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Taking a Broader View of “Junk Insurance”

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USC-Brookings Schaeffer Initiative for Health Policy

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EDITOR'S NOTE

This white paper is part of the USC-Brookings Schaeffer Initiative for Health Policy, which is a partnership between the Economic Studies Program at Brookings and the USC Schaeffer Center for Health Policy & Economics. The Initiative aims to inform the national health care debate with rigorous, evidence-based analysis leading to practical recommendations using the collaborative strengths of USC and Brookings.

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Executive Summary

The Affordable Care Act, building on decades of prior law, took important steps to establish a comprehensive regulatory structure that sets minimum standards for health care coverage. Despite those achievements, it remains possible for Americans to become enrolled in plans that do not meet the standards articulated in the ACA. This analysis explores these gaps in regulation and describes what can be done to close them.

We define good health care coverage as a plan that reflects three key attributes: it (1) covers a comprehensive array of health care services without regard to individuals' pre-existing conditions, (2) has a benefit design that ensures consumers must bear only a reasonable share of health care costs, and (3) is offered by a financially solvent entity within a stable system for pooling risk. Federal law attempts to achieve these objectives, in partnership with state insurance regulators, by regulating the benefits that employers provide to their employees and the insurance products that carriers sell to individual consumers.

Health plans that don't meet these standards are problematic for two reasons. First, consumers enrolled in such plans can face catastrophic financial risk if they have a significant health care need and may find their insurance of limited value. This is a particularly acute problem in market segments that use "post-claims underwriting" to exclude coverage for pre-existing conditions, since it makes it very difficult for consumers to evaluate coverage before enrolling. Second, non-compliant plans can use their low premiums to "cherry pick" healthy consumers away from broader and more regulated risk pools. This allows healthy individuals to access lower-cost plans (because they need not pool their risk with sicker people) but drives up costs for everyone that remains in the regulated market.


Gaps in the regulation of employer health coverage: There are three major gaps in federal regulation of employer health plans. The broadest and most significant is that while employer plans are subject to many regulatory standards, there is no provision in federal law that requires employer health plans to cover a comprehensive array of benefits. Most employers do provide a fairly comprehensive package in order to attract and retain employees, but even otherwise generous plans often exclude specific services or drugs. Further, the ACA's employer mandate incentivizes employers to offer some form of coverage, even for low wage workers where a comprehensive benefit package is not economically viable, which leads to some employers offering extremely limited benefit packages. Indeed, some employers offer plans that cover *only* the ACA's mandated preventive services, and no other benefits.

Second, federal law defines certain kinds of employer plans as "excepted benefits" and then exempts them from most federal regulation, even when they resemble a traditional plan. In particular, fixed indemnity plans are considered excepted benefits because they pay on a "per time period" basis, rather than paying based on actual medical costs incurred. But modern indemnity policies have developed detailed rubrics for payment, paying specific amounts "per day" an individual receives a particular health care service or "per month" they fill a prescription for a specific class of drugs. This benefit can come to look very much like regular health coverage, despite not being subject to otherwise applicable standards. While systematic data are not available, there is ample anecdotal evidence of employers offering the majority of their health care benefit through an unregulated fixed indemnity policy. A somewhat common approach appears to combine a *very* limited regulated plan (e.g. one covering only preventive services) with an excepted benefit fixed indemnity plan that offers all other benefits subject to various limitations and exclusions. Three other types of excepted benefits policies – accident, critical illness, and (to a lesser extent under current regulations) group supplemental coverage – could also serve the same function as fixed indemnity plans in this arrangement.


Replica plan documents combining a fixed indemnity and traditional benefit

IMPORTANT PLAN INFORMATION: You have two medical plan options. You may enroll in one or both. Additional benefits are available to add if you enroll in the Fixed Indemnity Medical Plan.

Advantages of the Fixed Indemnity Medical Plan

- Covers Day to Day Medical Expenses 
- Satisfies the Individual Mandate
- You may still be eligible to receive a subsidy from the health insurance exchange
- Offers Dental, Vision, Term Life and STD

Advantages of the MEC Wellness/Prevention Plan

- Covers Day to Day Medical Expenses 
- Satisfies the Individual Mandate
- You may still be eligible to receive a subsidy from the health insurance exchange
- Offers Dental, Vision, Term Life and STD

Source: Reddit.

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Finally, gaps in federal law enable small employers to avoid risk-pooling provisions that are generally intended to ensure pooling of risk across all small employers in a state. Small employers can leave the insurance market entirely by choosing to self-insure, and vendors across the country now sell “level-funding” plans that are stylized as a self-insurance arrangement with reinsurance coverage but in fact look very much like insurance. In addition, the federal government has attempted to facilitate small employers buying their coverage through “associations” that exclude them from the small group market, though some of those regulations have been enjoined by a federal court.

Gaps in the regulation of individual coverage: The market for individual coverage also features significant regulatory gaps. Plans that *are* subject to regulation are covered by a comprehensive scheme that satisfies the three criteria for “good” coverage described above; problems emerge from the many ways in which entities can offer coverage outside of that framework. The most familiar problem in the current market is short-term limited-duration plans. A provision in federal law exempts short-term plans from regulation but fails to define the phrase “short-term.” Current regulations take an expansive view, encompassing plans up to three years in duration. These plans can discriminate based on health status, exclude or cap major benefits, and impose very high cost-sharing, leaving consumers surprised by very large bills and pulling healthy enrollees from the regulated market.

Individual market regulation also provides an exemption for excepted benefits, which creates a similar loophole to that seen in employer coverage. New individual market fixed indemnity carriers offer benefit schedules with *thousands* of different payment amounts associated with receipt of specific medical services (with amounts paid directly to providers, just like standard health insurance). Even traditional carriers offer fixed indemnity benefits that pay on a highly detailed rubric, which varies with the severity of the hospitalization or outpatient service and the specific providers involved in care. Excepted benefits for accident and critical illness policies offer the same potential, and there is some evidence of misuse of accident policies. As with short-term plans, these types of excepted benefit policies discriminate against those with pre-existing conditions, leave consumers exposed to very high costs, and erode the regulated market’s risk pool.

Another gap arises because federal regulation of individual market benefits turns on what is considered “health insurance” under state law. A benefit that looks like health insurance and doesn’t fit into either of the regulatory exceptions described above can still be exempt from regulation if it is not considered a health insurance product that must be offered by a health insurance issuer under state law. Some states *deliberately* engineer exceptions from federal regulation in this way, using state law to classify health coverage offered by their state Farm Bureau as “not insurance.” Other exceptions arise more organically. When colleges and universities offer benefits to their students without involving an insurer, i.e. self-insured student health plans, the coverage is not considered insurance

and therefore not regulated under state or federal law. Health-care sharing ministries also offer an unusual benefit structure that can often evade regulation, despite the fact that their benefit looks very much like traditional coverage and is not closely linked to shared religious beliefs or practices. Moreover, the challenges associated with these benefit forms have worsened since the ACA's individual mandate penalty was reduced to \$0. Just as these policies are considered “not insurance” for purposes of federal regulation, many of them were also considered “not insurance” under the mandate, thus deterring some uptake while the mandate remained in force.

So, what can be done? Policymakers can consider federal legislation, state legislative or regulatory action, or federal administrative tools that do not require new statutes.

Comprehensive federal legislation: Federal legislators could close each of the gaps described above. Specifically, comprehensive federal legislation would take six steps:

- Require employer health plans to cover essential health benefits at a minimum actuarial value. This will ensure that all employer health plans indeed offer a comprehensive benefit package.
- Redefine excepted benefits (in both the employer and individual markets) to reflect benefits that truly deserve exemption from federal law. Legislators should reshape the exemption for the types of supplemental coverage most prone to abuse by requiring a truly distinct policy form and by requiring that enrollees have another source of coverage of all EHB. They should also limit excepted benefits to plans that are not intended to duplicate, mimic, or supplant regulated benefits, to deter future attempts to evade regulation.
- End the exclusion of short-term limited-duration insurance from the definition of health insurance coverage. All plans should be subject to the same standards, regardless of contract length.
- Modify the federal definition of health insurance coverage and health insurance issuer to bring “not insurance” within the federal regulatory environment. Legislation could define all non-employer benefits or payments for medical care as insurance that must be offered by an issuer. This would require states to update their own legislation but would preserve full state control over risk bearing entities. Alternatively, federal law could allow “not insurance” to exist outside the state-federal regulatory partnership but nonetheless directly apply federal standards to these plans.
- Limit stop-loss coverage so that an employer arrangement will not be considered self-insurance unless the employer bears significant risk. Existing model legislation from the National Association of Insurance Commissioners could be updated and adapted to federal law.
- Codify provisions in federal regulations and guidance that can limit some forms of abuse, including standards related to association health plans and some limits related to insured student coverage.

This suite of reforms would generally ensure that any benefit that “looked like” health coverage was subject to minimum standards. On its own, while these policies would benefit many, they would also be expected to have negative impacts on some stakeholders, such as increasing costs for some employers, inducing other employers to drop health coverage rather than offer a comprehensive benefit, and increasing premiums for individuals who currently buy unregulated insurance. Other policy tools are available to mitigate those consequences, and indeed, they will be the result of *any* attempt to close gaps in the regulation of health benefits.

Options for states: In the absence of new federal legislation, there are important opportunities for states to take action to protect consumers and strengthen risk pooling:

- Limit the reach of short-term plans, either by prohibiting their sale, prohibiting pre-existing discrimination in short-term plans, or limiting them to just 3 months.
- Reign in problematic excepted benefit policies. States can bar the sale of fixed indemnity, accident, and critical illness policies that look too much like traditional health insurance. They can also impose a requirement that enrollees carry other coverage. And states can attempt to take enforcement action against the pairing of insured fixed indemnity plans with very skinny traditional employer plans as a violation of the prohibition on benefits that are coordinated with an exclusion.
- States should avoid enacting legislation authorizing Farm Bureau plans.
- Limit Health Care Sharing Ministries through legislative and enforcement tools. State laws that exempt HCSMs from regulation as insurance can be tightened or repealed, and states can take enforcement action against fraudulent HCSMs.
- Regulate self-insured student health plans and stop-loss coverage. States can require that colleges and universities offering self-funded benefits meet certain substantive standards, and they can prohibit stop-loss plans with very low attachment points.
- Regulate MEWAs to limit fraud and insolvency in this market segment.
- Oversee agent and broker conduct. States can place limits on the ways that licensed agents and brokers sell non-compliant forms of coverage.

Options for federal regulators: Finally, just as states have options in the absence of new federal legislation, so, too, does the federal government:

- Restrict short-term plans to less than 3 months. It would be straightforward for the federal government to reinstate 2016 regulations adopting this limited definition.
- Narrow the reach of fixed indemnity, critical illness, and accident excepted benefit policies by adopting a more detailed regulatory definition. While some regulatory approaches are foreclosed by a 2016 court decision, other options remain available. Specifically, regulators should require that these policies be structured in ways that distinguish them from health coverage, rather than allowing them to vary payments based on health care services.
- Define “licensed under state law” broadly in determining who is an issuer, limiting states’ ability to deliberately promote unregulated forms of “not insurance.” Specifically, the federal government could construe state *authorization* of Farm Bureau products as a form of state licensure, bringing the plans under the umbrella of existing law.
- Regulate the conduct of brokers subject to federal standards. Tens of thousands of agents and brokers, including major online vendors, receive an annual certification from the federal government or a state-based Marketplace that permits them to sell subsidized coverage through the federal or state Marketplace. These certifications could be limited to those who agree to limitations on the marketing and sale of non-compliant forms of coverage.

Within any given state, these tools have a more limited reach than the full toolbox available to state regulators, but of course would have national scope.

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What does “good health coverage” mean?

This analysis provides a comprehensive review of the gaps in federal regulation for health coverage. It describes the ways in which, despite the achievements of the Affordable Care Act, it remains possible for Americans to become enrolled in sub-standard health plans – and what can be done to close the gaps. But to understand the ways in which “bad” health coverage proliferates, it is useful to start with an overview of what it means to have “good” health coverage. (In this paper, the terms “health benefit,” “health plan,” and “health coverage” are used interchangeably to refer to the general concept of health care coverage, while the terms “insurance” and “group health plan” are reserved for more technically precise contexts, as described below.)

For purposes of this analysis, we view three types of protections as critical to high quality health coverage:

- ***Covers major medical needs:*** It is perhaps somewhat obvious that a good health benefit needs to include coverage for a broad array of health care expenses. If a plan were to exclude cancer care, then a patient diagnosed with cancer would discover that while she “had” health coverage, she was in fact going to have to pay completely out of pocket for her treatment. Therefore, the plan should include all the types of medically necessary care a person may need.

In some markets for health coverage, plans are required to cover a complete array of health services referred to as the “Essential Health Benefits” (EHB) package. The EHB package includes ten major categories of benefits, like hospital care, doctors’ visits, prescription drugs, and emergency room care.¹ In other contexts, plans naturally cover a broad range of benefits even without a legal requirement to do so. However, there are cases where plans offer limited benefits, as we will see below.

It is also essential that plans not discriminate against consumers based on their pre-existing health conditions, so that all benefits under the plan are available to all consumers on the same terms.

- ***Provides meaningful financial protection:*** The plan must provide a meaningful degree of financial protection and not leave individuals exposed to an unreasonable share of health care costs. It is not enough that the plan include cancer care in its covered benefits if the consumer is still responsible for paying, say, 50% of the hundreds of thousands of dollars in costs she incurs in the course of treating cancer.

Two specific kinds of financial protections are especially critical. The plan must not impose a lifetime or annual cap on the amount of care the plan will cover, and conversely, the plan must include a reasonable out-of-pocket limit that caps consumers’ total annual exposure to cost sharing. Together, these two protections ensure that the health benefit transfers financial risk from the individual to the plan. In addition, a plan requirement to meet a minimum actuarial value can further ensure broad financial protection (though an out-of-pocket limit also imposes an actuarial value floor). All three of these requirements appear in parts of federal law, though they do not apply to all health coverage products.

¹ Under current law, EHB does not include adult dental care, adult vision care, or long-term care services. Many have argued that the concept of EHB should be expanded, particularly with respect to dental services. See Jane Koppelman, “Efforts to Expand Access to Oral Health Care to Continue in 2019,” Pew Charitable Trusts, January 15, 2019, <https://www.pewtrusts.org/en/research-and-analysis/articles/2019/01/15/efforts-to-expand-access-to-oral-health-care-to-continue-in-2019>.

Note that there is a separate question of whether the numeric thresholds that cap out-of-pocket spending and establish a minimum actuarial value ensure adequate financial protection, which this piece does not address. Certainly, additional protection may be necessary to ensure truly meaningful coverage,² especially for low-income families, but for purposes of this paper the limits of existing law are used as a floor.

- **System stability:** Health coverage relies on a third-party assuming risk of high health care spending for a pool of people. Consumers cannot rely on their coverage if that entity lacks the financial resources to bear this risk. Further, the way in which risk is pooled is significant. If markets face unmanaged adverse selection or segmentation of high and low risk individuals, consumers’ coverage cannot be offered at reasonable prices and ultimately will not be stable.

Therefore, the regulatory regime governing health benefits needs to ensure that the entity bearing the risk has adequate resources to meet anticipated needs. It must also ensure some reasonable mechanism for risk sharing that is not subject to “cherry-picking.” In some segments of the market this means pooling risk across a very broad market, but, at a minimum, risk must be pooled at a level that ensures a sustainable benefit.

Figure 1 summarizes these protections. Note that these standards are not the only goals of health coverage regulation. Other consumer protections – such as requiring no or low cost-sharing for specific services, the right to appeal decisions made by a health plan, network adequacy standards, or oversight of utilization management practices – are also valuable for consumers. And, of course, the ultimate premium for the coverage is of critical importance. However, the three concepts established above can form a minimum threshold for creating adequate coverage and for defining the product that policymakers want to make available at an affordable price.

| Figure 1: Policies that can ensure good health coverage | |
|---|---|
| Covers health care needs | Coverage of Essential Health Benefits (EHB) |
| | No pre-existing condition discrimination |
| Provides financial protection | Prohibits lifetime and annual limits |
| | Requires out-of-pocket limit |
| | Minimum actuarial value |
| System stability | Solvency protections |
| | Establishes effective risk pooling |

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There are several different reasons to be concerned about consumers becoming enrolled in coverage that fails to comply with these standards. First, the consumer herself can face significant adverse consequences in the form of unexpected or crippling large medical bills. We may be especially concerned when consumers unknowingly take on such risk, believing themselves to have purchased more adequate coverage than they actually have. But there is also reason to be troubled by the existence of these products at all. A large behavioral economics literature has established that consumers are

² See, e.g., Liz Hamel, Cailey Muñana, and Mollyann Brodie, “Kaiser Family Foundation/LA Times Survey Of Adults With Employer-Sponsored Insurance,” *Kaiser Family Foundation*, May 2, 2019, <https://www.kff.org/report-section/kaiser-family-foundation-la-times-survey-of-adults-with-employer-sponsored-insurance-section-2-affordability-of-health-care-and-insurance>.

especially bad at making decisions that involve risk. Consumers struggle with adequately understanding risks, especially for “highly technical products” such as health insurance.³

Further, when plans exclude coverage based on pre-existing conditions, it arguably becomes impossible for consumers to know the nature of their coverage. Whether a health care need arises from a pre-existing condition is something that often cannot be known in advance, and many plans engage in lengthy post-claims underwriting processes to determine the scope of an exclusion only after a consumer has become ill.⁴ A plan can evaluate the value of these exclusions at the level of an entire population, but an individual consumer simply cannot know what coverage they are “giving up” to a general pre-existing condition exclusion. In addition, consumers who are under-insured generate uncompensated care burdens for health care providers when they incur costs not covered by their limited insurance products.

Finally, sub-standard plans can be problematic because they undermine structures for pooling risk. Lower quality plans are much more attractive to relatively healthy people, since sicker individuals seek out more comprehensive benefits. Further, many plans that fall into regulatory gaps expressly exclude people with pre-existing conditions, or charge them much higher prices compared to healthy people. As a result, gaps in regulation will often pull healthy individuals out of the regulated risk pool with lower prices for more limited benefits, which drives up prices in the more generous and regulated segment of the market. This can be a burden for consumers who face higher premiums, and to the extent the government is subsidizing coverage in the regulated market segment, it imposes fiscal costs as well.

The next section describes how federal law attempts to protect consumers and markets from these risks by applying the three types of protections that are critical to good coverage.

How are federal and state health care laws structured?

