACA protections. The drafters of the proposed rule’s preamble acknowledge that this type of insurance will attract younger, healthier people and could impact the individual market single risk pool and that increased sales of short-term coverage will drive up premium rates in the individual market, thereby increasing the cost of providing premium tax credits.²⁶

Although those who qualify for premium tax credits may be protected, those who do not—and who are not young and healthy enough to qualify for short-term insurance—will face rising premiums. As individual health insurance premiums become more unaffordable as a result of this risk pool segmentation, many higher-risk individuals will truly be left no affordable options. In the meantime, some health insurers will gain an opportunity for greater profit, since past experience shows that the loss ratio for this type of product is considerably lower than the 80% medical loss ratio required in the individual market. Many of the insurers who are in the short-term health insurance market, or who are re-entering that market, have already abandoned the individual health insurance market for more profitable product lines.

As individual health insurance premiums become more unaffordable as a result of this risk pool segmentation, many higher-risk individuals will truly be left no affordable options.

States will play a critical role in regulating short-term plans, especially if the proposed rule is finalized.

States do regulate short-term coverage but current laws vary significantly by state. Some states (such as Arizona, Minnesota, New Jersey and Oregon) have taken steps to limit the sale and/or use of short-term plans.²⁷ State approaches will vary based on legal authority and regulatory capacity, with some states needing new legislation to regulate short-term coverage and others leveraging existing law.²⁸

State regulation of short-term plans will be important to increase the stability of individual market risk pools. States can increase consumer protections regarding the sale of short-term plans in several ways, including barring them altogether, limiting duration and renewability, applying state health insurance mandates to the coverage and increasing oversight of marketing and product forms and rate filings.

EXHIBIT 1

State Options to Regulate Short-Term Plans

States can increase consumer protections regarding the sale of short-term plans in several ways, including:

- barring them altogether
- limiting duration and renewability
- applying state health insurance mandates to the coverage
- increasing oversight of marketing and product forms and rate filings

Source: Georgetown University Health Policy Institute: Center on Health Insurance Reforms. 2017, December. State Options to Protect Consumers and Stabilize the Market: Responding to President Trump's Executive Order on Short-Term Health Plans. Retrieved from https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2017/rwjf441920

Health Care Sharing Ministries



Health Care Sharing Ministries (HCSMs) have existed for more than a century, originating with the Amish and Mennonites. The concept of sharing medical needs among members of a religious community was adopted in the 1990s by additional religious groups. Historically, enrollment in these organizations has been small and was confined to people who shared the same religious beliefs.

The ACA required that beginning in 2014, each individual must maintain “minimum essential coverage (MEC),” or pay a penalty on their taxes. The statute provides for several different exemptions from the penalty, including membership in a HCSM that has been in existence at all times since December 31, 1999, is a 501(c)(3) whose members share a common set of ethical or religious beliefs, and share medical expenses among its members according to those beliefs, and which conducts an annual audit available to the public.²⁹ The ACA does not state that HCSMs cannot be regulated as insurance under state laws; it is, indeed, a common misconception that federal law prohibits states from regulating HCSMs.

The ACA does not state that HCSMs cannot be regulated as insurance under state laws; it is, indeed, a common misconception that federal law prohibits states from regulating HCSMs.

Enrollment in HCSMs continues to grow and consumers face pre-existing condition exclusions and self-pay.

Since the ACA imposed the individual responsibility requirement in 2014, membership in HCSMs has escalated, although exact numbers are difficult to determine because there are no reporting requirements, and the IRS will not release the number of individuals claiming an HCSM exemption. Some recent news articles have estimated that the number of enrollees has increased from about 160,000 in 2014 to about 1 million in 2018.³⁰ If these numbers are even close to correct, it would appear that that the individual mandate penalty exemption was a significant motivation behind these increased numbers. Enrollment may decrease in 2019 when the penalty is no longer a factor.

