Health Insurance
Alternative Coverage Options

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INNOVATIONS IN HEALTH CARE | A TOOLKIT FOR STATE LEGISLATORS

Overview

While most Americans buy their health insurance in the private market, the issue remains at the forefront of political debate because consumers are paying persistently higher premiums. One analysis by the U.S. Department of Health and Human Services (HHS) showed that the average premium for individuals buying insurance in the private market more than doubled in four years—from $2,784 per year in 2013 to $5,712 in 2017.[1] With premiums in some states experiencing percentage increases in the double digits for the 2019 enrollment period, ensuring affordable plans for consumers continues to be a top priority for many policymakers.[2]

According to a Commonwealth Fund report, more than 60 percent of participants in the individual market are either self-employed, or own or work for a small business, making this population particularly susceptible to market fluctuations.[3] Recognizing these concerns, the federal government endorsed expanding certain coverage alternatives, which are intended to give states more flexibility to mitigate surges in premiums. Acting on these new possibilities, state legislatures have taken the lead in developing plans that offer broader choices for their residents.

Background

When the Affordable Care Act (ACA) was enacted in 2010, the law's individual mandate required, with a few exceptions, people to buy a qualifying health plan (QHP) that met specific ACA requirements, or risk paying a fine. Under the law, a QHP provides 10 essential health benefits (EHBs), follows established limits on cost-sharing (including deductibles, copayments and out-of-pocket maximum amounts), and meets other obligations.[4] The ACA also directed that all insurance policies sold on both the federal and state-based exchanges, and in the small group and individual markets, must cover the same set of services. These include mental health and substance use disorder services, pregnancy and maternity care, and prescription drugs. Although the mandate remains in federal law, as of January 2019, Congress repealed the monetary penalty starting in the 2019 tax year.[5]

Under the ACA, states have primary authority to regulate insurance carriers and products within their boundaries. Even without the protections of the ACA, all 50 states can regulate and initiate policies affecting health insurance. Before the ACA, many states had enacted a substantial number of laws that require private market health insurers to cover specific benefits and services. While laws vary from state to state, they generally provide a structure that combines business regulation, employer incentives and consumer protections. Nonetheless, the variations can be extensive, especially in required benefits.

These statutes, and state insurance departments and other agencies that administer them, play a significant role. States can allow or regulate alternative coverage, safeguard the solvency of insurance companies, prevent unfair or predatory practices by insurance companies, and address consumer complaints.

State Examples

■ **Association Health Plans,** or AHPs, are intended to offer low-cost, high-quality health coverage with less administrative burden to their members. Self-employed individuals and small businesses—those with 50 or fewer employees—who share a common business interest, such as trade organizations, farm bureaus and chambers of commerce, can band together to form AHPs. A type of multiple employer welfare agreement (MEWA), AHPs have been around since the 1970s but have attracted renewed attention in recent months due to a final regulation issued in June 2018 by the Trump administration. In the rule, the U.S. Department of Labor broadened the definition of "employer" under the federal Employee Retirement Income Security Act (ERISA) of 1974, making it easier for some AHPs to form and be considered a single plan for multiple employers.[6]

As a single, multi-employer plan under ERISA, these AHPs would not have to comply with many ACA requirements, such as the rating rules, which prohibit insurance carriers from discriminating based on gender, age and other factors. The plans are also exempt from providing the same consumer protections and comprehensive package of EHBs guaranteed under the ACA. AHPs can be either "self-insured" or "fully insured." Self-insured means the employers bear the risk of paying employees' medical claims while fully-insured means the company purchases insurance through a carrier that is responsible for administering and paying claims.[7]

ERISA sets standards of conduct for those who manage an employee benefit plan and its assets, also known as a fiduciary. According to the Department of Labor, states have primary responsibility over the solvency and licensing of MEWAs, and the Department of Labor enforces the fiduciary provisions for ERISA-covered plans.[8] One sur-

vey found that more than 60 percent of employees (more than 100 million, including family members) are in plans that fall under federal, rather than state, oversight, including over 90 percent of workers in companies with 5,000 or more employees.[9,10] This means that small businesses and proprietors who move into an AHP would no longer be protected by, or subject to, state regulation.

There are concerns that by exempting AHPs from state oversight, it could increase the risk of fraud, insolvency and market instability. Historically, AHPs have been susceptible to these types of unfavorable business practices, leaving policyholders responsible for unpaid claims. Additionally, this might also give AHPs the ability to "cherry-pick" healthy individuals from the larger risk pool, potentially destabilizing the individual market.

