

UNDER-COVERED:

How “Insurance-Like” Products Are Leaving Patients Exposed



This report was compiled on behalf of the following members of the Partnership to Protect Coverage. We are pleased to present this information to policymakers to ensure that health care is adequate, affordable, and accessible for all.



The AIDS Institute

The Alpha-1 Foundation

ALS Association

American Cancer Society Cancer Action Network

American Diabetes Association

American Heart Association

American Kidney Fund

American Liver Foundation

American Lung Association

Arthritis Foundation

Asthma and Allergy Foundation of America

Cancer Support Community

Chronic Disease Coalition

Cystic Fibrosis Foundation

Epilepsy Foundation

Hemophilia Federation of America

JDRF

The Leukemia & Lymphoma Society

Mended Hearts & Mended Little Hearts

Muscular Dystrophy Association

National Alliance on Mental Illness

National Hemophilia Foundation

National Kidney Foundation

National Multiple Sclerosis Society

National Organization for Rare Disorders

National Patient Advocate Foundation

Pulmonary Hypertension Association

Susan G. Komen

United Way Worldwide

WomenHeart: The National Coalition for Women with Heart Disease

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EXECUTIVE SUMMARY

Our organizations represent millions of patients and consumers across the country who live with serious, acute and chronic health conditions. These individuals need access to comprehensive, affordable health coverage to meet their medical needs. In March 2017, we adopted a core set of principles to guide and measure any work to reform, change or improve our nation's health insurance system. Our core principles are that **health care *must* be adequate, affordable and accessible.**¹

Today, millions of Americans, including many who are low-income or living with pre-existing health conditions, rely on health care coverage received through the Patient Protection and Affordable Care Act (ACA). Prior to the enactment of the ACA, it was difficult — and often impossible — for people with, or at risk of, serious illnesses to get or keep affordable and adequate health insurance. The enactment of the ACA has radically improved our patients' experience with health insurance. Now, issuers are required to provide comprehensive coverage and prohibited from unfair coverage restrictions that discriminate against people with serious or chronic illnesses on the basis of their pre-existing condition.

However, over the past several years, new insurance rules have allowed issuers across markets to discriminate against people with pre-existing conditions as they did prior to the passage of the ACA. The proliferation of these non-ACA-compliant (non-compliant) plans has weakened the overall effectiveness of the ACA by exposing consumers, particularly those with pre-existing conditions, to significant financial risk, segmenting the individual market risk pool and unnecessarily inflating insurance premiums for people who rely on comprehensive coverage provided through the ACA marketplaces.

In comparison to the consumer protections that apply to ACA-compliant health insurance, non-compliant plans utterly fail to provide the same degree of certainty and security for patients and consumers. A chart comparing non-compliant plans to these protections can be found at **Exhibit 1**.

Due to the unregulated nature of these plans, a full picture of their impact is unknown. This report endeavors to compile what is known about the most common kinds of non-compliant plans and make recommendations for Congress, the administration and state leaders. These actions, if implemented, would significantly improve patient protections for millions of people in the United States living with serious and chronic health conditions. The plans examined include:

- Short-Term, Limited-Duration Insurance
- Health Care Sharing Ministries
- Farm Bureau Plans
- Grandfathered Plans
- Misuse of arrangements subject only to non-ACA federal regulations (ERISA), including
 - Multiple Employer Welfare Arrangements and Association Health Plans
 - Spurious single-employer self-insured Group Health Plans (Data Marketing Partnership Scheme)
 - Minimum Essential Coverage-Only Plans
 - Excepted Benefit Plans

¹ <https://www.ils.org/sites/default/files/National/healthcare-principles.pdf>

Exhibit 1.

COMPARISON CHART — WHAT PROTECTIONS APPLY? STANDARDS FOR ACA-COMPLIANT INDIVIDUAL AND SMALL GROUP MARKET HEALTH COVERAGE VS. ALTERNATIVE COVERAGE PRODUCTS

Consumer Protection (applicable to Individual & Small Group Markets)	Description	ACA-Compliant Coverage	STLDI	HCSMs	Farm Bureau Coverage	Grandfathered Plans	AHPs	Single-Employer ERISA plans	MEC-Only Plans	Excepted Benefits
ACCESSIBILITY										
Guaranteed Availability of Coverage	Requires insurers to accept every applicant who applies for coverage.	✓	✗	✗	✗	Depends*	Depends*	✗	Depends*	✗
Dependent Coverage to Age 26	Requires plans that already provide dependent coverage to make it available until the dependent turns 26.	✓	✗	✗	✗	✓	✓	✓	✓	✗
Prohibition on Rescissions	Prohibits plans from retroactively canceling coverage, except in the case of fraud or an intentional misrepresentation of material fact; requires prior notice to the insured.	✓	✗	✗	✗	✓	✓	✓	✓	✗
AFFORDABILITY										
Premium Rating Requirements	Prohibits plans from charging a higher premium based on health status and gender; allows rates to vary based solely on the number of enrollees covered, geographic area, age (within limits), and tobacco use (within limits).	✓	✗	✗	✗	✗	✗**	✗	✗	✗
Medical Loss Ratio (MLR)	Requires insurers to spend a specified percentage of revenue on health care and quality improvement or issue rebate to enrollees.	✓	✗	✗	✗	✓†	Depends†	✗	Depends†	✗
ADEQUACY										
Prohibition on Pre-existing Condition Exclusions	Prohibits insurers from excluding coverage based on an enrollee's pre-existing condition.	✓	✗	✗	✗	Depends††	✓	✓	✓	✗
Essential Health Benefits	Requires plans to cover 10 specified categories of essential benefits.	✓	✗	✗	✗	✗	✗	✗	✗	✗
Actuarial Value	Requires plans to meet a minimum actuarial value standard of at least 60 percent of total plan costs; requires plans to meet one of four actuarial value tiers—bronze (60%), silver (70%), gold (80%), or platinum (90%)—as a measure of how much of a consumer's medical costs are covered by the plan.	✓	✗	✗	✗	✗	✗	✗	✗	✗
Annual Cost-Sharing Limits	Requires insurers to limit annual out-of-pocket costs, including copayments, coinsurance, and deductibles for essential health benefits.	✓	✗	✗	✗	✗	✓	✓	✓	✗
Ban on Annual Dollar Limits	Prohibits annual limits on the dollar value of covered essential health benefits.	✓	✗	✗	✗	Depends††	✓	✓	✓	✗
Ban on Lifetime Dollar Limits	Prohibits lifetime limits on the dollar value of covered essential health benefits.	✓	✗	✗	✗	✓	✓	✓	✓	✗
Preventive Services Without Cost-Sharing	Requires plans to cover specified preventive health services without cost-sharing when the insured uses an in-network provider.	✓	✗	✗	✗	✗	✓	✓	✓	✗
TRANSPARENCY										
Summary of Benefits and Coverage	Requires insurers to provide standardized, easy-to-understand summaries of the benefits, cost-sharing, limitations, and exclusions of a plan; summaries must include coverage examples that illustrate how the plan covers specific benefit scenarios.	✓	✗	✗	✗	✓	✓	✓	✓	✗
RISK MITIGATION										
Single Risk Pool	Each insurer must consider the claims experience of all of their enrollees in all of their individual (small group) market plans when setting individual (small group) market premiums.	✓	✗	✗	✗	✗	✗	✗	✗	✗
Risk Adjustment Program	Transfers funds from insurers with relatively low-risk enrollees to insurers with relatively high-risk enrollees.	✓	✗	✗	✗	✗	✗	✗	✗	✗

Source: Adapted from Lucia, K., Giovannelli, J., Corlette, S. et al., "State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market," *The Commonwealth Fund*, March 2018.

Note: The AHP category shows standards applicable to such plans that meet the definition of large group coverage under federal law.

* The ACA's guaranteed issue requirement applies to fully insured non-grandfathered health plans. It does not apply to self-funded plans, nor to grandfathered coverage. Fully insured grandfathered small group coverage is subject to the pre-ACA guaranteed issue requirements of the Health Insurance Portability and Accountability Act (HIPAA).

** Pathway 2 AHPs (which were authorized under Trump administration rules and are the subject of ongoing federal litigation) are allowed to charge higher rates based on factors such as age, gender, occupation, and group size, as long as the plan does not use the health status of individual members to determine eligibility, premiums, or benefits. Pathway 1 AHPs are subject to still less stringent rating rules and are permitted to charge higher premiums based on health status.

† Self-funded plans are exempt from the ACA's MLR requirements. The ACA's MLR standards that apply to the large group market (85%) apply to fully insured grandfathered large group plans, fully insured large group MEC-only plans, and large group plans sold to fully insured AHPs. The ACA's MLR standards that apply to the small group market (80%) apply to fully insured grandfathered small group plans.

†† The ACA's prohibitions on pre-existing condition exclusions and annual dollar limits on benefits apply to grandfathered group health plans but do not apply to grandfathered individual market coverage.

Recommendations at a Glance

Recommendations for Congress

- **Codify Short-Term, Limited-Duration Insurance (STLDI) Protections Into Law:** Congress should codify the three-month duration limit and additional provisions in statute in order to protect patients and consumers. These include restoring limiting renewability and closing the “stacking” loophole, halting sales of STLDI plans during open enrollment, limiting sales via internet and phone, establishing a prohibition on rescissions, improving disclosures, and requiring plans and brokers to report STLDI enrollment and plan data.
- **Prohibit the Use of Brokers for Enrollment:** Congress should prohibit brokers from selling HCSMs and other insurance-like products. Using brokers to enroll members contributes to consumer confusion and increases enrollment in inadequate coverage.
- **Revise the Federal Definition of Insurance:** Congress should revise the federal definition of insurance to curtail the inappropriate sale, marketing and development of insurance-like-products that jeopardize patient health and safety. This should capture any products that are marketed to consumers as—or resembling—health insurance, such as health care sharing ministries, farm bureau plans, association health plans and some limited-indemnity plans.
- **Investigate Spurious Single-Employer ERISA Plans Arrangements:** There has been a long history of attempts to avoid state insurance regulation by exploiting the ERISA exemption. Congress should thoroughly investigate arrangements that pose risks to patients and consumers.
- **Require Employer Plans to Cover Essential Health Benefits (EHBs) and Adhere to EHB Standards:** Congress should extend the EHB requirement and at least, a modified AV standard to large group plans, both fully insured and self-insured.
- **Require Issuers Selling Excepted Benefits to Confirm Enrollee is Covered by Comprehensive Coverage and Prohibit the Sale of Excepted Benefits that Mimic Fully Regulated Insurance:** At the federal level, Congress should provide clear authority to issue regulations that require issuers to confirm enrollees are covered by comprehensive coverage before selling excepted benefit policies. Additionally, Congress should amend federal law governing excepted benefits to clarify that excepted benefits are exempt from regulation only to the extent such benefits do not duplicate, supplant or mimic the benefits provided by fully regulated coverage.