HCSM membership materials usually state that they never guarantee payment of claims and are “not insurance.” HCSM plans provide significantly fewer protections than ACA-compliant health insurance. The plans have dollar limits, generally ranging between \$125,000 and \$250,000 per “incident.” It is sometimes possible to purchase additional coverage for an additional fee. Prescription drugs are usually excluded altogether, except for certain short-term episodes, meaning medications are not covered for chronic illness, such as diabetes or high blood pressure. Preventive services, such as immunizations for children, mammograms, and colonoscopies, are not covered.³¹ HCSMs emphasize healthy living and wellness, so the decision to exclude coverage for preventive services and prescription drugs that keep individuals healthy is difficult to understand, except when analyzed from a cost perspective. Prescription drugs and doctor visits make up a large portion of health care spending and are a major driver of health insurance premium costs.³²

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All HCSMs apply pre-existing condition exclusions and sometimes refuse to accept individuals who are already sick. The pre-existing condition exclusions mimic laws that were in place prior to the ACA: a 12-month pre-existing exclusion with a look-back period of 3 to 7 years. This means that a member of the religious community recently diagnosed with cancer would not be eligible to join an HCSM and have their medical needs shared, even if they were accepted. Many journalists writing on this topic have observed that the use of pre-existing condition exclusions appears to be contrary to the stated philosophy of religious individuals sharing with peers in need.³³ Also, the imposition of pre-existing condition exclusions was cited by a number of courts when determining that an HCSM was in fact acting as a health insurer.³⁴ HCSMs also refuse to cover any claim that is determined to be a violation of moral guidelines established by the HCSM’s board of directors, including diseases that may be related to pre-marital sex, pregnancy outside of marriage, and diseases that may be related to drug or alcohol use. Therefore, members face the uncertainty of having a claim rejected on moral grounds. There is no formal appeal process. Coverage for mental illness and substance use disorder is usually excluded or extremely limited, even though Congress and state legislatures have recognized the need for full parity of coverage between mental and physical illness.

In most cases, members are “self-pay,” and must have the financial ability to pay providers up-front and wait for reimbursement from the HCSM. (The exception may be Christian Care Medi-Share (CCM); it claims to have a provider network, just like health insurance.) Most HCSMs advise that members have to be willing to pay cash up front. This can create significant problems for individuals who end up with a hospitalization or other significant health event. Members are told to negotiate discounts with the providers and never pay full billed charges. Although many individuals report success with negotiating discounts, it must be assumed that it is unpredictable and “hit or miss.” Also, as these plans gain popularity and the membership numbers expand, health care providers may begin to resist providing discounts. Sometimes health care providers require proof of insurance or some other proof of guaranteed payment before they will agree to perform an expensive procedure. Legally, HCSMs cannot provide such guarantees, because their plans expressly state that there is no guarantee of payment.

Self-pay may sometimes result in “no pay” or paying only a portion of the bill. Uninsured or underinsured individuals cause higher health care costs for those individuals who purchase commercial health insurance. Payment from an HCSM is always delayed, at least by 30-60 days after receiving the “share,” and often by several months. This delay could affect an individual’s credit, if they do not have cash ready to pay medical bills quickly up

front. Many health care providers do not wait long before turning patients over to collections. Some HCSM members report that the process of personally negotiating discounts, keeping track of payments from many different providers, and managing payment from multiple sources is stressful and time consuming.

Health insurers expend significant time, energy and resources building provider networks and negotiating better discounts than their competitors, and they are required to follow laws regarding network adequacy. Building these networks requires time and money, but in return, covered individuals are held harmless from balance-billing by health care providers and the payment between the provider and the insurer is usually a seamless process for the insured. In addition, insurers often enter into business relationships with providers in an effort to bend the cost curve on health care costs, including global or bundled fee arrangements, or even capitated fee agreements. Eliminating or reducing fee-for-service health care is generally recognized as the quickest way to reduce health care costs in America.

Another reason for the recent growth in HCSM membership is undoubtedly the cost of premiums in the individual market, especially for individuals that do not qualify for premium tax credits. As premium costs have risen, so has membership in HCSMs. However, even the promoters of these ministries state that HCSMs are not for everyone, for instance, “Someone who isn’t of the faith and doesn’t have familiarity of the commands and requirements of the scripture,” said Tony Meggs, president and CEO of Christian Care Ministry. “We live our lives in a way that we share in each other’s needs. That’s a biblical mandate Christ gives us in scripture.”³⁵

Despite that warning from Christian Care Ministry, a few of the HSCMs have begun paying insurance agents to sell their memberships, and those agents have reported that many individuals who cannot afford health insurance are signing up for these memberships, even though some of them do not have any real religious affiliation. (Certain HCSMs do require a certification from a minister, but most do not.) Those insurance agents are now beginning to sell these memberships in conjunction with insurance products that fill the “gaps,” such as prescription drug coverage, direct primary care plans, and ambulance subscriptions.

