

# State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market

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## ABSTRACT

**ISSUE:** Certain forms of individual health coverage are not required to comply with the consumer protections of the Affordable Care Act (ACA). These “alternative coverage arrangements” — including transitional policies, short-term plans, health care sharing ministries, and association health plans — tend to have lower upfront costs and offer far fewer benefits than ACA-compliant insurance. While appealing to some healthy individuals, they are often unattractive, or unavailable, to people in less-than-perfect health. By leveraging their regulatory advantages to enroll healthy individuals, these alternatives to marketplace coverage may contribute to a smaller, sicker, and less stable ACA-compliant market. The Trump administration recently has acted to reduce federal barriers to these arrangements.

**GOAL:** To understand how states regulate coverage arrangements that do not comply with the ACA’s individual health insurance market reforms.

**METHODS:** Analysis of the applicable laws, regulations, and guidance of the 50 states and the District of Columbia.

**FINDINGS AND CONCLUSIONS:** No state’s regulatory framework fully protects the individual market from adverse selection by the alternative coverage arrangements studied. However, states have the authority to ensure a level playing field among coverage options to promote market stability.

## KEY TAKEAWAYS

- ▶ “Alternative coverage arrangements” that are not required to comply with the Affordable Care Act’s consumer protections tend to have lower upfront costs but offer fewer benefits than ACA-compliant insurance.
- ▶ Many of these alternative coverage options, including short-term plans and association plans, threaten the individual-market risk pool by siphoning off healthier enrollees, leaving sicker and costlier enrollees in ACA-compliant plans.
- ▶ States may want to consider regulatory options for protecting their individual insurance markets and their insured beneficiaries from the effects of alternative coverage products.

## BACKGROUND

Recent federal actions have created the potential for instability in the individual health insurance market, through which approximately 18 million Americans currently purchase their health insurance coverage.<sup>1</sup> In October 2017, President Trump issued an executive order to encourage the sale of health insurance products that do not comply with the consumer protections of the Affordable Care Act (ACA).<sup>2</sup> In December, Congress repealed, effective in 2019, the tax penalty for individuals who can afford to maintain health insurance coverage but decline to do so (the individual mandate penalty).<sup>3</sup>

Prior to health reform, insurers in the individual market had wide latitude to deny coverage, charge an unaffordable premium, or limit benefits based on a person's medical history. As a consequence, individual market health insurance routinely proved inadequate for consumers' health and financial needs and was often inaccessible to those with even minor health problems.<sup>4</sup> The ACA established numerous consumer protections designed to make it easier for consumers in the individual market to access affordable, adequate health insurance. The law requires insurers that sell individual health insurance to offer coverage to all individuals regardless of health status, requires coverage of preexisting conditions, and prohibits insurers from charging higher premiums based on a person's medical history or gender. It also includes limits on cost-sharing and requires insurers to cover a minimum set of essential health benefits, including coverage for mental and behavioral health care, prescription drugs, and maternity services.

For these consumer protections to work as intended and to keep premiums affordable, they need to be paired with policies that encourage a broad and balanced risk pool. To promote continuous enrollment by the sick and healthy alike, the ACA imposes an individual mandate and provides financial assistance to make coverage more affordable for those with lower and moderate incomes. Importantly, the ACA also defines what types of coverage were sufficiently protective for purposes of satisfying

the individual mandate. To prevent cherry-picking of individuals who are low health risks, it also requires all individual market insurers to play by the same rules.

In many ways, the ACA's regulatory approach to the individual market has proven successful. During the most recent open enrollment period, approximately 11.7 million Americans signed up for coverage through the ACA marketplaces (also called exchanges), most of whom are eligible for subsidies to help with the cost of coverage.<sup>5</sup> In turn, improved access to comprehensive individual health insurance under the ACA, along with the expansion of Medicaid, has helped to reduce the uninsured rate by a third, as of 2018, and lower consumers' average out-of-pocket costs.<sup>6</sup> And, despite insurers' continued uncertainty over the possible repeal of the health law and the Trump administration's approach to implementing the ACA, analysis showed that, on average, states' individual markets were stabilizing, with some insurers reaching profitability.<sup>7</sup>

However, challenges remain. In the past two years, the individual market in most states has seen significant increases in premiums, coupled with decreases in the number of participating insurers.<sup>8</sup> While the ACA's premium subsidies insulate many consumers from these price hikes, many millions of consumers are not eligible for subsidies, and those individuals identify the cost of coverage as a significant barrier to care.<sup>9</sup> And though marketplace sign-ups remain stable despite federal policy uncertainty and Trump administration actions seen as undermining the ACA, enrollment remains well below early expectations.<sup>10</sup>

These challenges are interrelated and can be attributed to many factors. Still, the availability of coverage options that are not compliant with the ACA's rules, as well as confusion over them, likely has played an important contributing role (Exhibit 1).<sup>11</sup>

In general, "alternative coverage arrangements" sit outside the individual market risk pool and do not have to meet many — or sometimes, any — of the federal consumer

## Exhibit 1. Federal Framework Governing Alternative Coverage Arrangements in the Individual Market

Type	Description
Transitional policies	Policies issued following the ACA's enactment in 2010 but before 2014. These "grandmothered plans" are not required to meet the ACA's most critical consumer protections applying to the individual market.*
Short-term plans	Health plans designed to fill temporary gaps in coverage. Generally, short-term plans are available only to consumers who can pass medical underwriting. Typically they provide minimal benefits and financial protection for those who become sick or injured. These policies do not have to meet any of the ACA's consumer protections.
Association health plans	Health insurance plans sponsored by an employer-based association, such as a professional or trade group. New proposed federal rules would allow association health plans (AHPs), a type of Multiple Employer Welfare Arrangement (MEWA), to be sold to employers of all sizes, including sole proprietors and the self-employed. The rule generally would treat the AHP as a large employer group plan for the purpose of federal law, rendering it exempt from ACA consumer protections that otherwise apply to individual and small-employer health insurance.
Health care sharing ministries	Health care sharing ministries (HCSMs) are entities whose members share a common set of religious beliefs and contribute funds to pay for the qualifying medical expenses of other members. HCSM coverage does not have to meet any of the ACA consumer protections.

\* Transitional policies are not to be confused with grandfathered policies, which were in effect *before* the ACA was enacted in March 2010. Although these policies can be renewed indefinitely as long as they do not undergo substantial changes, the issuance of a new grandfathered policy is not permitted.

Data: Authors' analysis.

protections that otherwise apply to individual health insurance (Exhibit 2). While these arrangements may be appealing to some healthy consumers, particularly because of their generally low upfront cost, they are typically far less protective than coverage compliant with the ACA and therefore less attractive, and less accessible, to individuals who believe they will need medical care. These coverage products siphon off healthy individuals who otherwise likely would have obtained insurance in the ACA-compliant individual market. As a result, they contribute to a smaller and relatively sicker risk pool in that market, with higher premiums and fewer plan choices for the consumers who remain. Although states have broad authority and ability to regulate these coverage arrangements, most generally do not.

Some of these coverage options, including short-term policies, health care sharing ministries, and other insurance-like arrangements, such as discount cards and direct primary care contracts, were generally not considered individual market health insurance prior to the ACA and were not brought within the federal definition by the health law. Others, including

"grandfathered" and "grandmothered" (or transitional) plans, are a product of the ACA or of its implementation. Association health plans (AHPs) predate the ACA. Shortly after the health law was enacted, federal regulators affirmed that such plans are generally treated as individual market coverage, subject to all individual market protections, if the plans are sold to individuals. The Trump administration, however, has proposed a reinterpretation of federal law that would exempt certain AHPs from many individual market protections, even when marketed to individuals.

The administration's actions to further encourage the availability of non-ACA-compliant policies, along with the loss of the individual mandate penalty, have sparked interest in how these alternative coverage arrangements are regulated at the state level. To inform state policymakers who are exploring opportunities to stabilize their risk pool, we identify and describe a number of alternative coverage options that are likely to threaten the individual market risk pool. We also examine the legal framework within which these arrangements are currently regulated, both federally and in each of the states.

