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Applicability of Federal Requirements to Selected Health Coverage Arrangements

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SUMMARY

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Applicability of Federal Requirements to Selected Health Coverage Arrangements

Federal health insurance requirements generally apply to health plans sold in the private health insurance market in the United States (i.e., individual coverage, small- and large-group coverage, and self-insured plans). However, not all private health coverage arrangements comply with these requirements. This includes *exempted health coverage arrangements* and *noncompliant health coverage arrangements*, as termed for purposes of this report. This report identifies and describes arrangements within these two categories. It is intended to help congressional policymakers better understand the scope of such arrangements available to individuals in the United States and to provide information about the limits of the application of federal health insurance requirements.

The arrangements described in this report can be divided into two categories:

Exempted Health Coverage Arrangements: Those that meet a federal definition of health insurance but are exempt from compliance with *some* or *all* applicable federal health insurance requirements. Such arrangements include the following:

- *Group health plans covering fewer than two current employees*, including *retiree-only plans*, are exempt from *all* federal health insurance requirements.
- Health plans in their provision of *excepted benefits* (e.g., auto liability insurance, limited-scope dental and vision benefits, and specific disease coverage) are exempt from *all* federal health insurance requirements.
- *Short-term, limited-duration insurance* (i.e., coverage sold in the individual market that must have a specified expiration date that is less than 12 months after the original effective date of the contract and that cannot be renewed or extended for longer than 36 months) is exempt from complying with *all* federal health insurance requirements.
- *Student health insurance coverage* (i.e., individual health insurance coverage that meets specified conditions and that may be provided only to students enrolled in an institution of higher education and their dependents) is exempt from complying with *some* federal health insurance requirements if such coverage is fully insured and is exempt from *all* federal health insurance requirements if the student health plan is self-insured.
- *Self-insured, nonfederal governmental plans* (e.g., group health plans sponsored by states, counties, school districts, and municipalities) may elect to exempt the plan from *some* federal requirements.
    - *Grandfathered plans* (i.e., group health plans or health insurance coverage in which at least one individual was enrolled as of enactment of the Patient Protection and Affordable Care Act [ACA; P.L. 111-148, as amended] and which have continued to meet specified conditions) are exempt from *some* federal requirements.
- *Transitional plans* (i.e., individual and small-group market plans that meet certain requirements and are in states that have continuously opted to exempt them, per federal guidance) are exempt from *some* federal requirements.

Noncompliant Health Coverage Arrangements: Those that the federal government has not explicitly exempted from compliance with federal health insurance requirements and that do not necessarily comply with those requirements. Such arrangements include the following:

- *Health care sharing ministries* (i.e., faith-based organizations that share resources for medical needs among their members) do not currently and have not historically complied with federal health insurance requirements.
- Certain types of *farm bureau coverage* (i.e., health coverage offered by a farm bureau in the three states with a law that specifies that such coverage is not considered insurance and is not subject to the state's insurance laws) do not comply with federal health insurance requirements.

The report includes a brief description of each arrangement, its status with respect to complying with federal health insurance requirements, and the history of its status. The report also includes information about whether and how the arrangements are subject to state regulatory authority. Where available, estimates of enrollment in an arrangement are provided.

Contents

Introduction 1
Background 1
Applicability of Federal Health Insurance Requirements to Selected Health Coverage Arrangements 3
Exempted Health Coverage Arrangements 5
Group Health Plans Covering Fewer Than Two Current Employees 5
Excepted Benefits 5
Short-Term, Limited-Duration Insurance 7
Student Health Insurance Coverage 9
Self-Insured, Nonfederal Governmental Plans 11
Grandfathered Plans 12
Transitional Plans 14
Noncompliant Health Coverage Arrangements 15
Health Care Sharing Ministries 16
Farm Bureau Coverage 17

Tables

Table 1. Applicability of Federal Health Insurance Requirements to Selected Health Coverage Arrangements 3
Table 2. Excepted Benefit Categories and Exemption Status from Federal Health Insurance Requirements 6
Table 3. Historical and Current Federal Definitions of Short-Term, Limited-Duration Insurance 8
Table 4. Federal Health Insurance Requirement Exemptions for Fully-Insured Student Health Insurance Coverage 10
Table 5. Federal Health Insurance Requirement Exemptions for Self-Insured, Nonfederal Governmental Plans 12
Table 6. Summary of State Laws in Iowa, Kansas, and Tennessee Pertaining to Farm Bureau Coverage 18

Table A-1. Applicability of Selected Federal Health Insurance Requirements to Grandfathered and Transitional Plans 20

Appendixes

Appendix. Applicability of Selected Federal Health Insurance Requirements to Grandfathered and Transitional Plans 20

Contacts

Author Information 24

Introduction

A majority of the population of the United States has private health insurance coverage (i.e., coverage not available through a public program, such as Medicare or Medicaid). In 2017, about 55% of the U.S. population had private group coverage (e.g., a health plan offered by an employer) and 13.5% had private individual coverage (e.g., a health plan offered through a health insurance exchange).[1] In general, health plans sold in the private health insurance market must comply with state and federal health insurance requirements. The federal requirements relate to how coverage is offered and issued, the benefits it must cover, and how it is priced, among other issues. An example of a federal health insurance requirement is the prohibition of preexisting condition exclusions.[2]

Although federal health insurance requirements generally apply to health plans sold in the private health insurance market, not all private health coverage arrangements comply with such requirements.[3] This includes *exempted health coverage arrangements* and *noncompliant health coverage arrangements*, as termed for purposes of this report. This report identifies and describes arrangements within these two categories. The report is intended to help congressional policymakers better understand the scope of these health coverage arrangements that are available to individuals in the United States private health insurance markets and to provide information about the limitations of the application of federal health insurance requirements.

Background

The private health insurance market has different segments. Understanding these different segments is relevant to the application of state and federal health insurance requirements.

The individual health insurance market segment is where individuals and families buying insurance on their own (i.e., not through a plan sponsor) may purchase health plans. In the group health insurance market, a plan sponsor, typically an employer, offers coverage to a group (e.g., the employer's employees). The group market is divided into small- and large-group market segments.[4] It is also categorized according to how the plan is insured. Group plans that are purchased by employers and other plan sponsors from state-licensed health insurance issuers and are offered to employees or other groups are referred to as *fully insured* plans. Employers or other plan sponsors that offer *self-insured* plans set aside funds to pay for health benefits directly, and

[1] See CRS In Focus IF10830, *U.S. Health Care Coverage and Spending*.

[2] For an overview of federal health insurance requirements and their application to private health plans, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[3] In this report, the term *private health coverage arrangement* refers to the various products or programs that consumers may purchase from private health insurers or other private organizations to pay for health care services, which are either exempt from or do not otherwise comply with federal health insurance requirements. Iterations of this term (*health coverage arrangements*; *arrangements*) are used interchangeably in this report. This term is not defined federally but is used here because not all of the arrangements discussed meet a federal definition of *health insurance*. Note that this report does not provide information about all such arrangements, and it categorically excludes information about products designed specifically to supplement a governmental program (e.g., Medigap plans, which are private supplemental insurance plans designed to fill some of the cost gaps left by Medicare).

[4] For purposes of the federal health insurance requirements, states may elect to define *small* as groups with 50 or fewer individuals (e.g., employees) or as groups with 100 or fewer individuals. As follows, a *large group* is a group with at least 51 individuals or a group with at least 101 individuals, depending on which small group definition is used in a given state.

they bear the risk of covering medical expenses generated by the individuals covered under the self-insured plan.