Three primary laws establish the basic structure for federal regulation of health benefits. At the highest level: the McCarran-Ferguson Act of 1945 establishes that states will be the primary regulators of insurance; the Employee Retirement Income Security Act of 1974 (ERISA) regulates health benefits offered by employers (regardless of whether the employer buys insurance within a state or offers a self-insured benefit); and Title XXVII of the Public Health Service Act (PHSA) establishes a definition of health insurance and a set of minimum federal standards that apply to insurance, even as states continue to be the primary regulators.⁵

³ See, e.g., Howard Kunreuther and Mark Pauly, “Behavioral Economics of Multiperiod Insurance Purchasing Behavior: The Role of Emotions,” 12 FOUNDATIONS AND TRENDS IN MICROECONOMICS 109 (December 2018), <http://dx.doi.org/10.1561/07000000069>; Andreas Richter, Jochen Ruß, and Stefan Schelling, “Insurance Customer Behavior: Lessons from Behavioral Economics,” 22 RISK MANAGEMENT AND INSURANCE REVIEW 189 (July 2019) <https://onlinelibrary.wiley.com/doi/abs/10.1111/rmir.12121>; Gregory Elliehausen, “Behavioral Economics, Financial Literacy, and Consumers’ Financial Decisions,” *Federal Reserve Board*, October 15, 2018, https://files.consumerfinance.gov/f/documents/cfpb_elliehausen-written-statement_symposium-behavioral-economics.pdf; Anthony D. Cox, Dena Cox, and Gregory Zimet, “Understanding Consumer Responses to Product Risk Information,” 70 JOURNAL OF MARKETING 79. (January 2006), www.jstor.org/stable/30162074.

⁴ See “Shortchanged: How the Trump Administrations Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk,” *U.S. House of Representatives*, June 2020, https://drive.google.com/file/d/1uiL3Bi9XVomYnxpyaIMeg_Q-BJaURXX3/view; Gary Claxton et al., “Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA,” *Kaiser Family Foundation*, December 12, 2016, <https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/>.

⁵ More specifically, the McCarran-Ferguson Act directs that insurance will be regulated by the “several States,” but that federal law will apply to the extent it “specifically relates to the business of insurance.” 15 U.S.C. § 1012. It provides only this general instruction, and not a more detailed roadmap. (The statute arose from concerns about the application of federal antitrust statutes to insurance.) ERISA regulates how employers may provide health benefits to their employees, and it includes parallel modifications to the Internal Revenue Code to clarify the terms on which health benefits are excluded from

Very roughly, that means that federal law regulates how employers provide benefits to their employees, while states, subject to federal standards, regulate insurance companies that sell insurance plans to individuals or to employers. Many of the substantive standards applied to the employer under ERISA and to insurance companies that sell coverage to employers under the PHSA are the same. The Affordable Care Act (ACA) and numerous other federal laws have modified ERISA and the PHSA to add new substantive standards within this framework, and those protections are codified within ERISA and the PHSA. The ACA also added some relevant policies that are codified outside ERISA and the PHSA.

To consider an example, the ACA prohibits most health plans from imposing a lifetime dollar limit on covered benefits. This is accomplished as follows:

- A provision in ERISA prohibits employers from including a lifetime limit in the benefits its employees receive.⁶
- A provision in the PHSA prohibits health insurance contracts offered by insurance companies from imposing a lifetime limit. This language applies to insurance companies when they sell contracts directly to individual consumers, and when they sell insurance contracts to employers. Note that the protection in the employer market duplicates the ERISA protection: if an employer arranged with an insurance company to provide coverage for employees that *did* include a lifetime limit, then the employer would be violating ERISA and the insurance company would be violating the PHSA.
- States are generally responsible for enforcing the requirement against insurance companies. State insurance departments will license health insurance companies and monitor the products they sell to ensure that lifetime limits are not included.

Each of these federal laws and the interaction between them is described in more detail below, first addressing regulation of employer benefits and then turning to regulation of insurance markets.

Regulation of employer health benefits

This section describes how employer benefits are regulated under federal law. It begins by laying out how ERISA defines employer benefits that are subject to regulation, and then describes the relevant substantive standards imposed under ERISA. Finally, it briefly addresses the role of the ACA's employer mandate in encouraging employers to offer coverage.

ERISA definitions

ERISA adopts a broad definition of health benefits that are subject to regulation. This is important; it ensures that employers cannot avoid the standards of the law by structuring their benefit in a novel way or buying it from a particular kind of vendor.

Specifically, ERISA regulates “employee welfare benefit plans.” An employee welfare benefit plan is defined very broadly as “any plan, fund, or program” that provides retirement benefits or benefits related to, among other things, “medical, surgical, or hospital care or benefits.”⁷ Any employer welfare benefit plan is subject to a variety of requirements related to transparency and financial management.

Further, ERISA defines a “group health plan” as an employee welfare benefit plan that “provides medical care... to employees or their dependents.” Medical care is in turn defined broadly as “the

income. The Health Insurance Portability and Accountability Act of 1999 (HIPAA) established a set of standards for health benefits and applied them to health insurance regulated by the states through the newly enacted Title XXVII of the PHSA and to employer plans through modifications to ERISA and the Internal Revenue Code.

⁶ Formally, the ERISA provision is a cross-reference to the PHSA provision.

⁷ ERISA § 3 (29 U.S.C. § 1002).

diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body,” or transportation related to the same.⁸ Group health plans are subject to ERISA’s substantive standards related to health care coverage, though some group health plans can be classified as excepted benefits and exempted from some of these standards, as discussed further below. Group health plans can be self-funded (or self-insured), where the employer bears the risk for plan benefits directly, or the employer can buy an insurance plan from an insurance company to deliver the benefit. In either case, the employer is offering a group health plan that is subject to regulation under ERISA. That is, whenever an employer offers a “program” that is related to the “diagnosis, cure, mitigation, treatment, or prevention of disease” it will be a “group health plan” under ERISA.

ERISA protections

ERISA applies a series of consumer protections to group health plans that are not excepted benefits. Some of these directly implement the standards for “good” health coverage enumerated above (though ERISA includes other consumer protections beyond those enumerated here):

- **Covers health care needs:** Plans may not discriminate based on pre-existing conditions in plan benefits. However, plans are not required to cover essential health benefits, though many do so.
- **Provides meaningful financial protection:** Plans may not impose lifetime or annual limits on the benefits they cover. Further, they must include an out-of-pocket limit on cost-sharing expenses (not to exceed \$8,150 for self-only coverage in 2020). There is no minimum actuarial value standard, though other laws create an incentive to meet a minimum AV, as discussed below.
- **System stability:** ERISA’s transparency and financial management standards are intended to ensure that when an employer promises to provide a benefit to its employees, it is able to meet its commitments. While there are no formal “solvency” requirements, the fiduciary obligations imposed by the law generally ensure sufficient plan resources to pay health care claims. ERISA does not include requirements related to risk pooling.

Employer responsibility requirement

Outside of ERISA, employers with more than 50 full-time employees are also subject to the Affordable Care Act’s employer mandate. This requires employers to offer coverage that meets certain standards in the benefit structure (which go beyond the minimum requirements for a group health plan under ERISA) or pay a penalty if any of their workers receive federal subsidies to buy individual market plans. These additional standards include offering coverage with an actuarial value of 60% and charging employees premiums that are sufficiently affordable for them. There are two “tiers” to the mandate penalty: large employers owe a smaller fee if they offer some form of coverage (other than excepted benefits) but that coverage does *not* meet the standards of the mandate, and they owe a larger fee if they offer no coverage at all.⁹ Thus, the standards of the employer mandate: (1) generally encourage but do not require employers to offer coverage that meets a minimum actuarial value and (2) incentivize offering some form of coverage over nothing at all.

Regulation of the insurance market

⁸ ERISA § 733(a) (29 U.S.C. § 1191b(a)).

⁹ For details on calculation of the mandate penalty, see Internal Revenue Service, “Types of Employer Payments and How They Are Calculated,” <https://www.irs.gov/affordable-care-act/employers/types-of-employer-payments-and-how-they-are-calculated> (last visited June 23, 2020).

We turn now to regulation of the insurance market. This section explains the relationship between state and federal law, then turns to the definitions applied to federal regulation of insurance and the substantive standards applied.

State and federal law

Federal regulation of insurance is structured differently from regulation of employer group health plans. Under the McCarran-Ferguson Act, states are the primary regulators of insurance. Until the 1990s, there was very little federal regulation of health insurance products. However, through the enactment of HIPAA in 1996, the federal government adopted a series of substantive standards that would apply to most health insurance products sold by health insurance companies. Since then, the ACA and other federal statutes have set forth additional protections.

Those standards, codified in Title XXVII of the PHSAs, apply to insurance companies when they sell insurance to employers in the group market and when they sell directly to consumers in the individual market. Many standards in the PHSAs apply in both the group and individual markets, though some provisions apply only to certain market segments.

Federal law provides that states generally should be the enforcers of these provisions through state laws that require insurance companies to comply with the federal standards.¹⁰ Some states accomplish this by codifying the specific provisions of the PHSAs into their own state codes, while others simply provide the state insurance department authority to enforce federal law. Federal law also establishes that the federal government will enforce the PHSAs standards only if the state has failed to “substantially enforce” them. Currently, the federal government enforces the PHSAs in four states: Missouri, Oklahoma, Texas, and Wyoming.¹¹

PHSA definitions

The substantive provisions in the PHSAs apply to “health insurance coverage,” which is defined within PHSAs § 2791. Critically, health insurance is not defined primarily based on an objective assessment of the product being sold; instead, it turns in large part on what entity is selling the benefit. Specifically, the law defines “health insurance coverage” as “benefits consisting of medical care... offered by a health insurance issuer.” A “health insurance issuer” is “an insurance company, insurance service, or insurance organization... which is licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance.”¹²

That means that the standards of the PHSAs apply to an entity that is regulated as an insurance company (or “issuer”) under state law whenever that issuer sells a product that involves medical care. However, federal law does *not* apply to entities that are not issuers under state law – even if those entities offer something that would otherwise be considered “health insurance coverage” and is functionally identical to health insurance. This creates an unusual relationship between state and federal law: a state’s definition of who is an issuer under state law defines the reach of federal law.

Moreover, like ERISA, insurance law also exempts certain benefits from regulation (even when they are considered “health insurance coverage”): “excepted benefits” and “short-term limited-duration” plans are exempted from substantive regulation. These exemptions are discussed in more detail below.

PHSA and insurance law protections

¹⁰ PHSAs § 2721 (42 U.S.C. § 300gg-21).

¹¹ Id., U.S. Centers for Medicare & Medicaid Services, “The Center for Consumer Information & Insurance Oversight,” <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance> (last visited June 24, 2020).

¹² PHSAs § 2791 (29 U.S.C. § 300gg-91).

Some substantive standards of the PHSA apply to group and individual market insurance, while others apply only to certain markets. In particular, the PHSA divides insurance into three markets. Individual market coverage is sold directly to individuals, small group market coverage is sold to employers with 50 or fewer employees, and large group coverage is sold to employers with more than 50 employees. Most employees covered by group insurance are in the large group market. Under the PHSA, coverage is only “group” coverage when sold to employers who are buying coverage for their employees. Other kinds of groups (like a university arranging coverage for its students or members of an affinity organization) cannot purchase group coverage – they are considered part of the individual market.

As in ERISA, the PHSA substantive protections (which do not apply to excepted benefits or short-term plans) include many of the standards necessary for good health insurance coverage:

- **Covers health care needs:** Insurance in the individual and small group market must cover all EHB. Insurance in the large group market, although tending to be comprehensive, is not required to cover all EHB. In addition, individual and small group insurance cannot impose any form of discrimination based on pre-existing conditions. Insurance in the large group market can charge *employers* different prices based on the health needs of the employer’s population as a whole but cannot discriminate against individual enrollees.
- **Provides meaningful financial protection:** As under ERISA, plans in all markets may not impose lifetime or annual limits and must include a reasonable out-of-pocket limit on household expenses, not to exceed \$8,150 for self-only coverage in 2020. In addition, plans in the individual and small group market must meet a minimum actuarial value standard of 60%; there is no actuarial value minimum in the large group market.
- **System stability:** The PHSA sets up a series of requirements related to the pooling of risk in the individual market and in the small group market that requires risk be pooled at the level of the entire state. In contrast, the PHSA does not impose risk pooling requirements in the large group market. Finally, while not contained within the PHSA, state law does regulate the solvency of health insurance issuers to ensure plans can meet their obligations to pay benefits, and these standards apply across all three markets.

Summary

Figure 2 summarizes the application of the relevant laws across employer coverage and individual market insurance.

Figure 2: Application of protections to individual and employer insurance

| | | ERISA regulated employer plans (other than excepted benefits) | PHSA regulated individual market insurance (other than excepted benefits and short-term plans) |
|-----------------------------|---|---|---|
| Health care needs | Coverage of Essential Health Benefits (EHB) | Common, but not generally required; is required for small groups purchasing insurance | Required |
| | No pre-existing condition discrimination | Required | Required |
| Financial protection | Prohibits lifetime and annual limits | Required | Required |
| | Requires out-of-pocket limit | Required | Required |
| | Minimum actuarial value | Common, encouraged by employer mandate for large employers, but not generally required; is required for small groups purchasing insurance | Required |
| System stability | Solvency protections | Insured benefits must meet solvency standards under state law; all plans subject to ERISA fiduciary requirements | Plans must meet solvency standards under state law |
| | Sharing of risk across many individuals | Risk pooling generally at the level of single employer; risk pooling across entire state for small groups purchasing insurance | Plans share risk across entire state |

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What are the gaps in regulation of health care coverage?

We now turn to a systematic overview of the gaps in this regulatory regime that allow sub-standard health plans to persist. We first address benefits provided by employers and then turn to individual insurance.

Gaps in regulation of employer health benefits

There are three ways in which regulation of employer-provided health benefits is incomplete: (1) federal law fails to apply certain substantive protections at all, (2) the statute exempts “excepted benefits” from coverage in ways that create opportunities for abuse, and (3) small employers can use several pathways avoid the risk pooling provisions of federal law. Each of these is discussed below.

The most significant gap in regulation of employer health benefits is analytically straightforward: federal law simply fails to apply certain key standards to employer benefits. Most importantly, employers are not required to offer plans that include coverage of the full range of health care benefits contained within the essential health benefits package. Insurance companies that sell plans to small employers (those with fewer than 50 employees) are required to cover EHB, but this is only a small segment of the market.¹³ As a result, it is legally permissible for all large employer group health plans and those small employers who self-insure to exclude coverage for, e.g., prescription drugs or physical therapy. Similarly, these employers are permitted to cover a benefit only very narrowly, by, for example, covering only one round of chemotherapy or only a few days of hospitalization.¹⁴

Similarly, employer health plans are not required to satisfy minimum actuarial value standards. Large employers are encouraged to offer plans with an AV of at least 60% that include some hospital and outpatient care to comply with the employer mandate, and insurers that sell coverage to small employers must satisfy a 60% AV standard.¹⁵ But large employers that are willing to pay penalties under the employer mandate and small employers that self-insure rather than buying coverage from an insurance company can offer plans with very low AVs that entirely exclude any category of benefit.

In practice, most employers do offer coverage for much of the EHB package at moderately generous AVs. Employers offer health benefits in order to attract workers, and so they generally want to offer a benefit that satisfies employee needs. Further, the tax exclusion for employer health benefits encourages employers to provide a benefit at least as rich as the marginal employee will value. As a result, a plan that completely excludes cancer care or prescription drugs will not thrive in much of the labor market.

However, an employer that is otherwise offering otherwise generous coverage may find it attractive to exclude a specific high cost service likely to be used by a small and predictable group of enrollees. For instance, a survey of employers found that in 2018, 45% of very large employers excluded coverage for Applied Behavior Analysis, a treatment for children with autism.¹⁶ Expensive new drugs to cure

¹³ As of 2016, only 14 million people were covered in the small group market. Mark Hall and Michael McCue, “The Health of the Small-Group Insurance Market,” *The Commonwealth Fund*, October 26, 2018, <https://www.commonwealthfund.org/publications/issue-briefs/2018/oct/health-small-group-insurance-market>.

¹⁴ There are some limits on employers’ exclusion of particular benefits. The Mental Health Parity and Addiction Equity Act (MHPEA) incorporates provisions into ERISA and the PHSA that prohibit some kinds of exclusionary benefit designs with respect to mental health care (though it remains permissible for employers to completely exclude all mental health benefits). The Pregnancy Discrimination Act generally requires coverage of pregnancy if a plan includes other hospital benefits. In addition, the Americans with Disabilities Act prohibits employers from discriminating against people with disabilities, and a benefit exclusion targeted at a specified health condition could be problematic under these laws. But these are weak limits and restrain employer behavior only at the margins.

¹⁵ The EHB, AV, and out-of-pocket limit protections are analytically related. All employers are required to impose an out-of-pocket limit below \$8,150 on benefits they cover. If an employer was also required to cover the full EHB package, then the out-of-pocket limit requirement would automatically ensure that the health benefit has an AV close to 60%. However, if the employer is not required to cover all EHB, then it can offer a plan that, e.g., does not cover hospital or emergency care. Such a plan can satisfy the out-of-pocket limit standard with an AV well below 60% (because consumer’s exposure to spending on the excluded hospital and emergency care is infinite). Conversely, if a plan is not required to cover EHB but does want to achieve a 60% AV, then it must cover an array of EHB – but not the full package. Notably, HHS and Treasury have also said that for a plan to satisfy the 60% standard of the employer mandate, it must cover some outpatient and hospital care, but that does not include the full value of these benefits contained with the EHB package. The EHB requirement also interacts with the prohibition on lifetime and annual limits. Plans are prohibited from placing lifetime and annual *dollar* limits on benefits, but they are permitted to apply visit limits, such as covering only 10 physical therapy appointments per year. When plans are required to cover EHB, the EHB standards generally prevent the plan from applying stringent visit limits. But when not required to cover EHB or to satisfy a generous AV, a plan can impose visit limits that mean a benefit is “included” but consumers still face significant cost exposure, such as covering only three days of hospitalization.

¹⁶ Beth Umland, “Beyond Autism Awareness: Making ASD Acceptance Part of Your Well-being Program,” *Mercer*, April 4, 2019, <https://www.mercer.us/our-thinking/healthcare/beyond-autism-awareness-making-asd-acceptance-part-of-your-well-being-program.html>.

Hepatitis C were brought to market in early 2014, but employers generally excluded the benefit for at least the first 18 months, and some still do not cover the drugs today.¹⁷

In a more extreme cases, some employers may feel compelled to offer a health benefit but will not face market pressure to offer a robust plan. In particular, the ACA's employer mandate can create an incentive to offer *some* type of health coverage for low wage workers, even when the labor market will not support offering a more complete health plan. In that case, employers may offer a "skimpy" plan that does not cover anything approaching the full set of EHB and instead provides only a minimal benefit (or may offer such a plan in combination with other benefits).

Comprehensive data are not available, but very limited group health plans that fail to cover meaningful benefits do exist. A survey by the National Business Group on Health in 2014 found that as many as 16% of very large employers were considering offering benefits that failed to cover at least 60% of the value of the EHB package,¹⁸ though that likely overstates the number that actually did so. A preliminary search of available plan offerings reveals many vendors that offer very thin benefits to employers. One plan covers doctors' visits, generic drugs, and some outpatient care, but excludes all brand-name drugs and services like diagnostic imaging and physical therapy, and covers only three days of hospital care -- and that is one of the more generous plans in this category.¹⁹ Other vendors offer plans that cover *nothing* except the ACA's required preventive care benefits; a plan like this would be expected to have an AV of far less than 5%.²⁰

As expected, press reports have uncovered examples of enrollees of such plans being denied care. For example, after breaking her wrist, a Minnesota woman discovered that her employer "health plan" covered only preventive services, and did not include coverage for hospital services or doctors' visits.²¹ That is, the failure under current law to apply EHB and AV standards to employer plans means that while many employees generally receive adequately comprehensive benefits, significant gaps persist and leave workers and their families exposed.