## Exhibit 2. Key Individual Market Reforms Under the Affordable Care Act: Applicability to Alternative Coverage Arrangements

Reform	Description	Transitional policies	Short-term plans	Association health plans	Health care sharing ministries
<b>Accessibility</b>					
Guaranteed issue	Requires insurers to accept every individual who applies for coverage.	–	–	–	–
Dependent coverage to age 26	Requires plans that already provide dependent coverage to make it available until the dependent turns 26.	✓	–	✓	–
Rescissions	Prohibits plans from retroactively canceling coverage, except in the case of a subscriber's fraud or intentional misrepresentation of material fact, and requires prior notice to the insured.	✓	–	✓	–
<b>Affordability</b>					
Rating requirements	Prohibits plans from charging a higher premium based on health status and gender; allows rates to vary based solely on the number of enrollees covered, geographic area, age (within limits), and tobacco use (within limits).	–	–	*	–
Medical loss ratio (MLR)	Individual health insurers must spend at least 80 percent of revenue on health care and quality improvement.	✓	–	**	–
<b>Adequacy</b>					
Preexisting condition exclusions	Prohibits insurers from imposing preexisting condition exclusions with respect to coverage.	***	–	✓	–
Essential health benefits	Requires coverage of 10 categories of essential benefits: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care.	–	–	–	–
Actuarial value	Requires plans to meet a minimum actuarial value standard of at least 60 percent of total plan costs; requires plans to meet one of four actuarial value tiers — bronze (60%), silver (70%), gold (80%), or platinum (90%) — as a measure of how much of a consumer's medical costs are covered by the plan.	–	–	–	–
Annual cost-sharing limits	Requires insurers to limit annual out-of-pocket costs, including copayments, coinsurance, and deductibles.	–	–	✓	–
Annual dollar limits	Prohibits annual limits on the dollar value of covered essential health benefits.	✓	–	✓	–
Lifetime dollar limits	Prohibits lifetime limits on the dollar value of covered essential health benefits.	✓	–	✓	–
Preventive services without cost-sharing	Requires coverage of specified preventive health services without cost-sharing, such as copayments, coinsurance, and deductibles, when the insured uses an in-network provider.	✓	–	✓	–
<b>Transparency</b>					
Summary of benefits and coverage	Requires insurers to provide standardized, easy-to-understand summaries of the benefits, cost-sharing, limitations, and exclusions of a plan; summaries must include coverage examples that illustrate how the plan covers specific benefit scenarios.	✓	–	✓	–
<b>Risk mitigation</b>					
Single risk pool	Each insurer must consider the claims experience of all of their enrollees in all of their individual market plans when setting premium rates.	–	–	–	–
Risk-adjustment program	Transfers funds from insurers with relatively low-risk enrollees to insurers with relatively high-risk enrollees.	–	–	–	–

Note: For association health plans (AHPs), exhibit shows standards applicable to such plans that meet the definition of a large-group plan under federal law (see [Exhibit 1](#)).

\* Under proposed federal regulations, AHPs will be allowed to charge higher rates based on factors such as age, gender, occupation, and group size, as long as the plan does not use the health status of individual members to determine eligibility, premiums, or benefits.

\*\* Under proposed federal regulations, self-funded AHPs would be exempt from the ACA's MLR requirements. The ACA's MLR standards that apply to the large-group market (85%) would apply to large-group policies sold to fully insured AHPs.

\*\*\* Transitional policies are prohibited from imposing a preexisting condition exclusion on individuals under age 19.

Data: Authors' analysis.

## FINDINGS

### Transitional Policies

Although the ACA required all nongrandfathered individual insurance policies to comply with its insurance market reforms by 2014, millions of consumers were permitted to remain in coverage that failed to meet core ACA standards.<sup>12</sup> In late 2013, insurers began to discontinue health coverage for people enrolled in plans that were neither grandfathered under the health law nor compliant with ACA protections slated to take effect in 2014. While these transitional or grandfathered plans postdated the ACA's enactment and therefore complied with the first wave of reforms effective in 2010, they did not meet the law's more rigorous 2014 standards. These included a ban on preexisting condition exclusions, a prohibition on the consideration of health status and gender when setting premiums, and a requirement to cover a minimum set of essential health benefits ([Exhibit 2](#)).

To provide transitional relief for consumers who preferred to keep their coverage, the Obama administration instituted a policy in late 2013 that paved the way for individuals to renew their noncompliant plans for up to two additional years, without running afoul of the individual mandate.<sup>13</sup> Since then, federal officials have repeatedly extended this policy — most recently in February 2017 — and enrollment in transitional plans is now permitted through the end of 2018.<sup>14</sup>

Importantly, federal officials have never *required* the continuation of grandfathered plans. Rather, the policy regarding transitional plans gives states the choice of whether to allow renewal of the noncompliant coverage. Insurers, in turn, must decide whether to continue to offer such plans if the state has provided the option.

Most states initially allowed the renewal of transitional plans at insurers' discretion and have continued to do so.<sup>15</sup> By January 2018, grandfathered plans were still permitted in 36 states, including most states that rely on the federal government to operate their ACA marketplace ([Exhibit 3](#)). By contrast, of the 14 states that prohibit noncompliant coverage, 13 manage their own health

insurance exchange. (The District of Columbia also operates its own marketplace and bars transitional plans.)

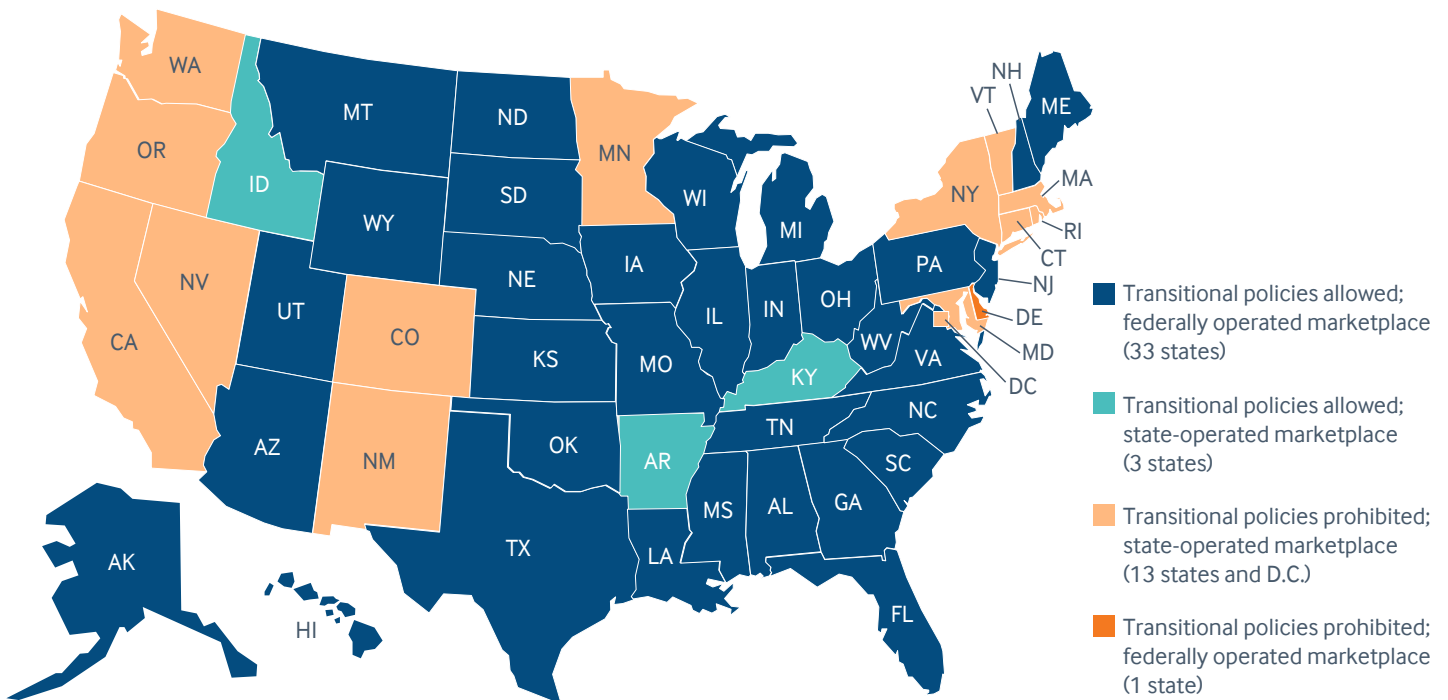
State decisions to allow grandfathered plans have had significant consequences. People who enrolled in and retained transitional coverage have tended to be healthier than those in the ACA-compliant market, for several reasons. First, such individuals likely passed medical underwriting when they initially bought coverage, before that practice was banned by the ACA. Second, because transitional policies offer fewer benefit and cost protections and, consequently, are cheaper than ACA-compliant coverage, they are more likely to retain enrollees who are younger or have limited care needs. By contrast, those with higher care utilization are more likely to migrate to more comprehensive plans that meet ACA standards. In states that have permitted it, this policy generally has contributed to a segmented market, where relatively healthy, low-cost consumers have remained outside the ACA-compliant risk pool. This has made that market relatively sicker and less stable.<sup>16</sup>

### Short-Term Plans

Short-term plans are designed to provide protection when a person experiences a temporary gap in comprehensive coverage, such as when transitioning between jobs. These plans, which predate the ACA, are not considered to be individual health insurance under federal law and are exempt from the ACA's consumer protections ([Exhibit 2](#)).<sup>17</sup> Consequently, short-term plans typically provide coverage far skimpier than ACA-compliant policies: they may decline to cover preexisting conditions, exclude health benefits such as preventive services, maternity care, and mental health and substance use services, and impose dollar limits on coverage. However, low premiums may make these policies attractive to healthy consumers. And they are much more profitable for insurers than coverage that meets federal consumer protections.