Courts in some states have found HCSMs to be offering insurance without a license.

Since 2014, “exemption-eligible” HCSMs have banded together as the Alliance of Health Care Sharing Ministries to lobby for state legislation that exempts these organizations from being regulated as insurance. The lobbying efforts in state legislatures were prompted by several lawsuits where courts ruled that a HCSM was, in fact, acting like an insurer without a license and therefore was in violation of state law. Courts concluded that HCSMs were acting as unauthorized insurers, despite written disclaimers placed on membership materials stating that the HCSM was “not insurance and not a guarantee of payment.” In general, the courts came to that conclusion because the HCSMs used terminology that mirrored insurance products and utilized the same underwriting and claims-paying tools that licensed health insurers used.

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In 2006, for instance, the First Judicial District Court in Montana granted a summary judgment motion for the plaintiff against CCM, finding that CCM was an insurer, acting without a license. The plaintiff was a minister whose claim for heart surgery had been denied on the grounds that it was based on a “pre-existing condition.” The court cited facts indicating that CCM offers different insurance plans with different benefit packages at different rates, determined rates based on actuarial principles and health histories, purchased stop loss to transfer risk for high medical claims, and used health insurance computer software to pay claims. The Montana Court cited a South Dakota case, which also found CCM to be offering insurance, as a matter of law, based on the fact that CCM created two health care plans, included deductibles, co-pays, and a preferred provider network, engaged in underwriting, rejected applicants on the basis of health status, and charged monthly “shares” that include administrative costs and stop loss premium.³⁶

Similar cases have been filed in other states.³⁷ In a 2010 case in Kentucky, the court ruled that the HCSM was providing a contract for insurance, despite the fact that the HCSM had placed disclaimers on its materials stating that it was not offering health insurance. In all of these cases, and others, the courts chose to look beyond those disclaimers and instead scrutinize the operations of the plan. In fact, Kentucky had a law at the time of this judgment entitled the “Religious Publication Exception,” that exempted certain types of sharing ministries from state regulation.

In reaction to these court decisions, HCSMs altered their practices somewhat and took greater care to avoid using insurance terms. They also took steps to create a system whereby the subscriber’s medical needs were paid directly from one subscriber to another. CCM refers to this as the “Member Share Exchange, which is a patented process for transferring funds from one member’s bank account to another member’s bank account.”³⁸

To date, 30 states have passed some kind of legislation exempting HCSMs from state insurance regulation. There are many differences in the language of these laws. However, most of the exemptions require the HCSM to meet certain standards in order to fall under the exemption, including a requirement to be faith-based and publish a list of members’ needs every month. If a state has passed one of these laws, regulators play a key role in assuring that HCSMs are, in fact, complying with state requirements to maintain that exemption. If a state has not passed one of these laws, regulators can investigate and, if sufficient evidence exists, regulate these plans as unauthorized insurers. With or without state law, however, HCSMs are not immune from civil lawsuits if they cross certain lines—for instance, if the memberships they market meet the definition of an insurance contract or fail to keep within the parameters of the exemption law.

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HCSMs raise the potential for market segmentation and may exacerbate the health care cost crisis.

Enrollment in HCSMs has implications for the health of the ACA-compliant risk pool. HCSM members that end up with significant healthcare costs may decide to switch to an ACA-compliant individual health plan that offers a guarantee of payment and has fewer limits on coverage. And because HCSMs do not cover pre-existing conditions and offer

minimal or no coverage of certain critical benefits, individuals who already have significant health care costs are less likely to buy this type of coverage in the future. Therefore, HCSMs add to the problem of segmentation of the individual market single risk pool.