States are the primary regulators of the business of health insurance, as codified by the 1945 McCarran-Ferguson Act,[5] and each state requires health insurance issuers to be licensed to sell plans in the state. Each state has a unique set of requirements that apply to state-licensed issuers and the plans they offer; these requirements are broad in scope and address a variety of issues, and often the requirements apply differently to the various market segments. In general, state oversight of health plans applies only to plans offered by state-licensed issuers. Because self-insured plans are financed directly by a plan sponsor, as opposed to a state-licensed insurer, such plans generally are not subject to state law.[6]

The federal government also regulates state-licensed issuers and the plans they offer, as well as self-insured plans and their sponsors. Federal requirements can, but do not necessarily, apply uniformly to health plans offered in the aforementioned market segments—individual, small-group, and large-group markets—and to self-insured plans.[7] For example, the requirement that plans cover preexisting health conditions applies uniformly; health plans offered in the individual, small-group, and large-group markets and self-insured plans must comply with the prohibition on excluding benefits based on health conditions for any individual.[8] The requirement to cover a core package of 10 "essential health benefits" does not apply uniformly; it applies only to health plans offered in the individual and small-group markets.[9]

Federal health insurance requirements are codified in three statutes—Title XXVII of the Public Health Service Act (PHSA), Part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and Chapter 100 of the Internal Revenue Code (IRC).[10] In general, federal standards establish a minimum level of requirements (*federal floor*) and states may impose additional requirements on issuers and the health plans they offer, provided the state requirements neither conflict with federal law nor prevent the implementation of federal health insurance requirements.

Enforcement of the federal health insurance requirements generally involves both the federal and the state governments. States are the primary enforcers of private health insurance requirements, but the federal government assumes this responsibility if it is determined that a state has failed to "substantially enforce" the federal provisions, including if a state indicates that it lacks authority to enforce or is otherwise not taking enforcement actions.[11]

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[5] 15 U.S.C. §§1011 et seq.

[6] See the section on "Student Health Insurance Coverage" in this report for an example of state law applying to a self-insured plan.

[7] For more information about the federal health insurance requirements and how they apply to the different types of health plans, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[8] 42 U.S.C. §300gg-3.

[9] The essential health benefits (EHB) are defined at 42 U.S.C. §18022(b), and the requirement for individual and small-group plans to cover the EHB is at 42 U.S.C. §300gg-6.

[10] In general, the federal health insurance requirements apply to *health insurance coverage* offered by *health insurance issuers* and to *group health plans*. Definitions for these terms are found in each statute—Title XXVII of the Public Health Service Act (PHSA; codified at 42 U.S.C. §300gg-91); Part 7 of the Employee Retirement Income Security Act of 1974 (ERISA; codified at 29 U.S.C. §1191b); and Chapter 100 of the Internal Revenue Code (IRC; codified at 26 U.S.C. §9832).

[11] For example, see 42 U.S.C. §300gg-22.

Applicability of Federal Health Insurance Requirements to Selected Health Coverage Arrangements

Some health coverage arrangements that consumers may purchase to help them pay for health care services do not comply with some or all of the federal health insurance requirements codified in Title XXVII of the PHSA, Part 7 of ERISA, and Chapter 100 of the IRC. This report focuses on such arrangements (**Table 1**). The health coverage arrangements listed in **Table 1** can be divided into two categories:[12]

1. **Exempted Health Coverage Arrangements:** Those that meet a federal definition of health insurance but that are exempt from compliance with some or all applicable federal health insurance requirements.
2. **Noncompliant Health Coverage Arrangements:** Those that the federal government has not explicitly exempted from compliance with federal health insurance requirements and that do not necessarily comply with those requirements.

The arrangements listed in **Table 1** are summarized in the remainder of this report. Each summary includes a brief description of the arrangement, its status with respect to complying with federal health insurance requirements, and the history of its status. The summaries also include information about whether and how the arrangements are subject to state regulatory authority. Where available, estimates of enrollment in an arrangement are provided.

Table 1. Applicability of Federal Health Insurance Requirements to Selected Health Coverage Arrangements

Health Coverage Arrangement	Applicability of Federal Health Insurance Requirements[a]		
	Current Status	Statutory/Regulatory Origin of Current Status	Citation
Exempted Health Coverage Arrangements			
Group Health Plans Covering Fewer Than Two Current Employees	Exempt from complying with all requirements	HIPAA set forth parallel exemption provisions in Title XXVII of the PHSA, Part 7 of ERISA, and Chapter 100 of the IRC.[b]	29 U.S.C. §1191a(a) 26 U.S.C. §9831(a)
Excepted Benefits		HIPAA set forth parallel exemption provisions in Title XXVII of the PHSA, Part 7 of ERISA, and Chapter 100 of the IRC.[c]	42 U.S.C. §300gg21(b), (c) 29 U.S.C. §1191a(b), (c) 26 U.S.C. §9831(b), (c)
Short-Term, Limited-Duration Insurance (STLDI)		The definition of individual health insurance coverage, as set forth by HIPAA in Title XXVII of the PHSA, does not include STLDI.[d]	42 U.S.C. §300gg-91

[12] There are other arrangements through which individuals may gain health coverage, but these arrangements are not discussed in this report because they do not meet the criteria for either of these two categories. For example, although some stakeholders list association health plans (AHPs) as one type of exempt arrangement, AHPs are a type of employment-based plan and are subject to federal health insurance requirements applicable to such plans.

Health Coverage Arrangement	Applicability of Federal Health Insurance Requirements[a]		
	Current Status	**Statutory/Regulatory Origin of Current Status**	**Citation**
Student Health Insurance Coverage	Exempt from complying with some or all requirements	HHS promulgated a rule that defined student health insurance coverage and exempted such fully insured coverage from selected requirements in response to ACA §1560(c).[e] Self-insured student health plans are exempt from all federal requirements.[f]	45 C.F.R. §147.145(b)
Self-Insured, Nonfederal Governmental Plans	Exempt from complying with some requirements	The exemption was established under HIPAA and modified by the ACA.	42 U.S.C. §300gg-21(a)(2)
Grandfathered Plans		ACA §1251 established grandfathered plans and identified applicable federal health insurance requirements.	42 U.S.C. §18011
Transitional Plans		HHS issued guidance on November 14, 2013, that established transitional plans and their exemption.[g]	HHS guidance issued November 14, 2013, and subsequent guidance
Noncompliant Health Coverage Arrangements			
Health Care Sharing Ministries	Does not necessarily comply with federal health insurance requirements		
Farm Bureau Coverage[h]			

Source: CRS analysis of federal statute and regulations.

Notes: There are other arrangements through which individuals may gain health coverage, but these arrangements are not discussed in this report because they do not meet the criteria for either of these two categories.

ACA = Patient Protection and Affordable Care Act (P.L. 111-148, as amended); C.F.R. = *Code of Federal Regulations*; ERISA = Employee Retirement Income Security Act; HHS = Department of Health and Human Services; HIPAA = Health Insurance Portability and Accountability Act (P.L. 104-191); IRC = Internal Revenue Code; PHSA = Public Health Service Act; U.S.C. = *U.S. Code*.

a. Specifically, the table addresses the applicability of the federal health insurance requirements codified in Title XXVII of the PHSA, Part 7 of ERISA, and Chapter 100 of the IRC.

b. After the ACA amended, reorganized, and renumbered Title XXVII of the PHSA, the exemption no longer existed in that statute but remained in ERISA and the IRC. See the section "Group Health Plans Covering Fewer Than Two Current Employees" in this report for more details.

c. After the ACA amended, reorganized, and renumbered Title XXVII of the PHSA, the exemption was changed in the PHSA in such a way that the exemption is ineffective in that statute but remains in ERISA and the IRC. See the section "Excepted Benefits" in this report for more details.

d. The basis of STLDI's status with regard to federal health insurance requirements is its exclusion from the definition of individual health insurance coverage. See the section "Short-Term, Limited-Duration Insurance" in this report for more details.

e. Centers for Medicare & Medicaid Services, HHS, "Student Health Insurance Coverage," 77 *Federal Register* 16453, March 21, 2012.

f. HHS has acknowledged that it does not have the authority to regulate self-insured student health plans. CMS, HHS, "Student Health Insurance Coverage," 76 Federal Register 7767, February 11, 2011.

g. Letter from Gary Cohen, Director, Center for Consumer Information & Insurance Oversight, to State Insurance Commissioners, November 14, 2013, at http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner- letter-11-14-2013.PDF.

h. *Farm Bureau Coverage* refers to arrangements offered by three state farm bureaus (in Iowa, Kansas, and Tennessee), which are described in the "Farm Bureau Coverage" section of this report.