After receiving reports that many individuals had begun to rely on short-term policies as a primary form of coverage, and not just as a gap-filler, the Obama administration issued new regulations in 2016. These limited the duration of short-term policies to less than

## Exhibit 3. State Decisions on Whether to Allow Transitional Policies in the Individual Market, 2018



Notes: In states where transitional policies are allowed, insurers may choose whether to continue to offer such policies. In some states, transitional policies may no longer exist in the individual market, even though permitted under state law. At the time federal officials first made available the option to allow transitional policies, in late 2013, the insurance marketplace in Arkansas was federally operated (it is now state-run), while the marketplace in Hawaii was run by the state (it is now federally operated).

Data: Authors' analysis.

three months and prohibited the policies from being renewed.<sup>18</sup> However, recently proposed regulations would reverse course and, subject to state law, allow short-term plans to last for up to 12 months and be more easily renewed or extended.<sup>19</sup>

Current state laws and regulations governing these products vary widely (Exhibit 4). Massachusetts, New Jersey, and New York apply extensive consumer protections, including guaranteed issue, to all new policies in the individual market, foreclosing underwritten short-term plans in these states.<sup>20</sup>

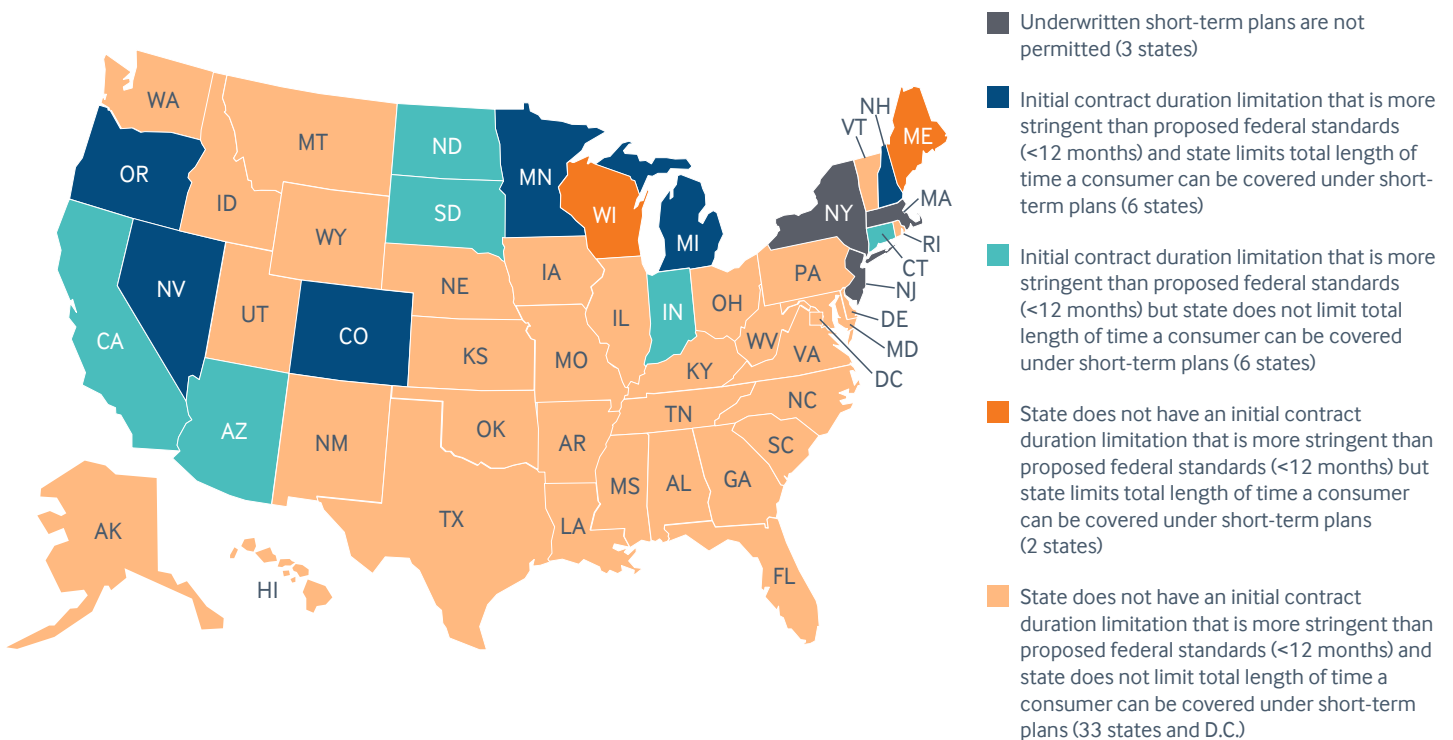
In the remaining 47 states and the District of Columbia, insurers may refuse to issue a short-term policy — or to renew a policy when an existing contract term ends — on the basis of a consumer's health status. Insurers generally are not limited as to the factors they may consider when

setting premiums and are not required to cover essential health benefits. Only six of these 47 states limit the initial contract duration of short-term plans to fewer than 12 months (the proposed federal standard) and restrict the sale of multiple consecutive short-term plans.<sup>21</sup>

Six other states similarly limit initial contract duration; however, they do not prohibit insurers from selling multiple consecutive short-term plans, essentially allowing a loophole to the limit on contract duration.<sup>22</sup> While 35 states and the District of Columbia require short-term plans to cover at least one state benefit mandate, none of them require short-term policies to cover all essential health benefits.

Limits on contract duration and requirements to cover some mandates have not diminished the availability of short-term policies in most states. These policies appear to

## Exhibit 4. State Law Limitations on Duration of Short-Term Plans, 2018



Notes: For the purposes of this exhibit, a state is marked as having a limit on initial contract duration if a short-term plan longer than the specified duration would become subject to one or more of the following state consumer protections: guaranteed issue, guaranteed renewability, or required coverage of essential health benefits. While a number of states have limitations on “renewal” of short-term plans, they do not prohibit issuers from issuing multiple new short-term plans consecutively. For the purposes of this map, such states have been marked as not having a limit on total length of time a consumer can be covered under short-term plans.

Data: Authors’ analysis.

be marketed in most states, aside from those that prohibit the sale of underwritten short-term policies.<sup>23</sup> However, at least in one state, Rhode Island, the imposition of other regulatory requirements have, as a practical matter, limited the availability of short-term plans. Rhode Island applies some consumer protections, including a prohibition on preexisting conditions and medical loss ratio requirements, to short-term policies.<sup>24</sup> A review of broker websites in that state suggests that, as a result, short-term policies are not being marketed there.