Recommendations for Federal Agencies

- **Revise Federal Regulations Related to STLDI:** At a *minimum*, the administration should work to restore the October 2016 regulation that prohibited STLDI plans from extending beyond three months. The administration should limit renewability and close the “stacking” loophole, halt sales of STLDI plans during open enrollment, limit sales via internet and phone, establish a prohibition on rescissions, improve disclosures and require plans and brokers to report STLDI enrollment and plan data.
- **Revoke Proposed Rule on Health Care Sharing Ministries (HCSM):** The June 2020 proposed IRS rule, which would allow HCSM premiums to be paid for with pre-taxed dollars, should be withdrawn.
- **Rescind the Grandfathered Plan Rule:** The Departments of HHS, Labor, and Treasury should withdraw the rule on grandfathered group health plans finalized in January 2021, which weakens existing regulations and further degrades patient protections.
- **Rescind the 2018 Association Health Plan (AHP) Rule:** The administration should move immediately to rescind the 2018 AHP rule. The rule, which was blocked in substantial part by a federal court, is unlawful, endangers consumers and undermines the functioning of the ACA-compliant individual and small group markets. A new rule should also prohibit sole proprietors from enrolling as a “small group” and strengthen licensing requirements for self-funded AHPs.
- **Codifying the “Look Through” Doctrine:** Centers for Medicare and Medicaid Services (CMS) should codify the “look through” doctrine in regulation. The doctrine holds that, except in “rare instances,” regulators must “look through” an association and regulate the health coverage that the association issues based on the type of entity that actually receives it.
- **Clarifying the Term “Issuer”:** CMS should clarify through guidance or regulation that a self-funded multiple employer welfare arrangements (MEWA) that is regulated by a state is an “issuer” for purposes of federal law and, therefore, subject to federal insurance requirements applicable to issuers. This would mean clarifying “issuer” to ensure that it is sufficiently broad to include entities that (1) must obtain state authorization to engage in what is the business of insurance and (2) are subject to at least some state insurance law standards.
- **Investigate Spurious Single-Employer ERISA Plans Arrangements:** Federal regulators should thoroughly investigate arrangements that pose risks to patients and consumers.

- **Vigorously Defend the Department of Labor's Position in the Data Marketing Partnership Lawsuit:** DOL's advisory opinion determining that Data Marketing Partnership (DMP) would not qualify for the ERISA exemption was correct. The Administration should continue to seek the reversal of a lower court decision holding otherwise. If necessary, DOL should codify this ruling by issuing a regulation clarifying that arrangements such as those developed by DMP do not qualify for the ERISA exemption.
- **Ensure Sufficient Oversight of ERISA Plans, Including AHPs and MEWAs:** Federal regulators should commit resources to ensure robust federal oversight of these entities and improved coordination with state regulators.
- **Monitor and Collect Data on Large Employer Plans:** DOL should conduct a study of large employer plans on a routine basis. These reports would help increase understanding of the employer-sponsored insurance market and may reveal existing or emerging gaps in coverage that would be considered essential services.
- **Require Strong Disclosures of Limited Benefits:** Policymakers should require plans to include disclosures that clearly define the limits of coverage and disadvantages of these plans, whether bought alone or in coordination with other coverage. Brokers should be required to first screen applicants for eligibility for financial assistance to buy an ACA plan or to enroll in Medicaid.

Recommendations for States

- **Limit or Consider Prohibiting STLDI Plans:** States should retain their capacity to regulate beyond a federal floor and should restore STLDI plans to a three-month duration or consider prohibiting the sale of STLDI plans outright—offering the fullest protection to patients and consumers in their jurisdiction.
- **Require STLDI Plans to Meet Minimum Standards:** In addition to limiting the duration, state regulators should consider going further by requiring STLDI plans to comply with important patient and consumer protections, as a catastrophic health event can occur within a three-month duration. These could include requiring issuers to comply with patient protections such as coverage of EHBs, bans on recessions, requiring plans to meet a minimum loss ratio and minimum actuarial values, amongst others. States should also improve disclosures for STLDI plans and require plans and brokers to report STLDI enrollment and plan data.
- **Increase Transparency and Data Reporting for HCSMs:** HCSMs should be required to disclose plan data, marketing practices, broker incentives, enrollment information and complaint information to state and federal regulators. Specifically, state regulators must have information on HCSMs marketing in their states in order to evaluate whether their operations constitute the business of insurance, to watch for deceptive marketing and to monitor enrollment.
- **Prohibit Sales Through Brokers:** Brokers should be prohibited from selling HCSMs and other insurance-like products. Using brokers to enroll members contributes to consumer confusion and increases enrollment in inadequate coverage.
- **Maintain or Reestablish Authority Over Farm Bureau Plans:** States where these plans exist should repeal the laws carving them out of regulation. States should maintain (or reestablish) regulatory authority over health coverage offered by the Farm Bureau and should not exempt such coverage from the state insurance code.
- **Strengthen Licensing Requirements for AHPs:** State regulators should require self-funded AHPs to satisfy the same licensure and financial standards required of commercial insurers.
- **Ensure Sufficient Oversight of AHPs and MEWAs:** States should commit sufficient resources to ensure robust state oversight of these entities.
- **Investigate Spurious Single-Employer ERISA Plans Arrangements:** State regulators should thoroughly investigate these arrangements. The Texas court ruling is not binding on states and does not limit the authority of state regulators to investigate potential violations of state law by entities doing insurance business within the state.

INTRODUCTION

The passage of the ACA resulted in significant improvements to the quality of health insurance coverage. The ACA requires most issuers selling insurance in the individual and small group and—to a lesser extent—the employer-sponsored coverage markets, to comply with a set of provisions that work together to promote adequate, affordable and accessible coverage for all consumers, including people with pre-existing conditions. For the individual and group markets, these include community rating², guaranteed issue³, essential health benefits, cost-sharing limits and the prohibition on pre-existing condition exclusions. These policies are inextricably linked and removing any of them threatens access to critical care for people with life-threatening, disabling, chronic or serious health care needs. These provisions protect everyone from discriminatory coverage practices as a result of their health status.^{4,5,6} Furthermore, these policies are designed to work in tandem, and, because of this, removing any one of them inevitably erodes the efficacy of the others and threatens access to necessary care for people with life-threatening, disabling, chronic or serious health care needs.

However, over the past several years, steps to deregulate the insurance industry have allowed issuers across markets to again employ practices that had, prior to the enactment of the ACA, been used to discriminate against people with pre-existing conditions. In addition to resurrecting discriminatory practices, these deregulatory actions have led to an increase in the number of un- or under-regulated insurance and insurance-like products being marketed to consumers as comprehensive health insurance.

The expansion of these non-compliant plans has had the cumulative result of weakening the overall effectiveness of the ACA. These plans may not provide coverage for the services patients need and can inappropriately expose patients to financial harm. Expanding access to these sub-standard products also negatively impacts the people who rely on high-quality, comprehensive coverage by siphoning younger and healthier individuals away from the ACA-compliant market risk pool, thereby segmenting the individual market risk pool and needlessly inflating premiums.⁷

Non-compliant plans, which include short-term, limited-duration insurance plans (STLDI) and others, are allowed to openly and legally discriminate against people with pre-existing conditions. Additionally, insurance-like products, such as limited-indemnity plans, Farm Bureau plans, health care sharing ministries (HCSMs) and multiple employer welfare arrangements (MEWAs), go entirely unregulated at the state and federal levels. This lack of regulation allows these insurance-like product to utilize misleading and deceptive marketing practices, ignore essential patient protections, and charge patients with pre-existing conditions, older individuals and women higher premiums for their products, if they are allowed to purchase a plan at all.

- 2 The community rating rule prevents health insurers from varying premiums within a geographic area based on age, gender, health status or other factors.
- 3 Guaranteed issue is a requirement that health plans must permit any individual to enroll in health insurance regardless of health status, age, gender or other factors that may predict an individual's use of health services.
- 4 Schwab, R. (2020, October 7). *From Acne to EcZema: The Return of Medical Underwriting Puts Millions at Risk for Losing Coverage or Higher Premiums*. Georgetown University's Center on Health Insurance Reforms. <http://chirblog.org/from-acne-to-eczema-the-return-of-medical-underwriting-puts-millions-at-risk-for-losing-coverage-or-higher-premiums/>
- 5 Pollitz, K., Sorian, R., & Thomas, K. (2001, June). *How accessible is individual health insurance for consumers in less-than-perfect health?* The Henry J. Kaiser Family Foundation. <https://www.kff.org/wp-content/uploads/2013/01/how-accessible-is-individual-health-insurance-for-consumer-in-less-than-perfect-health-report.pdf>
- 6 Pollitz, K. (2020, October 1). *Pre-existing Conditions: What Are They and How Many People Have Them?* Kaiser Family Foundation. <https://www.kff.org/policy-watch/pre-existing-conditions-what-are-they-and-how-many-people-have-them/>

- 7 Hansen, D., & Dieguez, G. (2020, February). *The impact of short-term limited-duration policy expansion on patients and the ACA individual market: An analysis of the STLD policy expansion and other regulatory actions on patient spending, premiums, and enrollment in the ACA individual market*. Milliman Actuarial. <https://www.lls.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>

While many of these plans are not intended to be a substitute for health insurance, many are marketed as such—some even mimicking the gold, silver and bronze metal value levels used to label compliant plans sold on ACA marketplaces.⁸ Enrollees may believe they are enrolled in health insurance, only to find that the product they have purchased provides little if any coverage.⁹

While various kinds of non-compliant plans have operated for many years, these products have experienced significant growth in enrollment in recent years amidst an environment of non-enforcement and deregulation. While the availability of enrollment data varies significantly by plan type, overall trends indicate that enrollment and market penetration of these substandard and non-compliant plans is increasing.

While this report explores the most common examples of these types of substandard insurance and insurance-like-products, it is not a comprehensive representation of all the growth in this area. This fact alone suggests that immediate additional regulatory and legislative actions should be taken to curb the growth of this market, which jeopardizes both the physical and financial health of patients and consumers.

Approximately 27% of adult Americans under the age of 65 have a pre-existing condition.¹⁰ With 25 million people diagnosed with COVID-19, as of March 2021, that number is expected to increase significantly.¹¹ This fact alone should serve as a strong incentive for policymakers to ensure that health insurance issuers are prohibited from considering an individual's pre-existing condition or health status when determining coverage, benefits, premiums or cost-sharing. All individuals, regardless of their health status, have a right to quality, affordable and accessible health care coverage. Allowing health issuers to engage in medical underwriting and circumvent key patient and consumer protections may lower premiums for healthy individuals, but such action threatens the physical, psychological and financial wellbeing of people who have or develop medical conditions. Additionally, many non-compliant plans do not meet the definition of minimum essential coverage. As a result, people enrolled in these plans do not qualify for a special enrollment period if they are

dropped from coverage, having to wait until open enrollment to get comprehensive, affordable coverage.

Policymakers at all levels of government must take swift action to reverse the proliferation of substandard insurance and insurance-like products and guard against the harms these arrangements pose to patients and consumers. In recognition of this threat, our organizations have cataloged the most common types of substandard coverage and provided policy recommendations that regulators and legislators at both the state and federal level should immediately implement to prevent further harm to patients and to our health care system.

8 Here is an Instant quote | Christian Healthcare Ministries. (n.d.). Christian Healthcare Ministries—Get an Instant CHM Quote. Retrieved March 10, 2021, from <https://www.chministries.org/programs-costs/instant-quote/>

9 Aleccia, J. (2019, May 21). 'Sham' Sharing Ministries Test Faith Of Patients And Insurance Regulators. Kaiser Health News. <https://khn.org/news/sham-sharing-ministries-test-faith-of-patients-and-insurance-regulators/>

10 Claxton G, Cox C, Damico A, Levitt L, Pollitz K. Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA. Kaiser Family Foundation. December 2016, available at <http://files.kff.org/attachment/Issue-Brief-Pre-existing-Conditions-and-Medical-Underwriting-in-the-Individual-Insurance-Market-Prior-to-the-ACA>.

11 CDC. (2020, March 28). *COVID Data Tracker*. Centers for Disease Control and Prevention. https://covid.cdc.gov/covid-data-tracker/#cases_casesper100klast7days

INVENTORY OF NON-COMPLIANT AND NON-COMPREHENSIVE COVERAGE

The following inventory of substandard insurance and insurance-like products details the most common plans and products on the market today. The list is meant to be extensive but not exhaustive. Our organizations are also deeply concerned about the unchecked growth of other types of sub-standard products, including novel products, such as no-network plans and plans that reclassify out-of-pocket costs as premiums.¹² While these plans are not discussed at length in this report, they require significant oversight and additional analysis such that target-

¹² Appleby, J. (2019, April 3). *New Health Plans Expose the Insured To More Risk*. Kaiser Health News. <https://khn.org/news/new-health-plans-expose-the-insured-to-more-risk/>

ed public policy responses, aimed at protecting patients and consumers, can be developed. The policy recommendations within this document represent a comprehensive approach to reigning in these products and would capture an array of plans beyond those detailed in this report.