Excepted benefits

While federal law does not require large employers to cover a broad array of benefits, it does place relatively stringent rules on the financial protection that must be provided once a plan has decided to cover a particular benefit. Regulated group health plans may not impose lifetime or annual dollar limits on covered benefits, and they must cap consumer out-of-pocket spending on covered benefits at \$8,150 per person per year (for 2020) – generally ensuring that catastrophic financial risk is transferred from the individual to the plan with respect to covered benefits. But these standards do not apply to plans that are considered "excepted benefits."

Recall that ERISA defines "group health plan" very broadly as any employer "plan, fund, or program" that involves "medical... care or benefits". But ERISA then exempts certain kinds of "excepted benefits" from its substantive requirements.²² The statute defines four categories of excepted benefits and some specific types of coverage within each category, and provides authority for the federal agencies to

¹⁷ Judith Graham, "Medicaid, Private Insurers Begin To Lift Curbs On Pricey Hepatitis C Drugs," *Kaiser Health News*, July 5, 2016, <https://khn.org/news/medicaid-private-insurers-begin-to-lift-curbs-on-pricey-hepatitis-c-drugs/>.

¹⁸ Stephen Miller, "Employers Adjust Health Benefits for 2015," *SHRM*, August 15, 2014, <https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/2015-health-benefits.aspx>.

¹⁹ Fundamental Care, "Limited-Day Health Plans for Employers," <https://www.fundamentalcare.com/limited-day-plans> (last visited June 22, 2020).

²⁰ Magnacare, "MEC Minimum Essential Coverage Plans," <https://www.magnacare.com/archive-healthplanmgmt/mec/> (last visited June 22, 2020).

²¹ Jay Hancock, "Surprise! Some Job-Based Health Plans Don't Cover Hospitalization," *NPR*, June 18, 2015, <https://www.npr.org/sections/health-shots/2015/06/18/415289504/surprise-some-job-based-health-plans-dont-cover-hospitalization>.

²² See ERISA § 732(c) (29 U.S.C. § 1191a(c)); ERISA § 733(c) (29 U.S.C. § 1191b(c)); 45 C.F.R. § 146.145; 29 C.F.R. § 2590.732.

define additional types of coverage within each category. The four categories as defined under current regulations are described below and listed in Figure 3:

- **Medical benefit is secondary or incidental:** This category includes things like workers compensation benefits, disability income coverage, auto insurance, and travel insurance. These are policies where the plan might cover some medical care, but the primary purpose of the benefit is not insurance against medical costs. Many secondary or incidental benefits are enumerated in the statute, and the agencies have authority to add additional benefits by regulation.
- **Limited excepted benefits:** Under the statute, limited excepted benefits are dental, vision, and long term care, as well as “other similar, limited benefits” defined by the federal government in regulation, as long as they are “offered separately” from a traditional group health plan. The agencies have used their regulatory authority to add several types of limited excepted benefits including Flexible Spending Arrangements (FSAs), employee assistance programs that meet certain conditions, and certain narrowly defined Health Reimbursement Arrangements (HRAs).
- **Noncoordinated excepted benefits:** ERISA also exempts “coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance.” Named illness policies, also called dread disease or critical illness plans, pay out upon a particular diagnosis like cancer or a heart attack. Fixed indemnity or hospital indemnity policies pay an amount for each day or month a person is sick, hospitalized, or receiving medical care. The excepted benefit plan must be separate from and not coordinated with a primary group health plan.²³
- **Supplemental excepted benefits:** Finally, the statute defines coverage intended to supplement Medicare or military health coverage, and subject to regulation under those programs, as an excepted benefit, along with “similar” coverage intended to supplement a group health plan. The federal government has specified that group supplemental coverage must be intended to fill in cost-sharing in a traditional group plan or cover benefits other than EHB that a traditional plan doesn’t cover, or both.

There are good policy reasons for exempting certain types of benefits from ERISA’s substantive regulations. Group health plans are subject to fairly detailed regulation of the content of the plan, and some types of employer benefits include coverage for medical care but are not really the sort of plan that anyone would consider “health coverage.” Indeed, a workers’ compensation or auto insurance policy may sometimes pay for medical care, but it should not generally be subject to health coverage regulations. Similarly, Medigap plans that supplement Medicare coverage are subject to an entirely separate set of regulations and are intended to be limited in scope.

²³ Federal law also contains a set of standards that define certain benefits as exempt only if they are, variously, under a “separate policy, certificate, or contract of insurance” and/or “not an integral part” of another plan. See PHS § 2721(c) (42 U.S.C. § 300gg-21(c)). The requirement that certain benefits be insured may provide some assurance of solvency, but in general these standards are no longer especially relevant to the way employers design their benefits and are not discussed here.

Figure 3: Excepted benefits under ERISA and the employer insurance market

| | |
|---|---|
| <p>Secondary or incidental excepted benefits</p> | <p>Workers compensation Disability income replacement insurance Auto insurance Accident-only insurance Liability or credit insurance On-site medical clinics Travel insurance</p> |
| <p>Limited excepted benefits</p> | <p>Dental coverage Vision coverage Long term care coverage FSAs Employee assistance programs Some HRAs</p> |
| <p>Noncoordinated excepted benefits</p> | <p>Critical illness policies Fixed or hospital indemnity</p> |
| <p>Supplemental excepted benefits</p> | <p>Medicare supplemental coverage TRICARE supplemental coverage Coverage supplemental to a group health plan</p> |

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However, the exception from regulation does create opportunities to skirt protections that otherwise should apply. Plans consisting solely of excepted benefits do not “count” for purposes of the ACA’s employer mandate. Therefore, large employers generally do not face strong incentives to evade regulation by offering *only* an excepted benefit plan, since costs-savings would be offset by employer mandate penalties.

But it can be attractive to use some kinds of excepted benefit policies alongside a traditional group health plan. The full suite of ERISA protections will still apply to the traditional plan, but the excepted benefit may impose lifetime and annual limits, is not required to include an out-of-pocket cap, and can use medical underwriting to deny benefits or charge more to individuals based on their health conditions. This could allow an employer to, e.g., place most specialty drug coverage outside the standard plan and provide coverage through an excepted benefit plan – where patients in need of these drugs could face an annual limit or even be denied coverage based on their health status.

Across the categories of excepted benefit coverage, four particular types are most susceptible to this kind of abuse, because they have the potential to “look” the most like a traditional health plans: critical illness, accident, fixed indemnity, and, to a lesser degree, group supplemental coverage.

Critical illness and accident policies

Critical illness policies pay benefits when consumers are diagnosed with a “specified disease” – most commonly cancer, but they are available for other conditions as well. A 2018 survey of employers found that 43% offered critical illness policies,²⁴ and others were considering the benefit for future years. These plans are generally marketed to “fill in” health plan cost-sharing and compensate for missed work in the event of a diagnosis. But it could be attractive for employers to exclude or limit care for a named condition from their primary plan and offer a separate critical illness policy associated with that condition – where the benefit could be subject to lifetime and annual limits, health status exclusions, and other limitations not permitted in regulated coverage. Similarly, accident policies pay claims when individuals experience injuries, but certain services could be relegated to a separate accident policy. It does not appear that employers are engaged in this behavior using critical illness and accident policies to a meaningful degree today, but it remains a potential loophole.

Fixed indemnity and other supplemental plans

With respect to fixed indemnity policies, there is evidence of ongoing abuse in the employer market. As noted above, an indemnity policy pays “a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses incurred.” In theory, the benefit replaces lost income or fills in cost-sharing. But in practice, many fixed indemnity policies are structured quite a bit like a typical health insurance plan.

Specifically, modern indemnity plans develop very detailed rubrics for determining payment amounts. These plans pay an amount per time period *if a specific medical treatment is received*. Example indemnity plans offered in the group market include benefits like:

- \$1,200 per month an individual is receiving chemotherapy,
- \$100 per month an individual is taking anti-nausea medicine,
- \$200 per day a patient gets an X-ray,
- \$75 per day a person gets a clinical lab test,
- 70% “co-insurance” per day an individual fills a prescription for generic prescription drugs.²⁵

While the amounts paid in these examples are sometimes lower than what true health coverage would pay, the structure mimics traditional benefits. The requirement that the benefit be paid on a “per time period” basis does not really constrain design; it has become fairly formulaic.

Therefore, employers can use a fixed indemnity policy with an elaborate payment rubric to offer a benefit that “looks like” typical health coverage but is not regulated as such. The most attractive arrangement for employers seeking to avoid regulation is to offer a fairly limited traditional plan, which satisfies the employer mandate, alongside an indemnity plan that offers benefits with limits and exclusions not otherwise allowed.²⁶ Federal law attempts to limit some of this behavior by only

²⁴ Willis Towers Watson, “Voluntary Benefits Now Viewed as Essential, Willis Towers Watson Survey Finds,” April 10, 2018, <https://www.willistowerswatson.com/en-US/News/2018/04/voluntary-benefits-now-viewed-as-essential-willis-towers-watson-survey-finds>.

²⁵ Aflac, “Cancer Protection Assurance Cancer Indemnity Insurance,” <http://www.aflacclients.com/MicrositePDF/MicrositePDFs/CANCER/CancerProtectionAssurance/Option2/DC.pdf> (last visited June 22, 2020); Aflac, “Accident Advantage Accident-Only Supplemental Only Insurance,” <http://www.aflacclients.com/MicrositePDF/MicrositePDFs/Accident/AA/Option3/DC.pdf> (last visited June 22, 2020); Stivers Staffing Services, “Limited Benefit & Self-Funded Minimum Essential Coverage Enrollment Guide,” <https://imgur.com/a/lLeHk> (last visited June 22, 2020).

²⁶ See, e.g., Meyers Glaros, “Insurance, Tailored For You,” <https://meyersglaros.com>, (last visited June 22, 2020).

excepting indemnity and critical policies on the condition that they are not “coordinated” with an exclusion in a primary plan, but that is a very weak limit that does not seem to hold much force in practice (though could perhaps be better enforced to deter some abusive behavior, as discussed below).

Indeed, while systematic data are not available, there is ample anecdotal evidence of employers combining fixed indemnity and traditional plans in problematic ways. In press reports and in social media forums where consumers offer details about their own insurance offers, you can find examples of employees offered an indemnity plan as if it is the primary form of health coverage. A seemingly common scheme,²⁷ with plan documents recreated from an image provided on social media as shown in Figure 4, operates as follows:



- The employer offers an extremely thin traditional health plan (often covering only ACA preventive services), satisfying its obligations under the employer mandate to offer some form of coverage.
- The employer places all other benefits in a fixed indemnity plan that mimics traditional insurance, but with a variety of limitations that would not be permitted in a traditional plan, like lifetime and annual limits and uncapped consumer exposure to out-of-pocket costs, or even pre-existing condition exclusions.
- The employee premiums can be structured to discourage enrollment in even the extremely limited traditional regulated plan. In a plan brochure from 2017, employees were charged \$58 per month for self-only enrollment in the plan that covered *only* preventive services, and about \$80 per month for self-only enrollment in the fixed indemnity plan.

Other variations exist. Some employers appear to offer a slightly more comprehensive traditional plan, covering, for example, outpatient services in the traditional plan, but hospital services in the indemnity plan. Plans can add dental and vision services to the indemnity plan or as a separate excepted benefit. But in all of these cases, employees are offered the fixed indemnity plan as if it were health coverage.

²⁷ See, e.g., Jaie Avila, “Show Me Your Bill Helps Wipe Out \$70K in Charges After Heart Attack,” *News 4 San Antonio*, October 10, 2019, <https://news4sanantonio.com/news/trouble-shooters/show-me-your-bill-helps-wipe-out-70k-in-charges-after-heart-attack>; Reddit, “UHC MEC Plan worth it?,” October 24, 2008, https://www.reddit.com/r/HealthInsurance/comments/72gdsi/uhc_mec_plan_worth_it/; Reddit, “I feel like my employer is deliberately giving me misleading information about my health insurance and I need your help,” February 9, 2009, https://www.reddit.com/r/personalfinance/comments/7jlv89/i_feel_like_my_employer_is_deliberately_giving_me/; Reddit, “I’m a temp worker and I think I’m getting screwed over,” February 9, 2009, https://www.reddit.com/r/personalfinance/comments/3qokhk/im_a_temp_worker_and_i_think_im_getting_screwed/.

Figure 4: Replica of plan documents combining a fixed indemnity and traditional benefit

IMPORTANT PLAN INFORMATION: You have two medical plan options. You may enroll in one or both. Additional benefits are available to add if you enroll in the Fixed Indemnity Medical Plan.

| Advantages of the Fixed Indemnity Medical Plan | Advantages of the MEC Wellness/Prevention Plan |
|--|---|
| <input checked="" type="checkbox"/> Covers Day to Day Medical Expenses  | <input type="checkbox"/> Covers Day to Day Medical Expenses  |
| <input type="checkbox"/> Satisfies the Individual Mandate | <input checked="" type="checkbox"/> Satisfies the Individual Mandate |
| <input checked="" type="checkbox"/> You may still be eligible to receive a subsidy from the health insurance exchange | <input type="checkbox"/> You may still be eligible to receive a subsidy from the health insurance exchange |
| <input checked="" type="checkbox"/> Offers Dental, Vision, Term Life and STD | <input type="checkbox"/> Offers Dental, Vision, Term Life and STD |

FIXED INDEMNITY MEDICAL BENEFIT

The Fixed Indemnity Medical Plan pays a flat amount for a covered event caused by accident or illness. If the covered event cost more, you pay the difference. But if the covered event cost less, you keep the difference.

| Outpatient Benefits ¹ | |
|---|---------------|
| Physician Office Visit | \$100 per day |
| Diagnostic (Lab) | \$75 per day |
| Diagnostic (X-Ray) | \$200 per day |
| Ambulance Services | \$300 per day |
| Physical, Speech, or Occupational Therapy | \$50 per day |
| Emergency Room Benefits - Sickness | \$200 per day |
| Emergency Room Benefits - Accident ² | \$500 per day |
| Outpatient Surgery | \$500 per day |
| Anesthesiology | \$200 per day |
| Annual Outpatient Maximum | \$2,000 |

| Prescription Drugs (via reimbursement) ^{3,4} | |
|---|-----------|
| Annual Maximum | \$600 |
| Generic Coinsurance / Brand Coinsurance | 70% / 50% |

¹all outpatient benefits are subject to the outpatient maximum
²covers treatment for off the job accidents only
³not subject to outpatient maximum
⁴to file a claim for reimbursement, save your receipts and submit to Planned Administrators, Inc.

OPTIONAL MEC WELLNESS/PREVENTIVE BENEFIT¹

The optional MEC Wellness/Preventive Benefit **DOES NOT** cover medical services. This plan provides coverage for preventive services such as immunizations and routine health screening. It does not cover conditions caused by accident or illness.

| Benefits | In-Network | Non-Network |
|---|------------|-------------|
| 15 Preventive Services for Adults | 100% | 40% |
| 22 Preventive Service for Women | 100% | 40% |
| 26 Covered Preventive Services for Children | 100% | 40% |

¹ for more information about preventive services, please visit www.healthcare.gov

Source: Reddit.

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Note that some of this same potential for abuse is also associated with the exception for coverage offered supplemental to a group health plan. Existing regulations limit group supplemental coverage to filling in cost-sharing for *already covered* benefits or covering non-EHB services. Therefore, it would generally not be permissible to exclude an EHB like specialty drugs or hospitalization from a traditional plan and cover it instead through a supplemental plan. However, visit limits or very high cost-sharing in the typical group plan coupled with a supplemental plan could facilitate some otherwise impermissible benefit designs, and, perhaps more importantly, the regulatory restrictions could be weakened.

Small group induced utilization

Finally, for a completely different set of reasons, small employers offering some sort of secondary coverage – whether fixed indemnity, critical illness, accident, or group supplemental – may be able to distort risk pooling in the small group insurance market. In particular, more generous insurance policies generally have higher premiums not only because the plan pays out higher amounts per service received, but also because lower cost-sharing leads to induced utilization – enrollees using more services because cost-sharing is lower. A supplemental policy could allow a small employer to buy a small group insurance plan with higher cost-sharing from its insurance company, but then provide enrollees the experience of lower cost-sharing through supplemental coverage. This would result in all small group market enrollees in the state bearing the costs of induced utilization, rather than the

individual firm. As above, this use of excepted benefits does not seem common, but it remains a potential loophole.

Evading protections in the small group market

Another problematic form of coverage arises from attempts by small employers to avoid offering an insurance plan that is considered part of the small group market. Recall that all group health plans (that are not excepted benefits) are subject to the general standards of ERISA, but small employers that buy insured coverage are generally required to comply with additional requirements, including covering all EHB, meeting a minimum AV, and being part of a risk pool with all other small groups in the state. Small employers need not comply with these standards if they self-insure their benefits by bearing risk themselves rather than purchasing an insurance product, but for most small employers, truly bearing the risk of employees' health costs is impractical. Nonetheless, some small employers – especially those with relatively healthy workforces – may wish to offer benefits that are less comprehensive than EHB or to avoid having to pool risk with firms with sicker workers. Gaps in existing regulation make that possible through two primary paths: “level-funding” plans and multiple-employer, or association, plans.

“Level-funding” arrangements allow a small employer to offer a benefit that is technically considered a self-insured plan but functions almost exactly like an insured product. These plans are built around a stop-loss product. Almost all self-insured employers, of any size, purchase stop-loss coverage (also called reinsurance), which covers a portion of their health care claims if beneficiaries' costs are far higher than expected. Level funding arrangements twist this approach significantly, offering stop-loss that kicks in at such low thresholds that the employer does not bear any meaningful amount of risk.²⁸ Instead, small employers are guaranteed that they will pay only a fixed (“level”) amount per month. Part of the small employer's monthly payment is considered a premium for stop-loss coverage, and part goes towards claims. From the small employer's perspective, then, this functions exactly as a health insurance product – but the employer is charged a monthly amount that considers only their own health care costs, not that of the whole pool, and the plan need not comply with the regulatory standards for small group insurance.²⁹ This increases costs for other small groups and enables employees of small employers to become enrolled in coverage that does not include all EHB. Indeed, some offerings to small employers combine level-funding arrangements with benefits far skimpier

Figure 5: Sample level funding plan materials

WHAT IS LEVEL FUNDING?