Exempted Health Coverage Arrangements

The arrangements discussed in this section have the following in common: they meet a federal definition of health insurance (i.e., they meet the federal definition of health insurance coverage or group health plan), but they are exempt from compliance with some or all applicable federal health insurance requirements. For most of the arrangements discussed in this section, the exemption is explicit in federal statute, regulations, or guidance (see **Table 1**).

Group Health Plans Covering Fewer Than Two Current Employees

Both fully insured and self-insured group health plans covering fewer than two current employees are exempt from all federal health insurance requirements.[13] This includes *retiree-only plans*, provided they cover fewer than two current employees. If retiree benefits are offered through the same plan offered to current employees (and there are two or more current employees enrolled in such plan), then the retiree benefits are not exempt from federal health insurance requirements.

The exemption was established in the Health Insurance Portability and Accountability Act (HIPAA; P.L. 104-191). HIPAA set forth parallel exemptions from federal health insurance requirements for group plans covering fewer than two current employees in Title XXVII of the PHSA, Part 7 of ERISA, and Chapter 100 of the IRC. After the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) amended, reorganized, and renumbered Title XXVII of the PHSA, the exemption that had been in the PHSA ceased to exist. However, in the preamble to an interim final rule implementing ACA provisions related to grandfathered plans (see "Grandfathered Plans" in this report), the Department of Health and Human Services (HHS) stated that it would not enforce HIPAA or ACA requirements with respect to group health plans covering fewer than two current employees, including retiree-only plans.[14] HHS encouraged states not to enforce the requirements, either, and said the federal government would not cite states for failing to enforce in this situation.[15] Given an Administration's authority to promulgate regulations and issue administrative guidance relating to federal health insurance standards, it is possible that an Administration may reconsider its position on enforcement, but no Administration has done so to date.

States may impose their own requirements on group health plans covering fewer than two current employees (including retiree-only plans), provided the plans are fully insured. States do not have the authority to regulate self-insured plans.

CRS did not find estimates of enrollment in group health plans covering fewer than two current employees.

Excepted Benefits

In general, health plans in their provision of *excepted benefits* are exempt from all federal health insurance requirements. A diverse collection of insurance benefits can be considered excepted

[13] 29 U.S.C. §1191a(a); 26 U.S.C.§9831(a).

[14] Internal Revenue Service (IRS), Department of the Treasury; Employee Benefits Security Administration, Department of Labor (DOL); Office of Consumer Information and Insurance Oversight, Department of Health and Human Services (HHS), "Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," 75 *Federal Register* 34538, June 17, 2010. Hereinafter, 75 *FR* 34538.

[15] 75 *FR* 34538. As of the date of this report, no states appear to enforce compliance with federal health insurance requirements for group health plans covering fewer than two current employees, including retiree-only plans.

benefits, including auto liability insurance, limited-scope dental and vision benefits, benefits for long-term care, specific disease coverage, and supplemental Medicare plans (i.e., Medigap plans). Per federal statute, there are four categories of excepted benefits.[16] One category is exempt from complying with all federal health insurance requirements in all circumstances; the other three categories are exempt from complying with all of the requirements only when specified conditions are met.[17] (See **Table 2** for details.)

Table 2. Excepted Benefit Categories and Exemption Status from Federal Health Insurance Requirements

Excepted Benefit Category[a]	Exemption Status from Federal Health Insurance Requirements	Examples of Benefits in Category
Benefits Not Subject to Requirements	Benefits in this category do not have to comply with any federal health insurance requirements in any circumstances.	• Auto liability insurance • Workers' compensation • On-site medical clinics
Benefits Not Subject to Requirements If Offered Separately	Benefits in this category are exempt from all federal health insurance requirements as long as • the benefits are provided under a separate policy, certificate, or contract of insurance, and • the benefits are not an "integral part" of a group health plan offered by the same benefit sponsor.[b]	• Limited-scope dental and vision benefits (i.e., benefits substantially all of which are for treatment of the mouth or eye) • Benefits for long-term care • Some health FSAs and HRAs[c]
Benefits Not Subject to Requirements If Offered as Independent, Non-coordinated Benefits	Benefits in this category are exempt from all federal health insurance requirements as long as • the benefits are provided under a separate policy, certificate, or contract of insurance; • no coordination exists between the provision of such benefits and the exclusion of such benefits under a group health plan offered by the same plan sponsor; and • the benefits are paid regardless of whether such benefits are provided under any group health plan offered by the same plan sponsor.	• Specific disease coverage (e.g., cancer policy) • Policies that pay a fixed dollar amount per time period (e.g., $50 per day) for hospitalization or illness regardless of the amount of expenses incurred
Benefits Not Subject to Requirements If Offered as Separate Insurance Policy	Benefits in this category are exempt from all federal health insurance requirements as long as • the benefits are provided under a separate policy, certificate, or contract of insurance, and • the benefits are coverage that is supplemental to Medicare; a Department of Defense program, such as TRICARE; or a group health plan.[d]	• Medigap plans • TRICARE supplemental insurance • Plans that are designed to fill the cost-sharing gaps of a group health plan or cover benefits not covered under a group health plan

Sources: 29 U.S.C. §§1191a(b), 1191a(c), and 1191b(c); 26 U.S.C. §§9831(b), 9831(c), and 9832(c); and 42 U.S.C. §300gg-91(c).

[16] The four categories of excepted benefits are described in parallel provisions in three titles of the *U.S. Code*: 29 U.S.C. §1191b(c); 26 U.S.C. §9832(c); and 42 U.S.C. §300gg-91(c).

[17] The exemption for the category that is exempt under all circumstances is at 29 U.S.C. §1191a(b) and 26 U.S.C. §9831(b). The conditions for the other three categories are described in parallel provisions at 29 U.S.C. §1191a(c) and 26 U.S.C. §9831(c).

Notes: FSA = flexible spending account; HRA = health reimbursement arrangement.

a. The four categories of excepted benefits are described in parallel provisions in three sections of the *U.S. Code:* 29 U.S.C. §1191b(c); 26 U.S.C. §9832(c); and 42 U.S.C. §300gg-91(c).

b. To satisfy the condition of not being an "integral part" of a group health plan, at least one of the following must be true: (1) participants must be able to decline coverage and (2) claims for the benefits must be administered under a separate contract from claims for any other benefits under the plan. See 45 C.F.R. §146.145(b)(3)(ii).

c. For details about the conditions FSAs and HRAs must meet to be considered excepted benefits, see 45 C.F.R. §146.145(b)(3).

d. For details regarding what is considered supplemental, see the regulations at 45 C.F.R. §146.145(b)(5).

The exemption for excepted benefits and the conditions for exemption were established under HIPAA. HIPAA set forth parallel exemptions and conditions in Title XXVII of the PHSA, Part 7 of ERISA, and Chapter 100 of the IRC. Enactment of the ACA modified the PHSA exemption in such a way that some federal requirements would apply to excepted benefits under the PHSA.[18] However, given that the ERISA and IRC exemptions for excepted benefits remained unchanged, HHS stated it would not enforce HIPAA or ACA requirements on excepted benefits and encouraged states not to enforce the requirements, either.[19]

States may impose requirements on excepted benefits, provided the benefits are not self-insured.

CRS did not find estimates of enrollment in the various types of excepted benefit plans.

Short-Term, Limited-Duration Insurance

Short-term, limited-duration insurance (STLDI) is defined as *health insurance coverage* provided pursuant to a contract with a *health insurance issuer* that meets the following standards:[20]

- the contract for the coverage must have a specified expiration date that is less than 12 months after the original effective date of the contract and cannot last longer than 36 months, taking into account renewals or extensions, and
- the contract and application materials must display a notice as specified in federal regulations indicating that the coverage does not have to comply with federal requirements.

Additionally, the 36-month maximum duration is severable from the rest of the definition, meaning the definition would be operative even if the 36-month maximum duration were challenged in court and found invalid or unenforceable.[21]

[18] For details, see the discussion starting on page 34539 in the interim final rule on grandfathered plans (75 *FR* 34538).

[19] As of the date of this report, no states appear to enforce compliance with federal health insurance requirements for plans in their provision of excepted benefits.

[20] 45 C.F.R. §144.103.