Allowing the unfettered sale of short-term plans puts enrollees at financial risk and weakens the individual insurance market. Because plans do not have to adhere to the ACA’s consumer protections, benefits are generally quite limited, and enrollees may find themselves without

coverage for services they need.<sup>25</sup> Depending on the state, those who do secure a policy may be at risk of having claims denied because of a preexisting condition or their policy rescinded because of post-claims underwriting.<sup>26</sup> The combination of limited benefits and relatively low premium costs enables short-term plans to siphon off healthy individuals from the individual marketplaces. This, in turn, leads to higher premiums and fewer choices for consumers seeking comprehensive plans.<sup>27</sup>

Enrollment in short-term policies was increasing prior to the 2016 federal regulations limiting their duration and renewal. Applications for short-term policies sold through e-Health, a large online broker, more than doubled between 2013 and 2014.<sup>28</sup> According to data reported to the National Association of Insurance Commissioners

(NAIC), there were about 160,000 people covered by short-term policies at the end of December 2016.<sup>29</sup> However, this count may significantly underestimate actual take-up: recent reports have suggested enrollment may be closer to a million.<sup>30</sup> In addition, sellers of short-term policies or similar policies may file their plans with insurance departments under other categories of coverage that may not be reflected in the reported data. If the proposed regulatory changes are finalized, enrollment in short-term plans is projected to expand to 4.2 million people.<sup>31</sup>

### Association Health Plans

Earlier this year, the Trump administration issued a proposed regulation that would make it easier for self-employed individuals and small businesses to purchase health insurance across state lines through association health plans, such as those offered by a professional or trade association.<sup>32</sup> Under federal law, AHPs generally would be treated as large-employer health plans and would not have to comply with the market standards and consumer protections that otherwise apply to the individual market, including coverage of essential health benefits ([Exhibit 2](#)).

This proposed federal approach to AHPs is a departure from how health insurance sold through associations is regulated today. Under current federal law, association coverage does not exist as a distinct category of health insurance. The general rule is that health insurance policies sold through an association to individuals are regulated under the same federal standards that apply to the individual market.<sup>33</sup> Following implementation of this “look through” approach to regulating AHPs, insurer interest in marketing health insurance to individuals through associations largely fell off in many states.<sup>34</sup> In states like Vermont, which had a significant AHP market prior to the ACA, this federal interpretation, coupled with state action, shifted AHPs into the ACA-compliant market, resulting in greater stability.<sup>35</sup>

Although it is difficult to estimate how much the AHP market would grow under the proposed federal framework, there was a sizable AHP market in some states prior to the ACA.<sup>36</sup> Often, states regulated coverage sold

through AHPs differently from coverage in the traditional individual and small-group markets, and these regulatory differences served as powerful incentives for insurers to market AHP coverage to small businesses and the self-employed.<sup>37</sup> For example, in 2011, state regulators in Wisconsin estimated that 30 percent of insurance in the individual market was sold through an association.<sup>38</sup> In Ohio, approximately 72 percent of individual market coverage was written “via association business.”<sup>39</sup>

Considering the interest in AHP coverage prior to the ACA and the significant regulatory incentives offered to AHPs under the proposed federal framework, there are indications that this market will reemerge. They are bolstered by recent statements by national insurers, such as UnitedHealthcare and Anthem, that they are interested in marketing association coverage.<sup>40</sup>

By creating an uneven playing field for AHPs to compete with ACA-compliant individual insurance products, the proposed federal framework could have a negative impact on the individual market risk pool.<sup>41</sup> In a recent analysis, it was reported that 31 percent of individuals with nongroup coverage are self-employed.<sup>42</sup> If a sizable and healthier component of this population gravitates toward lower-cost, less protective AHP coverage, it could leave the individual market risk pool sicker and smaller. Over the long term, this could raise premiums and reduce plan options in the ACA-compliant market.<sup>43</sup> It has happened before. In the mid-1990s, AHPs in Kentucky were exempted from benefit and rating requirements that applied to the traditional individual and small-group markets. Insurers abandoned the traditional markets and healthy consumers shifted to AHPs, with premiums dramatically increasing for those left behind.<sup>44</sup>

The impact of the Trump administration's AHP proposal on the individual market remains uncertain. It will likely depend on the leeway AHPs are afforded in marketing to the self-employed and using members' health status to determine eligibility, premiums, and benefits. Perhaps most critically, however, the proposal's effects will depend on whether states will continue to have broad authority to regulate AHPs to ensure a level playing field across their markets.



### Health Care Sharing Ministries

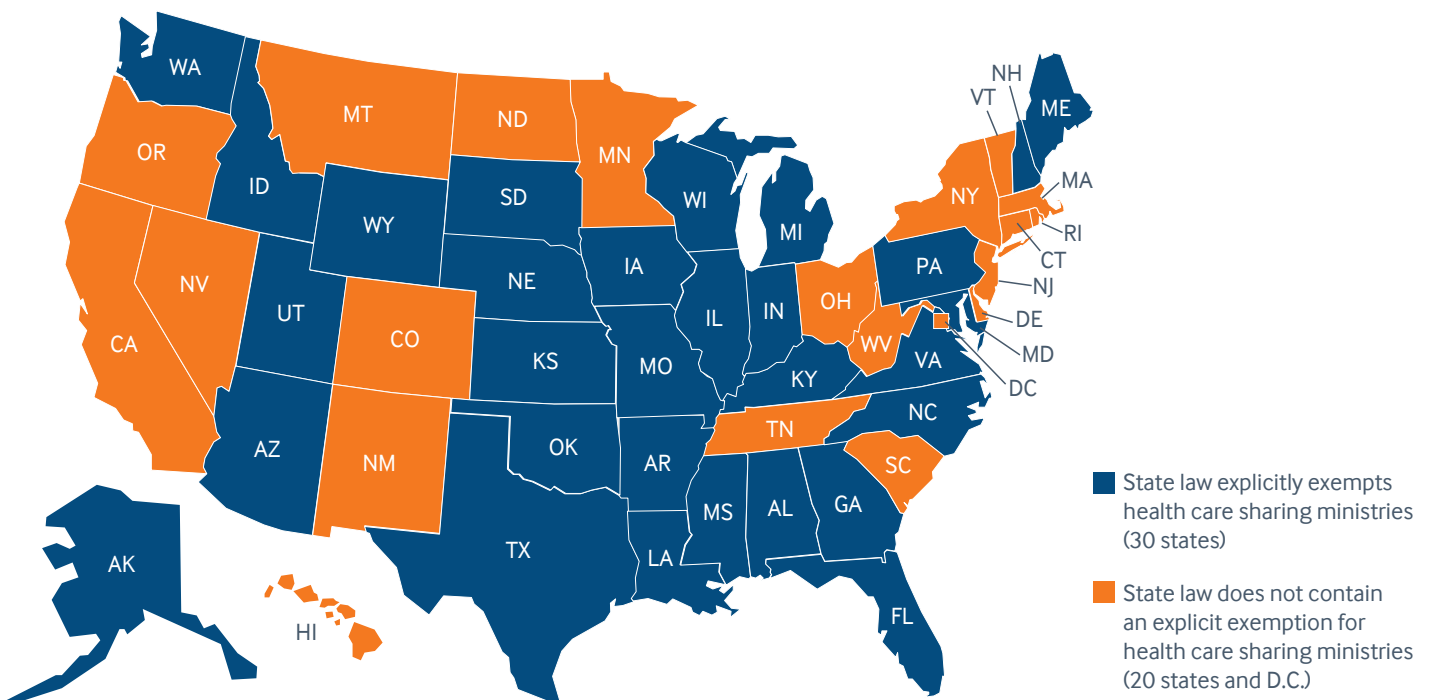
Health care sharing ministries (HCSMs) are entities whose members share a common set of religious beliefs and contribute funds to pay for the qualifying medical expenses of other members.<sup>45</sup> Members must generally pledge to follow religious principles and pay a monthly “share” that may vary based on age and level of coverage.<sup>46</sup> The HCSM either matches paying members directly with those who have health costs deemed eligible for help, or collects the shares to disburse to members in need. HCSMs take the position that, because they do not guarantee payment for member claims, they do not constitute insurance.<sup>47</sup> The arrangements are not regulated as insurance under federal law and do not comply with the ACA’s consumer protections (Exhibit 2).