Soon after the Trump administration issued the final rule, **Iowa** enacted legislation allowing the Iowa Farm Bureau Federation to provide a health benefit plan to its members that is similar to an AHP. In November 2018, the Farm Bureau Health Plan started accepting applications for coverage and offering three different plan designs from which customers can choose.[11] Under the new law, Farm Bureau health plans are not considered insurance and not subject to state insurance regulation. Farm Bureau plans are not considered QHPs and therefore do no have to meet federal ACA standards.

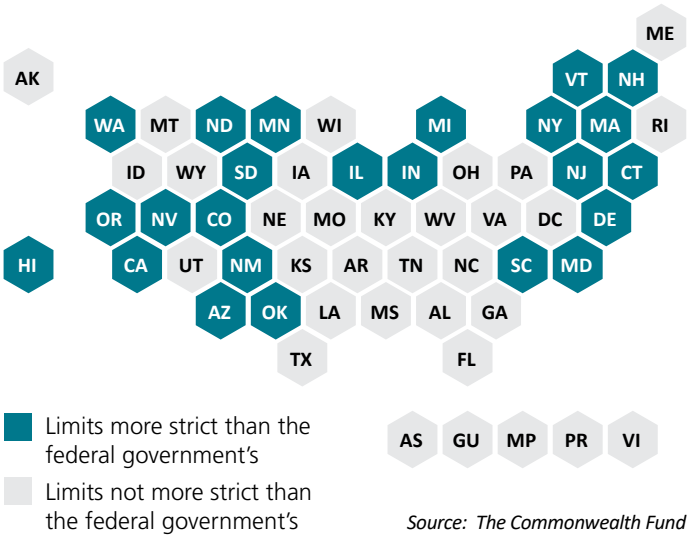
In **Nebraska**, the Farm Bureau (NEFB) announced its plan to adopt an AHP soon after the new rule took effect. The NEFB estimates that it represents 61,000 ranchers, farmers and their families across the state.[12] Medica, a nonprofit health insurer and the sole insurer for Nebraska under the ACA, developed coverage options and premiums for the plan and is working with Farm Bureau agents to sell the new health care products.[13] The AHP is fully insured through Medica and will be available to all NEFB members, regardless of current health status. NEFB also established the Nebraska Farm Bureau Employee Insurance Consortium to sponsor and manage the member health plan and help comply with state and federal laws for AHPs. The consortium is led by a seven-member board of NEFB employer-members.[14]

In contrast, **California** enacted a law that prohibits sole proprietors or co-owners of a business from participating in AHPs. It also restricts which plans and plan sponsors can offer an AHP. Researchers at Georgetown University's Health Policy Institute also noted that at least two states, **Utah** and **Pennsylvania**, require AHPs to be in existence for several years before they can sell insurance, and require some AHPs to be licensed as insurers.[15]

■ **Short-Term, Limited-Duration Plans,** or STLDs, are another option that the Trump administration has encouraged. These plans were originally designed for individuals who need temporary coverage, such as when a person has a transition in employment or needs coverage outside the open enrollment period.

Under the Obama administration, these plans were limited to a three-month duration and could not be extended or renewed. In August 2018, the Trump administration issued a new rule allowing these plans to be purchased for up to 12 months and extended for up to three years.

State Regulation of Short-Term Health Coverage



Source: The Commonwealth Fund

STLDs are not mentioned or defined in the ACA, putting them outside the scope of the law. In fact, the ACA defines individual health insurance coverage as, "coverage offered to individuals in the individual market, but does not include short-term limited-duration insurance."[16] Because STLDs are characterized in this way, they do not provide the same protections that plans on the exchanges afford. These include covering people with preexisting conditions, excluding lifetime caps on coverage and allowing parents to cover children on their plans until age 26.

Where some states like Iowa have applauded these moves, others have responded sharply to the new rule.[17] For instance, **California** enacted a law in September 2018 that will prohibit the sale or renewability of any STLD plans starting on January 1, 2019.[18] The state already had significant restrictions on STLD plans that limited them to a duration of six months with the possibility for a single six-month renewal. An analysis by the Commonwealth Fund found that three other states, **New York, New Jersey** and **Massachusetts,** also prohibit the sale of STLDs, while 23 others have adopted regulations severely restricting the sale, contractual duration and renewability of these plans.[19,20]