[21] This severability clause was not included in the proposed rule but was added in the final rule. See IRS, Department of the Treasury; Employee Benefits Security Administration, DOL; CMS, HHS, "Short-Term, Limited-Duration Insurance," 83 *Federal Register* 38212, August 3, 2018 (hereinafter, 83 *FR* 38212). In the preamble to the final rule, the Departments of Health and Human Services, Labor, and the Treasury explain the addition of the severability clause: "If a court should conclude that the 36-month maximum duration standard for short-term, limited-duration insurance in this final rule is invalid, the Departments wish to emphasize our intent that the remaining standards of the final rule will take effect and be given the maximum effect as permitted by law. Thus, we have added a severability clause." (p. 38217).

The federal definition of STLDI has changed twice since it was established. STLDI was first defined in regulations issued in 1997.[22] The term was redefined in regulations issued in 2016, and again in regulations issued in 2018.[23] (See **Table 3** for details.)

Table 3. Historical and Current Federal Definitions of Short-Term, Limited-Duration Insurance

Federal Rule	Definition of Short-Term, Limited-Duration Insurance	Effective Date
"Interim Rules for Health Insurance Portability for Group Health Plans," 67 *Federal Register* 16894, April 8, 1997	Health insurance coverage provided pursuant to a contract with an issuer that has an expiration date within 12 months of when the insurance contract became effective (including any extensions).	June 7, 1997
"Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance," 81 *Federal Register* 75316, October 31, 2016	Health insurance coverage provided pursuant to a contract with an issuer that • has an expiration date less than three months after the date the contract became effective, including any extensions, and • displays a notice that the coverage does not have to comply with federal health insurance requirements.	Applies to policies beginning on or after January 1, 2017
"Short-Term, Limited-Duration Insurance," 83 *Federal Register* 38212, August 3, 2018	Health insurance coverage provided pursuant to a contract with an issuer that • has an expiration date that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total, and • displays a notice stating that the coverage does not have to comply with federal health insurance requirements (the content and format of the notice was modified from the 2016 regulations). Additionally, the 36-month maximum duration is severable from the rest of the definition, meaning the definition would be operative even if the 36-month maximum duration were challenged in court and found invalid or unenforceable.	Applies to policies sold on or after October 2, 2018

Source: CRS analysis of the cited regulations.

Although the definition of STLDI has changed, the applicability of federal health insurance requirements to STLDI has remained the same. STLDI historically has not and currently does not have to comply with federal health insurance requirements. Although STLDI is health insurance coverage sold in the individual market, it is excluded from the federal definition of *individual health insurance coverage.*[24] Per the preamble to the final rule on STLDI, this exclusion from the

[22] IRS, Department of the Treasury; Pension and Welfare Benefits Administration, DOL; Health Care Financing Administration, HHS, "Interim Rules for Health Insurance Portability for Group Health Plans," 67 *Federal Register* 16894, April 8, 1997.

[23] IRS, Department of the Treasury; Employee Benefits Security Administration, DOL; CMS, HHS, "Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance," 81 *Federal Register* 75316, October 31, 2016; 83 *FR* 38212.

[24] 42 U.S.C. §300gg-91. The exclusion from the definition was established under the Health Insurance Portability and Accountability Act (HIPAA; P.L. 104-191).

definition of individual health insurance coverage provides the basis of STLDI's exemption from federal health insurance requirements.[25]

State regulation of STLDI varies.[26] Some states impose restrictions on STLDI that are more prohibitive than what is allowed under the federal definition. For example, 22 states (including the District of Columbia [DC]) impose expiration dates shorter than the 12 months allowed under federal law. States may opt to place additional restrictions on STLDI that are not addressed under federal law. For example, 34 states (including DC) require that individuals enrolled in STLDI have access to external appeals processes and 3 states restrict how issuers can vary rates for STLDI (e.g., Minnesota prohibits gender rating for STLDI policies). States also may ban the sale of STLDI in the state, as four states have done.

The most recent change to the definition of STLDI has been in effect for less than a year, and enrollment data for the new policies are not yet available. For a discussion of projected estimates of enrollment in STLDI under the latest definition, see the final rule on STLDI.[27]

Student Health Insurance Coverage

Student health insurance coverage is a type of individual health insurance coverage that may be provided only to students enrolled in an *institution of higher education* and their dependents.[28] The coverage has to meet the following conditions:

- it cannot be available to anyone other than a student in an institution of higher education and a student's dependent(s),
- it cannot condition eligibility for the coverage on any health status-related factor of a student or a student's dependent(s), and
- it must meet requirements imposed under state law.

As a type of individual health insurance coverage, fully insured student health insurance coverage would be required to comply with federal health insurance requirements that apply to individual coverage. However, regulations provide that it is exempt from complying with specified requirements that otherwise apply to individual health insurance coverage.[29] (See **Table 4** for details.)

Student health insurance coverage was defined and its exemption status was established through the rulemaking process in response to ACA Section 1560(c), which states, "Nothing in this title (or an amendment made by this title) shall be construed to prohibit an institution of higher education (as such term is defined for purposes of the Higher Education Act of 1965) from

[25] 83 *FR* 38212, p. 38213.

[26] The information in this paragraph is current as of April 30, 2019, and is from Dania Palanker, Maanasa Kona, and Emily Curran, "States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans," The Commonwealth Fund, May 2, 2019, at https://www.commonwealthfund.org/publications/issue-briefs/2019/may/states-step-up-protect-markets-consumers-short-term-plans.

[27] 83 *FR* 38212. Specifically, see the "Impact Estimates" starting on page 38236.

[28] The definition of *student health insurance coverage* is at 45 C.F.R. §147.145(a). In the preamble to the final rule on student health insurance coverage, HHS notes that student health insurance plans may determine who may be enrolled as a dependent under the terms of their plans. CMS, HHS, "Student Health Insurance Coverage," 77 *Federal Register* 16453, March 21, 2012. *Institution of higher education* is as defined for purposes of the Higher Education Act of 1965 (P.L. 89-329).

[29] 45 C.F.R. §147.145(b).

offering a student health insurance plan, to the extent that such requirement is otherwise permitted under applicable Federal, State, or local law."

In the preamble to the proposed rule on student health insurance coverage, HHS noted that it proposed to exempt student health insurance coverage from guaranteed issue and renewal, minimum actuarial value requirements, and the single risk pool requirement because it believed that having to comply with the requirements "would effectively prohibit institutions of higher education from being able to offer these [student health insurance coverage] plans" and doing so would not be in keeping with ACA Section 1560(c).[30] These regulatory exemptions went into effect for student health insurance coverage beginning on or after July 1, 2012. The exemption from rate review requirements was established later and went into effect for student health insurance plans beginning on or after July 1, 2018.[31]

HHS acknowledges that it does not have the authority to regulate self-insured student health plans, which means the federal health insurance requirements and the exemptions listed in **Table 4** apply only to fully insured student plans.[32] States, however, can regulate fully insured and self-insured student health plans.[33]

According to data from the National Association of Insurance Commissioners, in 2017, there were about 1.1 million student health insurance policies written and nearly 1.3 million covered lives.[34]

Table 4. Federal Health Insurance Requirement Exemptions for Fully-Insured Student Health Insurance Coverage

U.S. Code	Provision	Description of Student Health Insurance Coverage Exemption	Exemption Effective Date
42 U.S.C. §300gg-1	Guaranteed Issue	Student health insurance coverage is not required to accept individuals who are not students or dependents of students. Additionally, such coverage does not have to establish open enrollment periods or coverage effective dates that are based on a calendar policy year or offer policies on a calendar year basis.	July 1, 2012
42 U.S.C. §300gg-2	Guaranteed Renewability	Student health insurance coverage is not required to renew or continue coverage for individuals who are no longer students or dependents of students.	July 1, 2012

[30] CMS, HHS, "Student Health Insurance Coverage," 76 *Federal Register* 7767, February 11, 2011, p. 7769. Hereinafter, 76 *FR* 7767.

[31] For an explanation as to why HHS exempted student health insurance coverage from rate review requirements, see the discussion starting on page 51078 in the preamble to the proposed rule: CMS, HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019," 82 *Federal Register* 51052, November 2, 2017.