The ACA exempts members of HCSMs from the federal individual mandate, a fact advertised by sponsors of these

arrangements in the marketing materials provided to prospective members.<sup>48</sup> Federal law does not, however, dictate whether and how states may regulate these entities. In 30 states, legislatures have chosen to enact “safe harbor” rules that exempt HCSMs from state insurance regulation, provided they meet certain criteria (Exhibit 5). Many of these provisions have been adopted since the ACA’s passage and, in some cases, in response to efforts by regulators to conduct oversight of these arrangements.<sup>49</sup>

In states with a safe harbor, insurance regulators are generally barred from requiring HCSMs to meet standards and requirements, such as those governing benefits, premium rates, licensure, solvency, and oversight, applicable to health insurers and the products they offer. However, the states that have not enacted a safe harbor rarely regulate HCSMs as insurers either. For example, Montana’s regulator welcomed back one ministry

Exhibit 5. State Laws Governing Whether Health Care Sharing Ministries Are Exempt from State Insurance Codes, 2018



Note that states that have not explicitly exempted health care sharing ministries from the state insurance code do not necessarily regulate them.  
Data: Authors’ analysis.

previously barred from offering memberships in that state when a judge ruled that the HCSM was issuing insurance contracts without an insurance license. That ruling prompted a consent agreement whereby the HCSM agreed to refrain from doing business in the state unless it received a certificate of authority.<sup>50</sup>

Nevertheless, many aspects of HCSM arrangements resemble traditional insurance, according to a review of the three largest ministries.<sup>51</sup> In addition to paying a monthly share (akin to a premium), members typically must cover, out of pocket, the “unshareable” amount of a medical cost (similar to a deductible) and may be responsible for a coshare amount up to a financial cap. Limits on care costs deemed “shareable” by the HCSM range from \$4,000 to \$500,000, depending on the plan, and, in the case of at least one HCSM, may be reduced, increasing a consumer’s financial exposure, if “needs” exceed “shares.”<sup>52</sup> Some HCSMs also utilize a network of providers or help members negotiate discounts with providers, and some require members to pay program fees or a portion of their share directly to the HCSM itself to cover administrative costs. Some also pay commissions to brokers that sell memberships in the ministry.<sup>53</sup>

The HCSMs we reviewed exclude or strictly limit coverage for preexisting conditions. For example, under one HCSM, for medical costs associated with a condition to be eligible for sharing, the member must be symptom-free for one to five years prior to enrolling. Others apply stricter dollar limits to preexisting conditions, depending on how long the member has been symptom-free and gone without treatment.<sup>54</sup> HCSMs are not obligated to cover a minimum set of health benefits, and some services are routinely excluded from sharing. Birth control, mental health services, routine care, preventive services, prescription drugs (except in limited circumstances), and services to treat developmental delays fall outside guidelines for shareable expenses in the three ministries reviewed.<sup>55</sup>

Membership in HCSMs has spiked since enactment of the ACA, growing, by some estimates, from fewer than 200,000 members prior to 2010 to about 1 million.<sup>56</sup> State regulators have noted the growth in membership, often among those who do not qualify for marketplace

subsidies.<sup>57</sup> Marketing materials also promote HCSMs as a way for people to send monthly payments directly to someone with similar values, rather than to an insurance company.

But HCSM coverage leaves members at risk of substantial out-of-pocket costs for conditions either not covered or covered only up to a cap. Moreover, because HCSMs do not promise that members’ care costs will be paid, and are not subject to rules designed to ensure sufficient funds to cover claims, members face a greater risk that even eligible spending will not be reimbursed. And consumers living in the 30 safe-harbor states cannot count on help from their regulators when costs are only partially paid because of inadequate shares or are deemed ineligible for sharing. As with other arrangements that pair a low monthly payment with a plan that limits benefits for people in less-than-perfect health, the design of HCSMs encourages selection against the ACA-compliant market.

### Other Coverage Arrangements

In addition to the arrangements discussed above, many companies sell consumers other types of health coverage products that do not provide comprehensive protection in the case of an unexpected medical event and are not required to comply with the ACA’s individual market insurance reforms. Nonetheless, these products are sometimes marketed as alternatives to major medical coverage.<sup>58</sup> State regulation of these products varies but can play a critical role in protecting consumers from financial risk and helping to stabilize the individual market.

### Direct Primary Care Agreements

A direct primary care agreement is a contract between a primary care provider (PCP) and a consumer under which the consumer pays a periodic membership fee directly to the PCP and the PCP agrees to provide, at no extra cost, services within the scope of primary care practice, which in some cases includes management of chronic diseases. The agreement typically does not include coverage of prescription drugs, specialty care services, hospitalization, or most other benefits provided by a major medical insurance policy.

In the past few years, a number of states have either adopted or proposed legislation declaring that these arrangements are not insurance and therefore are not subject to state insurance laws.<sup>59</sup> However, these arrangements may cross the line into insurance if, for example, the practice takes on health care risk by allowing unlimited office visits for a flat fee or charges monthly fees that are less than the fair market value of the covered services.<sup>60</sup> Even in states that do not exempt direct primary care contracts from regulation under the insurance code, few insurance departments actively regulate these arrangements. In either case, when states do not conduct oversight of insurance or insurance-like products, consumers may find they have limited recourse if they have a complaint or if the provider goes out of business and cannot refund fees.

#### **Discount Medical Cards**

Discount medical cards offer purchasers discounts for certain medical care, goods, and services. Discount cards offered only for prescription drugs are common. In general, consumers pay a onetime enrollment charge plus monthly fees. In return, the card issuer pledges to give the purchaser discounts on covered medical services. However, in many cases, the “discounted” charges are no better than what consumers could negotiate on their own.<sup>61</sup>

Reports of significant marketing abuses by discount card sellers led the NAIC to develop a model state law and many states to enact consumer legislation.<sup>62</sup> For example, the NAIC model requires discount card companies to register with the state or obtain a license. It authorizes the insurance department to conduct investigations of discount card sellers, impose financial penalties, or undertake other enforcement actions when appropriate. The model law also restricts deceptive marketing tactics and requires the submission of provider contracts and up-to-date provider lists. According to NAIC, an estimated 21 states have implemented its model or some variation thereof.<sup>63</sup>

#### **Bundled Coverage Packages: Stacking Limited Benefit Plans and Other Arrangements**

The sellers of bundled products package together several types of coverage that, sold separately, would not be considered major medical coverage. While the products vary, they often combine a fixed indemnity policy that covers a set dollar amount for each day the consumer is in the hospital, a limited prescription drug benefit (often a discount card), and a policy that will cover a limited number of physician office visits each year. Some also may include accident-only coverage or coverage for a specified disease, such as cancer.<sup>64</sup> Because each policy on its own is not considered major medical coverage, these bundled products are not subject to the federal standards that apply to individual health insurance plans, including underwriting restrictions and prohibitions of preexisting-condition exclusions.

Companies market these products as a more affordable alternative to an ACA-compliant plan. But consumers face considerably greater financial risk if they have an unexpected medical event, and those with health conditions may be denied a policy or find that services to treat their needs are not covered.<sup>65</sup>

States have broad authority to set minimum standards for these products and regulate their marketing and sale. However, most state regulations do little more than establish minimal benefit standards and consumer disclosure requirements. Many of these are laid out in an NAIC model state law and model state regulation, adopted in 28 states.<sup>66</sup> However, there are a few exceptions. Minnesota, for example, requires companies to secure a consumer’s attestation that she has underlying major medical coverage before she can enroll in a fixed-indemnity product.<sup>67</sup>

## POLICY IMPLICATIONS

Although states' approaches to implementing the ACA can sharply differ, the law's consumer protections operate nationwide, and nearly all states have taken responsibility for enforcing these reforms in their jurisdictions. The insurance exchanges in most states have proven resilient in the face of significant change and uncertainty, with millions of Americans now able to depend on individual health insurance to protect them both medically and financially.

However, maintaining a stable individual market will become more challenging, thanks to an environment in which healthy consumers are not required to maintain insurance and federal regulations are loosened to promote coverage arrangements likely to weaken insurance risk pools and raise premiums. These developments may incline healthy individuals to look increasingly outside the compliant market for coverage, leaving those who remain to face higher costs and fewer plan choices.<sup>68</sup>

Based on our review of state laws and standards, it appears that no state maintains a regulatory environment that fully protects its individual health insurance market from being undermined by the alternative coverage options we have identified. However, states continue to be the primary regulators of private health insurance. Although the ACA set a federal floor of consumer protections for insurers that operate in the individual market, it did not curtail states' power to regulate above these minimum standards and to exercise full authority over coverage arrangements that fall outside the scope of federal insurance law.

A number of states have taken steps to limit the availability of non-ACA-compliant products and protect against adverse selection. Massachusetts and New York promptly discontinued transitional coverage and effectively prohibit underwritten short-term policies, while several other states tightly restrict the duration of such plans. Significantly, Massachusetts also has its own individual mandate, requiring state residents to maintain coverage that meets minimum standards.<sup>69</sup> Other states have begun to explore enactment of similar policies in anticipation of the federal mandate's 2019 repeal.