Short-Term, Limited-Duration Insurance

WHAT IS SHORT-TERM, LIMITED-DURATION INSURANCE?

Short-term, limited-duration insurance (STLDI) plans pre-date the ACA and were intended, as their name indicates,

Sam Bloechl (Lemont, IL)



Sam Bloechl, a 32-year-old landscape design business owner from Chicago, and his wife Megan are finally able to enjoy the life they have been planning. However, four years ago, they never could have prepared for what was to come.

Sam thought he was doing everything right. After experiencing back pain that wouldn't go away, he spoke to an insurance broker about upgrading his health insurance so he could better cover any potential treatment he might need. He was upfront about his prior visits to the chiropractor for his back issues, and the broker assured Sam that if there was no diagnosis, the plan she was recommending was the right plan for him. In fact, she told him that he would be wasting his money to buy anything more expensive. What he didn't know was that he was sold a short-term limited duration plan which wouldn't cover what it deemed pre-existing conditions, and his back pain was about to turn into a lifechanging diagnosis.

A month later, Sam was diagnosed with stage IV T-Cell non-Hodgkin lymphoma, an aggressive but treatable form of blood cancer, and he immediately began treatment. Six months into an aggressive regimen of chemotherapy and radiation, Sam achieved remission. However, because Sam's disease would likely return, a bone marrow transplant would be his only true hope for long-term remission.

As he was preparing for the procedure, he received the devastating news that his health plan deemed his diagnosis a pre-existing condition and was denying coverage for the bone marrow transplant Sam needed. Short-term health plans aren't covered by the ACA requirements that protect people with pre-existing conditions. And even more shocking, they were refusing to pay for the six-months of expensive care he had already received.

Sam thought this had to be a mistake and appealed the health plan's decision. After all, he had been truthful about his back pain and took the recommendation of the broker who had assured him this was the best plan for him. Fighting for coverage meant Sam had to endure additional treatments instead of getting the bone marrow transplant he needed to finally be cured. Sam was left to battle cancer with no meaningful insurance coverage and more than \$800,000 in medical debt.

Sam's appeals failed, and he found himself in the middle of a financial disaster that somehow proved to be as challenging as his fight against cancer itself. Instead of planning a life together with his girlfriend and a future for his business, Sam was kept up at night worrying about staying afloat, paying the next bill and avoiding bankruptcy.

The past four years have proved difficult and overwhelming, to say the least. But today, Sam is happy and healthy, and he has quality insurance that covered his transplant and will protect him should any potential health needs arise. Sam knows that his experience is not unique, and he is committed to fighting back to protect other people from short-term health plans.

to fill short gaps between coverage. For example, these plans were intended for a person who could not afford COBRA premiums and was between jobs with health benefits or for adult children aging off a parent's plan.

The ACA sought to address the underlying issues which made STLDs necessary by making changes to the law that have helped alleviate gaps in coverage. Today, the ACA allows individuals who lose employment-based coverage or most other coverage to qualify for a special enrollment period (SEP) to enroll in a comprehensive ACA plan. In addition, in an attempt to ensure that STLDI prod-

Andrew Blackshear (Benicia, CA)



In 2015, Andrew Blackshear was a healthy 27-year-old until his life took a dramatic turn with the sudden onset of extreme chest pain and a growing fever. Andrew later learned he had contracted an infectious fungal disease while driving through California's San Joaquin Valley weeks

before. The condition, known as "Valley Fever," is caused by inhaling fungal spores that are released from the dry soil. When the spores disseminated in his lung tissue, he developed fungal pericarditis and was left gasping for life.

Over the next few weeks, Andrew's blood tests and symptoms only got worse, resulting in emergency open heart surgery. Within weeks, he would need a second emergency surgery, but Andrew was fighting for more than his health. He was also fighting to get access to the health care he needed to stay alive.

Before his first open heart surgery, Andrew turned 27 and was no longer covered by his parent's health insurance. Having missed the open enrollment period for Covered California, the state's ACA insurance marketplace, he had to explore other options and ended up purchasing a short-term health insurance plan. As his condition worsened, medical bills started pouring in. Andrew was aware that his plan had a high deductible, so he paid the bills as they arrived. But then he started receiving letter after letter from his insurance company asking that he prove his heart problems were not caused by a pre-existing condition, which his short-term health plan wouldn't cover.

Still recovering from his first heart surgery, Andrew spent hours visiting every doctor he had ever seen collecting the records his insurance company was demanding, including a trip to a pediatrician he hadn't visited in over 15 years. Andrew owed nearly \$200,000 in medical bills. He continued to fight and even requested the state of California's help in taking his insurer to court.

In the end, the insurance company covered the cost of his medical bills. But patients who are fighting for their lives shouldn't have to worry their coverage will be canceled. Andrew was able to enroll in an ACA plan that provided him with the health insurance he needs to stay healthy. Now, as a member of the American Heart Association's You're the Cure grassroots network, Andrew advocates for policies that improve access to care for all.

ucts only operate as a temporary option to fill a coverage gap and not be marketed as an alternative to comprehensive, full-year coverage, the Obama administration issued regulations that defined STLDI as plans providing up to three months of coverage and prohibited the products from being renewed.¹³

The Trump administration reversed course and revised the regulations to allow for up to 364 days—one day short of a full year—of coverage under a STLDI plan and to allow them to be renewed for up to 36 months.¹⁴ This has led to more aggressive marketing and a rapid expansion in enrollment in STLDI plans.¹⁵

STLDI PLANS HARM PATIENTS AND CONSUMERS

STLDI plans do not have to meet the consumer protections and standards of the ACA and multiple studies have documented their limits and gaps.^{16,17,18,19} They are not required to adhere to important standards, including coverage of the 10 EHB categories, guaranteed issue, age and gender rating, prohibitions on discrimination against people with pre-existing conditions, annual out-of-pocket maximums and prohibitions on annual and lifetime coverage limits, amongst other critical patient and consumer protections. Applicants can be denied coverage based on their health history; coverage may be offered with an exclusion on all care required for a pre-existing condition; and plans typically exclude coverage for prescription drugs, mental health and substance use disorders, and maternity care. Furthermore, STLDI insurers may cancel a consumer's coverage based on claims that they deem related to a pre-existing condition.

STLDI plans also often require consumers to spend enormous sums during the deductible portion of their benefit design, which can quickly eclipse any premium savings consumers may accrue while covered by one of these

- 13 Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance. 81 F.R. 75316 (2016).
- 14 Short-Term, Limited-Duration Insurance, 83 F.R. 38212 (2018).
- 15 Government Accountability Office. (2020, August). *Private Health Coverage: Results of Convert Testing for Selected Offerings*. <https://www.gao.gov/products/gao-20-634r>
- 16 Palanker, D., Volk, J., & Lucia, K. (2018, October 30). *Short-Term Health Plan Gaps and Limits Leave People at Risk* | Commonwealth Fund. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2018/short-term-health-plan-gaps-and-limits-leave-people-risk>
- 17 Hansen, D., & Dieguez, G. (2020, February). *The impact of short-term limited-duration policy expansion on patients and the ACA individual market: An analysis of the STLD policy expansion and other regulatory actions on patient spending, premiums, and enrollment in the ACA individual market*. Milliman Actuarial. <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>
- 18 Committee on Energy & Commerce. (2020, June). *Shortchanged: How the Trump administration's expansion of junk short-term health insurance plans is putting Americans at risk*. U.S House of Representatives. https://drive.google.com/file/d/1uIL3Bi9XV0mYnxpyaIMeg_Q-BJaURXX3/view
- 19 American Cancer Society Cancer Action Network. (2019, May). *Inadequate Coverage: An ACS CAN Examination of Short-Term Health Plans*. ACS CAN. <https://www.fightcancer.org/sites/default/files/ACS%20CAN%20Short%20Term%20Paper%20FINAL.pdf>

plans.²⁰ In addition to the exclusions listed above, STLDI plans also frequently exclude coverage for many routine medical services that average consumers may not realize are not covered.^{21,22} This combination of extraordinary financial risk and the lack of basic patient and consumer protections led those who sell these plans to acknowledge that such plans are “designed solely to provide temporary insurance during unexpected coverage gaps”²³ and contribute to their status under federal regulation as separate and distinct from “individual health insurance coverage.”²⁴

Because STLDI plans screen out individuals with health conditions and can limit the coverage they provide, these plans typically have lower premiums. However, consumers looking for a low-cost coverage option may not understand that they are buying a plan that puts them at risk for coverage gaps and substantial costs. Even those consumers who seek a comprehensive ACA plan may be diverted to a STLDI plan through deceptive marketing and misleading websites.^{25,26,27,28} Private “direct enrollment” websites contracted to sell ACA-compliant coverage can (and do) also sell STLDI, and brokers report offering consumers STLDI products if an ACA plan is too costly.^{29,30} Further, if individuals without pre-existing conditions are not paying into the broader ACA health insurance risk pool, premiums go up for individuals with pre-existing conditions who are reliant on such insurance.

20 Short Term Health Insurance Plans | UnitedHealthOne. (n.d.). United Healthcare. Retrieved March 11, 2021, from <https://www.uhonline.com/health-insurance/short-term-health-insurance>

21 Everest Prime STM. (n.d.). Agile Health Insurance, pg.11. Retrieved March 11, 2021, from <https://assets.agilehealthinsurance.com/production/everest-1a794e476ffa887b6b62dcb8ba521733.pdf>

22 Pollitz, K., Long, M., Semanskee, A., & Kamal, R. (2018, April). *Understanding Short-Term Limited-Duration Health Insurance*. Kaiser Family Foundation. <http://files.kff.org/attachment/Issue-Brief-Understanding-Short-Term-Limited-Duration-Health-Insurance>.

23 Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act. 83 F.R. 57536 (2018).

24 *Ibid*.

25 Government Accountability Office. (2020, August). *Private Health Coverage: Results of Convert Testing for Selected Offerings*. <https://www.gao.gov/products/gao-20-634r>

26 Corlette, S., Lucia, K., Palanker, D., & Hoppe, O. (2019, January). *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses*. Urban Institute. https://www.urban.org/sites/default/files/publication/99708/moni_stldi_final_0.pdf

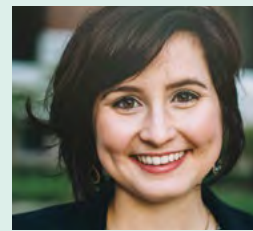
27 New Consumer Testing Shows Limited Consumer Understanding of Short Term Limited Duration Plans and Need for Continued State and NAIC Action, NAIC Spring 2019 National Meeting https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf

28 Linke Young, C., & Hannick, K. (2020, April 15). *Misleading marketing of short-term health plans amid COVID-19*. Brookings. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>

29 Straw, T. (2019, March 15). “Direct Enrollment” in Marketplace Coverage Lacks Protections for Consumers, Exposes Them to Harm. Center on Budget and Policy Priorities. <https://www.cbpp.org/research/health/direct-enrollment-in-marketplace-coverage-lacks-protections-for-consumers-exposes>

30 Corlette, S., Wengle, E., & Hoppe, O. (2020, June 29). *Perspectives from Brokers*. Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/research/2020/04/perspectives-from-brokers-the-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks.html>

Katrina Black (Austin, TX)



At 26 –years old, Katrina was on top of the world. About to finish her third year of law school, she had married the man of her dreams, a self-employed musician, and had just accepted her dream job halfway across the country. Katrina was finally in better health as well.

She was on a university-provided health insurance plan which allowed her to see a specialist for the first time in her life, who diagnosed her with endometriosis, a disease that had caused debilitating pain for as long as she could remember. She finally had some relief after two successful surgeries and was recovering well with physical therapy.