[32] The regulatory structure for self-insured student health plans is different from the regulatory structure for self-insured group health plans. This is because student health plans fall under the regulatory authority of HHS, pursuant to the PHSA. In the preamble to the proposed rule on student health insurance coverage (76 *FR* 7767, p. 7769), HHS explains that, pursuant to the PHSA, it has regulatory authority over "health insurance issuers offering health insurance coverage in the individual and group markets and non-federal governmental group health plans." Because self-insured student health plans are neither health insurance coverage offered by issuers nor group health plans, HHS does not have the authority to regulate them.

[33] States cannot regulate self-insured group health plans (see the discussion about self-insured plans in the "Background" section of this report), but they can regulate self-insured student health plans, because student health plans are not group health plans.

[34] National Association of Insurance Commissioners, *2017 Supplemental Health Care Exhibit Report, Volume 1*, September 2018, at https://www.naic.org/prod_serv/HCS-ZB_2017.pdf.

U.S. Code	Provision	Description of Student Health Insurance Coverage Exemption	Exemption Effective Date
42 U.S.C. §300gg-6[a]	Minimum Actuarial Value	Student health insurance coverage does not have to comply with the requirement to tailor cost sharing to comply with one of four levels of actuarial value, but it must have at least a 60% actuarial value.[b]	July 1, 2012
42 U.S.C. §18032(c)	Single Risk Pool	Student health insurance coverage is not subject to the single risk pool requirement. Additionally, issuers offering student health insurance coverage may establish one or more separate risk pools for the students and dependents covered, provided the separate risk pools are based on a "bona fide school-related classification and not on a health factor."[c]	July 1, 2012
42 U.S.C. §300gg-94	Rate Review	Student health insurance is not subject to rate review.	July 1, 2018

Sources: 45 C.F.R. §147.145(b) and 45 C.F.R. §154.103(b)(3).

a. The four levels of actuarial value are defined at 42 U.S.C. §18022(d), and the requirement for individual and small-group plans to comply with the requirement to tailor cost sharing according to the four levels is at 42 U.S.C. §300gg-6.

b. Actuarial value is a summary measure of a plan's generosity, expressed as the percentage of total medical expenses that are estimated to be paid by the issuer for a standard population and set of allowed charges.

c. 45 C.F.R. §147.145(b)(3).

Self-Insured, Nonfederal Governmental Plans

A *nonfederal governmental plan* is a governmental group health plan that is not sponsored by the federal government.[35] Examples of entities that may sponsor nonfederal governmental plans are states, counties, school districts, and municipalities.

Like private employers, sponsors of nonfederal governmental plans can choose to offer self-insured or fully insured plans. If a sponsor of a nonfederal governmental plan offers a self-insured plan, the sponsor may elect to exempt the plan from the specified federal requirements listed in **Table 5**.[36] The sponsor may choose to exempt the plan from some or all of the listed requirements. For example, a sponsor may elect to exempt its plan only from complying with the mental health parity requirement.

[35] *Nonfederal governmental plan* is defined at 42 U.S.C. §300gg-91(d)(8)(C) and uses the definition of *governmental plan* at 29 U.S.C. §1002(32).

[36] 42 U.S.C. §300gg-21(a)(2).

Table 5. Federal Health Insurance Requirement Exemptions for Self-Insured, Nonfederal Governmental Plans

U.S. Code	Provision
42 U.S.C. §300gg-25	Minimum Hospital Stay After Childbirth
42 U.S.C. §300gg-26	Mental Health Parity
42 U.S.C. §300gg-27	Reconstruction After Mastectomy
42 U.S.C. §300gg-28	Coverage for Students Who Take a Medically Necessary Leave of Absence

Source: Steve Larsen, Director, Office of Oversight, *Amendments to the HIPAA Opt-Out Provisions (Formerly Section 2721(b)(2) of the Public Health Service Act) Made by the Affordable Care Act*, Office of Consumer Information and Insurance Oversight, Department of Health and Human Services, September 21, 2010.

Notes: Self-insured, nonfederal governmental plans may be grandfathered plans. In such cases, the plans could be exempt from the requirements listed in this table and would be exempt from all other federal requirements from which grandfathered plans are exempt. **Table A-1** in the Appendix identifies the federal requirements from which grandfathered plans are exempt.

The exemption for self-insured, nonfederal governmental plans was established in the PHSA under HIPAA as an exemption from seven federal requirements. Because of how the ACA amended and reorganized the PHSA, the exemption was modified and, as of September 2010, self-insured, nonfederal governmental plans may opt out of only the four requirements listed in **Table 5**.[37] Because these plans are self-insured group health plans, states do not have the authority to regulate these plans.

According to an analysis of data published by the Center for Consumer Information & Insurance Oversight, as of June 21, 2019, at least 174 nonfederal governmental entities across 35 states have elected to exempt at least one self-insured plan they offer from one or more of the four requirements.[38] Nearly all of the 174 entities offer at least one plan that is exempt from the mental health parity requirement; significantly fewer entities offer plans that are exempt from each of the other three requirements.[39] About 11% of the 174 entities offer at least one plan that is exempt from all four requirements.[40]

CRS did not find estimates of enrollment in self-insured, nonfederal governmental plans.

Grandfathered Plans

The ACA provided that group health plans and health insurance coverage in which at least one individual was enrolled as of enactment of the ACA (March 23, 2010) could be *grandfathered*.[41] For as long as a plan maintains its grandfathered status, the plan is exempt from specified federal health insurance requirements established under the ACA. Since grandfathered plans existed as of March 23, 2010, they must comply with applicable federal health insurance requirements that were established prior to enactment of the ACA, as long as the prior requirements do not conflict

[37] CCIIO, *Self-Funded, Non-Federal Governmental Plans*, at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/nonfedgovplans.html.

[38] CCIIO, "List of HIPAA Opt-Out Elections for Self-Funded Non-Federal Governmental Plans," June 21, 2019, at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIPAAOptOuts.pdf. Hereinafter, CCIIO, "List of HIPAA Opt-Out Elections."

[39] CCIIO, "List of HIPAA Opt-Out Elections."

[40] CCIIO, "List of HIPAA Opt-Out Elections."

[41] 42 U.S.C. §18011. See https://www.healthcare.gov/glossary/grandfathered-health-plan/.

with the ACA's grandfathered rules.[42] For example, both grandfathered and non-grandfathered plans offered in the individual market must comply with federal health insurance requirements that applied to the individual market prior to enactment of the ACA. However, a grandfathered plan is required to comply with only some ACA requirements that apply to the individual market, whereas a non-grandfathered plan must comply with all such requirements. **Table A-1** in the Appendix identifies which federal health insurance requirements apply to grandfathered plans.[43]

A plan can lose its grandfathered status. To maintain grandfathered status, a plan must continue to meet specified conditions and avoid making specified changes regarding employer contributions (where applicable), access to coverage, benefits, and cost sharing (e.g., changes in coinsurance requirements).[44] A health plan offered in any market segment—individual, small group, large group, or self-insured—could be grandfathered. There is no time limitation on grandfathered status; as long as a plan avoids making the specified changes, it can remain a grandfathered plan. Once a plan has lost its grandfathered status, it cannot regain that status.

Grandfathered plans generally are not available to new enrollees. Only individuals who have been continually covered and any new dependents can be covered under grandfathered plans in the individual market, and only individuals who have been continually covered, new dependents, and new employees can be covered under self-insured grandfathered plans and grandfathered plans offered in the group market.[45]

As of the date of this report, no repository for enrollment data for grandfathered plans was found, but the federal government has commented on enrollment. In October 2018, the Departments of HHS, Labor, and the Treasury commented that "only a small number of individuals are currently enrolled in grandfathered individual health insurance coverage" and "the number of individuals with grandfathered individual health insurance coverage has declined each year since ... [the ACA] was enacted, and the already small number of individuals who have retained grandfathered coverage will continue to decline each year."[46] In February 2019, the Departments issued a request for information on grandfathered group health plans and grandfathered group health insurance coverage.[47] In the request, they noted the following: "It is the Departments' understanding that the number of group health plans and group health insurance policies that are considered to be grandfathered has declined each year since the enactment of ... [the ACA], but many employers continue to maintain group health plans and coverage that have retained grandfathered status."[48] Data from the Kaiser Family Foundation's annual surveys on employer-sponsored health benefits underscore the decline among grandfathered group plans. According to the surveys, the percentage of employers that offer at least one grandfathered plan declined from

[42] 45 C.F.R. §147.140(c)(2).