■ **Health Reimbursement Accounts,** also known as HRAs or health savings accounts (HSAs), are another way that small employers can offer coverage to their employees. An HRA allows small businesses to put aside money in a tax-free account that employees most commonly use to pay for out-of-pocket medical costs such as routine medical visits and treatments for disease. In addition, many expenses that may not be covered by traditional health insurance can be paid for through HRA accounts. These include prescription drugs, eye care, dental care, COBRA premiums, acupuncture, Braille books, midwife services, seeing-eye dogs, qualified long-term care services and more.[21]

Soon, other types of employers may be able to opt out of a "one-size-fits-all" group plan and provide funds to their workers to buy

coverage in the individual market with a tax-free HRA. Employers with fewer than 50 workers already have the option to create HRAs under the 21st Century Cures Act.[22] Furthermore, a proposed rule by HHS and the departments of labor and treasury would relax HRA guidelines, allowing companies of all sizes that don't have group health plans to pay for employees' individual premiums through HRAs. The rule would also allow employers that do offer group health plans to fund HRAs with up to $1,800 that workers could use to buy certain benefits, like dental insurance, or to pay for short-term plan premiums.[23] If adopted, the U.S. Treasury expects this ruling to affect 10 million employees spread across 800,000 employers, with almost 1 million newly insured though HRAs.[24]

One concern about expanding the use of HRAs is that it could lead to employers persuading their employees with high health costs to use an HRA to buy individual coverage through the ACA, ultimately reducing their own group health plan costs. This could cause an imbalance in the individual market risk pool, with sicker enrollees potentially leading to higher premiums in the marketplace. In the absence of an individual mandate penalty, higher premiums might provide incentives to people who cannot afford them to leave the market and go without insurance completely.[25]

Conclusion

Interest in alternative coverage options has been renewed in recent years, though not without arguments on both sides. These alternatives may be attractive for small businesses and sole proprietors, yet critics have expressed apprehension about how they will not only affect the individual market, but also consumers. Since these types of plans fall outside ACA oversight, consumers are not afforded the same protections as they would be under the ACA. These include the guaranteed issue clause, under which an insurance carrier must sell a policy to an applicant regardless of health status, and the community rating rule, where insurance companies must charge all members in the pool the same premium. Plans sold under the ACA are also banned from imposing lifetime limits.

One concern raised is that AHPs and STLDs have a history of fraud due to the lack of regulatory oversight. One of the most common forms of misappropriation is when plan administrators collect premiums from their members but fail to pay the medical claims submitted from facilities, patients and providers. Between 2000 and 2002, 144 scams left more than 200,000 policyholders with more than $252 million in medical bills.[26] Just recently, the Federal Trade Commission (FTC) shut down a health insurance carrier in Florida that allegedly collected over $100 million in premiums but left tens of thousands uninsured and responsible for substantial medical bills.[27]

There is also concern that these policy changes will destabilize the individual and small group market by siphoning younger, healthier people away from the private marketplaces, leaving an older, sicker population in the ACA-compliant market.[28] Some worry that these new coverage options will only confuse consumers when they emulate major medical coverage. When someone buys a plan under such a circumstance, they often can run into substantial medical bills, not because they lack health insurance but because the insurance plan they purchased does not provide adequate coverage.

While many states have welcomed the new rules, attorneys general from 11 states and Washington, D.C., have filed suit against the Trump administration. They charge that the rules allow the selling of insurance that offers less coverage and consumer protections than are required by law.[29] Four states, Texas, Nebraska, Georgia and Louisiana, have pledged to defend the rule. They contend that the department is engaged in "reasoned decision-making" by expanding the definition of "employer" to allow more companies to "easily enter into multiple-employer welfare plans and take advantage of the group buying power that large employers naturally use."

Alternative Coverage Options: State Policy Options and Considerations

- States have broad authority to regulate insurance products, including AHPs and STLDs, and can issue rules on the sale, duration or renewability of these plans.
- States can mandate which benefits or services insurance plans must cover, such as substance abuse treatment, maternity services, prescription drugs and smoking cessation.

Self-employed Population in the Individual Market

Income	Percent of self-employed enrolled in individual market*	Percent of self-employed projected to move to AHPs**	
		Low	High
<250% FPL	7%	0%	0%
250%-400% FPL	5%	7%	22%
Unsubsidized	12%	24%	78%
Total	**24%**	**13%**	**43%**

* Urban Institute, Health Insurance Policy Simulation Model 2018, simulation in 2016

** The 'low' and 'high' projections reflect estimates about how many self-employed individuals will leave the ACA-compliant market for AHPs.

Notes

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