After Katrina graduated in May, the couple moved to Texas to await the start of her new job as a non-profit attorney. Unfortunately, Katrina’s student health coverage was about to end, and she couldn’t risk even a day without insurance. Knowing that she could qualify for a marketplace plan for the five months before her employer-sponsored health coverage would begin, Katrina visited [healthcare.gov](https://www.healthcare.gov) to purchase insurance. However, when a pop-up appeared asking for her phone number and zip code, she was unknowingly led out of the trusted marketplace.

Within minutes of entering her contact information her phone was ringing nonstop with solicitors trying to sell her a plan. One sales agent, an empathetic young woman, called apologizing for all the solicitations and provided an inexpensive quote for a short-term limited duration plan. The couple took the time to compare several different options and decided to call the woman back. Her quote was the cheapest.

Katrina asked specific questions to be sure her endometriosis care would be covered. The agent assured her it would and sent pages and pages of documents, some with very small font, for Katrina to review and sign. The agent gained her trust and told her she would be covered.

Midsummer, Katrina started to receive concerning letters from her short-term plan provider saying that the physical therapy sessions she was attending three times per week would not be covered. Her patient responsibility totaled hundreds of dollars per visit.

Katrina’s plan refused to pay the bills, claiming the endometriosis was a pre-existing condition. Between her denied claims and premiums, Katrina was forced to pay \$6,000 for a plan that never actually provided the coverage she needed.

Katrina knew this would have been illegal had her insurance been regulated by the ACA. She had been upfront with the agent about her illness and the need for a plan to cover her endometriosis treatment. It’s been a full-time job for Katrina to navigate the paperwork that her short-term plan continues to send. Short-term limited duration plans often practice deceptive marketing tricks causing even well-informed people to fall victim to their trap. That’s why Katrina has become a passionate advocate for consumer protections.

STLDI PLANS ARE EXPANDING

Enrollment in STLDI plans is growing at a significant rate as a result of Trump administration rules. A Congressional investigation of STLDI insurers found enrollment in STLDI plans grew by 27% in the year following the Trump administration's expansion of STLDI.³¹

As STLDI plan enrollment has grown, pulling away healthier individuals from the ACA marketplaces, premiums for ACA plans have risen. For example, a study commissioned by The Leukemia & Lymphoma Society found that 2020 premiums for ACA plans increased as much as 4.3% in states that chose not to regulate STLDI plans, and forecasted that marketplace enrollment would drop as a result.³² In contrast, states that have taken regulatory action to restrict or prohibit the sale of these substandard insurance options have seen premiums drop by as much as 1.2%.³³

To date, about half of states have enacted greater restrictions on STLDI—limiting the duration to six months or less, prohibiting renewals, applying standards that make them less profitable or less attractive for insurers to offer or prohibiting them outright.³⁴ But without tighter federal restrictions, nationwide consumer protection will not be guaranteed.

RECOMMENDED POLICY ACTION

As we have established, STLDI plans pose a significant risk to patient and consumer populations. Congress, the administration and states should take immediate regulatory and legislative action to limit enrollment in and harm caused by these plans by pursuing the following policy measures:

- **Restore Three-Month Duration:** At a *minimum*, the administration should work to restore the October 2016 regulation that prohibited STLDI plans from extending beyond three months.³⁵ While we urge immediate regulatory action, we also believe Congress should codify the limit in statute to ensure that these products are used solely for their original purpose: a short-term option intended only to bridge a gap in coverage between comprehensive health plans. States should retain their capacity to regulate beyond

a federal floor and should consider prohibiting the sale of STLDI plans outright, offering the fullest protection to patients and consumers in their jurisdiction.

— Limiting Renewability and Closing the “Stacking”

Loophole: STLDI plans should not be renewable or allowed to continue for more than three months because of the significant financial risk posed to consumers by their combination of extraordinary deductibles and limited catastrophic financial protection. The renewability of plans should be reserved for health insurance that meets the definition of minimum essential coverage (MEC), which short-term plans do not meet. Allowing short-term plans to be renewed or purchased consecutively from different issuers—a loophole in the duration limit protections known as “stacking”—contributes to consumer confusion, increased premiums and financial risk for consumers. We therefore recommend that the administration and Congress take action to ensure plans cannot be renewed and that consumers cannot purchase consecutive STLDI plans from different issuers.

- **Halting Sales During Open Enrollment:** Studies indicate that STLDI plans have been aggressively and deceptively marketed to consumers, especially during the ACA's annual Open Enrollment period.³⁶ We therefore urge the administration and Congress to end the sale of STLDI plans during federal and state open enrollment periods to decrease consumer confusion.

- **Limiting Sales via the Internet and Phone:** Sales of STLDI plans via the internet and phone have also increased since they were deregulated in 2018.³⁷ The increased availability of these plans, combined with deceptive marketing practices, leave consumers at increased risk of purchasing a plan that does not meet their medical needs. As a result, we ask the Department of Health and Human Services (HHS) to restrict sales of non-compliant plans to in-person encounters, in compliance with COVID restrictions.

- **Establishing a Prohibition on Rescissions:** Unlike comprehensive insurance plans sold on the individual market, short-term plan insurers are able to rescind a patient's coverage following a process called post-claims underwriting. Insurers have utilized this process to initiate retroactive coverage rescissions, leaving patients who thought they were covered without any financial or medical protection whatsoever. This practice leaves patients without access to necessary services

31 Committee on Energy & Commerce. (2020, June). *Shortchanged: How the Trump administration's expansion of junk short-term health insurance plans is putting Americans at risk*. U.S House of Representatives. https://drive.google.com/file/d/1uiL3Bi9XV0mYnxpyalMeg_Q-BJaURXX3/view

32 Hansen, D., & Dieguez, G. (2020, February). *The impact of short-term limited-duration policy expansion on patients and the ACA individual market: An analysis of the STLD policy expansion and other regulatory actions on patient spending, premiums, and enrollment in the ACA individual market*. Milliman Actuarial. <https://www.ils.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>

33 *Ibid.*

34 Palanker, D., Kona, M., & Curran, E. (2019, May). *States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans*. The Commonwealth Fund. <https://www.commonwealthfund.org/publications/issue-briefs/2019/may/states-step-up-protect-markets-consumers-short-term-plans>

35 Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance. 81 F.R. 75316 (2016).

36 Findlay, S. (2019, January 31). *Ads For Short-Term Plans Lacking ACA Protections Swamped Consumers' Online Searches*. Kaiser Health News. <https://khn.org/news/ads-for-short-term-plans-lacking-aca-protections-swamped-consumers-online-searches/>

37 Committee on Energy & Commerce. (2020, June). *Shortchanged: How the Trump administration's expansion of junk short-term health insurance plans is putting Americans at risk*. U.S House of Representatives. https://drive.google.com/file/d/1uiL3Bi9XV0mYnxpyalMeg_Q-BJaURXX3/view

and at significant financial risk.³⁸ As such, we urge HHS and state policymakers to place strong prohibitions on the practice of rescissions within this market.

- **States Should Require STLDI to Meet Minimum Standards:** In addition to limiting the duration, state regulators should consider going further by requiring STLDI plans to comply with important patient and consumer protections as a catastrophic health event can occur within a three-month duration. These could include requiring issuers to comply with patient protections such as coverage of EHBs, bans on rescissions, requiring plans to meet a minimum loss ratio and minimum actuarial values, amongst others.
- **Improving Disclosures:** Disclosure alone is not an adequate solution to the risks posed by the proliferation of STLDI plans.³⁹ However, state and federal policymakers should ensure that consumer information is provided in a clear and comprehensive way to reduce the risk that consumers are misled into purchasing inadequate coverage. Consumer disclosure should be provided both in writing and verbally; be available in a number of commonly spoken languages for any geographic area and conveyed in a culturally competent manner; be of sufficient font size using bold text and boxes to aid consumers in identifying critical information and ensure readability; explicitly say that a STLDI plan is not comprehensive, including a list of EHB services that are not provided; and, when applicable, provide a clear explanation that the plan does not have a network of providers and/or offer protection against being balance billed by providers following a service. Disclosure information should also meet standard requirements so that there is a high degree of consistency across individual types of insurance products, including what information is included and how it is presented.
- **Require Plans and Brokers to Report STLDI Enrollment and Plan Data:** State and federal policy makers should require issuers to report the number of covered lives, medical loss ratios, the actuarial value of plans and any details related to services, reimbursements, claims, complaints and commissions to brokers from the sale of STLDI plans. These important data points can help inform policy decisions regarding changes to STLDI requirements and marketplace policy.
- **Codifying Regulations into Law:** Leaders and members of both parties have repeatedly committed to protecting patients from discriminatory practices,

such as those utilized by STLDI plans. We urge state and federal legislators to codify the protections above into law to robustly protect patients and consumers.

Health Care Sharing Ministries

WHAT ARE HEALTH CARE SHARING MINISTRIES?

Health care sharing ministries (HCSMs) are a form of non-compliant insurance-like coverage in which members who typically share religious beliefs make monthly payments to cover health care expenses of themselves and other HCSM members. HCSMs are not considered insurance, so there is no guarantee that members' claims will be paid even for expenses that meet membership guidelines for "covered services." However, the features of these arrangements closely resemble insurance: monthly payments vary by age and, in some cases, health status, similar to insurance premiums; members are required to pay out-of-pocket costs similar to deductibles and copayments; many claim to have provider networks; and some pay commissions to brokers who sell memberships.

The ACA includes an exemption from the individual mandate penalty for individuals enrolled in HCSMs that meet the definition included in the law, but the exemption has no bearing on whether and how states may regulate them.⁴⁰ Today, 30 states have "safe harbor" laws that exempt HCSMs from state insurance regulation if they meet the states' HCSM definitions, and no state regulates them as insurance. However, all states have the authority to enforce insurance standards on HCSMs that are engaged in the business of insurance.⁴¹

HCSMS HARM PATIENTS AND CONSUMERS

HCSMs have adopted features closely resembling traditional insurance coverage, and they are often marketed as a low-cost alternative to ACA plans. Consumers may enroll in HCSMs thinking that they are purchasing comprehensive coverage and without fully understanding the financial risks of a product that provides no guarantee of paid claims. Even the services that are purportedly "covered" are limited and expose enrollees to substantial risk. HCSMs typically do not cover pre-existing conditions and routinely exclude coverage for key services, such as mental health and substance use disorder services, preventive services and prescription drug coverage. HCSMs also note that they provide "last dollar" payment for medical bills and require that members first exhaust all other options, including other coverage, workers' compensation, charity and government entitlements (for those

38 Palanker, D., & Goe, C. (2020, March 27). *States Don't Know What's Happening in Their Short-Term Health Plan Markets and That's a Problem* | Commonwealth Fund. Commonwealth Fund. <https://www.commonwealthfund.org/blog/2020/states-dont-know-whats-happening-their-short-term-health-plan-markets-and-thats-problem>

39 *Ibid.*

40 26 US Code §5000A

41 Volk, J., Curran, E., & Giovannelli, J. (2018, August). *Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?* The Commonwealth Fund. <https://www.commonwealthfund.org/publications/fund-reports/2018/aug/health-care-sharing-ministries>

with certain lower incomes).⁴² Further, members whose claims are denied have no right to appeal to an independent reviewer with medical expertise as they would under ACA-compliant coverage. This regulatory vacuum has allowed HCSMs to operate with little oversight. Consumer complaints led to several states taking action against one HCSM that has left consumers with unpaid claims.^{43,44}

Marketing tactics, including advertising during open enrollment for ACA plans, the use of brokers to sell memberships, and claims that HCSMs are a low-cost alternative, suggest HCSMs are not just targeting individuals who would never buy commercial insurance for religious reasons. The pursuit of non-religiously affiliated individuals indicates that some HCSMs are deviating from the statutory intent of current law to expand their market share. For example, one HCSM notes that “only religious communities have used the medical cost sharing approach *until now*” (emphasis added).⁴⁵