On many fronts, states face a federal regulatory approach to the individual market that is significantly different from what was originally envisioned under the Affordable Care Act. In light of these changed circumstances, there may be value for states in considering regulatory options for protecting their individual insurance markets and their insured beneficiaries from the detrimental effects of non-ACA-compliant policies. The decisions states make will likely have a significant impact on their residents' access to adequate and affordable coverage and on the stability of their individual health insurance markets.

### How We Conducted This Study

This analysis is based on a review of applicable laws, regulations, and guidance enacted or promulgated prior to February 1, 2018, by each of the 50 states and the District of Columbia. This review was supplemented by correspondence with state regulators in 49 states and the District of Columbia.

## NOTES

- <sup>1</sup> Mark Farrah Associates, *A Brief Look at the Turbulent Individual Health Insurance Market* (Mark Farrah Associates, July 19, 2017).
- <sup>2</sup> Exec. Order No. 13813, 82 FR 48385 (2017).
- <sup>3</sup> Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018 (commonly known as the Tax Cuts and Jobs Act of 2017), H.R. 1, 115th Congress (2017).
- <sup>4</sup> J. Giovannelli, K. Lucia, and S. Corlette, *Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market* (The Commonwealth Fund, July 2014).
- <sup>5</sup> Centers for Medicare and Medicaid Services, “Final Weekly Enrollment Snapshot for 2018 Open Enrollment Period,” Press release (CMS, Dec. 28, 2017); and National Academy for State Health Policy, *State Health Insurance Marketplace Enrollment (Plan Selections) 2017 and 2018* (NASHP, Feb. 7, 2018).
- <sup>6</sup> National Center for Health Statistics, *Early Release of Selected Estimates Based on Data from the National Health Insurance Survey, January–June 2017* (Centers for Disease Control and Prevention, Dec. 2017); and A. L. Goldman, S. Woolhandler, D. U. Himmelstein et al., “Out-of-Pocket Spending and Premium Contributions After Implementation of the Affordable Care Act,” *JAMA Internal Medicine*, March 2018 178(3):347–55.
- <sup>7</sup> C. Cox, A. Semanskee, and L. Levitt, *Individual Insurance Market Performance in Late 2017* (Henry J. Kaiser Family Foundation, Jan. 2018); and M. J. McCue and M. A. Hall, “On the Road to Recovery: Health Insurers’ 2016 Financial Performance in the Individual Market,” *To the Point*, The Commonwealth Fund, March 22, 2018.
- <sup>8</sup> A. Semanskee, C. Cox, G. Claxton et al., *Insurer Participation on ACA Marketplaces, 2014–2018* (Henry J. Kaiser Family Foundation, Nov. 10, 2017); A. Semanskee, G. Claxton, and L. Levitt, *How Premiums Are Changing in 2018* (Henry J. Kaiser Family Foundation, Nov. 29, 2017); and J. Holahan, E. Wengle, L. J. Blumberg et al., *What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary Across the Country?* (Robert Wood Johnson Foundation and Urban Institute, Jan. 2017).
- <sup>9</sup> S. R. Collins, M. Z. Gunja, and M. M. Doty, *Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage?* (The Commonwealth Fund, Sept. 2017).
- <sup>10</sup> For a discussion of actions by the administration that have undermined ACA implementation, see, e.g., J. Rovner, “Timeline: Roadblocks to Affordable Care Act Enrollment,” *Kaiser Health News*, Nov. 1, 2017; S. Kliff, “This Is What Obamacare Sabotage Looks Like,” *Vox*, Sept. 5, 2017; and A. Carlsen and H. Park, “The Same Agency That Runs Obamacare Is Using Taxpayer Money to Undermine It,” *New York Times*, Sept. 4, 2017.
- <sup>11</sup> For a more detailed discussion of coverage options not compliant with the ACA’s market rules and the threats posed to insured markets, see T. S. Jost, “Loopholes in the Affordable Care Act: Regulatory Gaps and Border Crossing Techniques and How to Address Them,” *St. Louis University Journal of Health Law & Policy*, 2011 5(1):27–82.
- <sup>12</sup> Grandfathered policies are policies that were in effect before the ACA was passed in March 2010. These policies can be renewed indefinitely as long as they do not undergo substantial changes. They may not include some rights and protections provided under the ACA. See American Academy of Actuaries, Individual and Small Group Markets Committee, *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes* (AAA, Jan. 2017).
- <sup>13</sup> Center for Consumer Information & Insurance Oversight, *2013 Letter to Insurance Commissioners: Extension of Transitional Policies* (CCIIO, Nov. 14, 2013).
- <sup>14</sup> J. Wu, *Extended Transition to Affordable Care Act–Compliant Policies* (Center for Consumer Information & Insurance Oversight, Feb. 23, 2017).
- <sup>15</sup> K. Lucia, S. Corlette, and A. Williams, “The Extended ‘Fix’ for Canceled Health Insurance Policies: Latest State Action,” *To the Point*, The Commonwealth Fund, Nov. 21, 2014; and K. Lucia, K. Keith, and S. Corlette, “Update: State Decisions on the Health Insurance Policy Cancellations Fix,” *To the Point*, The Commonwealth Fund, Jan. 8, 2014.

- <sup>16</sup> E. Huth and J. Karcher, *A Financial Post-Mortem: Transitional Policies and the Financial Implications for the 2014 ACA Individual Market* (Milliman, July 20, 2016); and American Academy of Actuaries, *Drivers of 2015 Health Insurance Premium Changes* (American Academy of Actuaries, June 2014).
- <sup>17</sup> 42 U.S.C. § 300gg–91 (2012).
- <sup>18</sup> “Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance,” 81 Fed. Reg. 75316, 75326 (Oct. 31, 2016).
- <sup>19</sup> “Short-Term, Limited-Duration Insurance,” 83 Fed. Reg. 7437 (Feb. 21, 2018).
- <sup>20</sup> For example, New Jersey requires that all plans sold on the individual market be standard individual plans, and confirmed via correspondence with a state regulator, Nov. 13, 2017.
- <sup>21</sup> For the purposes of this report, we counted a state as having a limit on initial contract duration if a short-term plan longer than the specified duration would become subject to one or more of the following state consumer protections: guaranteed issue, guaranteed renewability, or required coverage of essential health benefits.
- <sup>22</sup> Two states, Maine and Wisconsin, do not go further than federal law in terms of limiting contract duration, but they do limit how many short-term plans an insurer can sell to an individual.
- <sup>23</sup> Authors’ analysis. Authors searched for short-term plans for a 40-year-old, nonsmoking male on ehealthinsurance.com. We limited our search to one zip code per state capital city.
- <sup>24</sup> Rhode Island Code, chapter 27-18, *Accident and Sickness Insurance Policies*, applies to all short-term plans. This chapter includes the section on prohibition on preexisting condition exclusions (§ 27-18-71) and medical loss ratio reporting requirements (§ 27-18-75); confirmed via correspondence with state regulator, Feb. 13, 2018.
- <sup>25</sup> R. Abelson, “Without Obamacare Mandate, ‘You Open the Floodgates’ for Skimpy Health Plans,” *New York Times*, Nov. 30, 2017; and E. Larsen and Z. Tracer, “The Health Plans Trump Backs Have a Long History of Disputes,” *Bloomberg*, Oct. 17, 2017.
- <sup>26</sup> See, for example, G. Schuman, “Post Claims Underwriting: A Life & Health Insurer’s Right to Investigate or Bad Faith?,” *Tort Trial & Insurance Practice Law Journal*, Spring/Summer 2010 45(3–4):697–760; and P. Harbage and H. Haycock, *Primer on Post-Claims Underwriting* (Robert Wood Johnson Foundation, June 12, 2009).
- <sup>27</sup> S. A. Westerfield, *Comment Letter to Departments of Labor, Treasury, and Health and Human Services Regarding Proposing Regulations and Revising Guidance Pursuant to Executive Order Issued on October 12* (American Academy of Actuaries, Nov. 7, 2017).
- <sup>28</sup> eHealth, *Costs and Trends in the Short-Term Health Insurance Market, 2015* (eHealth, April 2016).
- <sup>29</sup> National Association of Insurance Commissioners, *2016 Accident and Health Policy Experience Report* (NAIC, July 2017).
- <sup>30</sup> R. Abelson, “Without Obamacare Mandate, ‘You Open the Floodgates’ for Skimpy Health Plans,” *New York Times*, Nov. 30, 2017.
- <sup>31</sup> L. J. Blumberg, M. Buettgens, and R. Wang, *The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending* (Urban Institute, Feb. 2018).
- <sup>32</sup> Exec. Order No. 13813, 82 FR 48385 (2017).
- <sup>33</sup> G. 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* (Centers for Medicare and Medicaid Services, Sept. 1, 2011); and 45 C.F.R. § 144.102(c) 2017.
- <sup>34</sup> K. Lucia, S. Corlette, S. Ahn et al., *Post-Affordable Care Act Trends in Health Coverage for Small Businesses: Views from the Market* (Robert Wood Johnson Foundation and Urban Institute, Sept. 2015).
- <sup>35</sup> BlueCross BlueShield of Vermont, *We’re Here to Help You Transition to the New Health Exchange* (BCBSVT,