[43] **Table A-1** in Appendix A also identifies the federal health insurance requirements with which transitional plans do and do not have to comply.

[44] 45 C.F.R. §147.140.

[45] 42 U.S.C. §18011(b), (c).

[46] The comments were made in the preamble to the proposed rule on health reimbursement arrangements. IRS, Department of the Treasury; Employee Benefits Security Administration, DOL; CMS, HHS, "Health Reimbursement Arrangements and Other Account-Based Group Health Plans," 83 *Federal Register* 54420, October 29, 2018, p. 54429.

[47] IRS, Department of the Treasury; Employee Benefits Security Administration, DOL; CMS, HHS, "Request for Information Regarding Grandfathered Group Health Plans and Grandfathered Group Health Insurance Coverage," 84 *Federal Register* 5969, February 25, 2019. Hereinafter, 84 *FR* 5969.

[48] 84 *FR* 5969, p. 5971.

72% in 2011 to 22% in 2019.[49] The percentage of covered workers covered under a grandfathered plan declined from 56% in 2011 to 13% in 2019.[50]

States may regulate grandfathered plans in the same way they regulate non-grandfathered plans—they may impose requirements on issuers of grandfathered plans and the plans themselves, provided the state requirements neither conflict with federal law nor prevent the implementation of federal health insurance requirements. States do not have the authority to regulate self-insured grandfathered plans.

Transitional Plans

The ACA included many new federal requirements that applied to health insurance coverage and the entities that offer such coverage. Some of the requirements were effective shortly after the ACA was enacted, but most became effective for plan years beginning on or after January 1, 2014. Many of the 2014 requirements applied to plans offered in the individual and small-group markets.

In the fall of 2013, issuers offering non-grandfathered individual and small-group plans began notifying their enrollees that their coverage would soon be canceled because the plans did not comply with the 2014 ACA requirements. If the individuals and employers enrolled wanted to continue to be covered in the individual or small-group market, they would have to find plans (offered by their current issuer or a different issuer) that complied with the 2014 ACA requirements.

In response to the announced plan terminations, CMS issued guidance in November 2013 that established what are often referred to as *transitional plans* (or *grandmothered* plans).[51] In the guidance, CMS stated it would not find individual and small-group market plans out of compliance with specified 2014 ACA requirements if the plans did not satisfy such requirements, provided the plans were renewed for plan years starting between January 1, 2014, and October 1, 2014. Pursuant to the guidance, state insurance commissioners could choose whether to enforce compliance with the specified 2014 ACA requirements in their individual and small-group markets. If state insurance commissioners chose not to enforce compliance in one or both of the markets, then issuers selling plans in the market(s) could choose to (but would not be required to) renew coverage for enrollees who otherwise would receive cancellation notices.

Table A-1 in the Appendix identifies the ACA requirements with which transitional plans do and do not have to comply.[52] Transitional plans must comply with federal health insurance requirements that went into effect prior to enactment of the ACA and all ACA requirements that went into effect prior to 2014.

Initially, the transitional plan guidance applied to plans that were renewed for plan years starting between January 1, 2014, and October 1, 2014. The transitional plan guidance has been extended

[49] Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits Survey*. The 2011 estimate is from the 2011 survey, and the 2019 estimate is from the 2019 survey. See https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/ (2019 survey) and https://www.kff.org/health-costs/report/employer-health-benefits-annual-survey-archives/ (all prior surveys).

[50] See footnote 49.

[51] Letter from Gary Cohen, Director, CCIIO, to State Insurance Commissioners, November 14, 2013, at http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

[52] **Table A-1** in the Appendix also identifies the federal health insurance requirements with which grandfathered plans do and do not have to comply.

multiple times (most recently on March 25, 2019); currently, states may allow issuers that have continually renewed transitional plans since 2014 to continue to cover individuals under transitional plans through 2020.[53]

In states that allow transitional plans, issuers can choose to continue their transitional plans or not. Discontinued transitional plans cannot be revived. Transitional plans generally are not available to new enrollees. Only individuals who have been continually covered and any new dependents can be covered under transitional plans in the individual market, and only individuals who have been continually covered, new dependents, and new employees can be covered under transitional plans in the small-group market.

Most states opted to allow transitional plans in both their individual and small-group markets when the policy was first established.[54] Some states have changed their policies since then. In 2019, transitional plans are available in both the individual and small-group markets in 32 states; most of these states have indicated they will allow transitional plans to continue in their markets through 2020 under the recent federal extension. In four states, transitional plans are allowed in both markets, but issuers have stopped offering transitional plans in each state's individual market. Fifteen states (including DC) either never allowed or no longer allow transitional plans in the state.

As of the date of this report, no repository of enrollment data for transitional plans could be found.[55] Given that transitional plans, for the most part, may only be renewed by those currently involved and may not be sold to new consumers, enrollment in transitional plans likely has declined since the plans were established.

Noncompliant Health Coverage Arrangements

The two health coverage arrangements discussed in this section have the following in common: the federal government has not explicitly exempted them from compliance with federal health insurance requirements, and they do not necessarily comply with those requirements.[56]

The arrangements summarized in this section are just two examples that share the aforementioned characteristics. There may be other health coverage arrangements that share the same characteristics, but it is difficult to make a comprehensive list of such arrangements, given that one of their defining characteristics is that the federal government does not appear to have discussed their status with respect to the application of the federal health insurance requirements.

[53] Randy Pate, "Insurance Standards Bulletin Series - INFORMATION - Extension of Limited Non-Enforcement Policy Through 2020," CCIIO, CMS, HHS, March 25, 2019, at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Limited-Non-Enforcement-Policy-Extension-Through-CY2020.pdf.

[54] The information in this paragraph comes from the links to source documents found at healthinsurance.org, "Should I Keep My Grandmothered Plan?," June 8, 2019, at https://www.healthinsurance.org/obamacare-enrollment-guide/should-i-keep-my-grandmothered-health-plan/.

[55] Some states publish enrollment estimates. For a roundup of these estimates, see healthinsurance.org, "Should I Keep My Grandmothered Plan?," June 8, 2019, at https://www.healthinsurance.org/obamacare-enrollment-guide/should-i-keep-my-grandmothered-health-plan/.

[56] The arrangements discussed in this section are not prohibited from complying with federal health insurance requirements.

Health Care Sharing Ministries

A *health care sharing ministry* (HCSM) is a faith-based organization that shares resources for medical needs among its members.[57] The idea of pooling financial resources for medical needs among a religious community has a long history in the United States. The idea originated with the Amish and Mennonites over a century ago, and other religious groups began offering HCSMs in the 1990s.[58] In general, members of an HCSM are expected to follow a set of religious or ethical beliefs and regularly contribute a payment (e.g., monthly) to cover the medical expenses of other members. The contributions are distributed, either through the HCSM or via a member-to-member match, to members who need funds for health care costs. Members are often responsible for a portion of their health care costs prior to receiving funds from the HCSM, and most HCSMs exclude coverage of specified illnesses, care, or treatments.

HCSMs maintain that they are not providing insurance and do not guarantee payment for members' health care costs.[59] However, the federal government does not appear to have defined HCSMs for regulatory or exemption purposes.[60] HCSMs do not necessarily currently comply, and have not historically complied, with federal health insurance requirements.