⁴² *Ibid.*

⁴³ Carlesso, J. (2020, December 30). Best of 2020: ‘I’m relying on prayer.’ Complaints pile up against health care sharing ministries as state mounts a defense. *The CT Mirror*. <https://ctmirror.org/2020/12/30/best-of-2020-im-relying-on-prayer-complaints-pile-up-against-health-care-sharing-ministries-as-state-mounts-a-defense/>

⁴⁴ Kreidler fines OneShare Health LLC \$150,000 for selling illegal insurance | Washington state Office of the Insurance Commissioner. (2021, February 21). Office of the WA Insurance Commissioner. <https://www.insurance.wa.gov/news/kreidler-fines-oneshare-health-llc-150000-selling-illegal-insurance>

⁴⁵ Knewhealth. “FAQ”. <https://knewhealth.com/faq/>

Today, almost half of ACA coverage is sold through insurance brokers, including HCSMs and other non-compliant products, allowing them additional market penetration.⁴⁶ With the elimination of the individual mandate in 2017, and the subsequent proliferation of non-ACA compliant plans such as STLDI plans and association health plans (AHPs) pushed by the Trump administration, the Centers for Medicare and Medicaid Services (CMS) has stopped requiring exemption certifications.^{47,48} As a result, new companies claiming to be HCSMs have formed and accelerated marketing and enrollment.^{49,50}

⁴⁶ Corlette, S., Wengle, E., & Hoppe, O. (2020, June 29). *Perspectives from Brokers*. Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/research/2020/04/perspectives-from-brokers-the-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks.html>

⁴⁷ Keith, K. (2019, June 25). *Unpacking The Executive Order On Health Care Price Transparency And Quality*. Health Affairs. <https://www.healthaffairs.org/doi/10.1377/hlbg20190625.974595/full/>

⁴⁸ Aleccia, J. (2019, May 21). ‘Sham’ Sharing Ministries Test Faith Of Patients And Insurance Regulators. Kaiser Health News. <https://khn.org/news/sham-sharing-ministries-test-faith-of-patients-and-insurance-regulators/>

⁴⁹ Salzmänn, J. R. (2018). Statutory Millennialism: Establishment and Free Exercise Concerns Arising from the Health Care Sharing Ministry Exemption's 1999 Cutoff Date — Note by James R. Salzmänn. *Southern California Law Review*, 91(2), 303–336. <https://southern.californialawreview.com/2018/01/02/statutory-millennialism-establishment-and-free-exercise-concerns-arising-from-the-health-care-sharing-ministry-exemptions-1999-cutoff-date-note-by-james-r-salzmänn/>

⁵⁰ Aleccia, J. (2019, May 21). ‘Sham’ Sharing Ministries Test Faith Of Patients And Insurance Regulators. Kaiser Health News. <https://khn.org/news/sham-sharing-ministries-test-faith-of-patients-and-insurance-regulators/>

Jill Baine (Spring, TX)



Jill and her husband James were dedicated to their family, work and faith. Jill had retired from her position as a hospital marketing manager and James was self-employed in the real estate market. The couple had been covered by a private health insurance policy for several years and in the process of reevaluating

their finances Jill began to search for a less expensive health plan for herself. She trusted a broker who sold her an unfamiliar yet inexpensive health care sharing ministry policy.

Several months later, a routine mammogram turned into an unexpected breast cancer diagnosis for Jill, and in an instant, the couple's world was upended. What followed seemed like a never-ending procession of painful procedures, surgery and grueling treatments.

But this was only the beginning. Within weeks, Jill began receiving medical bills which seemed inaccurate since all her treatments had received pre-approval from her health coverage company. Even with her health care background, she couldn't make sense of the mountains of paperwork. Sixty-eight phone calls

later, the couple faced the unimaginable — they owed over \$200,000, and the health plan that was meant to protect them when they needed it the most refused pay a dime. The company deemed Jill's cancer diagnosis a pre-existing condition, even though she had no family history of breast cancer and no symptoms. Since health care sharing ministries are not federally regulated, they do not have to cover pre-existing conditions.

Still recovering, Jill took matters into her own hands, sharing her story with the news media and filing appeals with the health care company and consumer complaints with both the Georgia and Texas Departments of Insurance. Ultimately the company relented and paid Jill's medical bills in full, but not before she had spent countless hours and precious energy fighting back when she should have been focusing on her health.

Jill dropped the health care sharing plan that she had been deceived into buying and is now covered by a comprehensive healthcare plan that doesn't discriminate against pre-existing conditions, allowing Jill to receive the follow-up care that she needs.

Today, Jill is in remission and feeling healthy. She'll always wonder what would have happened to someone in her shoes who wasn't able to fight back. Jill has become a passionate advocate and is determined to make a difference to stop this nightmare from happening to others.

A review of broker perspectives regarding HCSMs notes that most brokers are reluctant to sell HCSM coverage and view it as overly risky for consumers. However, incentives exist that may push brokers to inappropriately enroll consumers in these plans. For example, brokers note that HCSMs offer higher commissions, sometimes between 15–30% of a plan's monthly premium, compared to only 1–2% for plans subject to medical loss ratio (MLR) regulations that limit how much of a consumer's premium can go toward administrative costs, including broker reimbursement.⁵¹ Further, because many HCSMs employ terminology that mirrors that used by ACA-compliant health insurance products, consumers may be misled to believe that HCSMs are providing insurance. For example, HCSMs have and continue to offer gold, silver and bronze level sharing plans, mirroring the language used to describe the different tiers of coverage for high-quality ACA plans.^{52,53}

Like other products that can discriminate based on health status, HCSMs may siphon off healthier individuals from the ACA-regulated market, raising premiums for those who rely on ACA-guaranteed coverage for pre-existing conditions. For example, growth of HCSM membership in some states such as Alaska has grown such that it potentially risks affecting the ACA individual market risk pool.⁵⁴

HCSMS ARE EXPANDING

As with STLDI plans, HCSM enrollment has ballooned in recent years. The Alliance for Health Care Sharing Ministries, a national trade/advocacy organization that represents only a handful of HCSMs currently operating in the United States, estimates their member HCSMs have enrolled 1.5 million people nationwide, up from 130,000 in 1999.⁵⁵ HCSMs have directly appealed to consumers from across the income spectrum, including those who may be eligible for the ACA, Medicare or Medicaid.

As enrollment has grown, so too have reports of misleading and fraudulent marketing of HCSMs as health insurance products. In the last year, states have taken action to warn consumers about the shortcomings of HCSMs and curb

Megan Martinez (Dallas, TX)



In April 2018, Dave and his wife Megan were celebrating life together—enjoying their health, working hard and giving back to their community. It seemed like icing on the cake when Dave was offered a new career opportunity, along with a stipend to cover the expense of

the family's health insurance. Dave was sold an inexpensive health care sharing ministry policy from a broker with a local company that looked just like insurance. After all, he thought, his family was steadily employed, in good health and could use a little cost savings in premiums as they started a new chapter in their lives.

In June, Megan began experiencing some stomach discomfort and scheduled a visit with her primary care doctor. Before she knew what was happening, she was rushed into surgery to treat two ruptured abscesses on her small intestines. Thankfully, the surgery was a success and within a week, Megan was back at home recovering. There was no hint of the stress and emotional toll that the couple would soon face.

As part of the pre-operative procedures, Megan's medical team received a pre-verification from the health care sharing ministry. Dave paid the family's \$5,000 "Member Shared Responsibility" fee and was told the remainder of their costs would be fully covered by the health plan. However, just a few weeks later, the couple was faced with a shocking piece of mail: a bill for over \$126,000. The health plan was refusing to pay for Megan's surgery.

The health care sharing ministry deemed Megan's diagnosis a pre-existing condition. Since health care sharing ministries are not federally regulated, they do not have to cover pre-existing conditions. However, after securing paperwork from Megan's surgeon and proving this claim untrue, the couple was met with other excuses for why the company would not pay, from missing paperwork to unpaid bills. While Dave should have been caring for his wife and assisting with her recovery, he was spending hours on the phone attempting to disprove untrue claims and protect his family's financial future.

Unfortunately, Dave and Megan were forced to take legal action. The couple learned from the Texas Department of Insurance that the health care sharing ministry was operating in the state of Texas without a license and was facing multiple legal claims and an investigation. Ultimately, the health care sharing ministry paid the family's medical bill in full.

Thankfully, Megan has recovered from her surgery, and she and Dave are back to enjoying a full life together. She enrolled in an ACA plan that provides her with the protections she needs to stay healthy. However, the experience has left a lasting impact on the couple, and they are now committed advocates, speaking out against unregulated health plans. Patients who are fighting for their lives shouldn't have to worry whether their coverage will protect them when they need it the most.

51 Corlette, S., Wengle, E., & Hoppe, O. (2020, June 29). *Perspectives from Brokers*. Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/research/2020/04/perspectives-from-brokers-the-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks.html>

52 Galarneau C. Health care sharing ministries and their exemption from the individual mandate of the affordable care act. *Bioethical Inquiry*. 2015;12(2):269-282. https://natlib-primo.hosted.exlibrisgroup.com/primo-explore/search?query=any,contains,998399133602837&tab=innz&search_scope=INN&vid=NLNZ&offset=0. doi: 10.1007/s11673-015-9610-3.

53 *Christian Healthcare Ministries: The Biblical Solution to Healthcare Costs "Guidelines."* (n.d.). Christian Healthcare Ministries. Retrieved March 11, 2021, from <https://www.chministries.org/media/5189/chmguidelines.pdf>

54 Volk J, Curran E, Giovannelli J. Health care sharing ministries: What are the risks to consumers and insurance markets? *Issue brief (Commonwealth Fund)*. 2018;2018:1-12. <https://www.ncbi.nlm.nih.gov/pubmed/30091863>.

55 Alliance of Health Care Sharing Ministries. (2020, June 5). *About Us*. <http://ahcsm.org/about-us/>.

enrollment through brokers.⁵⁶ But enrollment is likely to continue growing. Brokers report that HCSMs pay higher commissions than insurers offering ACA plans.⁵⁷ In addition, pending federal action may lead to greater enrollment. In June 2020, the Internal Revenue Service (IRS) released a proposed rule that would give members' monthly fees for HCSMs the same tax advantages as health insurance premiums, allowing them to be deducted from personal income taxes or reimbursed under a Health Reimbursement Arrangement. If finalized, the rule would drive more aggressive marketing, invite fraud, and exacerbate consumer confusion about a coverage option that already looks a lot like insurance but without the guarantees or consumer protections of the ACA. This proposed rule has fueled concern among some states that HCSMs need further regulation and oversight, and that the lines between insurance and HCSMs are becoming increasingly blurred.^{58,59}

RECOMMENDED POLICY ACTIONS:

- **Include Health Care Sharing Ministries in the Federal Definition of "Insurance":** Congress should revise the federal definition of insurance to curtail the inappropriate sale, marketing, and development of insurance-like-products that jeopardize patient health and safety. While this should include HCSMs, it should also capture any products that are marketed to consumers as—or resembling—health insurance, such as farm bureau plans, and some limited-indemnity plans.
- **Revoke IRS Proposed Rule:** The June 2020 proposed IRS rule, which would allow HCSM premiums to be paid for with pre-taxed dollars, should be withdrawn.
- **Increase Transparency and Data Reporting:** HCSMs should be required to disclose plan data, marketing practices, broker incentives, enrollment information and complaint information to state and federal regulators. Specifically, state regulators must have information on HCSMs marketing in their states in order to evaluate whether their operations constitute the business of insurance, to watch for deceptive marketing and to monitor enrollment.