Level funding allows small employers to manage¹ the risk for large claims, while enjoying the **cost savings and refund² potential of self-funding a health plan.**

Twelve level monthly payments each year covers¹ the costs for your plan, with the **potential for earning a refund² at the end of the year.**

¹Large claim risk managed by stop-loss insurance with run-out coverage, subject to policy exclusions, solvency of insurance carrier, policy effective dates, mid-year Plan termination, and other policy terms and conditions.
²Refund subject to claims experience, run-out claims, mid-year Plan termination, and the terms and conditions of the administrative agreement.

LEVEL-FUNDED LIMITED-DAY PLANS INCLUDE:

- Preventative Services
- Outpatient care
- Inpatient Hospitalization (3 Days)
- Surgeries
- Generic Rx

Source: fundamentalcare.com

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²⁸ See U.S. Department of Labor, “Guidance on State Regulation of Stop-Loss Insurance,” November 6, 2014, <https://www.dol.gov/agencies/ebsa/employers-and-advisers/guidance/technical-releases/14-01>.

²⁹ See Sabrina Corlette, Jack Hoadley, Kevin Lucia, and Dania Palanker, “Small Business Health Insurance and the ACA: Views from the Market 2017,” *Urban Institute*, July 2017, https://www.urban.org/sites/default/files/publication/92291/2001459_small_business_health_insurance_and_the_aca_views_from_the_market_2017_0.pdf.

than the full EHB package that the small employer would be required to cover if purchasing coverage in the small group market, as shown in Figure 5.

Another tool that can achieve the same objectives is if small employers are able to purchase coverage as if they were a large group. Federal law allows employers to join together in a multiple employer welfare arrangement (MEWA), which is sometimes also known as an Association Health Plan (AHP). A detailed review of the federal and state law regulating MEWAs and AHPs is beyond the scope of this piece.³⁰ For our purposes, it is sufficient to note that, prior to 2018, federal guidance generally treated each member of the association as a separate employer.³¹ Therefore, small employers buying coverage through one of these arrangements were usually treated as part of the small group market, which generally limited the appeal of this type of coverage.

However, a 2018 rulemaking – which has been largely enjoined by a federal court – would make it easier for all the members of an association to be treated as a single large group.³² This would make MEWA arrangements that qualify as AHPs under the rule far more attractive to small employers. As with level funding plans, if this rule were in effect, it would enable small employers to purchase coverage that does not cover all EHB and to avoid being priced with their state’s full small group market risk pool, exposing their employees to sub-par coverage and increasing small group premiums. The enjoined rules would also allow self-employed individuals to be considered part of the large group market, which would increase premiums in the individual market as well. Historically, the MEWA market has also featured a significant risk of insolvency and fraud among entities that “look like” health insurance but are in fact not fully regulated as such and often lack the resources to pay member health care claims. States have tools to ensure the financial stability of MEWAs, but not all states take advantage of them.³³

Therefore, as long as the 2018 AHP rule is enjoined, the existence of MEWA-related regulatory gaps will likely have limited impact. However, if the rule were to be reinstated, AHPs serving small employers could undermine small group market risk pooling and protections, driving some small employers to fraudulent or insolvent MEWA offerings.

Summarizing the gaps in the employer market

ERISA adopts a broad view of what constitutes a “group health plan,” and therefore clearly brings all employer offerings within its framework regardless of the benefit structure or the vendor selected. However, the discussion above reveals three major gaps within that framework, as shown in Figure 6. First, some important substantive protections to ensure high quality health coverage are simply never

³⁰ See Julie Mix McPeak, Eric A. Cioppa, Raymond G. Farmer, Gordon I. Ito, National Association of Insurance Commissioners to Office of Regulations and Interpretations, “Definition of Employer—Small Business Health Plans RIN 1210-AB85,” March 6, 2018, https://www.naic.org/documents/index_health_reform_section_180306_comments_assoc_plan_nprm.pdf; Mila Kofman, Eliza Bangit, and Kevin Lucia, “MEWAs: The Threat of Plan Insolvency and Other Challenges,” *The Commonwealth Fund*, March 2004, https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2004_mar_mewas_the_threat_of_plan_insolvency_and_other_challenges_kofman_mewas_pdf.pdf; Brief of Amici Curiae Health Policy Scholars, *New York v. Department of Labor*, <https://affordablecareactlitigation.files.wordpress.com/2019/07/dcc-health-policy-history-scholars-amicus.pdf>

³¹ Gary Cohen, “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,” *Department Of Health & Human Services*, September 1, 2011, https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_0_1_2011.pdf.

³² “Definition of “Employer” Under Section 3(5) of ERISA-Association Health Plans,” 83 Fed. Reg. 28912 (June 21, 2018), <https://www.federalregister.gov/documents/2018/06/21/2018-12992/definition-of-employer-under-section-35-of-erisa-association-health-plans>; *New York v. Department of Labor*, 363 F. Supp. 3d 109 (D.D.C. 2019), <https://affordablecareactlitigation.files.wordpress.com/2019/03/5940153-0-12659.pdf>.

³³ Mila Kofman, Eliza Bangit, and Kevin Lucia, “MEWAs: The Threat of Plan Insolvency and Other Challenges,” *The Commonwealth Fund*, March 2004, https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2004_mar_mewas_the_threat_of_plan_insolvency_and_other_challenges_kofman_mewas_pdf.pdf.

applied to employer plans, leaving most employers free under ERISA to offer benefits that do not include all EHB and do not satisfy a minimum AV standard. Second, the law includes defined regulatory exemptions for “excepted benefits” that are not subject to the substantive standards that otherwise apply, and this creates potential pathways for abuse. Finally, federal law adopts a set of standards for risk pooling by small employers but does not always adopt sufficiently strong guardrails to ensure risk stays in the appropriate pool – and the routes out of the appropriate pool create additional financial risk.

Figure 6: Gaps in regulation of the employer market

Substantive protections not applied uniformly

- EHB requirement does not apply to group health plans outside the small group market
- Minimum actuarial value standard is not required of group health plans

Skirting application of substantive protections

- Fixed indemnity plans offer benefits similar to traditional insurance and yet are treated as excepted benefits
- These plans offer an opportunity to segment benefits, so that coverage (or coverage for a particular condition or treatment) can be subject to underwriting or avoid financial protections

Undermining system stability

- Fixed indemnity and supplemental coverage can undermine small group market risk pooling by misallocating cost of induced utilization
- MEWAs and AHPs and self-funding arrangements offer ways to for small groups to be treated as large groups, undermining the small group risk pool and creating financial risks for the employer and its enrollees.

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Gaps in regulation of individual coverage

We turn now to the gaps in regulation of the coverage sold directly to individuals. The problems here are somewhat different from the problems of the employer market. Unlike the employer market, in the individual insurance market substantive regulations guaranteeing good coverage apply fairly completely to plans that are regulated by federal law. Regulated individual market insurance must offer essential health benefits without discriminating based on pre-existing conditions, limit consumers’ financial exposure with an out-of-pocket limit, prohibit lifetime and annual dollar limits, meet a minimum AV, and operate within a framework that ensures solvency and risk pooling. However, there is an array of excepted and unregulated market segments that leave individuals exposed to major gaps.

There are two ways in which the coverage sold to individuals can evade regulation. The first is by offering insurance that fits within a regulatory exception named in federal law, which exempts the plan from complying with the individual market protections. The second is by offering coverage that is not

formally considered individual market “insurance” at all and is therefore entirely exempt from regulation despite functioning like a health insurance product. Each of these paths is described below.

Regulatory exceptions

Recall that the provisions of federal law regulating insurance products appear within the Public Health Service Act, as modified by the Affordable Care Act. The PHSA includes longstanding exemptions from regulation for short-term limited-duration insurance and excepted benefits.

Short-term plans

The most familiar regulatory exception is a provision that exempts “short-term limited-duration insurance” from the definition of individual market coverage.³⁴ Because it is not considered individual market coverage, it is not subject to any of the substantive standards described above. Federal statute does not define “short-term limited-duration insurance,” but federal regulations have offered a definition that has been subject to change over time. Prior to enactment of the Affordable Care Act, the regulations defined a short-term plan as a plan lasting less than 12 months, after taking account any options for renewal.³⁵ After the passage of the ACA, and in light of several new provisions in federal law that generally treat three months as a “short” interval with respect to health coverage, the federal government defined short-term coverage to include only plans lasting less than three months, after taking account of any renewals.³⁶ However, in 2018, the Trump Administration modified these regulations again, defining short-term coverage as plans lasting up to three *years*: an initial term of 12 months plus two renewals.³⁷ Some states have regulated short-term plans, as discussed further below, but coverage consistent with the federal definition is available in 26 states.³⁸

Short-term coverage need not comply with any of the federal standards in the PHSA. These plans may deny coverage or charge more to individuals with pre-existing conditions, exclude essential health benefits, impose annual or lifetime limits, or leave out-of-pocket costs uncapped. And they do. Because short-term plans can last up to three years, they can compete effectively with traditional plans for all enrollees, not just those who need temporary coverage. Therefore, these plans can attract relatively healthy consumers with the low costs that come from excluding sick enrollees and from offering more limited benefits. Many researchers have offered detailed analyses of the short-term plan market that has emerged since the implementation of the 2018 regulatory change. For example, a Kaiser Family Foundation analysis of short-term plans found that 43% do not cover mental health needs, 62% do not cover substance abuse services, and 71% do not cover prescription drugs.³⁹ None of the plans in their analysis cover maternity care. Cost-sharing in these plans sometimes exceeds \$20,000 per person per policy period (compared to the \$8,150 limit for regulated coverage), and annual and lifetime limits are

³⁴ PHSA § 2791(b)(5) (42 U.S.C. § 300gg-91(b)(5)).

³⁵ Prior to the ACA, classifying coverage as short-term was far less consequential, since it was not until the ACA that significant substantive regulations applied to individual coverage. “Interim Rules for Health Insurance Portability for Group Health Plans,” 62 Fed. Reg. 16894 (April 8, 1997), <https://www.federalregister.gov/documents/1997/04/08/97-8275/interim-rules-for-health-insurance-portability-for-group-health-plans>.

³⁶ “Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance,” 81 Fed. Reg. 75316 (October 31, 2016), <https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance>.

³⁷ “Short-Term, Limited-Duration Insurance,” 83 Fed. Reg. 38212 (August 3, 2018), <https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance>.

³⁸ Justin Giovannelli, Kevin Lucia, and JoAnn Volk, “States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership,” *The Commonwealth Fund*, January 2020, https://www.commonwealthfund.org/sites/default/files/2020-01/Giovannelli_states_indiv_market_coverage_affordable_ib.pdf.

³⁹ Karen Pollitz, Michelle Long, Ashley Semanskee, and Rabah Kamal, “Understanding Short-Term Limited Duration Health Insurance,” *Kaiser Family Foundation*, April 23, 2018, <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

common.⁴⁰ All of these plans entirely exclude individuals with significant pre-existing conditions, exclude coverage for services associated with past health care needs for people they do cover, and charge more based on health status.

Other researchers have demonstrated that entities marketing short-term plans often do not disclose the limitations of these plans. Consumers searching for health coverage online are presented with web advertisements that direct them to online vendors selling short-term plans.⁴¹ Site names and branding are often designed to mimic the federal HealthCare.gov website, such that consumers have no reason to think they are buying non-compliant forms of coverage. Many sites that appear in searches related to purchasing health coverage are “lead generators” that ask consumers to provide contact information that the site then shares with health insurance agents.⁴² Agents contact the consumer and sell them products over the phone; the agent is paid a commission by the insurance vendor. A small scale secret-shopper survey revealed that agents selling coverage over the phone promoted short-term coverage even for consumers whose incomes qualified them for generous subsidies to purchase compliant coverage, that agents declined to provide written materials that would disclose plan limitations, and that consumers were pressured to make a quick decision to purchase coverage in the absence of written material about the plan.⁴³ These problems appear particularly acute during the COVID-19 pandemic.⁴⁴ At least one company has been sued by consumers and state regulators over its marketing of short-term plans.⁴⁵

In this climate, it is no surprise that consumers are unaware of the limitations of their plans. A Montana man was left with \$43,000 in medical bills associated with testicular cancer after his coverage was rescinded, a form of pre-existing condition discrimination in which coverage is canceled retroactively.⁴⁶ A Pennsylvania man was surprised when eye surgery associated with a pre-existing condition was excluded, since he was not aware his coverage had such limitations.⁴⁷ A woman in Ohio faced \$48,000 in bills for a knee replacement – and has foregone needed surgery on the other knee – because she was led to believe her short-term plan was regulated coverage.⁴⁸

Excepted benefits

While short-term limited-duration plans have received the most attention, there are other similar market segments that evade regulation. Specifically, federal law also exempts excepted benefits as defined in the statute from complying with standards that otherwise apply to individual market

⁴⁰ Gabriela Dieguez and Dane Hansen, “The Impact Of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” *Milliman*, February 25, 2020, <https://us.milliman.com/en/Insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>; see also See “Shortchanged: How the Trump Administrations Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk,” *U.S. House of Representatives*, June 2020, https://drive.google.com/file/d/1uiL3BiqXVomYnxpyaIMeg_Q-BJaURXX3/view.

⁴¹ U.S. Senator Bob Casey, “Health Care Sabotage Online: A Warning to Consumers,” October 2019, <https://www.casey.senate.gov/download/casey-report-on-health-care-sabotage-online>.

⁴² Sabrina Corlette, Kevin Lucia, Dania Palanker, and Olivia Hoppe, “The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,” *Robert Wood Johnson Foundation & Urban Institute*, January 31, 2019, <https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html>.

⁴³ Id.

⁴⁴ Christen Linke Young and Kathleen Hannick, “Misleading Marketing of Short-Term Health Plans Amid COVID-19,” *Brookings Institution*, March 24, 2020, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>.

⁴⁵ GlobeNewswire, “HIIQ Resolves Legacy regulatory matter in the State of Washington,” January 02, 2020, <https://www.globenewswire.com/news-release/2020/01/02/1965684/0/en/HIIQ-Resolves-Legacy-regulatory-matter-in-the-State-of-Washington.html>.

⁴⁶ Noam N. Levey, “Skimpy Health Plans Touted by Trump Bring Back Familiar Woes for Consumers,” *Los Angeles Times*, April 2, 2019, <https://www.latimes.com/politics/la-na-pol-trump-shortterm-health-insurance-consumer-problems-20190402-story.html>.

⁴⁷ U.S. Senator Bob Casey, “Health Care Sabotage Online: A Warning to Consumers,” October 2019, <https://www.casey.senate.gov/download/casey-report-on-health-care-sabotage-online>.

⁴⁸ Reed Abelson, “Florida Company Sued Over Sales of Skimpy Health Plans,” *The New York Times*, June 12, 2019, <https://www.nytimes.com/2019/06/12/health/insurance-lawsuit-obamacare.html>.

coverage. Excepted benefits in the individual and employer markets are generally defined in analogous ways under the statute and implementing regulations, though some specific kinds of excepted benefits applicable to employers have no logical analogue in the individual market and are not reflected in individual market regulations, as shown in Figure 7.

Figure 7: Excepted benefits in the individual market

| | |
|--|--|
| Secondary or incidental excepted benefits | Workers compensation |
| | Disability income replacement insurance |
| | Auto insurance |
| | Accident-only insurance |
| | Liability or credit insurance |
| | On-site medical clinics |
| Limited excepted benefits | Travel insurance |
| | Dental coverage |
| | Vision coverage |
| Noncoordinated excepted benefits | Long term care coverage |
| | Critical illness policies |
| | Fixed or hospital indemnity |
| Supplemental excepted benefits | Medicare supplemental coverage |
| | TRICARE supplemental coverage |
| | Coverage supplemental to a group health plan |

Benefits excepted in the employer market with no analogue in the individual market: FSAs, employee assistance programs, and some HRAs.

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As we saw above, while the exemption for excepted benefits may be intended to encompass plans that are very different from traditional health coverage, in fact, products can be designed to classify as an excepted benefit while offering a benefit design very similar to health coverage – thus evading regulation under federal law while competing for healthy consumers.

Similar to the employer context, the most significant opportunity is associated with fixed indemnity coverage, defined in federal regulations as coverage that pays a “fixed dollar amount per period... without regard to the amount of benefits provided,” but in practice benefits scale with services received. Perhaps the most extreme example can be found in a relatively new online vendor that allows consumers to customize exactly which benefits they want covered from a list of *thousands* of potential options.⁴⁹ The coverage offers an extraordinarily detailed payment rubric, accessed via app, that informs enrollees what they will be paid “per day” they receive that particular service. (Unsurprisingly, there is limited transparency in the product design, and it is difficult to find information on the exact reimbursement rates without completing a coverage application.)

⁴⁹ Ron Hurtibise, “Cheaper than Obamacare? Budget-Priced Plans can Cost Far More if you Get Sick,” *South Florida Sun Sentinel*, November 8, 2019, <https://www.sun-sentinel.com/business/fl-bz-should-middle-income-earners-consider-obamacare-alternatives-20191108-wqam2vgmsvbhxo44xi53qb7o4-story.html>.

This sort of plan design is not limited to new online vendors; major brand name carriers also offer such plans. For example, one fixed indemnity plan from a major carrier (available in 37 states) has a detailed rubric for determining payment in the event of hospitalization, varying payment based on the setting and the providers involved in care, as shown in Figure 8.⁵⁰ The plan even has a provider network: hospitals and other providers have agreed to offer their services to plan enrollees at discounts, which presumably align with the plan’s payment formula, and the plan pays directly to providers.

Figure 8: Sample individual market fixed indemnity benefit schedule

| Hospital & Ambulance Benefits | | Choice Value | Choice Plus | Select Value | Primary Preferred | Select Preferred | Premier Plus | |
|---|--------|--------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|-----------------------------------|------------------------------------|
| Inpatient Hospital Confinement (unlimited) | | We pay: | \$1,000 per day | \$2,000 per day | \$3,000 per day | \$4,000 per day | \$5,000 per day | \$5,000 per day |
| Increasing Injury Reimbursement* (unlimited) Inpatient Hospitalization Benefits increase 25% each year, years 2-5, for injury-related hospital stays. | Year 2 | We pay: | \$1,250 per day | \$2,500 per day | \$3,750 per day | \$5,000 per day | \$6,250 per day | \$6,250 per day |
| | Year 3 | | \$1,500 per day | \$3,000 per day | \$4,500 per day | \$6,000 per day | \$7,500 per day | \$7,500 per day |
| | Year 4 | | \$1,750 per day | \$3,500 per day | \$5,250 per day | \$7,000 per day | \$8,750 per day | \$8,750 per day |
| | Year 5 | | \$2,000 per day | \$4,000 per day | \$6,000 per day | \$8,000 per day | \$10,000 per day | \$10,000 per day |
| Inpatient Hospital Intensive Care Unit (ICU) or Critical Care Unit (CCU) (maximum per confinement) | | We pay: | \$2,000 per day (31 days) | \$4,000 per day (31 days) | \$6,000 per day (31 days) | \$2,000 per day (60 days) | \$2,000 per day (60 days) | \$10,000 per day (31 days) |
| ICU/CCU benefit amounts are in addition to Inpatient Hospital Confinement benefits. | | | | | | | | |
| Inpatient Physician Visits (maximum during Inpatient Hospital Confinement) | | We pay: | \$100 per visit (1 visit per day) | \$100 per visit (1 visit per day) | \$100 per visit (1 visit per day) | \$100 per visit (1 visit per day) | \$100 per visit (1 visit per day) | \$100 per visit (2 visits per day) |
| Emergency Room (maximum per calendar-year) | | We pay: | \$200 per day (2 days) | \$200 per day (2 days) | \$300 per day (2 days) | \$300 per day (3 days) | \$300 per day (3 days) | \$500 per day (2 days) |
| Ambulance-Ground or Water (maximum per calendar-year) | | We pay: | \$500 per trip (1 trip) | \$500 per trip (1 trip) | \$500 per trip (1 trip) | \$500 per trip (1 trip) | \$500 per trip (1 trip) | \$1,000 per trip (1 trip) |
| Ambulance-Air (maximum per calendar-year) | | We pay: | \$5,000 per trip (1 trip) | \$5,000 per trip (1 trip) | \$5,000 per trip (1 trip) | \$5,000 per trip (1 trip) | \$5,000 per trip (1 trip) | \$5,000 per trip (1 trip) |

* Not available in OH.