However, HCSMs may represent more of a threat than just siphoning off the good risk from the regulated health insurance market. Care management and negotiated arrangements with providers not only protect consumers but strive to bend the health care cost curve. These alternative arrangements do not usually engage in that activity and may actually add to the problem, instead of contributing to the solution. Many experts agree that health care delivery reform begins with coverage for preventive benefits and management of chronic disease. That is why ACA includes \$0 cost sharing for preventive health care services and requires coverage for prescription drugs in all individual and small group health insurance. In this way, a more expensive health crisis can be avoided later on. Despite this, HCSMs exclude coverage for preventive services and most prescriptions.

Members of HCSMs interviewed for news articles share good experiences and bad experiences with HCSMs. Many members state that they join, in part, because they like the idea of sharing needs with a larger community of individuals who share their values. However, ultimately most admit that lower premiums (membership cost) were the driving factor. Certainly, individuals with true religious beliefs should be allowed to share their medical needs, as they have in decades past.

However, when HCSMs begin marketing memberships in a way that makes it easy for individuals to join that do not share common religious beliefs, the HCSMs may lose touch with their original religious purpose, which was the basis for their legal exemptions from consumer protection laws. If HCSMs continue to adopt practices that mirror actual health insurance, they may face additional state oversight and more lawsuits from members suing for unmet needs. If membership in these organizations continues to grow, the HCSMs will present a greater threat to the stability of the single risk pools.

In the past, there have been HCSMs that were convicted of fraud.³⁹ In 2000, members of the Christian Sharing Ministries—formerly the Christian Brotherhood Newsletter—reported that there was about \$34 million in unpaid claims. After an investigation, the Ohio Attorney General took action, and the organization’s founder and his nephew were found guilty of civil and solicitation fraud because they used donations to fund higher salaries, motorcycles, large homes, and vacations. As membership in these organizations grows, creating ever increasing pools of money, and because these organizations are generally not regulated, the opportunity for bad actors to get involved again in the future is apparent.

As noted above, states are not limited by federal law should they choose to regulate HCSMs. Although some states have adopted their own legislation to exempt HCSMs from state insurance law, regulators play a critical role in investigating fraud, referring cases to the Attorney General’s office, and assisting consumers who may have been harmed.

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Other Non-ACA-Compliant Products

Transitional plans were a key contributing factor to current risk pool instability in some states.

Transitional or “grandmothered” health plans are available for yet another year, through December 31, 2018 (and potentially longer if the federal government offers an additional extension). Transitional health plans resulted from guidance issued by the Obama administration in 2013, which allowed individual and small group health plans issued between March 2010 and December 2013 to be renewed temporarily (if the state’s insurance department agreed), to allow the markets a longer time to “transition.” These plans must comply with the ACA’s early market reforms that went into effect in 2010 but not the more extensive 2014 market reforms, such as coverage of EHBs, MOOP restrictions, minimum AV requirements. They often contain pre-existing condition exclusions, and do not comply with adjusted community rating rules.

It is estimated that there are about 1 million covered individuals still left in these plans in the individual and small group markets.⁴⁰ Even though 32 states allowed transitional plans, those plans did not flourish in all of those states. In many states, marketplace health insurers chose to discontinue transitional plans for ease of administration and also to protect their own risk pools.

Allowing insurers to continue to sell these plans had a significant negative impact on the ACA-compliant risk pool. The states that had the highest number of individual market transitional plans (above 21%) in 2014 are New Mexico, North Carolina, Wisconsin, Hawaii, Illinois, Tennessee, Kansas, South Dakota and Iowa. South Dakota and Iowa had the highest number (about 55%). In 2014, insurers in states that had more than 20% of the individual market in transitional plans had average loss ratios that were 36% higher (125% vs. 89%), and averaged higher rate increases in the ACA-compliant individual market between 2014 and 2016 than states that had no transitional plans (33% vs. 12%).⁴¹

“Actuaries estimated that states adopting the transitional policy experienced 10% higher rates for the Exchange market than states that did not elect this policy.”