56 Volk, J., Giovannelli, J., & Goe, C. (2020, February). *States Take Action on Health Care Sharing Ministries, But More Could Be Done to Protect Consumers*. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2020/states-take-action-health-care-sharing-ministries-more-could-be-done-protect-consumers>

57 Corlette, S., Urban Institute, Wengle, E., & Hoppe, O. (2020, June 29). *Perspectives from Brokers*. Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/research/2020/04/perspectives-from-brokers-the-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks.html>

58 Alliance of Health Care Sharing Ministries. (2020b, August 25). *IRS Rule Comments Expose Anti-Christian and Anti-Freedom Attacks*. <http://ahcsm.org/irsrule/>

59 Abelson, R. (2020, January 2). It Looks Like Health Insurance, but It's Not. 'Just Trust God,' Buyers Are Told. *The New York Times*. <https://www.nytimes.com/2020/01/02/health/christian-health-care-insurance.html>

- **Prohibit Sales Through Brokers:** State and federal legislators should pass legislation prohibiting brokers from selling HCSMs and other insurance-like products. Using brokers to enroll members contributes to consumer confusion and increases enrollment in inadequate coverage.

Farm Bureau Plans

WHAT ARE FARM BUREAU PLANS?

Whether federal health insurance standards apply to a particular coverage arrangement depends in significant part on whether the arrangement is defined as insurance, and regulated as such, under state law.⁶⁰ As a result, the default approach of most states is to define insurance broadly. However, certain arrangements have been deliberately excluded from the definition of insurance and therefore may operate outside of both federal and state insurance regulation.

As of March 2021, five states—Indiana, Iowa, Kansas, South Dakota and Tennessee—allow the Farm Bureau, a member-based organization representing farmers and their families, to sell to its members health benefit plans that have been carved out from the definition of insurance and exempted from the states' insurance code. As a consequence of this deliberate exclusion, the Farm Bureau plans in these states are also exempt from all federal standards governing health coverage—meaning that they are effectively unregulated.⁶¹ Such plans may (and do) utilize extensive medical underwriting⁶², deny enrollment based on an individual's health status, impose waiting periods and refuse to provide coverage for pre-existing conditions. They are not required to provide EHB, may charge higher premiums based on whatever factors they wish and may impose annual and lifetime limits on benefits, practices now outlawed by the ACA.

60 Federal health insurance standards apply to "issuer[s]," a term defined in part as any entity "which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance." 42 U.S.C. § 300gg-91.

61 More specifically, the plans are not "health insurance coverage" offered by an "issuer" for purposes of the ACA and other federal law standards governing individual market insurance. Nor are they "group health plans" subject to ERISA, since the benefits are offered to individuals outside the context of employment.

62 Iowa Farm Bureau. (n.d.). *Iowa Farm Bureau Pre-Enrollment Check List*. Iowa Farm Bureau Health Plans. Retrieved March 11, 2021, from https://www.iowafbhealthplan.com/page/file?path=Files%2Fwebsite%2FFiles%2FPreEnrollmentChecklist_9.15.20_FINAL.pdf

FARM BUREAU PLANS HARM PATIENTS AND CONSUMERS

As with the other under- and unregulated arrangements discussed in this report, enrollees in Farm Bureau plans risk financial hardship and difficulties accessing needed care. Unregulated Farm Bureau plans are extensively underwritten, require prospective enrollees to pass a thorough medical screening and exclude coverage for benefits and services relating to pre-existing conditions. For those healthy enough to make it through this process and enroll, their covered benefits usually will not include mental health and substance use disorder services.

Farm Bureau plans purport to provide coverage for working people and families, including those working in the agricultural sectors. However, the coverage they offer may freely exclude services or deny enrollment to their key constituencies. In a survey conducted by the U.S. Department of Agriculture (USDA) published in 2017, two out of three farmers and ranchers reported having at least one pre-existing health condition and 73% reported that health insurance was “important” or “very important” due to the high-risk nature of their occupation.⁶³ An additional 45% of farmers and ranchers are concerned that they will need to sell some or all of their farm or ranching assets to address health-related costs at some time in their life.⁶⁴ Farming and ranching are physically demanding professions where the risk of injury is high. Expanding the availability of plans that do not offer comprehensive coverage and fail to adequately protect enrollees from financial harm doesn’t mitigate the risks faced by farmers, ranchers and their families—it exacerbates them.

In addition, unregulated Farm Bureau plans harm the regulated individual market by siphoning away healthy enrollees who are able to pass medical underwriting. This phenomenon negatively impacts people who depend on the ACA-compliant market, including those who, because of their health status, would be denied access to Farm Bureau coverage. Tennessee, which created a regulatory carve out for Farm Bureau plans, allowed the Farm Bureau to continue selling underwritten health insurance policies even after the passage of the ACA. Not only did this raise premiums for people who relied upon the comprehensive coverage offered on the marketplaces, it harmed private competition on the marketplaces, dissuading insurers that sold ACA-compliant plans to leave the state.⁶⁵

63 Health Insurance, Rural Economic Development and Agriculture (HIREDnAg). (2017, July). *Health Insurance is Key to Farm & Ranch Economic Viability: 2017 National Farmer and Rancher Survey Findings*. HIREDnAg. http://docs.wixstatic.com/ugd/85136a_2cc79e77a6ab471688a5b76bf9ec1c04.pdf

64 *Ibid.*

65 Lucia, K., & Corlette, S. (2017, June 16). *What's Going on in Tennessee? One Possible Reason for Its Affordable Care Act Challenges*. Georgetown University's Center on Health Insurance Reforms. <http://chirblog.org/whats-going-tennessee-one-possible-reason-affordable-care-act-challenges/>

FARM BUREAU HEALTH PLAN

DISCLOSURE OF ANY MEDICAL CONDITION

Each application will require disclosure of any conditions for which you have been diagnosed, been treated or recommended treatment. Categories of conditions include the following:

<input type="checkbox"/> Ear, nose or throat	<input type="checkbox"/> Brain or nervous system
<input type="checkbox"/> Lung or respiratory	<input type="checkbox"/> Bone or skeletal
<input type="checkbox"/> Diabetes/growth/hormonal	<input type="checkbox"/> Autoimmune
<input type="checkbox"/> Liver or pancreas	<input type="checkbox"/> Reproductive
<input type="checkbox"/> Urinary system	<input type="checkbox"/> Mental
<input type="checkbox"/> Digestive or stomach	<input type="checkbox"/> Muscle/tissue
<input type="checkbox"/> Blood artery	<input type="checkbox"/> Transplants
<input type="checkbox"/> Heart or coronary	<input type="checkbox"/> Drug/alcohol

If you answer yes to any condition, you will need to provide additional information, such as:

<input type="checkbox"/> Condition beginning date	<input type="checkbox"/> Doctor's name
<input type="checkbox"/> Duration	<input type="checkbox"/> Medications for the condition
<input type="checkbox"/> Present state of condition	<input type="checkbox"/> Detailed explanation of treatments and tests
<input type="checkbox"/> Date of recovery	<input type="checkbox"/> Surgery

For certain conditions, you will be asked for specific additional detail. For example if you have elevated blood pressure, you will be asked to provide your most recent BP readings. If you have diabetes, you will be asked to provide your most recent blood sugar readings.

☐ **SIGNATURES AND ATTESTATIONS**

Once you have completed the demographic information and have responded to the health questions for each individual on the application, your agent will need all applicants 18 years of age or older to electronically sign and attest to the following:

- ☐ Accuracy of answers to health questions.
- ☐ Accuracy of answers to health questions for any dependent minors under the age of 18.
- ☐ After receiving the attestation email, review and electronically sign accuracy of application.³ This will expire after 15 days. The application will not be reviewed until it has been signed and returned, possibly impacting your effective date of coverage.

☐ **UNDERWRITING REVIEW**

Once you submit your final signature via email, the application will be sent for underwriting review. The following process will occur:

- ☐ Farm Bureau Health Plan will review your application for eligibility and disclosed health conditions.
- ☐ Farm Bureau Health Plan may call you directly with any questions.
- ☐ Farm Bureau Health Plan may request medical records. If asked for medical records, respond within the requested timeframe to avoid a delay in the application process.
- ☐ Once the decision is made, you and your agent will be notified of underwriting approval or denial.
- ☐ Following underwriting approval or denial, meet with your agent to review your options.
- ☐ If you are approved, meet with your agent to enroll in your preferred plan.

*If you notice that there is a discrepancy, you will be able to decline and go back into the questions to update information. Return to your agent for them to resubmit on your behalf.

FARM BUREAU PLANS ARE EXPANDING

While Tennessee has long exempted its Farm Bureau's health plans from regulation, Indiana, Iowa, South Dakota and Kansas did so only recently. By creating alternatives to ACA-compliant coverage, these states are undermining their own ACA insurance markets and increasing premiums for patients and consumers who rely on ACA-compliant coverage. There is currently no federal legal impediment to this deregulation strategy and other agricultural states, particularly those in which Farm Bureau wields particular political clout.

RECOMMENDED POLICY ACTIONS

— Include Farm Bureau Plans in the Definition of Insurance:

Farm Bureau plans are deliberately attempting to circumvent state and federal regulation by seeking exemptions from state legislatures while selling health insurance coverage that incorporates pre-ACA discriminatory practices that are now against the law. Congress should modify the definitions of “issuer” and “health insurance coverage” to ensure that federal standards apply to all forms of medical benefits.

— States Should Maintain Regulatory Control:

States where these plans exist should repeal the laws carving them out of regulation. States should maintain (or reestablish) regulatory authority over health coverage offered by the Farm Bureau and should not exempt such coverage from the state insurance code.

66 Iowa Farm Bureau, Enrollment Check List. https://www.iowafbhealthplan.com/page/file?path=Files%2Fwebsite%2FFiles%2FPreEnrollmentChecklist_9.15.20_FINAL.pdf

Grandfathered Plans

WHAT ARE GRANDFATHERED PLANS?

Grandfathered plans are health insurance plans that were on the market before March 23, 2010. These plans do not have to provide the same level of coverage or have all the patient protections required by the ACA. Grandfathered plans can be either individual or group plans. Individual market grandfathered plans have not been able to enroll new members since March 23, 2010. In contrast, grandfathered group plans offered by employers can continue to enroll new members (employees and dependents), provided certain conditions are met.

WHAT RISKS DO GRANDFATHERED PLANS POSE FOR PATIENTS?

Grandfathered plans pose significant risk to the patients we represent because, by definition, these plans offer coverage that does not include key patient protections. Unlike ACA-compliant plans are required to do, grandfathered coverage is not required to adhere to annual limitations on cost-sharing and can impose cost-sharing for preventive services, including charging co-pays, co-insurance and deductibles. Grandfathered plans may also exclude coverage for patients who are eligible to participate in clinical trials. And unlike small-group health plans that are fully compliant with the ACA's consumer protections, grandfathered small-group plans are not required to provide coverage of EHBs.

This risk of consumers being confused about what they can expect from their coverage is perhaps more acute now than it was prior to the ACA. Because new employees and their beneficiaries may enroll in grandfathered group coverage, consumers who previously were insured by a non-grandfathered plan—and who may have grown to expect that the ACA's protections apply as a matter of course—may start a new job only to find themselves enrolled in coverage that does not cover EHB and requires significant cost-sharing for preventive services.

GRANDFATHERED PLANS STILL COVER MANY PATIENTS

While the prevalence of grandfathered plans has decreased since 2010, there is still a significant portion of individuals and families with employer-sponsored coverage who have grandfathered plans. A 2019 report from the Kaiser Family Foundation found that 22% of firms that provide health insurance offer at least one grandfathered plan and 13% of employees in employer-sponsored coverage across the country are in these plans.⁶⁷ In January of 2021, the Trump administration issued a final rule that will allow more plans to retain their grandfathered status while increasing cost-sharing and making other changes that harm people with chronic conditions.

67 2019 Employer Health Benefits Survey—Section 13: Grandfathered Health Plans. (2020, September 14). KFF. <https://www.kff.org/report-section/ehbs-2019-section-13-grandfathered-health-plans/>

RECOMMENDED POLICY ACTIONS

- **Rescind the Grandfathered Plan Rule:** The Departments of HHS, Labor and Treasury should withdraw the rule on grandfathered group health plans finalized in January 2021, which weakens existing regulations and further degrades patient protections. Any future changes to the rules impacting health plans with grandfathered plans should encourage those plans to come into compliance with the ACA.