Source: uhone.com

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This is not *exactly* like traditional health insurance and is not a perfect substitute for traditional benefits. Most importantly, of course, it lacks the consumer protections necessary for quality coverage. Pre-existing conditions are excluded from coverage, and it still leaves individuals exposed to very significant out-of-pocket costs – the amounts shown in the Figure above may be sufficient to pay for the average hospital stay, but not a very complex one. Nonetheless, it shares many features with a traditional health plan. Some individuals (especially healthier people) might deliberately select this benefit, and unsuspecting consumers could easily be steered toward it without fully appreciating the limitations. Indeed, one fixed indemnity product website answers the question “Is this insurance?” by explaining, “Yes, it is! [Our product] pays fixed amounts for every medically necessary service, procedure and drug except for maternity.”⁵¹

Just as with short-term plans, there is ample anecdotal evidence of consumers who are surprised by the limitations of their coverage, often because of misleading agent and broker sales practices. A professor in Pennsylvania found herself facing \$20,000 in medical bills after a partial amputation of her foot; she expected her health plan to cover the benefit and was not aware she had enrolled in a fixed indemnity plan that would exclude costs arising from her pre-existing diabetes.⁵² Another Pennsylvania woman was surprised to discover her health coverage was actually a fixed indemnity plan that would cover only \$2,000 towards her tens of thousands of dollars in hospital bills after an

⁵⁰ United Healthcare, “Hospital & Doctor Fixed Indemnity Insurance,” <https://www.uhone.com/filehandler.ashx/?FileName=45173-G201912.pdf> (last visited June 23, 2020).

⁵¹ Sidecar Health, “Start Your Health Insurance Now,” <https://app.sidecarhealthinsurance.com/signup/packages> (image on file with authors).

⁵² Sarah Gantz, “Villanova Prof Contracted Sepsis and Needed an Amputation — and Her Health Plan Wouldn’t Pay,” *The Philadelphia Inquirer*, April 5, 2019, <https://www.inquirer.com/health/obamacare-skimpy-health-plan-villanova-professor-20190405.html>.

injury.⁵³ She thought she had purchased fully regulated coverage through the federal HealthCare.gov website but was misled by a broker's website and a phone conversation with a salesperson. A man in Texas detailed the lengths to which an insurance agent went to sell him a fixed indemnity plan, rushing to complete a sale without, in the consumer's view, any disclosure of plan limitations.⁵⁴ When reporters contacted the agent, he seemed surprised that anyone would be unhappy with the benefit design.

As we saw with employers, other excepted benefit plans – accident and critical illness policies – could also design their benefits in this way. In the employer context, abuse of these benefit forms seems largely theoretical; in the individual market, there is some evidence it is beginning to become real. Widely available accident insurance plans pay an amount associated with having a particular type of injury, coupled with additional payments based on the type of medical care received. One plan from a major national carrier pays \$200 for a concussion, plus \$200 for an Emergency Room visit, \$250 for a CT scan, and \$65 for a follow-up visit with the neurologist.⁵⁵ These amounts are lower than the prices for those health care services, but the design mimics a health benefit and could certainly scale up. It is harder to find problematic critical illness policies – the most widely available policies do seem to pay a large lump sum at diagnosis – but there is little reason to doubt that such policy forms could exist, particularly if other options to offer non-compliant coverage are foreclosed. Indeed, combination critical illness and accident policies could replicate nearly everything covered by traditional plans. Further, existing federal regulations contain essentially no guardrails about the form these products must take, defining accident policies as “coverage only for accident (including accidental death and dismemberment),” and critical illness policies as “coverage only for a specified disease or illness (for example, cancer policies),” as long as they are not coordinated with a group health plan.

Unregulated markets

Until this point, we have considered gaps in regulation of individual coverage that arise because federal law has expressly exempted a form of coverage from oversight, and entities classify their product as exempted within those definitions. We turn now to a very different kind of gap in the regulation of health coverage: forms of individual coverage that are not considered “insurance” at all – and therefore are beyond the reach of the regulatory scheme.

In the employer market, any time an employer offers a benefit that involves health care, it is a “group health plan” that must either comply with applicable standards or be classified as an excepted benefit. (Even when small employers try to avoid the risk pooling provisions of federal law, they are still group health plans subject to regulation as such). Not so in the individual market. In federal law, health insurance coverage means “benefits consisting of medical care... offered by a health insurance issuer.” A health insurance issuer is an entity that is “licensed to engage in the business of insurance in a State and which is subject to State law that regulates insurance.” So, if an entity is not considered a “health insurance issuer” under state law (and no employer is involved), then that entity can offer coverage without coming under the umbrella of federal regulation.

States generally do take a broad view of what constitutes “insurance” in their state. They want to ensure that when a third party accepts risk for health care costs, its financial affairs are subject to review by the state insurance commissioner. Therefore, states generally treat certain sorts of transactions as insurance contracts that *require* licensure as an issuer and oversight of the product being sold. In all states, if a payday lender attempted to sell a product that offered protection against medical costs but

⁵³ Sarah Gentz, “A Philly Woman’s Broken Back and \$36,000 Bill show how some Health Insurance Brokers Trick Consumers into Skimpy Plans,” *The Philadelphia Inquirer*, November 14, 2019, <https://www.inquirer.com/health/consumer/limited-benefit-skimpy-health-plans-sales-pitch-20191114.html>.

⁵⁴ Jenny Deam, “Risky Business: Buying Health Insurance in the New Age of Deregulation,” *Houston Chronicle*, November 27, 2019, <https://www.houstonchronicle.com/business/article/Risky-Business-Buying-health-insurance-in-the-14865415.php>.

⁵⁵ United Healthcare, “Accident SafeGuard,” <https://www.uh.com/filehandler.ashx?FileName=43936C1-G201712.pdf> (last visited June 22, 2020).

claimed it was not a health insurance issuer and therefore not selling health insurance coverage, state law would take a different view: it would say that a transaction is an insurance contract, and the payday lender must become licensed as an insurance issuer and have the product regulated as insurance if it wants that health care product to be for sale.

In this way, state and federal law are usually in balance. States generally want to define the types of transactions that constitute insurance broadly, and federal law requires that once the state starts regulating the issuer and the product, federal protections will apply. Problems emerge when the type of transaction an entity engages in is able to slip through state law definitions of insurance, and when states *deliberately* write their insurance laws so that a product that otherwise would be considered insurance is expressly defined as “not insurance.”

In either case, consumers can become enrolled in something that seems like “health coverage” but is in fact not regulated as such. The sections that follow consider three existing examples – Farm Bureau plans, health care sharing ministries, and self-insured student health plans – and then offers a brief discussion of the potential for future abuse.

Farm Bureau plans

Three states authorize the state Farm Bureau to sell a product that looks quite a bit like health insurance, but state law defines as *not* health insurance and therefore not subject to state or federal insurance law. Tennessee has provided for such plans since 1993, defining the Farm Bureau as a “not-for-profit membership services organization.”⁵⁶ The Farm Bureau thus offers a benefit to its members (i.e. anyone who pays an annual fee) in the form of a medically underwritten health care benefit. Individuals must pass a health care screening to be allowed to enroll in the plan, and pre-existing conditions are excluded from coverage. Likewise, the plans do not cover all Essential Health Benefits. Maternity services are subject to a waiting period and are only available if an entire family is covered, not just a single adult. Mental health and substance use disorder services do not appear to be covered, and there are significant limitations in coverage of benefits like habilitative and rehabilitative coverage.

For benefits that are covered and for those that are healthy enough to enroll, some of the Tennessee Farm Bureau plans offer cost-sharing that resembles what an enrollee would experience in regulated sections of the market, while other plans require about 85% more exposure to out-of-pocket costs than would be allowed in regulated plans, with out-of-pocket limits as high as \$15,000 per person.⁵⁷ The Tennessee plans do not have annual and lifetime limits (though they could). That is, while the coverage available is somewhat more robust than the thinnest versions of coverage described above, these plans suffer from some of the same exclusions and potential gaps in coverage as short-term plans and similar benefits. Moreover, just as we saw above, these plans exclude pre-existing conditions from coverage and allow only healthy individuals to enroll, relegating higher cost enrollees to the regulated segments of the market and driving up premiums in the regulated risk pool.

Tennessee was the first state to authorize this “not insurance” model of insurance. Enrollment in Tennessee Farm Bureau plans has grown since enactment of the ACA, and other states have followed

⁵⁶ Sabrina Corlette and Kevin Lucia, “What’s Going on in Tennessee? One Possible Reason for Its Affordable Care Act Challenges,” *Georgetown University Health Policy Institute*, April 11, 2017, <http://chirblog.org/whats-going-tennessee-one-possible-reason-affordable-care-act-challenges/>.

⁵⁷ See Farm Bureau Health Plans, “Enhanced Choice Services”, https://www.fbhealthplans.com/SiteMedia/Documents/Schedule_of_Benefits/Enhanced-Choice.pdf (last visited June 26, 2020); Farm Bureau Health Plans, “Core Choice Services”, https://www.fbhealthplans.com/SiteMedia/Documents/Schedule_of_Benefits/Core-CHOICE.pdf (last visited June 26, 2020).

suit.⁵⁸ Iowa passed its own Farm Bureau legislation in 2018,⁵⁹ and Kansas passed similar legislation in 2019.⁶⁰ Plans available in Kansas are nearly identical to those in Tennessee and use the same policy forms and exclusion language.⁶¹ Farm Bureau plans in Iowa are structured a bit differently.⁶² As in Tennessee and Kansas, they are only available to those who can pass the underwriting screen, and enrollees with pre-existing conditions are excluded. For the benefits that are covered for those healthy enough to enroll, however, plans cover benefits that are similar to regulated plans and appear to include most of the full EHB package, including maternity and mental health. Some plans do have out-of-pocket limits somewhat higher than allowed in the regulated market (\$10,000 for a single person), and all plans are subject to a \$3 million lifetime limit.

Therefore, in the three states that allow them today, Farm Bureau plans suffer from some gaps in coverage that leave individual enrollees exposed, and significant harms arise from the fact that they pull healthy individuals out of the regulated risk pool.

Health care sharing ministries

Another problematic form of “not insurance” is coverage offered by health care sharing ministries (HCSMs). This is a loosely defined market segment, but it generally means a group of individuals with some sort of religious affiliation who agree to share health care costs with one another. No insurance company is involved, so the coverage can evade being considered health insurance coverage subject to regulation.

In their original incarnation, HCSMs would ask members to contribute directly to one another’s medical bills with monthly mailers listing claims in need of reimbursement. Indeed, some early state laws attempting to define the relationship between HCSMs and the state insurance code characterized the organizations as “religious publications,” because the primary tool they used to share health care costs were mailings that would “match[] subscribers with the present ability to pay with subscribers with present financial or medical need.”⁶³

Over time, some HCSMs have evolved to look much more like regular health care coverage. A mid-2000s legal dispute involved an HCSM that would collect all medical bills their members incurred in a month, divide total costs by their number of enrollees (weighted by household characteristics), and ask each enrollee to contribute their share of those costs.⁶⁴ Today, certain HCSMs have shed all but the most formulaic pretense of directly sharing costs between members. Instead, they charge advertised monthly amounts to enrollees based on characteristics like age and sex. They structure their benefits with deductibles, co-pays, per-service allowed amounts, networks – and pre-existing condition exclusions as well as annual and lifetime limits. Indeed, the only reference to the “sharing” nature of the benefit is the fact that the plan disclaims any obligation to fully comply with the terms of

⁵⁸ Sabrina Corlette and Kevin Lucia, “What’s Going on in Tennessee? One Possible Reason for Its Affordable Care Act Challenges,” *Georgetown University Health Policy Institute*, April 11, 2017, <http://chirblog.org/whats-going-tennessee-one-possible-reason-affordable-care-act-challenges/>.

⁵⁹ Sarah Lueck, “Kansas Bill Would Harm People With Pre-Existing Conditions,” *Center on Budget and Policy Priorities*, April 10, 2019, <https://www.cbpp.org/blog/kansas-bill-would-harm-people-with-pre-existing-conditions>.

⁶⁰ Alice Mannedette, “Seeking Affordable Care, Kansas Farmers Explore KFB Health Offering,” *The Hutchinson News*, October 20, 2019, <https://www.hutchnews.com/news/20191020/seeking-affordable-care-kansas-farmers-explore-kfb-health-offering>.

⁶¹ Kansas Farm Bureau Health Plans, “Individual & Family,” <https://www.kfbhealthplans.com/individual-family> (last visited June 22, 2020).

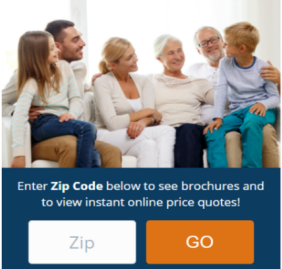
⁶² Farm Bureau Health Plans, “Outline Of Coverage For Farm Bureau Health Plans 2019 Plan Year,” https://www.iowafbhealthplan.com/page/file?path=Files%2Fwebsite%2FFiles%2FM9319667_08_18_v5_10_01_18_FINA_L.PDF (last visited June 22, 2020).

⁶³ See, e.g., *Kentucky v. Reinhold*, 325 S.W.3d 272 (Supreme Court of Kentucky 2010), available at https://scholar.google.com/scholar_case?case=12027759278514462230&q=Commonwealth+of+Kentucky+v.+E.+John+Reinhold+D/B/A+American+Evangelistic+Association&hl=en&as_sdt=20006&as_vis=1.

⁶⁴ Diana B. Henriques, “Ministry’s Medical Program Is Not Regulated,” *The New York Times*, October 20, 2006, <https://www.nytimes.com/2006/10/20/business/2oreligion.html>.

its benefit design, instead asserting that payment depends on other enrollees making “voluntary” contributions. Nor are they necessarily particularly rooted in a religious tradition. Some HCSMs do limit enrollment to those with shared faith commitments. For others, plan documents may be sprinkled with biblical quotes and enrollees might “agree” to a set of faith-based principles, but there is nothing linking enrollees beyond having clicked on the same paid advertisement in their web-browser. Figure 9 shows excerpts from one HCSM’s website and plan documents.

Figure 9: Excerpts from sample health care sharing ministry plan documents



Christian Healthcare Sharing
The “Faith-Based” Healthcare Alternative

Enter Zip Code below to see brochures and to view instant online price quotes!

Zip

| | |
|---|---|
| Individual Sharing Amount (ISA) | ✓ \$5,000 / \$10,000 |
| Specialists | ✓ \$75 Visit Fee ✓ Hospitalization or Post Outpatient Surgery |
| Emergency Room | ✓ \$300 Visit Fee |
| Diagnostic/X-Ray/Labs | ✓ 100% after ISA is met, up to Maximum Sharing Limit ✓ Outpatient: Pre-Admission and Post In-Patient |
| In/Outpatient Surgery <small>Life threatening emergency immediately available.</small> | ✓ 100% after ISA up to Maximum Sharing Limit ✓ 2 month waiting period |
| Hospitalization | ✓ 100% after ISA up to Maximum Sharing Limit |
| Maximum Limit Per Incident | ✓ \$150,000 / \$250,000 / \$500,000 |
| Lifetime Sharing Maximum | ✓ \$300,000 / \$500,000 / \$1,000,000 |

Note: If you join this organization instead of purchasing health insurance, you will be considered uninsured. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance.

Source: christianhealthplans.com

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Unsurprisingly, there is widespread anecdotal evidence of consumers caught in these gaps. An 8-year-old boy who suffered an aneurism exceeded the \$250,000 limit of his family’s HCSM.⁶⁵ A New Hampshire man was surprised when a back injury was treated as a pre-existing condition.⁶⁶ State regulators in Washington state identified three different consumers enrolled in the same HCSM who were left with thousands of dollars in medical bills after their HCSM failed to pay for services.⁶⁷ A Connecticut consumer had \$280,000 in unpaid bills that the HCSM claimed were associated with a pre-existing condition.⁶⁸ Consumers have even reported difficulties with getting small bills for flu shots and lab tests paid, generating marks against their credit.⁶⁹

There is nothing in federal law that requires HCSMs be exempt from state insurance law. However, there are a variety of reasons that HCSMs may be treated as “not insurance.” First, HCSMs argue that they are truly not insurance: they do not claim to assume risk (and, in fact, insist that they are not responsible for paying medical bills in full); they merely provide a way to share resources among a group of people. In addition, 30 states have passed laws that expressly exempt HCSMs from state

⁶⁵ Reed Abelson, “It Looks Like Health Insurance, but It’s Not,” *The New York Times*, January 2, 2020, <https://www.nytimes.com/2020/01/02/health/christian-health-care-insurance.html>.

⁶⁶ Todd Bookman, “Regulators Allege Christian-Based Health Care Provider Broke State, Federal Rules,” *NPR*, November 25, 2019, <https://www.npr.org/2019/11/25/780612410/regulators-allege-christian-based-health-care-provider-broke-state-federal-rules>.

⁶⁷ JoNel Aleccia, “‘Sham’ Sharing Ministries Test Faith Of Patients And Insurance Regulators,” *Kaiser Health News*, May 17, 2019, <https://khn.org/news/sham-sharing-ministries-test-faith-of-patients-and-insurance-regulators/>.

⁶⁸ State of Connecticut Insurance Department, “Commissioner Mais Takes Action to Protect Consumers Against Unauthorized Insurance Company,” December 3, 2019, <https://portal.ct.gov/CID/News-Releases/Press-Releases/Press-Releases-20191203>.