States may choose whether and how to regulate HCSMs operating in their state. As of August 2018, 30 states had opted to explicitly exempt HCSMs from state insurance law (i.e., the HCSM does not have to comply with the state's body of insurance laws), provided the HCSM meets specified requirements.[61] State HCSM requirements vary; examples of requirements include providing to consumers written disclaimers stating the HCSM is not an insurance company and having an annual audit.[62] In the remaining 21 states (including DC), HCSMs have not been explicitly exempted from state insurance law; however, the lack of an explicit exemption does not necessarily mean that such states regulate HCSMs.[63]

Regardless of whether a state has exempted an HCSM from its body of insurance laws, a state's role in regulating HCSMs is complex and varied. In states that exempt HCSMs from their insurance laws, state regulators are responsible for ensuring that HCSMs meet the requirements necessary to maintain their exemption and for taking action if they do not. In states that do not

[57] Health care sharing ministries (HCSMs) are defined in the federal tax code (26 U.S.C. §5000A(d)(2)(B)(ii)) for purposes of implementing the individual mandate and its associated penalty. (Enrollment in an HCSM that meets specified conditions allows one to be exempt from the individual mandate penalty; however, since the penalty was zeroed out beginning in 2019, an exemption from the penalty is unnecessary.) This definition is often cited when discussing HCSMs, but its applicability does not extend beyond implementation of the individual mandate and its penalty.

[58] Christina Lechner Goe, *Non-ACA-Compliant Plans and the Risk of Market Segmentation,* National Association of Insurance Commissioners, March 2018, at https://www.naic.org/meetings1803/cmte_conliaison_2018_spring_nm_additional_materials.pdf. Hereinafter, Goe, *Non-ACA-Compliant Plans.*

[59] For more information about the characteristics of HCSMs, see 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, at https://www.commonwealthfund.org/publications/fund-reports/2018/aug/health-care-sharing-ministries. Hereinafter, Volk, Curran, and Giovannelli, *Health Care Sharing Ministries.*

[60] See footnote 57.

[61] Volk, Curran, and Giovannelli, *Health Care Sharing Ministries*. See the report for a list of the 30 states.

[62] Volk, Curran, and Giovannelli, *Health Care Sharing Ministries.* Appendix 1 in the Commonwealth Fund report cited in footnote 59 lists three requirements and identifies which states require compliance with each. CRS learned through correspondence with the primary author of the report that the list in Appendix 1 is not comprehensive, as some states have established other requirements with which HCSMs must comply to maintain their exemption from state insurance laws.

[63] Volk, Curran, and Giovannelli, *Health Care Sharing Ministries.*

exempt HCSMs from their insurance laws, state regulators "can investigate and, if sufficient evidence exists, regulate these plans as unauthorized insurers."[64] In all states, regulators may have roles to play in "investigating fraud, referring cases to the Attorney General's office, and assisting consumers who may have been harmed [by an HCSM]."[65]

The Alliance of Health Care Sharing Ministries reports that there are 104 HCSMs in 29 states, and 7 of the 104 are open to new members.[66] As of the date of this report, the alliance estimates enrollment in HCSMs at just under 970,000.[67]

Farm Bureau Coverage

The American Farm Bureau Federation is a national organization established in 1919 to advocate for the financial and political interests of farmers, ranchers, and others associated with agriculture.[68] There are local farm bureau offices in all 50 states and in Puerto Rico (but not in DC). Membership in a local farm bureau is open to anyone who pays the membership fee,[69] but typically membership is tiered, with members associated with agriculture having a status different from other members (e.g., agriculture-associated members may have voting rights in the organization, whereas other members may not).[70]

Each state farm bureau provides member benefits. The benefits include discounts on a variety of products and services, such as hotel stays, farm equipment, and membership in air ambulance networks. Additionally, many state farm bureaus assist their members with obtaining insurance, including health insurance. The assistance with health insurance takes different forms. Many state farm bureaus have agents available to assist their members with finding and enrolling in a health plan; some state farm bureaus sponsor coverage that is available to their members; and at least one state farm bureau is divided in two parts, with one part being an insurance company that serves the farm bureau's members.[71]

As of the date of this report, three states—Iowa, Kansas, and Tennessee—have enacted laws that allow the farm bureaus in each state to offer a different type of health coverage arrangement. Each state allows the state's farm bureau to sponsor health benefits coverage that is not defined by the state as insurance and is not subject to the state's insurance laws, provided the coverage and the farm bureau comply with specified requirements.[72] (See **Table 6** for details.) Iowa and

[64] Goe, *Non-ACA-Compliant Plans,* p. 23.

[65] Goe, *Non-ACA-Compliant Plans,* p 24.

[66] Alliance of Health Care Sharing Ministries, Data and Statistics, at http://www.healthcaresharing.org/about-us/data-and-statistics/. (Hereinafter, Alliance of HCSM, Data and Statistics.) According to the alliance, the seven that are open to new members have "open membership" or "modified open membership."

[67] Alliance of HCSM, Data and Statistics. The enrollment estimate is for "Alliance partner and affiliates."

[68] American Farm Bureau Federation, American Farm Bureau through the Years, at https://www.fb.org/about/centennial.

[69] The membership fee varies across locations. Each state's farm bureau website has details about its membership fee.

[70] See, for example, how the Wisconsin Farm Bureau Federation differentiates between types of members, at Wisconsin Farm Bureau Federation, Membership Types, at https://wfbf.com/membership/.

[71] Each state farm bureau has health insurance information under the "Member Benefits" section of its website. Kentucky Farm Bureau is the one with two parts; for information about its insurance company, see Kentucky Farm Bureau, Insurance Products, at https://www.kyfb.com/insurance/insurance-products/.

[72] None of the laws mention the state's farm bureau by name; however, the descriptions of the entities allowed to sponsor coverage that is deemed not insurance are fairly specific. In Iowa and Tennessee, each state's farm bureau is the only entity offering such coverage; in Kansas, a supplemental note to the legislation identifies only the Kansas Farm Bureau as a sponsor of the coverage. *Supplemental Note on Senate Bill NO. 32*, prepared by Kansas State Legislature, 2019, http://www.kslegislature.org/li/b2019_20/measures/documents/supp_note_sb32_01_0000.pdf.

Kansas passed their laws recently—in 2018 and 2019, respectively—and Tennessee passed its law in 1993. The farm bureaus in Iowa and Tennessee currently offer such coverage; the Kansas Farm Bureau's coverage became available for purchase beginning October 1, 2019, with coverage starting as early as January 1, 2020.

Table 6. Summary of State Laws in Iowa, Kansas, and Tennessee Pertaining to Farm Bureau Coverage

State	Citation	Summary of Relevant Provisions
Iowa	Iowa Code §505.20	A "health benefits plan" sponsored by the state's farm bureau is deemed not insurance and not subject to Iowa's insurance laws provided such plan • is self-insured and • is administered by an entity that meets the specified requirements.[a]
Kansas	Kansas Statutes Annotated §40-2222	"Health care benefit coverage" offered by the Kansas Farm Bureau is not considered insurance and is not under the jurisdiction of the Kansas Commissioner of Insurance. The coverage may be reinsured by a company that is allowed to undertake reinsurance in Kansas. The Kansas Farm Bureau, as a provider of the health care benefit coverage, must file a "signed, certified actuarial statement of plans reserves" annually with the Kansas Commissioner of Insurance.
Tennessee	Tenn. Code Annotated §56-2-121(2016)	A "plan" sponsored by the state's farm bureau is deemed not insurance and not subject to state requirements governing insurance provided • the plan is self-insured and • "any stop-loss, excess, or similar insurance coverage purchased as part of the plan" is considered insurance and subject to the state's insurance requirements.

Source: CRS analysis of cited state laws.

Notes: None of the laws mention the state's farm bureau by name; however, the descriptions of the entities allowed to sponsor coverage that is deemed not insurance are fairly specific. In Iowa and Tennessee, each state's farm bureau is the only entity offering such coverage; in Kansas, a supplemental note to the legislation identifies only the Kansas Farm Bureau as a sponsor of the coverage. *Supplemental Note on Senate Bill NO. 32*, prepared by Kansas State Legislature, 2019, at http://www.kslegislature.org/li/b2019_20/measures/documents/supp_note_sb32_01_0000.pdf.

a. The health benefits coverage must be administered by a third-party administrator (TPA) that has been acting as such for the Iowa Farm Bureau for more than 10 consecutive years prior to the farm bureau offering its health benefits coverage. The fiscal note accompanying the law establishing the coverage assumed that the TPA would be Wellmark Blue Cross Blue Shield, and Wellmark Blue Cross Blue Shield has been administering the coverage for Iowa Farm Bureau. *Fiscal Note for Senate File 2349*, prepared by Legislative Services Agency, March 28, 2018, https://www.legis.iowa.gov/docs/publications/FN/961243.pdf.