- April 2014); and Vt. Gen. Assemb. H.559. Reg. Sess. 2011-2012 (2012).
- <sup>36</sup> M. Kofman, K. Lucia, E. Bangit et al., “Association Health Plans: What’s All the Fuss About?” *Health Affairs*, Nov./Dec. 2006 25(6):1591–602; M. Kofman, K. Lucia, E. Bangit et al., “Association Health Insurance: Is It Time to Regulate This Product?” *Journal of Insurance Regulation*, Fall 2005 24(1):31–45; M. A. Hall, “The Geography of Insurance Regulation,” *Health Affairs*, March 2000 19(2):173–84; National Association of Insurance Commissioners, *Rate Review Comment Letter on Associations and Survey Responses* (NAIC, July 20, 2011); and National Association of Insurance Commissioners, *Rate Review Regulation State Survey Responses* (NAIC, n.d.).
- <sup>37</sup> M. Kofman, K. Lucia, E. Bangit et al., “Association Health Plans: What’s All the Fuss About?” *Health Affairs*, Nov./Dec. 2006 25(6):1591–602; M. Kofman, K. Lucia, E. Bangit et al., “Association Health Insurance: Is It Time to Regulate This Product?” *Journal of Insurance Regulation*, Fall 2005 24(1):31–45; and M. A. Hall, “The Geography of Insurance Regulation,” *Health Affairs*, March 2000 19(2):173–84.
- <sup>38</sup> National Association of Insurance Commissioners, *Rate Review Comment Letter on Associations and Survey Responses* (NAIC, July 20, 2011); and National Association of Insurance Commissioners, *Rate Review Regulation State Survey Responses* (NAIC, n.d.).
- <sup>39</sup> *Ibid.*
- <sup>40</sup> Anthem, *Anthem’s (ANTM) CEO Gail Boudreaux on Q4 2017 Results — Earnings Call Transcript* (Jan. 31, 2018); and UnitedHealth Group, *UnitedHealth Group (UNH) CEO David Wichmann on Q4 2017 Results — Earnings Call Transcript* (Jan. 16, 2018).
- <sup>41</sup> American Academy of Actuaries, “Actuaries Suggest Focus on Risk and Financial Security Issues to Policymakers Ahead of State of the Union Speech,” Press release (American Academy of Actuaries, Jan. 25, 2018); and American Academy of Actuaries, *Issue Brief: Association Health Plans* (AAA, Feb. 2017). AHP coverage may pose difficulties for enrollees, as well. In the past, AHPs have been used as vehicles for selling fraudulent coverage and have a history of financial instability and insolvency. See, for example, M. Kofman, E. Bangit and K. Lucia, *MEWAs: The Threat of Plan Insolvency and Other Challenges* (The Commonwealth Fund, March 2004); and M. Kofman, K. Lucia and E. Bangit, *Health Insurance Scams: How Government Is Responding and What Further Steps Are Needed* (The Commonwealth Fund, Aug. 2003).
- <sup>42</sup> L. Hamel, J. Firth, L. Levitt et al., *Survey of Non-Group Health Insurance Enrollees, Wave 3* (Henry J. Kaiser Family Foundation, May 20, 2016).
- <sup>43</sup> This dynamic may be exacerbated by the proposed rule’s lax approach to coverage eligibility. Though individual enrollment in AHP coverage is ostensibly limited by the proposal to “working owners” — sole proprietors and the self-employed — individuals would be permitted to enroll based only on an attestation of eligibility without the requirement that AHPs take steps to confirm such information. This approach makes fraudulent or erroneous sign-ups far more likely, further expanding AHP enrollment at the expense of the compliant market.
- <sup>44</sup> Kentucky Department of Insurance, *Market Report on Health Insurance* (KY DOI, April 1997).
- <sup>45</sup> Defined in 26 U.S.C. § 5000A(d)(2)(B) (2012).
- <sup>46</sup> The information and examples provided in this section are based on a review of the guidelines for the three largest health care sharing ministries. See Samaritan Ministries, *Guidelines for Health Care Sharing* (Samaritan Ministries, Jan. 2018); Christian Healthcare Ministries, *Guidelines Version 1, 2018* (Christian Healthcare Ministries, 2018); and Medi-Share, *Program Guidelines and Frequently Asked Questions* (Medi-Share, Nov. 2017).
- <sup>47</sup> *Ibid.*
- <sup>48</sup> *Ibid.*
- <sup>49</sup> L. Turner, “How Over a Million Christians Have Opted Out of Health Insurance,” *BuzzFeed News*, June 1, 2017; Tulsa Business Staff, “Holland Orders Medi-Share Program to Stop Offering Insurance,” *Tulsa Business and Legal News*, Feb. 7, 2008; M. Steffan, “Court Rules Medi-Share Must End Cost-Sharing Ministry

- in Kentucky,” *Christianity Today*, Oct. 3, 2012; and J. Aleccia, “Banking on Faith: Cost-Sharing Ministries Offer Obamacare Alternative,” *Seattle Times*, May 2, 2015.
- <sup>50</sup> Commissioner of Securities & Insurance, Office of the Montana State Auditor, “Rosendale Welcomes Medi-Share to Montana,” Press release (Office of Montana State Auditor, April 3, 2017).
- <sup>51</sup> See note 46.
- <sup>52</sup> Ibid.
- <sup>53</sup> T. Leys, “More Iowans Opting for ‘Health Sharing Ministries’ as Alternative to Increasingly Pricey Insurance,” *Des Moines Register*, Dec. 8, 2017.
- <sup>54</sup> See note 46.
- <sup>55</sup> Medi-Share has an exception to the exclusion of preventive care for children up to age 6. See Medi-Share, *Program Guidelines and Frequently Asked Questions* (Medi-Share, Nov. 2017).
- <sup>56</sup> L. Santhanam, “1 Million Americans Pool Money in Religious Ministries to Pay for Health Care,” *PBS News Hour*, Jan. 16, 2018.
- <sup>57</sup> J. O’Malley, “More Self-Employed Alaskans Are Choosing Faith-Based Coverage,” *Anchorage Daily News*, updated Dec. 3, 2017.
- <sup>58</sup> C. L. Engelhard, “Is Direct Primary Care Part of the Solution or Part of the Problem,” *The Hill*, Oct. 13, 2014; Zenith Direct Care, *Homepage* (accessed Feb. 15, 2018); Delaware Department of Insurance, *Discount Medical Card Scams* (DE DOI, accessed Feb. 15, 2018); L. Norris, “Bundled Plans: a New Obamacare ‘Alternative?’” (HealthInsurance.org, Dec. 20, 2017); and Nasdaq GlobeNewswire, “The IHC Group Unveils Fusion: The Innovative, First-to-Market Health Plan for Consumers Integrating Fixed-Indemnity Benefit and Short-Term Medical Plans,” Press release (IHC Group, Sept. 6, 2017).
- <sup>59</sup> Direct Primary Care Frontier, *States with Direct Primary Care Laws* (DPC Frontier, n.d.).
- <sup>60</sup> Maryland Insurance Administration, *Report on “Retainer” or “Boutique” or “Concierge” Medical Practices and the Business of Insurance*, MIA-2008-12-002 (MD Insurance Administration, Jan. 2009).
- <sup>61</sup> M. Kofman, J. Libster, and E. Bangit, *Discount Medical Cards: Innovation or Illusion?* (The Commonwealth Fund, March 2005).
- <sup>62</sup> Ibid.; and National Association of Insurance Commissioners, *Discount Medical Plan Organization Model Act*, Model #98 (NAIC, Oct. 2007).
- <sup>63</sup> National Association of Insurance Commissioners, *Discount Medical Plan Organization Model Act*, Model #98 (NAIC Oct. 2007).
- <sup>64</sup> J. Appleby, “Brokers Tout Mix-and-Match Coverage to Avoid High-Cost ACA Plans,” *Kaiser Health News*, Dec. 7, 2017.
- <sup>65</sup> Ibid. See also L. Norris, “Bundled Plans: a New Obamacare ‘Alternative?’” (HealthInsurance.org, Dec. 20, 2017).
- <sup>66</sup> National Association of Insurance Commissioners, *Accident and Sickness Insurance Minimum Standards Model Act*, Model #170 (NAIC, April 1999); and National Association of Insurance Commissioners, *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act*, Model #171 (NAIC, April 1999).
- <sup>67</sup> Minn. Stat. §§ 62A.48, 62A.135, 62E.02; Minn. R. 2740.1200.
- <sup>68</sup> L. J. Blumberg, M. Buettgens, and R. Wang, *The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending* (Urban Institute, Feb. 2018).
- <sup>69</sup> Massachusetts regulations provide that membership in “any health arrangement provided by established religious organizations comprised of individuals with sincerely held beliefs” satisfies the state’s individual mandate requirement. 956 Mass. Code Regs. § 5.03(3)(b)(3). In correspondence, state officials note that this provision encompasses membership in a health care sharing ministry.