⁶⁹ Reed Abelson, “It Looks Like Health Insurance, but It’s Not,” *The New York Times*, January 2, 2020, <https://www.nytimes.com/2020/01/02/health/christian-health-care-insurance.html>.

insurance regulation.⁷⁰ States vary widely in how they define HCSMs, and it is not at all clear that all modern HCSMs necessarily satisfy the definition that some states use, but the entities seem to treat themselves as exempt regardless of the particularities of state law. Next, the individual mandate of the ACA exempted consumers from paying mandate penalties if they were enrolled in an HCSM that met a federal definition: the entity must be a non-profit that has been in continuous existence since 1999, and members must “share a common set of ethical or religious beliefs and share medical expenses among members in accordance with those beliefs.” While the individual mandate is no longer in effect, several of the 30 states noted above use the federal individual mandate language to define the exemption from state insurance law. And even in states that do not expressly exempt HCSMs or that use a different state law definition, the entities tend to argue that the federal individual mandate language indicates a federal intent to exempt HCSMs that satisfy the federal definition from state insurance regulation. HCSMs may also argue that as religious entities, the federal Religious Freedom Restoration Act exempts them from compliance with the federal Public Health Service Act insurance reforms that states enforce.

Student health plans and similar “self-funded” benefits

Student health insurance plans are another place where we can find health care coverage that is “not insurance” under state law. Colleges and universities typically offer a health care benefit for their students, and many require students to enroll or document that they have another source of coverage. Even though a group of students are enrolled in the coverage, this is not a group health plan under federal law because it is not offered by an employer to its employees. Therefore, a student health plan is considered individual coverage.

One model is for a college or university to arrange with an insurance company that the insurer will provide coverage to the students under specified terms. This is health insurance in the individual market; formally, the insurance contract is between the student and the insurance company. Because it is health insurance in the individual market, it will generally be subject to all of the standards that otherwise apply to individual market coverage, like the requirement to cover EHB and the prohibition on annual limits.

Federal law specifies that nothing in the ACA “shall be construed to prohibit an institution of higher education... from offering a student health insurance plan.”⁷¹ Since 2011, the federal government has interpreted that language to authorize the waiver of ACA individual market provisions as applied to insured student health plans if applying the provision would make it effectively impossible for the coverage to be offered. The federal government has used this authority sparingly. They have waived only requirements that would otherwise compel the plan to be available to non-students and the requirement to pool risk with other individual market plans.⁷² Therefore, insured student health plans must, for example, cover EHB, refrain from discrimination based on pre-existing conditions, and comply with all financial protections (though they are not subject to individual market risk pooling).⁷³ They will generally comply with our definition of good health coverage.

However, colleges and universities have another option that does not result in such comprehensive application of protections. If, instead of arranging for an insurance company to offer coverage, the

⁷⁰ JoAnn Volk, Emily Curran, and Justin Giovannelli, “Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?,” *The Commonwealth Fund*, August 8, 2018, <https://www.commonwealthfund.org/publications/fund-reports/2018/aug/health-care-sharing-ministries>.

⁷¹ ACA § 1560(c) (42 U.S.C. § 18118).

⁷² Subsequent rules allowed plans to vary their actuarial value as long as they maintained an AV of at least 60%. “Student Health Insurance Coverage,” 77 Fed. Reg. 16453, (March 21, 2012), <https://www.federalregister.gov/documents/2012/03/21/2012-6359/student-health-insurance-coverage>.

⁷³ Students are generally healthier than the average member of the population, so the exclusion from the risk pool will have some adverse impact on other segments of the market. However, because coverage *within* the student health plan is high quality and because the plan is not individually cherry-picking healthy students, nor may it charge sicker students higher prices, the negative impact is limited.

university finances the coverage itself, state law will generally not consider that insurance. That is, unlike the payday lender in our example above, state law will not take the view that the benefit the university is providing to its students is a “health insurance” product that can only be offered by a “health insurance issuer” – because the university is self-funding and bearing the risk itself. And as above, if it is exempt from state law, it will also be exempt from federal law, and thus free to exclude or limit benefits.

On the one hand, available evidence suggests that this affects only a limited number of institutions; the federal government in 2011 estimated that only 200,000 students were enrolled in self-funded student plans.⁷⁴ On the other hand, there is reason to be concerned about the quality of benefits provided in these plans. A currently available self-insured student health plan has a \$400,000 annual limit (and found itself the subject of public outcry after it attempted to require students to enroll even if they also had Medicaid coverage).⁷⁵ Similarly, prior to implementation of the ACA’s prohibition of lifetime limits in insured student health plans, a major flagship public university offered an insured benefit with a \$300,000 lifetime limit (and this plan also found itself facing public scrutiny after a student with cancer exceeded this cap), suggesting lifetime and annual limits in unregulated student health plans could be widespread.⁷⁶ These plans are also free to exclude benefits or impose pre-existing condition limitations, though there is less evidence that they have done so.

This same model can arise in other situations where an entity other than an employer is “self-funding” benefits. For example, participants in AmeriCorps (in both the VISTA and NCCC programs) are offered health benefits that do not cover pre-existing conditions.⁷⁷ AmeriCorps participants are not technically employees of the program, so the coverage is not an employer group health plan. And because no issuer is involved, it is also not health insurance coverage; therefore, it is not regulated and is free to impose these exclusions. The program fully discloses these exclusions, and therefore most participants with any significant health needs likely obtain coverage through the regulated segments of the market. This avoids blindsiding consumers with unexpected bills, but shifts costs onto the regulated risk pool.

Future potential

Farm Bureau plans, HCSMs, and self-insured student health plans are the most prominent existing examples of “not insurance” forms of individual coverage. But there is significant future opportunity for other forms of abuse, particularly given the status of the ACA’s individual mandate.

While the ACA’s individual mandate penalty was in effect, it deterred a robust market for “not insurance” forms of coverage. To comply with the mandate, an individual was required to obtain specific qualifying forms of coverage, which included regulated employer and individual market coverage, coverage through specified public programs, and HCSMs meeting the federal definition. Other forms of coverage that existed outside the regulated environment, like self-insured student health plans or other HCSMs, could apply to the federal government to be deemed a qualifying form of coverage. To grant these applications, the government required coverage to comply with key ACA standards, like the prohibitions on annual and lifetime limits and pre-existing condition exclusions,

⁷⁴ “Student Health Insurance Coverage,” 77 Fed. Reg. 16453, (March 21, 2012), <https://www.federalregister.gov/documents/2012/03/21/2012-6359/student-health-insurance-coverage>.

⁷⁵ Brigham Young University-Idaho Student Health Plan 2019-2020, “Student Health Plan 2019-2020,” <https://www.dmba.com/nsc/handbooks/student/hbbyuid2019.pdf> (last visited June 22, 2020); Courtney Tanner, “BYU-Idaho No Longer Accepts Medicaid, and Some Students Are Dropping out of School,” *The Salt Lake Tribune*, November 22, 2019, <https://www.sltrib.com/news/education/2019/11/22/byu-idaho-no-longer/>.

⁷⁶ Sarah Kliff, “Arijit Guha, Student Who Battled Aetna Over Cancer Coverage, Dies,” *The Washington Post*, March 25, 2013, <https://www.washingtonpost.com/news/wonk/wp/2013/03/25/arijit-guha-student-who-battled-aetna-over-cancer-coverage-dies/>.

⁷⁷ VISTA Campus 2020, “Health Care Benefits,” <https://www.vistacampus.gov/members/benefits-of-service/healthcare-benefit> (last visited June 22, 2020); AmeriCorps, “AmeriCorps Healthcare Benefits Plan and the Affordable Care Act,” https://www.nationalservice.gov/sites/default/files/documents/NCCC%20Healthcare%20Election%20Info_o.pdf (last visited June 22, 2020).

and substantial coverage of EHB; if coverage could not meet those standards, it would not satisfy the individual mandate.⁷⁸ Therefore, while non-compliant forms of “not insurance” were not illegal under federal law, enrollees would have to pay mandate penalties, making them somewhat less attractive alternatives to regulated coverage. Now that the penalty has been reduced to \$0, it will no longer deter these coverage forms, which could lead to further proliferation.

This creates significant opportunities for states seeking to undermine the ACA’s protections. Additional states could authorize Farm Bureau plans. States could adopt the Farm Bureau model to authorize other kinds of membership entities to offer plans, like the Chamber of Commerce or the Junior League. Indeed, states *themselves* could begin selling coverage to individuals without pre-existing conditions, and the product would be entirely unregulated under federal law.

Additionally, these variants do not necessarily require state law authorization. Any membership entity could begin offering benefits to its members that include payment for medical services and try to claim it was not an issuer under state law but was instead “self-insuring” a benefit. For example, a ski resort could sell a season pass that included lift tickets as well as reimbursement for up to \$300,000 in medical expenses (whether or not connecting to skiing) for those without pre-existing conditions. A health system could offer a subscription service that covered all hospital services – essentially a scaled-up version of concierge primary care services that exist today. A church could offer medically underwritten reimbursement for the health care claims of members who have paid a membership fee, foregoing even the pretense of a HCSM. State law will have widely varying tolerance for these arrangements; an aggressive state insurance regulator relying on clear state law could likely defeat all of them, but in other states, they may simply fall through gaps in the text of state statute or the attention of state regulators.

What can be done?

The discussion above reveals that while federal law provides a foundation for the regulation of health coverage, major gaps persist. We turn now to the options available to policymakers who wish to plug these holes. We first consider what a comprehensive federal legislative fix would entail, and then turn to options available to states and to federal regulators in the absence of new federal legislation.

The discussion that follows assumes an intent to ensure that all benefits that “look like” health coverage are in fact subject to the protections of federal law that establish comprehensive coverage, with meaningful financial protection, offered in a stable way with appropriate pooling of risk. On its own, while these policies will benefit many, they would also be expected to have negative impacts on some stakeholders, such as increasing costs for some employers, inducing other employers to drop health coverage, and increasing premiums for some people who currently buy non-compliant insurance. Other policy tools are available to mitigate those consequences – including changes to the structure of the employer mandate and more generous subsidies for those purchasing individual market coverage – but they are not discussed here.

Federal legislation

Comprehensive federal legislation to close the gaps in our existing regulation of health insurance would require 6 steps:

1. Require all employer health plans to cover essential health benefits at a minimum actuarial value.
2. Redefine excepted benefits (in both the employer and individual markets) to more narrowly reflect benefits that truly deserve exemption from federal law.

⁷⁸ 26 U.S.C. § 5000A(f)(1)(E).

3. End the exclusion of short-term limited-duration insurance from the definition of health insurance coverage.
4. Simplify and strengthen federal definitions of health insurance coverage and health insurance issuer.
5. Establish that an arrangement will not be considered “self-insurance” unless the employer bears a significant share of risk.
6. Codify federal regulations and guidance that prevent additional gaps.

Each of these strategies is described below.

Require all employers to cover EHB at a minimum AV

Modifying federal law such that all group health plans (other than excepted benefits) are required to cover EHB and comply with an AV limit would be a significant policy change, but it would be technically straightforward. Section 2707 of the Public Health Service Act requires all individual and small group market plans to cover EHB; this language could be modified to apply to group health plans and the large group market, and incorporated into ERISA in the same way as all other substantive group health plan standards. Similarly, Section 2707 could be modified to impose an actuarial value floor of 60%.⁷⁹ (There is no policy justification for requiring all group health plans to be at a specific “metal level.”) Conforming changes to the employer mandate should be made to reflect the fact that plans with an AV below 60% will no longer be available.

Under current regulations, the exact set of benefits that constitute essential health benefits vary by state, which can theoretically pose a problem for employer group health plans that self-insure and are not linked to any state’s insurance market. However, federal regulations already specify that, for a variety of other purposes, a self-insuring employer can elect to have its compliance with federal requirements judged against the EHB package of any state, and the same standard could easily be applied here. The one area where it may be prudent to provide additional flexibility to group health plans in complying with EHB is in design of their prescription drug benefit. Formulary limitations that are not otherwise permitted in EHB plans may be appropriate if the requirement to cover EHB were scaled to a much larger group of beneficiaries, to avoid giving pharmaceutical manufacturers additional leverage in price negotiations.

Policymakers should also consider the appropriate access standards. While employers need not be subject to network adequacy standards, it may be prudent to incorporate some minimum concept of benefit access into a requirement to cover EHB. This would establish a relatively low bar that the plan needs to provide access to some relevant providers but would not establish numeric standards or other specific tests. The federal government has done this in other contexts where it is enforcing a requirement against all employer plans, including in defining what it means to “cover” preventive services, and in explaining the interaction between reference pricing benefits designs and the out-of-pocket limit requirement.⁸⁰

In general, the most significant impact of this policy would be on the very limited plans described above that fall far short of comprehensively covering EHB. However, many employers that otherwise offer reasonably generous coverage would have to make modest changes in their benefits to comply with this standard by, for example, more completely covering habilitative and rehabilitative services.

⁷⁹ As noted above, a 60% AV floor is not necessary if a plan is also required to cover EHB and comply with the existing out-of-pocket limit requirement; it would largely be a matter of symmetry and of simplifying employer mandate enforcement.

⁸⁰ Department of Labor, “FAQs About Affordable Care Act Implementation (Part XII),” February 20, 2013, <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/faqs/aca-part-xii.pdf>; Department of Labor, “FAQs About Affordable Care Act Implementation (Part XIX),” May 2, <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebbsa/our-activities/resource-center/faqs/aca-part-xix.pdf>.

Closing the gaps associated with excepted benefits can be best accomplished by largely rewriting the applicable statutory language defining excepted benefits in both the employer and individual markets, with a number of specific objectives. A proposed rewrite that accomplishes these objectives appears in the Appendix.

First, fixed indemnity, critical illness, and accident policies should be defined narrowly to give more meaning to the ways in which they must be distinct from regulated coverage and to prevent payment schedules that are linked to the medical care received. (See specific language in the Appendix and in the discussion of regulatory options, *infra*.) Equally important, these plans should be limited to those who have already have another form of coverage that includes the complete EHB package. This prevents individual market issuers from marketing fixed indemnity, accident, or critical illness policies as a substitute for traditional insurance, and it keeps employers from offering an excepted benefit policy that imposes limits not otherwise allowed in lieu of traditional coverage.⁸¹

Second, with respect to all excepted benefits, the statutory language should only offer an exception to the extent the excepted benefit does not duplicate, supplant, or mimic the benefits of a traditional health plan. That is, the statutory language should provide an opportunity for federal (or state) regulators to enforce against benefits that claim to be exempt from the statute but are in fact trying to avoid substantive regulation. For example, if an auto-insurance policy were to develop an extensive “add on” to their traditional coverage that looked like a health plan or a policy attempted to classify itself as long-term care despite covering an array of acute care services, this sort of language would render it no longer an excepted benefit.

Third, a redrafted statute should remove language that provides federal regulators expansive authority to define new excepted benefits. This will require codifying the exception for the types of excepted benefits that are enumerated in regulations but not currently referenced in the statute (like employee assistance programs and flexible spending arrangements). The primary use of this authority in recent years has been to create new tax expenditures through various account-based benefits, and it also continues to create opportunities to inappropriately expand excepted benefits to evade substantive regulation. Codifying the existing excepted benefits while closing off the opportunity to create new variants should strike an appropriate balance.⁸²

Fourth, policymakers should strike the excepted benefit for group supplemental coverage. There is limited policy justification for offering supplemental coverage outside of a regulated employer plan; employers can offer multiple plan options and allow enrollees to select the appropriate package while retaining full protections across their entire set of benefits. (In the alternative, if this exception were retained, then the limits in existing regulations should be codified, as described below, and the requirement to have other EHB coverage should be applied here as well.)

In addition, policymakers may wish to consider prohibiting the use of fixed indemnity and other forms of supplemental coverage for employers in the small group market in order to avoid employers shifting costs of induced utilization. Finally, while not directly related to the closing gaps in regulation, the

⁸¹ Note that if employer plans are generally required to cover EHB in their non-excepted benefit group health plans, then it may become more attractive for employers to offer fixed indemnity plans as an alternative to a traditional benefit – making the requirement to have other coverage important. On the other hand, if federal law is not changed to require EHB in employer plans, then it remains attractive to segment certain benefits into a fixed indemnity, critical illness, or accident policy, making it particularly important to enforce the standard that the other coverage specifically must cover EHB.

⁸² The text that appears in the appendix does not codify the existing excepted benefit for certain Health Reimbursement Arrangements (HRAs). The author has previously argued that this is an inappropriate use of existing statutory authority and, in any case, the purpose of these arrangements is to promote the purchase of sub-standard short-term plans. Christen Linke Young, Matthew Fiedler, and Jason Levitis, “The Trump Administration’s Final HRA Rule: Similar to the Proposed but Some Notable Choices,” *Brookings Institution*, June 14, 2019, <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/06/14/the-trump-administrations-final-hra-rule-similar-to-the-proposed-but-some-notable-choices/>.

statute's existing reliance on exempting benefits only when offered in specific policy forms (like a separate contract of insurance) could be streamlined by a general requirement that all excepted benefits be offered "separate from" traditional benefits.

End the short-term plan exclusion

In addition to closing the regulatory loopholes associated with excepted benefits in both the group and individual markets, policymakers should end the exclusion from regulation for short-term limited-duration benefits. The language in Section 2791(b)(5) that defines short-term plans as not included in the definition of individual market coverage should simply be struck from the statute.

An alternative approach would retain the existing exemption but define short-term plans as coverage not exceeding 3 months in duration (including any renewals), though there is little policy justification for subjecting even very limited short-term plans to a different set of regulatory standards than other coverage.

Define health insurance and health insurance issuer

It is also important to close down the potential for unregulated forms of "not insurance" to proliferate. While one could imagine legislation that tried to close loopholes associated with specific forms of coverage that have entered the market today, a stronger approach would foreclose the possibility of offering any kind of unregulated product. There are two general paths that could accomplish this objective: modifying federal definitions to bring all coverage into the existing regulatory framework or adopting a stand-alone requirement that all coverage comply with key protections.

The first option would modify federal definitions of "health insurance issuer" and "health insurance coverage" under the PHSA, effectively requiring that only those authorized to operate as an issuer under state law could offer a benefit that looked like health insurance. Under current law, "health insurance coverage" is "benefits consisting of medical care" that are offered by a "health insurance issuer." A "health insurance issuer" is defined as an entity "licensed to engage in the business of insurance in a State."

A modified definition must do three things. First, it should establish that "health insurance coverage" is *any* benefits or payments for medical care that are not otherwise regulated (regardless of who offers the benefit or how the risk is transferred). Second, it should exempt from this definition specific forms of otherwise regulated coverage, including group health plans, Medicare and Medicaid, and military and veterans' coverage – to avoid applying the Public Health Service Act protections to these other forms of regulated coverage. Finally, it should establish that a health insurance issuer is any entity that offers health insurance coverage. Illustrative text appears in the appendix.

These three steps would make illegal all forms of health care risk-bearing or reimbursement by third parties that fall outside a group health plan or a regulated market. This would include all Farm Bureau plans, self-funded student health plans (or other self-funded benefits like AmeriCorps plans), and most self-insured multiple-employer welfare arrangements (MEWAs) and association health plans (AHPs). It would also include Health Care Sharing Ministries regardless of the nature of their benefits. Recall that because HCSMs disclaim any responsibility for paying claims in full – and instead reimburse only to the extent of the resources available – they insist that they are not insuring any risks. But a modified definition as described above would make that type arrangement illegal by saying that if an entity wants to reimburse for health care services by pooling resources across many people, it *must* do so as an insurance contract that is obliged to play claims. All of these entities would only be permitted to exist to the extent that state law allows them to operate as issuers, in which case they would be required to offer fully compliant benefits.