— AHIP, 2017

In 2017, America’s Health Insurance Plans (AHIP) made the following observation, citing the American Academy of Actuaries: “A key contributing factor to the current risk pool instability in certain states was the transitional policy, which allowed individuals to renew non-compliant plans. That is because it segments the market—allowing healthier individuals to remain in their existing medically underwritten plans while depriving the new Exchange markets of younger and/or healthier individuals necessary for risk pool stability. Actuaries estimated that states adopting the transitional policy experienced 10% higher rates for the Exchange market than states that did not elect this policy.”⁴²

The individual health insurance market appears to have suffered more dramatically than the small group market in states where transitional plans flourished. This appears to be because the small employer group market had richer benefit packages, pre-ACA. For instance, a comparison of 2015 small group rates indicated that the difference in premiums between transitional and ACA-compliant plans was only about 6% and the difference in loss ratios was only about 2 points. However, in the individual market, the difference between premiums for ACA-compliant and transitional health plans was much higher—54%, and the difference in the loss ratios was 16 points.⁴³

In certain states, it appears that risk pool segmentation has caused greater problems for the ACA individual marketplaces than in other states. For example, Iowa has a large number of non-ACA-compliant transitional plans remaining in the market—over 115,000 consumers were enrolled in grandfathered or grandmothered individual market plans for 2016, compared to about 50,000 individuals covered through the marketplace. In 2018, Iowa was faced with possibility of having no insurer in its marketplace because two out of three health insurers withdrew. The risk pool segmentation created by a large number of transitional health plans in the individual market may have contributed to these challenges. Loss of the cost-sharing reduction payments and removal of the individual mandate penalty also contributed and could contribute further.⁴⁴

Like Iowa, Tennessee also faced the prospect of having no insurer offering marketplace plans in 2018 in certain counties. In addition to a high number of transitional health plans (27% in 2014), Tennessee also “grandfathered in” health plans marketed by the Tennessee Farm Bureau. The Tennessee Farm Bureau markets an “individual market type” association health plan to its members. Any Tennessee resident can join the Farm Bureau for a fee. Tennessee has allowed the Farm Bureau to continue to market and sell non-ACA-compliant plans because these plans are not considered health insurance under a Tennessee law that exempted them from most regulation. The Farm Bureau has continued to medically underwrite members of its health plan, and its plans do not comply with EHB and several other ACA protections. Therefore, members of the Farm Bureau may be subject to the individual mandate penalty, at least until 2019.⁴⁵

Despite the penalty, Farm Bureau membership has grown significantly since the passage of the ACA, and it had about 73,000 members in 2017. The Tennessee individual marketplace has approximately 230,000 covered lives. Having 73,000 individuals in non-compliant, medically underwritten plans—combined with an additional large number of individuals in transitional plans—has likely had a significant impact on the ACA-compliant risk pool. According to a recent report by the Society of Actuaries, “in 2015, the population enrolled in individual market non-ACA-compliant plans in Tennessee had the worst overall health risk score in the country.”⁴⁶

The health insurance market, pre- and post-ACA, varies widely from state to state, and there are many reasons why some states are experiencing more challenges than others in the individual market. But experts agree that risk pool segmentation caused by non-compliant plans contributes significantly to the instability of a health insurance market. “If people who benefit the least from the standard requirements are allowed to opt for cheaper noncompliant plans, then the risk pool for the compliant plans will worsen, driving their prices higher, and possibly to an unsustainable level.”⁴⁷ As AHIP and others have warned, allowing health insurance products to be governed by different rules and standards will further de-stabilize the individual market and increase costs for those with pre-existing conditions.⁴⁸

“If people who benefit the least from the standard requirements are allowed to opt for cheaper noncompliant plans, then the risk pool for the compliant plans will worsen, driving their prices higher, and possibly to an unsustainable level.”

— Mark Hall & Michael McCue, 2017

Mini-med and excepted benefit plans exacerbate market segmentation.