Coverage Arrangements Subject to ERISA

Compared to health insurance for individuals and small employers, health coverage for large groups is subject to fewer ACA standards (for example, it is exempt from the requirement to provide EHBs and the ACA's premium rating protections)⁶⁸. These types of coverage typically receive less regulatory oversight and exist in a separate risk pool. One way that purveyors of substandard coverage products have historically attempted to evade the core protections of the ACA is by facilitating the purchase of less regulated large group coverage by entities that are not, in fact, large groups. They do this by exploiting loopholes in the Employee Retirement Income Security Act (ERISA). In short, they promote business arrangements that allow individuals and small businesses to be re-categorized, under ERISA, not as individuals and small businesses buying coverage in the individual and small group markets, but rather as large employers buying large group coverage. While there are many types of plans that fall into this category, some plans subject to ERISA regulation have been used both historically and in recent years to skirt important patient and consumer protections.

MEWAs and AHPs

WHAT ARE MEWAs AND AHPs?

ERISA allows employers to work together to form a multiple employer welfare arrangement (MEWA) for the purpose of providing certain benefits to their employees. An association health plan (AHP)—a health benefit plan sponsored by an employer-based association—is one type of MEWA.

Prior to 2018, forming an AHP usually would not affect how an employer's health coverage was regulated. Usually, federal law would apply a regulatory standard known as the "look through" doctrine. For the purposes of regulation, the Department of Labor (DOL) would "look through" the association and treat each employer member of the association as a separate employer. Accordingly, the health coverage each employer made available to its

68 Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review. 78 F.R 13405 (2013).

employees would be regulated based on each employer's size, as if the association did not exist.⁶⁹ For example, if two small employers formed an AHP, their health coverage still would be treated as small group health insurance and would be subject to all of the ACA insurance standards applicable to the small group market.

In "rare instances," the analysis would be different.⁷⁰ If the businesses that formed the AHP were so bound together that the association itself operated as a single employer (by satisfying a federal legal test, "Pathway 1"), federal law would treat the group as one employer. The health coverage made available by the "single employer" association would be regulated based on its collective size. Typically, it would be sizable enough to constitute a large employer for purposes of federal law. Consequently, its health coverage would be subject to the less rigorous insurance standards of the large group market.

In 2018, the Trump administration issued a regulation that created a second, weaker test (known as "Pathway 2") for determining whether members of an association constitute a single employer.⁷¹ The new rule makes it easier for small businesses to form an AHP that qualifies as a single large employer under ERISA—allowing them to more easily circumvent the patient and consumer protections that apply to the small group market. In addition, the rule also allowed sole proprietors to be classified as "small employers," enabling these individuals to join an employer-based association and obtain large group AHP coverage (and therefore circumvent the more stringent consumer protections applicable to the coverage they would have otherwise purchased in the individual market).

MEWAS AND AHPs UNDERMINE KEY PATIENT PROTECTIONS AND HARM CONSUMERS

AHPs pose risks to enrollees. The track record of AHPs and MEWAs in reliably providing comprehensive coverage for consumers is quite poor. These entities have a long history of fraud and other dubious practices and, according to state insurance regulators, "have been notoriously prone to insolvencies."⁷² AHPs are not required to cover services included in the EHB package, may charge higher premiums based on occupation (a loophole that allows discrimination based on gender and other factors

as well⁷³), and in the case of "Pathway 1" AHPs,⁷⁴ health status. As a result, these plans expose enrollees to the financial and health risks inherent in substandard coverage. Meanwhile, the marketing of these products can be confusing or misleading and can cause individuals to enroll in plans that do not align with their medical needs or expectations.

AHPs pose risks to the many consumers who do not enroll in them, too. By leveraging the regulatory advantages they enjoy, compared to ACA-compliant individual and small group coverage, AHPs can siphon away healthy individuals from those markets. This leaves the individual and small group markets smaller and with a larger proportion of individuals with pre-existing conditions than they would be otherwise, which leads to higher premiums and fewer plan choices for the people who depend on those markets to access comprehensive coverage.

AHPs CONTINUE TO ENDANGER PATIENTS AND CONSUMERS

Though the key provisions of the 2018 Trump Administration AHP rule were blocked by a federal court, the litigation is ongoing and the rule could be reinstated.⁷⁵ States have broad authority to regulate MEWAs and AHPs. In response to the rulemaking, some states have established or recommitted to regulatory approaches for AHPs that are designed to limit the harms they pose. However, other states have signaled an openness to AHPs as an alternative to the ACA and have adopted policies intended to facilitate enrollment in Pathway 2 AHPs in the event the Trump Administration rule is restored.

RECOMMENDED POLICY ACTIONS

- **Rescind the 2018 AHP Rule:** The administration should move immediately to rescind the 2018 AHP rule. The rule, which was blocked in substantial part by a federal court, is unlawful, endangers consumers and undermines the functioning of the ACA-compliant individual and small group markets.

69 CMS. (2011, September). *Insurance Standards Bulletin Series: Application of Individual and Group Market Requirements under Title XXVII of the Public Health Service Act when Insurance Coverage Is Sold to, or through, Associations*. https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf

70 *Ibid.*

71 Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans. 83 F.R. 28912 (2018).

72 National Association of Insurance Commissioners. (2018, March 6). *NAIC Letter to Employee Benefits Security Administration, U.S. Department of Labor Definition of Employer—Small Business Health Plans RIN 1210-AB85*. NAIC. https://www.naic.org/documents/index_health_reform_section_180306_comments_assoc_plan_nprm.pdf

73 Patient Groups Comments on RIN 1210-AB85; Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans (2018, August 22). <https://www.heart.org/-/media/files/get-involved/advocacy/regulatory-comments-and-correspondence-letters/access/030618-coalition-ahp-comments-final.pdf>

74 Importantly, AHPs formed under the old, much more stringent "Pathway 1" test are permitted to charge higher premiums based on a wide range of factors including health status. The "Pathway 2" AHPs authorized by the Trump administration may also impose higher rates based on factors such as age, gender, occupation, and group size (all of which are prohibited or, in the case of age, limited, in the ACA-compliant individual and small group markets), but may not take account of the health status of individual members.

75 *State of New York, et al. v. U.S. Department of Labor*. (March 28, 2019). U.S. District Court for the District of Columbia. [Case 1:18-cv-01747-JDB](https://www.courtlistener.com/docket/11111111/state-of-new-york-et-al-v-us-department-of-labor/).

- **Prohibit Sole Proprietors From Enrolling:** DOL should not allow sole proprietors to enroll as a “small group.” Sole proprietors must use the ACA-compliant individual market to obtain coverage and cannot qualify as a small employer in order to join an employer-based AHP.
- **Strengthen Licensing Requirements:** Federal and state regulators should require self-funded AHPs to satisfy the same licensure and financial standards required of commercial insurers.
- **Ensure Sufficient Oversight of AHPs and MEWAs:** States and the federal government should commit sufficient resources to ensure robust federal oversight of these entities and improved coordination with state regulators.
- **Codifying the “Look Through” Doctrine:** CMS should codify the “look-through” doctrine⁷⁶ in regulation. The doctrine holds that, except in “rare instances,” regulators must “look through” an association (effectively disregard it) and regulate the health coverage that the association issues based on the type of entity that actually receives it. For example, an individual who buys coverage through an association must receive a plan that complies with federal laws applicable to the individual health insurance market, and a small employer must receive coverage that complies with federal small group market rules.
- **Clarifying the Term “Issuer”:** CMS should clarify through guidance or regulation that a self-funded MEWA that is regulated by a state is an “issuer” for purposes of federal law and, therefore, subject to federal insurance requirements applicable to issuers.⁷⁷ This would mean clarifying “issuer” to ensure that it is sufficiently broad to include entities that (1) must obtain state authorization to engage in what is the business of insurance and (2) are subject to at least some state insurance law standards.
- **Revise the Federal Definition of “Insurance”:** Congress should revise the federal definition of insurance to curtail the inappropriate sale, marketing and development of insurance-like-products that jeopardize patient health and safety. This should capture any products that are marketed to consumers as—or resembling—health insurance.

76 Please see https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf for most recent interpretation of the “look through” doctrine.

77 This means clarifying “issuer” to ensure that it is sufficiently broad to include entities that (1) must obtain state authorization to engage in what is the business of insurance; and (2) are subject to at least some state insurance law standards.

Spurious “Single-Employer Self-insured Group Health Plans” (Data Marketing Partnership Scheme)

WHAT ARE SPURIOUS SINGLE-EMPLOYER SELF-INSURED GROUP HEALTH PLANS LIKE DATA MARKETING PARTNERSHIPS?

ERISA exempts single-employer self-insured employee benefit plans from state insurance regulation. Notably, this is different from how ERISA treats MEWAs, which states have the ability to fully regulate. However, single-employer self-insured group health plans do share something in common with MEWAs: they are not bound by some of the ACA’s core consumer protections (including, for example, the EHB requirement and premium rating rules) that apply only to individual and small group market coverage.

There has been a long history of attempts to avoid state insurance regulation by exploiting the ERISA exemption, to the detriment of consumers. A full inventory of these efforts exceeds the scope of this report. However, a recent scheme for obtaining the exemption, which has won backing from some state officials and one federal court, merits particular attention.⁷⁸ The scheme, advanced by an entity known as Data Marketing Partnership (DMP) and its affiliates, allows members of the general public to become “limited partners” in a partnership by downloading tracking software that allows the partnership to collect and sell their data to third parties. According to the promoters of the arrangement, the individuals who download the software qualify as “working owners” of the partnership and are therefore eligible to buy health coverage through the arrangement. In other words, individuals and small businesses can avoid the individual and small group markets and purchase a less regulated product simply by downloading tracking software.

SPURIOUS SINGLE-EMPLOYER ERISA PLANS HARM PATIENTS AND CONSUMERS

The harms posed by spurious single-employer ERISA plans such as DMPs are similar to those posed by AHPs. Enrollees face the risk of what one former DOL regulator described as a “wave of fraudulent payers organized as Ponzi schemes leaving unpaid claims.”⁷⁹ They also must contend with confusing and potentially misleading marketing and the financial and health risks of relying on a subpar coverage product. Meanwhile, the ACA-compliant individual and small group markets, and the consumers who depend on them, face the prospect of higher premiums and fewer plan choices.

78 *Data Marketing Partnership LP v United States Department of Labor*. U.S. District Court of Northern Texas Fort Worth Division. Case 4:19-cv-00800-O

79 Wheeler, L., & Glovin, D. (2020, September 30). *Health Plans Undercutting Obamacare Get Boost From Texas Ruling*. Bloomberg. <https://www.bloomberg.com/news/articles/2020-09-30/health-plans-undercutting-obamacare-get-boost-from-texas-ruling>

In addition—unlike MEWAs and AHPs—single-employer ERISA plans are exempt from state regulation and oversight. Though they are within the purview of the DOL, the agency has often had difficulty maintaining robust oversight. Consequently, the danger that these entities may engage in potentially illegal and abusive practices, and persist unchecked, is perhaps even greater than with AHPs.

In an advisory opinion issued in January 2020, the DOL concluded that the DMP arrangement would *not* qualify for the ERISA exemption and that DMP was engaged in an effort to avoid regulation of commercial insurance. However, in September 2020, a federal judge in the Northern District of Texas overruled the DOL and issued a ruling in favor of the arrangement. The case is now on appeal. In the meantime, about 50,000 people across the country have reportedly signed up for the DMP scheme, and, with the federal court ruling as a cover, it is possible this and similar arrangements may be aggressively marketed going forward.