If policymakers wished to allow relatively compliant forms of these coverage to exist outside the insurance market, they could add additional, very tightly constrained exemptions from the definition of health insurance coverage. For example, the definition could exempt self-insured student health plans only so long as the coverage complies with protections related to EHB, pre-existing condition discrimination, annual and lifetime limits, an out-of-pocket maximum, and AV. An exemption for narrowly defined MEWAs may also be desired.⁸³ HCSMs and Farm Bureau-type plans should generally not be permitted to continue to exist outside the insurance market; these entities could certainly qualify as issuers under state law and participate in the individual market, but there is no reason they should be allowed to continue to offer discriminatory and otherwise non-compliant coverage. As such, the language in federal law defining HCSMs should be struck.⁸⁴

Modifying the definitions of “health insurance coverage” and “health insurance issuer” will require significant conforming amendments in the insurance laws of nearly all states – but would leave states fully in control of licensing entities to bear risk and regulating issuers (as more broadly defined). That is, despite the short-term disruption for states, this is arguably the approach for regulating forms of “not insurance” that is most consistent with the spirit of the PHSA’s approach to federalism. However, a less disruptive alternative is available.

Specifically, a second option would leave the existing structure of the PHSA unchanged but adopt a freestanding requirement that any “benefits or payments for medical care” that are not otherwise regulated still must comply with substantive protections of the PHSA. The federal government should be provided authority to enforce these standards, just as they enforce standards in the four states that do not enforce PHSA protections today, and language should clarify that states remain free to bring these types of benefits under their own definitions of insurance and issuer. Illustrative language appears in the appendix. Under this language MEWAs could operate largely as they do today, and self-insured student health plans could operate provided they offered a compliant benefit design free of annual limits and other limitations. Farm Bureau plans and HCSMs would be allowed to operate, but they would be required to offer compliant benefits and stop discriminating based on pre-existing conditions. Federal law should also address whether these entities must assume responsibility for paying claims in full, or if they would be permitted to operate as HCSMs do today and pay benefits only up to the amount of voluntary contributions.

This second approach still leaves some gaps in the regulation of these entities. Federal regulators would not oversee the solvency of these entities, and they would remain outside the “single risk pool” for purposes of risk-sharing – meaning these unregulated market segments would still pose risks of insolvency for enrolled consumers and could cause adverse selection against the regulated risk pool. But once compliance with substantive protections (including a prohibition on pre-existing condition discrimination) is required, these alternative forms of coverage would compete on something more closely resembling a level playing field. This should make them less attractive as tools to evade regulation and generally limit the impact of these coverage forms.

Require self-funding arrangements to involve true risk bearing

To protect small group market risk-pooling, federal law should also restrict “level-funding” arrangements (or other problematic self-insurance arrangements) by limiting stop-loss coverage, such that the self-insuring employer is required to bear a meaningful amount of risk. Since the 1990s, the National Association of Insurance Commissioners (NAIC) has endorsed model state legislation that prohibits entities from offering stop-loss coverage with very low attachment points.⁸⁵ (The dollar

⁸³ If all group health plans are required to offer EHB, then MEWAs become a less attractive tool to undermine protections. Solvency concerns would still exist.

⁸⁴ Language directly applying these standards to HCSMs may also be appropriate, to avoid any claims that federal law does not apply under the Religious Freedom Restoration Act.

⁸⁵ National Association of Insurance Commissioners, “NAIC Model Laws, Regulations, Guidelines and Other Resources,” July 2002, <https://www.naic.org/store/free/MDL-092.pdf?64>.

figures used in this model legislation are likely far too low, but the structure applies at any dollar amount.) Because the federal government does not directly regulate insurance, it cannot precisely replicate this approach; however, the federal government can define stop-loss coverage with attachment points below a specific threshold as coverage in the group market, which would achieve the same objective.

Specifically, if the federal government pursues either approach described in the preceding section to limit “not insurance” forms of coverage, it can simply add an exemption for stop-loss coverage, only to the extent that the policy has attachment points that exceed thresholds established by the federal government in regulation, as illustrated in the appendix. This establishes that other forms of stop-loss coverage should be treated as regulated coverage. Alternatively, or additionally, the federal definitions related to employer coverage that appear in PHSA 2791(e) (and parallel statutes) could include a new paragraph noting that stop-loss coverage with attachment points below thresholds established by the federal government should be considered coverage in the group market.⁸⁶

Codify important components of regulations and guidance

Finally, the discussion in this paper illustrates three places where existing regulations prevent gaps, but the federal statute is perhaps less clear. A comprehensive legislative effort to close gaps should codify those protections.

First, policymakers should codify the “look through” guidance that was in force prior to 2018, which provides that members of an association generally continue to be treated as individuals, small groups, or large groups depending on their own status, despite purchasing coverage through an association.⁸⁷ This will make unregulated association or MEWA coverage less attractive as a tool for evading regulation.

Second, recall that federal agencies have narrowly interpreted an ACA provision that provides authority to waive the application of insurance market standards to insured student health plans. That narrow view should be codified. Specifically, ACA 1560(c) should be modified to exempt student health plans only from the requirement to cover non-students and the requirement to pool risk with other individual market plans, rather than a blanket rule of construction that could be subject to a more expansive interpretation.⁸⁸

Finally, we saw that current regulations define group supplemental coverage as an excepted benefit only to the extent that it covers non-EHB or fills in cost-sharing for otherwise-covered EHB. This standard has likely prevented group supplemental coverage from mutating in a way similar to the fixed indemnity plans that are being offered as the employer’s main source of health benefits. The simplest

⁸⁶ This type of regulation would not foreclose one option for small business that wish to leave the small group health insurance market: transferring their workforce to a Professional Employer Organization (PEO). In this arrangement, a large third-party staffing firm, the PEO, becomes the official employer of the small business’s staff, for all formal purposes, like taxes and workers compensation, not just health insurance.

⁸⁷ Gary Cohen, “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,” *Department of Health & Human Services*, September 1, 2011, https://www.cms.gov/CCIIO/Resources/Files/Downloads/association_coverage_9_1_2011.pdf.

⁸⁸ Federal law also contains a confusing provision related to self-funded non-federal governmental plans (i.e. self-funded benefits offered by state and local governments). Longstanding law allowed these plans to opt-out of certain federal insurance standards that predate the ACA, like the requirement to cover two nights in the hospital after a baby is born. The ACA modified the language of the opt-out provision, and it also modified the numbering of the various subparts of the PHSA – but made typographical errors in each that render it impossible to say which provisions are eligible for opt-out. Federal agencies have interpreted the language to allow opt-out of only pre-ACA provisions. Future federal regulators might try to argue that these plans could in fact opt-out of other provisions as well, though that would not be well supported by the statute. Nonetheless, there is an ambiguity here that should be corrected, more to correct an error than prevent future abuse. “Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond,” 79 Fed. Reg. 30239, (May 27, 2014), <https://www.federalregister.gov/documents/2014/05/27/2014-11657/patient-protection-and-affordable-care-act-exchange-and-insurance-market-standards-for-2015-and#p-210>.

approach, as described above, would be to simply eliminate group supplemental coverage as a category of excepted benefits, but if it is retained, the limits of existing regulation should be codified in PHSA § 2791(c).

Options for states under current law

In the absence of new federal legislation, states governments can act to protect their consumers and their insurance markets, and many have done so. While states cannot comprehensively address all forms of problematic coverage, a menu of targeted tools is available. States can:

1. Restrict short-term plans.
2. Restrict indemnity and other problematic and excepted benefit plans and enforce existing limits.
3. Refrain from adopting legislation authorizing Farm Bureau plans.
4. Modify or restrict state law definitions of HCSMs, and/or enforce against HCSMs under existing state law.
5. Regulate self-funded student health plans and stop-loss coverage.
6. Regulate MEWAs.
7. Monitor and regulate agent and broker conduct with respect to non-compliant coverage forms.

Additional detail on each of these policies follows.

Restrict short term plans

Federal law allows short-term plans with an initial term of less than 12 months, plus two renewals, but states need not tolerate this definition. In fact, 25 states already restrict short-term plans further.⁸⁹ Some states entirely prohibit the sale of short-term plans. Others allow short-term plans to be sold but prohibit pre-existing condition discrimination and apply other consumer protections, which has essentially the same effect. Additional states use the pre-2018 federal rule and limit short-term plans to less than 3 months (including renewals). Still others restrict short-term plans to a contract period somewhat shorter than federal law allows, such as 6 or 12 months inclusive of renewals, and others limit “stacking” – a practice in which a broker sells multiple consecutive short-term plans at the same time.

States that have not adopted restrictions on short-term plans can do so, and states that have put in place limits of 12, 6, or even 3 months can consider tightening their policies.

Restrict excepted benefits, including fixed indemnity

The abusive forms of excepted benefits policies described above are regulated in the insurance market of a state (even though they are not required to comply with health insurance consumer protections). Because they are a form of insurance, policy forms must be approved by the state; therefore, states have tools to disallow the sale of problematic plans.

Some of the most problematic and newer fixed indemnity policies, with thousands of different payments for specific services, can be – and have been – rejected by motivated state regulators, because they stray so far from any understanding of what distinguishes indemnity coverage from a traditional plan. Many states also have existing authority to reject indemnity policies that have a somewhat less radical design but still vary payment substantially based on health care services

⁸⁹ Justin Giovannelli, Kevin Lucia, and JoAnn Volk, “States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership,” *The Commonwealth Fund*, January 2020, https://www.commonwealthfund.org/sites/default/files/2020-01/Giovannelli_states_indiv_market_coverage_affordable_ib.pdf.

received, and some states do reject policies with certain characteristics. Should more problematic behavior attempt to shift into accident and critical illness policy forms (as may be likely if other routes to offer non-compliant coverage were foreclosed) states could also use existing authority to disapprove abusive policy forms.

And of course, state legislators can also adopt new legislation that directly limits the form that these types of policies could take. States could adopt state law requirements like the proposed federal legislation described above, allowing carriers to sell fixed indemnity and other products only when payment does not vary with the type of health care services received and only to consumers who otherwise have comprehensive coverage. These requirements could apply to indemnity products sold to individuals and to employers; states cannot regulate the employer directly, but they can regulate the insurance product sold by a fixed indemnity carrier in the employer market.

States may also have a tool to attempt enforcement against employers' combination of a very skimpy traditional plan with a fixed indemnity plan that serves as the primary source of coverage for employees. Recall that fixed indemnity plans are only excepted benefits to the extent they are "not coordinated" with an "exclusion" in another plan. There is little evidence that this has been an effective tool for deterring problematic employer offerings. However, state regulators could certainly make a case that the ways in which some employers combine benefits today violates this standard. The argument would be buttressed by the way in which benefits are presented – with the fixed indemnity product clearly being marketed as a complement to the exclusions in the skinny plan. (See *supra* Figure 4.) As above, states can enforce against the fixed indemnity carrier, not the employer, but that would still prevent this type of coverage from being offered.

Avoid Farm Bureau plans

States that wish to limit non-compliant coverage in their market should not adopt state legislation authorizing "not insurance" forms of coverage, like Farm Bureau plans, and existing law should be repealed.

Restrict Health Care Sharing Ministries

States also have tools to regulate Health Care Sharing Ministries. Recall that 30 states have state law that exempts certain HCSMs from being treated as insurance, but entities offering HCSMs often sell plans in all states without regard to the specifics of state law definitions. Therefore, at a minimum, states can take enforcement action against HCSMs that offer benefits that do not comply with the terms for state law exemption. For example, four states that exempt HCSMs have nonetheless taken enforcement action against the same entity for offering a benefit that operates outside the terms of the state law exemption.⁹⁰ Texas state law exempts from the definition of insurance "faith-based non-profit organizations that operate only to facilitate the sharing of medical expenses among participants,"⁹¹ but the state has successfully blocked operation of a HCSM that is effectively operated by a for-profit company that uses up to 70% of its revenue for profit and administrative costs.⁹² This same entity is embroiled in a legal dispute with the state of Washington; the exemption from Washington state law is contingent on a HCSM having been in continuous existence since 1999, a condition that the state claims this entity cannot satisfy. States can maintain familiarity with the

⁹⁰ Maryland, New Hampshire, Texas, and Washington state have argued that this HCSM does not qualify for state law exemption; Colorado and Connecticut have also enforced against this same company. See JoAnn Volk, Justin Giovannelli, and Christina L. Goe, "States Take Action on Health Care Sharing Ministries, But More Could Be Done to Protect Consumers," *The Commonwealth Fund*, February 19, 2020, <https://www.commonwealthfund.org/blog/2020/states-take-action-health-care-sharing-ministries-more-could-be-done-protect-consumers>.

⁹¹ See First Amended Petition Seeking Injunctive Relief, Civil Penalties, Temporary Restraining Order and Temporary Injunction, *Texas v. Alieria Healthcare, Inc.*, No. D-1-GN-19-003388 (July 11, 2019) (available at <https://www.tdi.texas.gov/news/2019/documents/Alieria-First-Amd-Petition-July-2019.pdf>).

⁹² Texas Department of Insurance, "State Files Lawsuit Against Alieria Healthcare," July 19, 2019, <https://www.tdi.texas.gov/news/2019/tdio5172019-faq.html>.

HCSMs that are offering benefits to their residents and take swift enforcement action to obtain information needed to verify compliance with state law and block sales from entities that don't meet state definitions.

States can also modify their state law exemptions to require registration with state regulators, disclosure of financial statements, and particular marketing practices and disclosures.⁹³ These sorts of transparency tools would make it easier to identify entities that were out-of-compliance with the substantive standards of state law. And state law substantive standards could also be modified to ensure that entities that receive exemption as HCSMs have true "sharing" features in their benefit design and that members are meaningfully connected by religious beliefs.

More aggressive tools are also available if states wish to foreclose most or all HCSM activity in their state. Twenty-one states do not expressly exempt HCSMs under the state law definition of insurance; those states could bring an enforcement action against any HCSM claiming that the entity was selling a product that must be treated as insurance under state law. Recent enforcement activity has largely been focused on entities with marketing practices so aggressive as to support claims of fraud, but states could certainly broaden their scope. States could also write state law to expressly treat HCSMs as insurance, disallowing the dodge by which HCSMs disclaim responsibility for paying bills and therefore say they have not taken any insurance risk because they are merely pooling resources. Alternatively, state law could simply prohibit HCSMs from discriminating based on pre-existing conditions, as proposed legislation in Connecticut would do, which would likely shut down the market in the state while not technically prohibiting these entities.⁹⁴

As noted above, in response to this sort of aggressive action, HCSMs may claim, variously, that state law is preempted by the federal individual mandate language or that they are not insurance because they do not take risk. States would have their own defenses, including that some states courts have treated "normal" HCSMs as insurance since at least the mid-2000s, and that the claim for preemption based on the individual mandate language requires unsupported interpretative leaps.⁹⁵

Regulate student health plans and stop-loss coverage

States can restrict potentially problematic forms of self-insurance. Self-insured student health plans are not regulated as insurance, but colleges and universities are themselves regulated by state government. Therefore, a state can directly regulating the benefits made available to students. For example, Massachusetts requires all colleges and universities to make available a student health plan that, among other things, does not discriminate based on pre-existing conditions and does not impose annual or lifetime limits.⁹⁶ Consumer representatives to the NAIC have recommended that states take this or a similar approach.⁹⁷

The NAIC has also offered model legislation for state regulation of stop-loss coverage to protect the small group market. (Stop-loss coverage is not regulated as health insurance, but it is usually subject

⁹³ JoAnn Volk, Justin Giovannelli, and Christina L. Goe, "States Take Action on Health Care Sharing Ministries, But More Could Be Done to Protect Consumers," *The Commonwealth Fund*, February 19, 2020, <https://www.commonwealthfund.org/blog/2020/states-take-action-health-care-sharing-ministries-more-could-be-done-protect-consumers>.

⁹⁴ Connecticut General Assembly, "An Act Requiring Health Care Sharing Ministries To Comply With The Patient Protection And Affordable Care Act," https://cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=SB-209 (June 23, 2020).

⁹⁵ Michael Rowden v. American Evangelical Association, No. BDV-2006-109 (January 2, 2001) (available at <https://csimt.gov/wp-content/uploads/INS-2006-109-OVM.pdf>)

⁹⁶ Commonwealth Health Insurance Connector Authority, "Student Health Insurance Program," June 28, 2019, <https://www.mass.gov/doc/956-cmr-8-student-health-insurance-program/download>.

⁹⁷ National Association of Insurance Commissioners, "Implementing the Affordable Care Act's Insurance Reforms: Consumer Recommendations for Regulators and Lawmakers," August 2012, https://www.naic.org/documents/committees_conliaison_1208_consumer_recs_aca.pdf.

to state regulation as property insurance.) The NAIC recommends that states simply prohibit the sale of stop-loss coverage with attachment points below certain threshold, though, as noted above, the thresholds used in existing model legislation may be too low. Some states also prohibit the sale of stop-loss coverage entirely to certain small employer groups or require it be rated in a manner similar to health insurance in the small group market.⁹⁸ These policies sharply limit “level-funding” or other small employer self-funding arrangements in those states.

Regulate MEWAs

As noted above, MEWAs and AHPs are problematic because they allow small employers to exit the small group market, and because they involve unregulated entities bearing health care costs – exposing enrollees to risks of fraud and insolvency. Since 1983, federal statute has granted states the authority to regulate self-insured MEWAs as risk-bearing entities (and the state can regulate the insurer offering insured MEWAs). Following significant fraud and insolvency in these markets throughout the 1990s, state regulators developed tools to oversee these forms of coverage, though not all states have adopted them.⁹⁹ As interest in opportunities to avoid small group market regulation and risk pooling increases, states can ensure they have full authority to regulate the solvency of MEWAs.

Recall, also, that recent federal rules have attempted to expand the circumstances under which small employers (and individuals) could purchase coverage as if they were part of the large group market – but those rules have been enjoined by a federal court. If that rule were to be reinstated, then states could attempt to use their authority over MEWAs to prevent entities in their state from making available offerings that undermine risk pooling.

Regulate agents and brokers

Finally, states have a powerful opportunity to protect consumers through regulation of agent and broker conduct. We saw above that many forms of non-compliant coverage offered to individuals – short-term, fixed indemnity, and HCSP plans – are aggressively marketed by agents and brokers who may not disclose the coverage limitations. This includes individual agents and brokers, who work one-on-one with a consumer, as well as online web-brokers that operate technology platforms for the sale of insurance.