## APPENDIX. STATE LAW LIMITATIONS ON DURATION OF SHORT-TERM PLANS, 2018

State	Transitional policies allowed?	HCSMs exempt from state insurance code?	Short-term plans		
			Initial contract duration limitations more stringent than proposed federal standards, i.e., <12 months?	Limits on total length of time a consumer can be covered under STPs?	How many state individual market benefit mandates apply to short-term plans?
Alabama	Yes	Yes	No	No	None
Alaska	Yes	Yes	No	No	None
Arizona	Yes	Yes	Yes, 185 days	No	None
Arkansas	Yes	Yes	No	No	All
California	No	No	Yes, 185 days	No	Some
Colorado	No	No	Yes, 6 months	Yes, a consumer must wait 6 months to apply after enrollment in two short-term plans within a period of 12 months	All
Connecticut	No	No	Yes, 6 months <sup>1</sup>	No	All
Delaware	No	No	No	No	Some
District of Columbia	No	No	No	No	Some
Florida	Yes	Yes	No	No	All
Georgia	Yes	Yes	No	No	Some <sup>7</sup>
Hawaii	Yes	No	No	No	None <sup>9</sup>
Idaho	Yes	Yes	No	No	None
Illinois	Yes	Yes	No	No	Some
Indiana	Yes	Yes	Yes, 6 months <sup>2</sup>	No	Some
Iowa	Yes	Yes	No	No	Some
Kansas	Yes	Yes	No	No	All
Kentucky	Yes	Yes	No	No	Some
Louisiana	Yes	Yes	No	No	None
Maine	Yes	Yes	No	Yes, a consumer's coverage under a short-term plan cannot exceed 24 months	Some
Maryland	No	Yes	No	No	All
Massachusetts	No	No	Underwritten short-term plans are not permitted in the state		
Michigan	Yes	Yes	Yes, 185 days	Yes, a consumer's coverage under a short-term plan cannot exceed 185 days in a 365-day period per insurer	Some
Minnesota	No	No	Yes, 185 days	Yes, a consumer's coverage under a short-term plan cannot exceed 365 days in a 555-day period per insurer	All
Mississippi	Yes	Yes	No	No	None
Missouri	Yes	Yes	No	No	Some <sup>7</sup>
Montana	Yes	No	No	No	None
Nebraska	Yes	Yes	No	No	None <sup>8</sup>
Nevada	No	No	Yes, 185 days	Yes, a consumer's coverage under a short-term plan cannot exceed 185 days in a 365-day period per insurer	Some

State	Transitional policies allowed?	HCSMs exempt from state insurance code?	Short-term plans		
			Initial contract duration limitations more stringent than proposed federal standards, i.e., <12 months?	Limits on total length of time a consumer can be covered under STPs?	How many state individual market benefit mandates apply to short-term plans?
New Hampshire	Yes	Yes	Yes, 6 months	Yes, a consumer's coverage under a short-term plan cannot exceed 540 days in a 24-month period	Some
New Jersey	Yes	No	Underwritten short-term plans are not permitted in the state		
New Mexico	No	No	No	No	Some
New York	No	No	Underwritten short-term plans are not permitted in the state		
North Carolina	Yes	Yes	No	No	Some
North Dakota	Yes	No	Yes, 185 days	No	Some
Ohio	Yes	No	No	No	Some
Oklahoma	Yes	Yes	No	No	None <sup>8</sup>
Oregon	No	No	Yes, 3 months	Yes, a consumer's coverage under a short-term plan cannot exceed 3 months (including any renewals) per insurer <sup>3</sup>	Some
Pennsylvania	Yes	Yes	No	No	All
Rhode Island	No	No	No	No	All
South Carolina	Yes	No	No	No	Some
South Dakota	Yes	Yes	Yes, 6 months	No	Some
Tennessee	Yes	No	No	No	Some
Texas	Yes	Yes	No	No	All
Utah	Yes	Yes	No	No	Some
Vermont <sup>4</sup>	No	No	No	No	Some
Virginia	Yes	Yes	No	No	Some <sup>7</sup>
Washington	No	Yes	No <sup>5</sup>	No	None
West Virginia	Yes	No	No	No	Some
Wisconsin	Yes	Yes	No	Yes, a consumer's coverage under a short-term plan cannot exceed 18 months per insurer <sup>6</sup>	Some
Wyoming	Yes	Yes	No	No	None <sup>8</sup>

Notes: States that have not explicitly exempted health care sharing ministries from the state insurance code do not necessarily regulate them. There are currently no short-term policies being sold in Massachusetts, New Jersey, New York, Rhode Island, and Vermont. For the purposes of this table, a state is marked as having a limit on initial contract duration if a short-term plan longer than the specified duration would become subject to one or more of the following state consumer protections: guaranteed issue, guaranteed renewability, or required coverage of essential health benefits. While a number of states have limitations on "renewal" of short-term policies, they do not prohibit issuers from issuing multiple new short-term policies consecutively. For the purposes of this table, such states have been marked as "No" in the column titled "Limits on total length of time a consumer can be covered under STPs?". For the purposes of this table, we have excluded state mandates that are conditioned on the coverage of a broader benefit category, such as when inpatient maternity stay is mandated only for those plans that cover maternity services.

<sup>1</sup> Connecticut: Makes consecutive short-term policies subject to certain preexisting condition coverage requirements.

<sup>2</sup> Indiana: This is per Indiana Department of Insurance's statutory interpretation.

<sup>3</sup> Oregon: Definition of "renewal" includes the issuance of a new short-term policy by an insurer to a policyholder within 60 days after the expiration of a policy previously issued.

<sup>4</sup> Vermont: Per discussion with regulators at the Department of Financial Regulation, current law does not explicitly address non-major medical short-term plans, nor does it restrict them. However, no short-term plans have been approved by the Department so far. The Vermont legislature is currently considering legislation that would limit the duration of short-term plans in the state.

<sup>5</sup> Washington: Plans have to be approved by the insurance commissioner and deemed to have a short-term limited purpose or duration before they can be exempt from certain individual market requirements.

<sup>6</sup> Wisconsin: Coverage periods are considered consecutive if there are no more than 63 days between the coverage periods.

<sup>7</sup> Georgia, Hawaii, Missouri, and Virginia: Short-term policies longer than 6 months are subject to additional state benefit mandates.

<sup>8</sup> Nebraska, Oklahoma, and Wyoming: Short-term policies longer than 6 months are subject to some state benefit mandates.

<sup>9</sup> Per Hawaii Department of Commerce and Consumer Affairs, Insurance Division's statutory interpretation.

Data: Authors' analysis.

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## ACKNOWLEDGMENTS

The authors thank the state insurance regulators who shared their time and valuable insights with us. We are also grateful to Linda Blumberg, Christina Goe, Tim Jost, Jon Kingsdale, and Sarah Lueck for their thoughtful review.

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*Editorial support was provided by Joris Stuyck.*

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The Commonwealth Fund, among the first private foundations started by a woman philanthropist — Anna M. Harkness — was established in 1918 with the broad charge to enhance the common good.

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Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff. To learn more about new publications when they become available, visit the Fund's website and [register to receive email alerts](#).