Once the individual mandate penalty disappears in 2019, insurance marketers may double down on efforts to promote health insurance products that are not minimum essential coverage, such as mini-meds. Mini-meds are limited coverage plans that have very low dollar limits (as low as \$2,000 and as high as \$250,000, but typically \$10,000 to \$50,000). Unlike excepted benefit type products that frequently have a cash benefit paid when a specific event occurs (i.e. a cancer diagnosis or an accident), mini-meds are “fee for service,” with low dollar value benefit levels. The ACA essentially eliminated the expense-incurred mini-meds when it imposed the prohibition on annual and lifetime limits on EHB. Mini-meds were popular with some large employers who employed low-wage workers, often on a part-time, seasonal or temporary basis.⁴⁹ Depending on how they are structured, fee-for-service mini-meds with annual dollar limit remain illegal under current ACA statute, regulations and guidance.

One significant concern with mini-meds was that a serious accident, cancer diagnosis, or heart attack would quickly wipe out the annual limits on these types of plans. The low premium and cost-sharing for these plans may appeal to consumers, until they have a health event which would bankrupt them and leave health care providers to foot the bill for charity care. That individual would not be able to buy comprehensive coverage until the next open enrollment period and may have to forgo necessary health care in the interim. Healthier, younger individuals would be more likely to purchase this type of coverage, which would further segment the risk pool.

Pre-ACA mini-meds were especially popular when sold in “bundles,” along with other excepted benefit plans such as accident only, specified disease (such as cancer) and hospital indemnity, which generally provide cash payments made upon the occurrence of specified event. Often these types of bundled plans were sold through individual market associations. Mini-meds in particular were sold to employers, sometimes in conjunction with stop loss insurance with low attachment points to cover higher claims. Some of the mini-meds with higher limits, such as \$250,000, have 30% copayments, but no MOOP, which appears to mean that an individual’s share could be \$75,000 by the time the maximum limit is reached.⁵⁰

Bundled plans were usually sold through “individual market type” associations that sometimes used deceptive marketing practices. Consumers were told that these plans were “as good as major medical.” It took significant effort to understand the gaps in coverage or even how to submit claims, since each plan was often underwritten by a different insurer. Average consumers were frequently deceived by these types of products.

State regulators have dealt with these scams in the past and filed actions against these entities. The names of these associations would change when a cease and desist order or agency action was issued, but often the same group of individuals would start up a new association under a different name.⁵¹ States usually included the insurers who agreed to sell their products through these scam associations in the agency action. Sometimes the associations were created by the insurance companies. In 2009, Consumer Reports referred to these plans as “hazardous health plans” and listed seven signs that a health plan might be junk, including limitations on benefits, low overall coverage limits (policies with a \$25,000 limit or even \$100,000 are not adequate to covers a catastrophic health event), “affordable premiums,” and ceilings on categories of care, such as outpatient care.⁵²

Legal actions by state regulators did little to stop the spread of these scams because as soon as one was stopped, another would spring up. The prevalence of these types of individual market association products was greatly reduced when the ACA was passed. Insurance regulation became more uniform and consumers had access to guaranteed issue health coverage and, often, premium tax credits that increased affordability. Many long-time state insurance regulators have decades worth of experience in dealing with association health insurance scams that include complicated products with significant gaps in coverage and hidden limits that leave consumers holding the bag for their medical costs, often resulting in medical bankruptcy. It appears that those experiences may be repeated soon without additional state action and oversight.

Legal actions by state regulators did little to stop the spread of these scams because as soon as one was stopped, another would spring up. The prevalence of these types of individual market association products was greatly reduced when the ACA was passed.

Conclusion

Most insurance experts, including AHIP and the American Academy of Actuaries, agree that the proliferation of the types of health coverage discussed in this report will lead to risk pool segmentation that will damage the single risk pools in the individual and small group health insurance markets. The extent of the damage will undoubtedly vary from state to state, depending on many factors, including how those states regulate these types of products. The individual health insurance market appears to be more at risk than the small group market. If the individual health insurance market collapses, many individuals with pre-existing conditions who are not eligible for Medicaid, Medicare, or employer group health coverage could be faced with no viable option for health care financing that would ensure their access to necessary health care. If the minimum protections established by the ACA continue to be eroded, a consumer's ability to access and pay for health care will again depend on what state they live in.

State regulators play an important role in ensuring that minimum federal standards are met and protecting the consumers in their state from fraud, scams, insolvency, and devastating financial loss. States can also take additional action to protect their consumers and markets and to mitigate the potential for market segmentation outlined above.

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