Non-compliant products tend to pay much higher commissions to agents and brokers than regulated plans, at least in part because they are medically underwritten and spend a much higher percentage of premium revenue on administrative costs (like broker commissions) and offeror profits as opposed to medical costs.¹⁰⁰ This can create powerful incentives to steer all healthy consumers towards non-compliant coverage forms, even if the individual could pay comparable or lower premiums for comprehensive coverage using subsidies under the ACA. Indeed, one small scale secret-shopper

⁹⁸ National Association of Insurance Commissioners, “Stop Loss Insurance, Self-Funding and the ACA,” 2015, https://www.naic.org/documents/SLI_SF.pdf.

⁹⁹ Mila Kofman, Eliza Bangit, and Kevin Lucia, “MEWAs: The Threat of Plan Insolvency and Other Challenges,” *The Commonwealth Fund*, March 2004, https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_issue_brief_2004_mar_mewas_the_threat_of_plan_insolvency_and_other_challenges_kofman_mewas_pdf.pdf.

¹⁰⁰ See, e.g., Kevin Lucia, Sabrina Corlette, Dania Palanker, Olivia Hoppe, “Views From the Market: Insurance Brokers’ Perspectives on Changes to Individual Health Insurance,” *Urban Institute*, August 15, 2018, <https://www.urban.org/research/publication/views-market-insurance-brokers-perspectives-changes-individual-health-insurance>; <https://www.commonwealthfund.org/blog/2020/states-take-action-health-care-sharing-ministries-more-could-be-done-protect-consumers>; Julie Appleby, “Short-Term Health Plans Boost Profits For Brokers And Insurers,” *NPR*, December 21, 2018, <https://www.npr.org/sections/health-shots/2018/12/21/678605152/short-term-health-plans-boost-profits-for-brokers-and-insurers>.

analysis found that half of brokers steered subsidy-eligible but healthy consumers away from comprehensive coverage; one noted “Obamacare is only for sick people.”¹⁰¹

Agents and brokers are directly licensed and regulated by state insurance regulators. Therefore, states can put in place – and enforce – a variety of requirements for those that sell non-compliant coverage forms. Illinois has required brokers to read specific disclosures about pre-existing conditions and other limitations to consumers;¹⁰² California has required certain brokers to screen for ACA subsidy eligibility and make eligible consumers aware of the benefits of subsidized options.¹⁰³ Alaska and Texas are enforcing a requirement that brokers selling HCSMs are *themselves* liable for certain unpaid claims because HCSMs are not insurance.¹⁰⁴

Aggressive state regulators could combine all of these features. They could require that all brokers screen for subsidy eligibility and inform consumers of the results, and require specific verbal disclosure of the limits of non-compliant coverage forms (perhaps including illustrative examples to better help consumers process information about risk). Brokers could be required to contact existing consumers in non-compliant coverage forms during the annual open enrollment period to make them aware of the opportunity to switch to comprehensive coverage. They could establish annual reporting on sales of compliant and non-compliant coverage forms to monitor statewide trends and potentially as a tool to direct enforcement activity. Web-brokers could be subject to additional oversight of the way materials are presented to consumers.

Options for the federal government under current law

Current law also provides several options for enhanced federal regulation:

1. Restrict short-term plans to less than 3 months.
2. Narrow the reach of fixed indemnity, critical illness, and accident excepted benefit policies by adopting a more detailed regulatory definition.
3. Define “licensed under state law” broadly in determining who is an issuer.
4. Regulate the conduct of brokers subject to federal standards.

Restrict short-term plans

The federal government can dramatically restrict the market for short-term plans by for modifying the regulatory definition, returning to a definition that limits these plans to three months.¹⁰⁵ Some consumers may still elect these unregulated plans during short coverage gaps, but short-term plans would no longer compete with regulated benefits for most health plan consumers.

¹⁰¹ Sabrina Corlette, Kevin Lucia, Dania Palanker, and Olivia Hoppe, “The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,” *Urban Institute*, January 31, 2019, <https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html>.

¹⁰² *Id.*

¹⁰³ Covered California, “Covered California Policy And Action Items,” November 21, 2019, <https://board.coveredca.com/meetings/2019/11-21%20Meeting/PPT.Policy%20and%20Action.Nov%202019.FINAL.1025.pdf>.

¹⁰⁴ Justin Giovannelli, Kevin Lucia, and JoAnn Volk, “States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership,” *The Commonwealth Fund*, January 2020, https://www.commonwealthfund.org/sites/default/files/2020-01/Giovannelli_states_indiv_market_coverage_affordable_ib.pdf.

¹⁰⁵ In litigation that is currently before the D.C. Circuit, a group of health plans argues that limiting short-term plans to three months in duration is the only permissible interpretation in light of other provisions in the ACA. See *Association for Community Affiliated Plans v. Department of Treasury* 392 F. Supp. 3d 22 (D.D.C. 2019), available at https://scholar.google.com/scholar_case?case=15889321369186939868&q=Association+for+Community+Affiliated+Plans+%&hl=en&as_sdt=20006&as_vis=1.

Narrow certain excepted benefits

As discussed above, fixed indemnity, accident, and potentially critical illness policies have increasingly come to resemble “typical” health insurance, despite the fact that they are classified as excepted benefits.

The federal government has previously tried – and failed – to more stringently regulate fixed indemnity coverage in the individual market. In 2014, the government adopted a regulation that required fixed indemnity coverage in the individual market to be limited to individuals who had purchased another form of comprehensive coverage.¹⁰⁶ Fixed indemnity carriers sued, arguing that the statute did not permit HHS to limit who could enroll in fixed indemnity coverage, and a federal appeals court agreed.¹⁰⁷ This, therefore, forecloses the simplest pathway to limit the scope of these policy forms.

However, other options remain available to the federal government. In striking down the 2014 rule, the courts held that the government could not create “additional criteria” for fixed indemnity coverage. But the agencies still have the authority to define the features that distinguish fixed indemnity coverage from non-excepted traditional coverage. Indeed, problems arise precisely because fixed indemnity plans in today’s market are *not* easily distinguished from regulated forms of coverage. Therefore, the federal government can pursue regulations that more carefully explain the characteristics that make a policy a fixed indemnity (or accident or critical illness) policy rather a traditional form of health insurance.

Current group market regulations explain that fixed indemnity coverage “must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses incurred.”¹⁰⁸ Today’s fixed indemnity carriers interpret this language to allow them to vary payment based on any medical care received, as long as they don’t vary based on the specific costs the enrollee is billed for the service. That is, they say a “day” where you visit the emergency room and receive an X-ray is a different kind of illness than a “day” where you visit the emergency room and don’t get an X-ray and therefore it merits a different payment amount. Fixed indemnity carriers have simply appended the phrase “per day” to an otherwise traditional health coverage benefit design. There is no reason to believe the statute compels such an expansive reading of what it means to be fixed indemnity coverage.

A more precise regulatory definition could foreclose this sort of benefit design. For example, the regulations could specify that fixed indemnity coverage “must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses incurred, the services received, the severity of the illness, injury, or diagnosis, or other characteristics particular to a course of treatment.” This would shift fixed indemnity coverage back towards a form that more closely aligns with the common law understanding of indemnification.

¹⁰⁶ “Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond,” 79 Fed. Reg. 30239 (May 27, 2014), <https://www.federalregister.gov/documents/2014/05/27/2014-11657/patient-protection-and-affordable-care-act-exchange-and-insurance-market-standards-for-2015-and>.

¹⁰⁷ Central United Life v. Burwell, 827 F.3d 70 (D.C. Cir. 2016), [https://www.cadc.uscourts.gov/internet/opinions.nsf/3766CC3E5DD5914085257FE30050BBA1/\\$file/15-5310-1622677.pdf](https://www.cadc.uscourts.gov/internet/opinions.nsf/3766CC3E5DD5914085257FE30050BBA1/$file/15-5310-1622677.pdf).

¹⁰⁸ 45 C.F.R. § 146.145 The individual market definition adopted in conjunction with the 2014 regulatory changes is phrased slightly differently, referring to “a fixed dollar amount per period of hospitalization or illness and/or per service (for example, \$100/day or \$50/visit) regardless of the amount of expenses incurred.” 45 C.F.R. § 148.220 (emphasis added). Prior to 2014, the group and individual definitions were the same. The addition of the “per service” language was premised on the expectation that coverage would not be available to those that did not have traditional coverage, and therefore there was little need to guard against fixed indemnity coverage that mirrored traditional benefits. This change should also be reversed.

The same language could be incorporated into the regulatory definition of accident and critical illness coverage. A critical illness policy could be defined as “coverage for only a specified disease or illness (for example, cancer-only policies), provided that payment does not vary with the services received, the severity of the illness, injury, or diagnosis, or other characteristics particular to a course of treatment,” and accident coverage could be defined as “Coverage only for accident (including accidental death and dismemberment), provided that payment does not vary with the services received, the severity of the illness, injury, or diagnosis, or other characteristics particular to a course of treatment.”

As with states, federal regulators could also attempt to better enforce existing regulations that prohibit fixed indemnity (and critical illness) policies from being “coordinated with an exclusion” in the primary plan, which may help deter some behavior where employers pair traditional and fixed indemnity coverage.

These changes would not completely foreclose abuse in the excepted benefits market, but they would reduce direct competition between these policy forms and traditional insurance.

Broadly define the “business of insurance”

The federal government may also have tools to eliminate or restrict the loophole associated with Farm Bureau plans. Recall that these plans are authorized in state legislation and they are loosely supervised by state insurance regulators. For example, in all three states the plans are required to file annual actuarial certifications. Yet state law defines these plans as “not insurance” and not subject to the state insurance code.

However, the federal government has at least a plausible argument that under these facts Farm Bureau plans *are* in fact health insurance coverage offered by a health insurance issuer – and therefore subject to current law protections. Under current law, an issuer is an entity that is “licensed to engage in the business of insurance in a State and which is subject to State law which regulates insurance.” Farm Bureau plans have been authorized by the state to offer a product that insures families against the risk of catastrophic health care claims, which can arguably be construed as a form of “licens[ure] to engage in the business of insurance.” And state law does restrict their behavior in offering the benefit in at least some ways, which can arguably be construed as “state law which regulates insurance.” This is admittedly a leap from existing interpretation of the definition of health insurance issuer, but especially if faced with further proliferation of this benefit form, it is a possible federal policy tool.

The federal government may also have a related argument that states that authorize Farm Bureau plans are failing to “substantially enforce” PHSA requirements. Federal law provides that the federal government shall become responsible for enforcement if a state “has failed to substantially enforce a provision (or provisions) [of federal law] with respect to health insurance issuers in the State.” By writing state law to deliberately exclude a benefit from regulation, states are arguably running afoul of this standard, which could support additional federal action.

Expand federal broker regulation

As noted above, states are primarily responsible for licensing and regulating insurance agents and brokers. However, the federal government does have some opportunity to supervise the conduct of agents and brokers and web-brokers. In particular, the Federally Facilitated Marketplace (FFM), i.e. HealthCare.gov, sets standards for the agents and brokers that want to sell federal Marketplace coverage to consumers. The federal government certified more than 48,000 agents and brokers in

2019.¹⁰⁹ State-based Marketplaces (SBMs) set their own standards for agents and brokers, but SBMs are themselves regulated by the federal government.

Therefore, the federal government has the opportunity to adopt a broad code of conduct for agents and brokers that want to interact with either the FFM or an SBM. In order to be licensed to sell Marketplace coverage, agents and brokers could be required to adhere to standards that limit the ways they market non-compliant coverage forms to consumers. These restrictions would not reach brokers that elect to forego any formal relationship with the Marketplace, but they would nonetheless shape a significant fraction of the market.

At the extreme, Marketplace-licensed agents and brokers could be prohibited from selling non-compliant coverage forms at all. Such a prohibition may be particularly appropriate for online web-brokers that receive extensive support from the government. More limited policies are also available. Licensed agents and brokers could be required to provide specific disclosures to consumers considering such coverage, make sure all consumers are aware of the differences between compliant and non-compliant coverage, and report to the Marketplace on sales of non-compliant coverage. Indeed, the California SBM requires that certified brokers who also sell certain types of non-compliant policies must assess eligibility for financial assistance and disclose limitations before selling a non-compliant plan; the federal government could also adopt such a rule.¹¹⁰ Web-brokers could also be subject to more stringent regulation in how non-compliant coverage forms are displayed and marketed.

Certainly, these types of standards for agent and broker conduct would go beyond the federal government's traditional role. However, in today's market, the federal government provides billions of dollars in subsidies linked to the purchase of insurance through Marketplaces, and it surely has an expanded interest in how the entities that market (and profit from their marketing of) such coverage engage in these activities.

Conclusion

Forms of sub-standard or unregulated coverage exist across our markets for health coverage. Benefits offered by employers to their employees can be problematic because they do not cover a robust array of benefits, use regulatory exceptions to avoid complying with financial protections, or undermine policies that are supposed to promote risk-sharing in the small group markets. Benefits sold directly to individuals suffer from gaps, because they are classified as short-term or excepted benefits forms of insurance, or because they are not treated as insurance at all. The federal government has legislative tools to close each of these gaps, and states and federal regulators can take meaningful action even in the absence of new federal legislation.

¹⁰⁹ U.S. Centers for Medicare & Medicaid Services, "Agent and Broker Program Overview," July 2019, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/AB-Summit-Agent-and-Broker-Overview.pdf>.

¹¹⁰ Covered California, "Covered California Policy And Action Items," November 21, 2019, <https://board.coveredca.com/meetings/2019/11-21%20Meeting/PPT.Policy%20and%20Action.Nov%202019.FINAL.1025.pdf>.

Appendix: Illustrative Statutory Language

Excepted benefits

The text below is an illustrative set of modifications to the definition of excepted benefits in PHSA § 2791(c) that would implement the policy changes suggested above. Parallel modifications would be needed at § 2721(c), other PHSA cross references, and throughout ERISA and the IRC. (Paragraph 14, below, should arguably appear only in ERISA, but is included here for simplicity.) This illustrative language does not mark all deletions or reorganizations of existing text, but significant new statutory text is indicated in underline.

“(c) EXCEPTED BENEFITS.—For purposes of this title, the term “excepted benefits” means benefits under one or more (or any combination thereof) of the following, only to the extent the benefit is offered separate from and does not duplicate, supplant, or mimic the benefits otherwise provided under this title:

- (1) Disability income insurance.
- (2) Coverage issued as a supplement to liability insurance.
- (3) Liability insurance, including general liability insurance and automobile liability insurance.
- (4) Workers’ compensation or similar insurance.
- (5) Automobile medical payment insurance.
- (6) Credit-only insurance.
- (7) Coverage for on-site medical clinics.
- (8) Travel insurance.
- (9) Limited scope dental or vision benefits.
- (10) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.
- (11) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act).
- (12) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code.
- (13) Supplemental coverage described in subparagraph (A) that meets all of the requirements of subparagraph (B).
 - (A) Coverage described:
 - (i) Coverage only for accident,
 - (ii) Coverage only for a specified disease or illness, or
 - (iii) Hospital indemnity or other fixed indemnity insurance.
 - (B) Requirements:
 - (i) The coverage is provided only to individuals enrolled in other coverage that includes the essential health benefit package as defined in section 2707(a) of this title,
 - (ii) The coverage is not coordinated with an exclusion in any other plan; and
 - (iii) The coverage does not vary payment with the services received, the severity of the illness, injury, or diagnosis, or other characteristics particular to a course of treatment.
- (14) Coverage that meets the requirements of subparagraph (A) or (B) and is provided in addition to coverage not consisting solely of excepted benefits:
 - (A) Health flexible spending arrangements as defined in section 106(c)(2) of the Internal Revenue Code; or
 - (B) Benefits provided under employee assistance programs for which no premiums, cost-sharing, or other employee contributions are required and which do not provide significant benefits in the nature of medical care.”

Definitions of health insurance coverage and health insurance issuer

The text below modifies federal definitions of “health insurance coverage” and “health insurance issuer” to generally prohibit entities other than licensed issuers from offering coverage, as described above. Parallel modifications would be needed to definitions in ERISA and to ERISA’s definition of a multiple employer welfare arrangement. This illustrative language does not mark all deletions or reorganizations of existing text, but significant new statutory text is indicated in underline.

“(b) DEFINITIONS RELATING TO HEALTH INSURANCE.—

(1) HEALTH INSURANCE COVERAGE.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the term “health insurance coverage” means benefits or payments for medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care).

(B) EXCEPTIONS.—Such term shall not include:

(i) A group health plan,

(ii) Coverage provided under title XVIII, XIX, or XXI of the Social Security Act,

(ii) Coverage provided under chapter 55 of title 10, United States Code,

(iv) Coverage provided under part 2 of title 38, United States Code,

(v) A health plan under section 2504(e) of title 22, United States Code,

(vi) The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Pub. L. 103-337),

(vii) Coverage offered by an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) to its enrollees where the institution bears meaningful financial risk for the costs of coverage, provided that such coverage complies with the requirements of sections 2704, 2705, 2707, and 2711 of this title, or

(viii) Stop-loss coverage, provided that the policy has individual and aggregate attachment points that exceed thresholds established by the Secretary.

(2) HEALTH INSURANCE ISSUER.—The term “health insurance issuer” means an insurance company, insurance service, insurance organization (including a health maintenance organization, as defined in paragraph (3)), or any other entity that makes available health insurance coverage. Such term does not include a group health plan.”

Freestanding application of requirements to unregulated coverage

As an alternative to modifying PHSA definitions, the text below adds a new section the PHSA that would broadly establish that otherwise unregulated coverage forms must comply with certain substantive standards, enforced by the federal government. The substantive standards should include at least the minimum set of protections to prevent truly abusive benefit forms, but could also encompass a broader set to create an equal playing field. Conforming edits should be made to PHSA section 2723(b)(2) to reflect federal enforcement authority, and ERISA and the IRC.

“Sec. 2796. APPLICATION OF PROTECTIONS TO BENEFITS OTHER THAN HEALTH INSURANCE COVERAGE

(a) IN GENERAL.—Except as provided in subsection (b), all benefits or payments for medical care that are not health insurance coverage under this title must comply with the standards of sections 2701, 2704, 2705, 2707, [2708, 2709,] 2711, [2712, 2713, 2719A, 2725, 2726, 2727, 2729, and 2751].

(b) EXCEPTIONS.—This section shall not apply to:

(1) A group health plan,

(2) Coverage provided under Title XVIII, XIX, or XXI of the Social Security Act,

- (3) Coverage provided under chapter 55 of title 10, United States Code,
 - (4) Coverage provided under part 2 of title 38, United States Code,
 - (5) A health plan under section 2504(e) of title 22, United States Code,
 - (6) The Nonappropriated Fund Health Benefits Program of the Department of Defense, established under section 349 of the National Defense Authorization Act for Fiscal Year 1995 (Pub. L. 103-337), or
 - (7) Stop-loss coverage, provided that the policy has individual and aggregate attachment points that exceed thresholds established by the Secretary.
- (c) SECRETARIAL ENFORCEMENT.—Pursuant to section 2723 (b), the Secretary shall enforce these requirements insofar as they relate to the issuance, sale, renewal, and offering of such benefits.
- (d) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of states to define or regulate health insurance coverage, health insurance issuers, or entities offering benefits or payments for medical care.”

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