RECOMMENDED POLICY ACTIONS

— Investigate Spurious Single-Employer ERISA Plans

Arrangements: State and federal regulators, as well as Congress, should thoroughly investigate these arrangements. The Texas court ruling is not binding on states and does not limit the authority of state regulators to investigate potential violations of state law by entities doing insurance business within the state.

— Vigorously Defend the DOL's Position in the DMP

Lawsuit: DOL's advisory opinion determining that DMP would not qualify for the ERISA exemption was correct. The Administration should continue to seek the reversal of a lower court decision holding otherwise. If necessary, DOL should codify this ruling by issuing a regulation clarifying that arrangements such as those developed by DMP do not qualify for the ERISA exemption.

— Ensure Sufficient Oversight of ERISA Plans:

Federal regulators should commit resources to ensure robust federal oversight of these entities and improved coordination with state regulators.

Minimum Essential Coverage-Only Plans

WHAT ARE MINIMUM ESSENTIAL COVERAGE-ONLY PLANS?

Large-group health plans (50 or more employees in most states) are not subject to the requirement to cover EHBs, giving large employers the flexibility to exclude key categories of coverage that would be considered EHBs. Instead, to comply with the ACA and be considered minimum essential coverage (MEC), large group health plans, whether insured or self-insured, have to meet minimal requirements for benefits and cost-sharing: they must cover preventive services without cost-sharing, cap out-of-pocket costs and not impose annual or lifetime dollar limits on benefits that would

be considered EHBs. The result is that large employers can offer "MEC-only" plans that provide inadequate coverage and can leave employees uninsured for key services that would be considered "essential" for small employer plans.

HOW DO MEC-ONLY PLANS HARM CONSUMERS?

The loopholes that allow for MEC-only plans can trap employees in plans with limited coverage and bar them from qualifying for premium tax credits to buy an ACA plan with comprehensive coverage, so long as the plan meets "minimum value" or an actuarial value (AV) of 60%. The Treasury Department updated the guidance for meeting minimum value when it was found that employers were offering plans that omitted coverage for hospital and physician services.⁸⁰ The Treasury guidance noted these services are "fundamental benefits that are nearly universally covered, and historically have been considered integral to coverage."⁸¹ However, the guidance stops short of requiring employer plans to include coverage of any other categories of care that would be considered an EHB. As a result, even a "skinny plan" that provides only limited coverage can bar an employee from accessing more affordable coverage with financial help.

MEC-ONLY PLANS RE-EXPANDING

Short of a change in the statutory requirements that apply to large employer plans, employers can continue to offer MEC-only skinny plans and meet their obligations under the ACA. Even with the updated Treasury guidance on minimum value, some employer benefit firms continue to offer products claiming to be MEC that fail to cover more than preventive services.⁸² The economic downturn and high unemployment brought about by COVID may mean more employers are more likely to slim down the benefits they offer to meet their ACA obligations.

RECOMMENDED POLICY ACTIONS

— Monitor and Collect Data on Large Employer Plans:

DOL should conduct a study of large employer plans on a routine basis. These reports would help increase understanding of the employer-sponsored insurance market and may reveal existing or emerging gaps in coverage that would be considered essential services.

— Require Employer Plans to Cover EHB and Adhere to EHB Standards:

Congress should extend the EHB requirement and at least a modified AV standard to large group plans, both fully insured and self-insured.

80 Woodman, S. (2015, December 28). *How Large Companies Are Exploiting a Loophole in Obamacare*. The New Republic. <https://newrepublic.com/article/126575/large-companies-exploiting-loophole-obamacare>

81 Internal Revenue Service. (n.d.). *Notice 2014-69: Group Health Plans that Fail to Cover In-Patient Hospitalization Services*. IRS. Retrieved March 11, 2021, from <https://www.irs.gov/pub/irs-drop/n-14-69.pdf>

82 Linke Young, C. (2020, July). *Taking a broader view of "junk insurance."* Brookings. <https://www.brookings.edu/research/taking-a-broader-view-of-junk-insurance/>

Excepted Benefit Plans

WHAT ARE EXCEPTED BENEFITS?

Excepted benefits are a category of coverage that is exempt from the ACA and most other federal and state standards that apply to health insurance. The coverage can take many different forms, including disease policies like cancer-only plans, dental plans, and perhaps most notably, fixed indemnity plans. Fixed indemnity plans differ from traditional insurance in that they pay a fixed amount for covered services based on a period of time or procedure (for example, \$100 per day of a hospital stay or \$1,000 for a surgical procedure). They are designed to supplement a traditional insurance plan, covering costs not covered by the plan, but in recent years they have been marketed and sold as stand-alone replacements for traditional health insurance. Employers may also offer them to employees as a supplemental plan, though to comply with the ACA's employer mandate, an employer would have to also offer a plan that meet MEC requirements.

WHAT ARE THE PROBLEMS CAUSED BY FIXED INDEMNITY PLANS?

Because they do not have to comply with the ACA or other insurance standards, fixed indemnity plans sold as stand-alone coverage leave enrollees at risk of incurring catastrophic costs for their care. Insurers and brokers employ many of the same deceptive and aggressive marketing tactics used to sell STLDI plans.^{83,84} The same sites that sell STLDI may offer fixed indemnity plans bundled together with other types of coverage, including HCSMs and products like drug discount cards.⁸⁵ And, like other under and un-regulated products, they pull healthier individuals from ACA plans.

83 Linke Young, C., & Hannick, K. (2020b, October 7). *Fixed indemnity health coverage is a problematic form of "junk insurance."* Brookings. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance/>

84 Gantz, S. (2019, May 26). *Pa. woman was convinced she bought Obamacare insurance. She got scammed by a look-alike website.* The Philadelphia Inquirer. <https://www.inquirer.com/health/consumer/google-short-term-health-plans-20190522.html>

85 Corlette, S., Lucia, K., Palanker, D., & Hoppe, O. (2019, January). *The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses.* Urban Institute. https://www.urban.org/sites/default/files/publication/99708/monistldi_final_0.pdf

Ali Middlesworth (Fenton, MO)



In 2019, Ali and Elijah made the exciting decision to begin planning to grow their family. Since neither she nor her husband had access to employer-sponsored coverage, and her existing health coverage provided no coverage for prenatal care, Ali knew she needed a plan that would protect her throughout

her pregnancy. In her search for an affordable, comprehensive Marketplace insurance plan through the Affordable Care Act, she inadvertently connected on the phone with someone selling non-compliant plans. Ali was upfront about her prenatal care needs and was assured by the sales agent that a health care sharing ministry plan was the best option for her. Unfortunately looks can be deceiving. Despite the paperwork she signed and the card she received in the mail resembling insurance; she knows now that what she purchased was not really insurance at all. What should have been a time of celebration for the couple turned into a financial nightmare.

During the early stages of her pregnancy, Ali's routine appointments were covered, offering no hint of the financial challenges to come. Unfortunately, as the weeks past, Ali was diagnosed with preeclampsia, a dangerous pregnancy complication marked by high blood pressure, and she had to visit a pre-natal specialist several times a week. Unexpectedly in her last six weeks of pregnancy, her condition became much more severe, and Ali was admitted to the hospital. Within days, her son Declan was born. Because he was premature, he required an extended hospital stay and follow-up with

specialists. Ali also needed extra attention and time at the hospital until she was stable enough for discharge. As their recovery time increased, so did the amount the couple would be forced to pay out-of-pocket for Ali and their new baby's health care.

While Ali and Elijah should have been enjoying time as a new family of three with their son Declan and celebrating their health, the family began receiving worrisome bills for thousands of dollars. The family's total bills for the premature birth, hospital stay, and doctor visits for Ali and her son totaled more than \$250,000. And the coverage Ali had purchased refused to pay these costs. It quickly became clear the plan she had purchased wasn't really insurance at all and wasn't required to provide the minimum essential benefits that patients should be able to rely on when they're needed the most.

The total she owed was reduced to \$58,000, but this was still too much for the young couple to afford. They continue to appeal and hope to find a way to pay for these medical bills, which have now been sent to collections. Ali and Elijah never imagined they would begin their life together as a new family in financial distress.

In January 2020, Ali signed up for a new health insurance plan that would provide adequate coverage for Declan, who would need additional follow-up care. This time, the family purchased an ACA Qualified Health Plan (QHP) from the marketplace. She said the difference has been night and day—and she can rest assured she has a plan that will protect her new family.

Ali has become a passionate advocate, sharing her story about the importance of comprehensive health insurance, to protect others from experiencing the financial and emotional toll this has had on her and her husband.

When offered by employers as coverage intended to supplement a group health plan, there is also the risk that employees enroll only in the fixed indemnity plan, providing virtually no protection against catastrophic costs. In cases where an employer's coverage strategy is to use a fixed indemnity plan to help cover the substantial costs of a MEC-only plan, consumers may wind up paying two premiums and still be well short of adequate coverage and financial protection.⁸⁶

FIXED INDEMNITY PRODUCTS MARKETING AS STAND-ALONE PRODUCTS RE-EXPANDING

There is no comprehensive data on enrollment in fixed indemnity plans, but where states have taken steps to curb enrollment in STLDI plans, there is a risk that more aggressive marketing of fixed indemnity plans may fill the gap to attract healthy consumers looking for lower cost coverage options. A court ruling barred an Obama administration rule that would require fixed indemnity insurers to confirm an individual has a MEC plan prior to selling them a fixed indemnity plan, so there is no current federal limitation on selling the products to people who have comprehensive coverage.⁸⁷ And, like other non-ACA products, fixed indemnity plans pay higher commissions to brokers than ACA plans do, providing a financial incentive for brokers to prioritize the non-ACA products over ACA plans.⁸⁸

RECOMMENDED POLICY ACTIONS

— Require Strong Disclosures of Limited Benefits:

The administration and Congress should require plans to include disclosures that clearly define the limits of coverage and disadvantages of these plans, whether bought alone or in coordination with other coverage. Brokers should be required to first screen applicants for eligibility for financial assistance to buy an ACA plan or to enroll in Medicaid.

— Require Issuers Selling Excepted Benefits to Confirm Enrollee is Covered by Comprehensive Coverage:

At the federal level, Congress should provide clear authority to the administration to issue regulations like those struck down in the 2016 ruling in *Central United Life v. Burwell*. Additionally, states can implement legislation or regulation that require issuers to confirm that enrollees are covered by comprehensive coverage prior to enrolling in an excepted benefit plan.

— Prohibit the Sale of Excepted Benefits that Mimic Fully Regulated Insurance Coverage:

Congress should amend federal law governing excepted benefits to clarify that excepted benefits are exempt from regulation only to the extent such benefits do not duplicate, supplant or mimic the benefits provided by fully regulated coverage.

86 Linke Young, C., & Hannick, K. (2020b, October 7). *Fixed indemnity health coverage is a problematic form of "junk insurance."* Brookings. <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance/>

87 Jost, T. (2016, July 3). *Appeals Panels Affirm Injunction Against Fixed Indemnity Regulation, Turn Back Challenge To "Administrative Fix."* Health Affairs Blog. <https://www.healthaffairs.org/do/10.1377/hblog20160703.055703/full/>

88 Corlette, S., Urban Institute, Wengle, E., & Hoppe, O. (2020, June 29). *Perspectives from Brokers.* Robert Wood Johnson Foundation. <https://www.rwjf.org/en/library/research/2020/04/perspectives-from-brokers-the-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks.html>

CONCLUSION



Our organizations appreciate the opportunity to share our priorities for the substandard and non-compliant health insurance markets. Patients, now more than ever, need access to adequate and affordable health insurance coverage, and limiting the sale and availability of the harmful products detailed in this report is just one step toward securing the health and wellbeing of patients across the country. It is imperative that policymakers take steps immediately to pursue the changes we have outlined in this document.

For questions or comments regarding the content of this document, please contact Katie Berge, Director of Federal Government Affairs, at The Leukemia & Lymphoma Society at katie.berge@lls.org.

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