As explained above, the arrangements sponsored by farm bureaus in Iowa, Kansas, and Tennessee are not considered insurance in their respective states and do not have to comply with state requirements that apply to insurance.[73] Additionally, *farm bureau coverage* in these three states does not necessarily comply with any federal health insurance requirements. However, the federal government does not appear to have defined such coverage for regulatory or exemption purposes.

[73] Nebraska and Minnesota are two other states that have recently increased agriculture-related health insurance offerings; however, the approaches taken in these two states differ from the approach taken in Iowa, Kansas, and Tennessee. Nebraska Farm Bureau established a large-group AHP for its farmers, ranchers, and agribusiness members. (See footnote 12 in this report for a brief reference to AHPs.) Minnesota passed a law allowing agricultural co-ops to offer self-insured plans to their members. The law requires that individuals are involved in agriculture and stay in the co-ops for at least three years to be eligible for the co-op insurance.

In 2017, about 23,000 individuals had Tennessee Farm Bureau coverage.[74] Estimates for the Iowa Farm Bureau were not found. Kansas Farm Bureau estimates that 11,000-42,000 residents of Kansas will be covered by its health benefits coverage.[75]

[74] Kevin Lucia and Sabrina Corlette, *What's Going on in Tennessee? One Possible Reason for its Affordable Care Act Problems,* Georgetown University Health Policy Institute's Center on Health Insurance Reforms, April 11, 2017, at http://chirblog.org/whats-going-tennessee-one-possible-reason-affordable-care-act-challenges/#_edn1.

[75] Harris Meyer, *Kansas Bypasses Obamacare; Will Other States Follow?,* Modern Healthcare, April 23, 2019, at https://www.modernhealthcare.com/insurance/kansas-bypasses-obamacare-will-other-states-follow.

Appendix. Applicability of Selected Federal Health Insurance Requirements to Grandfathered and Transitional Plans

Table A-1 shows the applicability of selected federal health insurance requirements to grandfathered and transitional plans. Both types of plans are described in detail in this report; as a reminder, any type of plan could be grandfathered, but only fully insured small-group plans and individual-market plans could become transitional plans.

The check marks in the table indicate that the grandfathered or transitional plan must comply with the requirement. The term *N.A.* indicates that the requirement does not apply to the specified market segment, regardless of whether the plan is a grandfathered or transitional plan. The use of *Exempt* in the table indicates that the grandfathered or transitional plan is exempt from complying with the requirement. For example, the ACA's rate review requirement applies only to fully insured small-group plans and individual market plans. Grandfathered plans do not have to comply with the requirement, which is why the table indicates that grandfathered fully insured small-group plans and grandfathered individual plans are "Exempt" from the requirement. Transitional plans do have to comply with the requirement, which is why the table has check marks for these plans. The rate review requirement does not apply to fully insured large-group plans or self-insured plans; as such, the table indicates that the requirement is not applicable (N.A.) to grandfathered versions of these plans.

Table A-1. Applicability of Selected Federal Health Insurance Requirements to Grandfathered and Transitional Plans

U.S. Code	Provision	Grandfathered Plans[a]				Transitional Plans[b]	
		Fully Insured[c]		Self-Insured[d]	Individual Market[e]	Small Group, Fully Insured	Individual Market
		Large Group[f]	Small Group				
Obtaining Coverage							
42 U.S.C. §300gg-1	Guaranteed Issue	Exempt	Exempt	N.A.	Exempt	Exempt	Exempt
42 U.S.C. §300gg-4(a)	Prohibition on Using Health Status for Eligibility Determinations	√[g]	√[g]	√[g]	Exempt	√	Exempt
42 U.S.C. §300gg-14	Extension of Dependent Coverage	√	√	√	√	√	√
42 U.S.C. §300gg-16, 26 U.S.C. §105(h)	Prohibition of Discrimination Based on Salary	Exempt	Exempt	√[h]	N.A.	√[h]	N.A.
42 U.S.C. §300gg-7	Waiting Period Limitation	√	√	√	N.A.	√	N.A.

U.S. Code	Provision	Grandfathered Plans[a]				Transitional Plans[b]	
		Fully Insured[c]		Self-Insured[d]	Individual Market[e]	Small Group, Fully Insured	Individual Market
		Large Group[f]	Small Group				
Keeping Coverage							
42 U.S.C. §300gg-2	Guaranteed Renewability	Exempt	Exempt	N.A.	Exempt	Exempt	Exempt
42 U.S.C. §300gg-12	Prohibition on Rescissions	√	√	√	√	√	√
Developing Health Insurance Premiums							
42 U.S.C. §300gg-4(b)	Prohibition on Using Health Status as a Rating Factor	√[g]	√[g]	√[g]	Exempt	√	Exempt
42 U.S.C. §300gg	Rating Restrictions	N.A.	Exempt	N.A.	Exempt	Exempt	Exempt
42 U.S.C. §300gg-94	Rate Review	N.A.	Exempt	N.A.	Exempt	√	√
42 U.S.C. §18032(c)	Single Risk Pool	N.A.	Exempt	N.A.	Exempt	Exempt	Exempt
Covered Services							
42 U.S.C. §300gg-25	Minimum Hospital Stay After Childbirth	√	√	√	√	√	√
42 U.S.C. §300gg-26	Mental Health Parity	√	N.A.[i]	√[j]	√	N.A.	√
42 U.S.C. §300gg-27	Reconstruction After Mastectomy	√	√	√	√	√	√
42 U.S.C. §300gg-3	Nondiscrimination Based on Genetic Information	√	√	√	√	√	√
42 U.S.C. §300gg-28	Coverage for Students Who Take a Medically Necessary Leave of Absence	√	√	√	√	√	√
42 U.S.C. §300gg-6[k]	Coverage of Essential Health Benefits	N.A.	Exempt	N.A.	Exempt	Exempt	Exempt
42 U.S.C. §300gg-13	Coverage of Preventive Health Services Without Cost Sharing	Exempt	Exempt	Exempt	Exempt	√	√
42 U.S.C. §300gg-3	Coverage of Preexisting Health Conditions	√	√	√	Exempt	√	Exempt

U.S. Code	Provision	Grandfathered Plans[a]				Transitional Plans[b]	
		Fully Insured[c]		Self-Insured[d]	Individual Market[e]	Small Group, Fully Insured	Individual Market
		Large Group[f]	Small Group				
42 U.S.C. §300gg-4(j)	Wellness Programs	√[l]	√[l]	√[l]	N.A.	Exempt	N.A.
Cost-Sharing Limits							
42 U.S.C. §300gg-6[m]	Limits for Annual Out-of-Pocket Spending	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
42 U.S.C. §300gg-6[n]	Minimum Actuarial Value Requirements	N.A.	Exempt	N.A.	Exempt	Exempt	Exempt
42 U.S.C. §300gg-11	Prohibition on Lifetime Limits	√	√	√	√	√	√
42 U.S.C. §300gg-11	Prohibition on Annual Limits	√	√	√	Exempt	√	√
Consumer Assistance and Other Patient Protections							
42 U.S.C. §300gg-15	Summary of Benefits and Coverage	√	√	√	√	√	√
42 U.S.C. §300gg-18	Medical Loss Ratio	√	√	N.A.	√	√	√
42 U.S.C. §300gg-19	Appeals Process	Exempt	Exempt	Exempt	Exempt	√	√
42 U.S.C. §300gg-19a	Patient Protections	Exempt	Exempt	Exempt	Exempt	√	√
42 U.S.C. §300gg-8	Nondiscrimination Regarding Clinical Trial Participation	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
Plan Requirements Related to Health Care Providers							
42 U.S.C. §300gg-5	Nondiscrimination Regarding Health Care Providers	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt
42 U.S.C. §300gg-17	Reporting Requirements Regarding Quality of Care	Exempt	Exempt	Exempt	Exempt	√	√

Source: CRS analysis of federal statutes, regulations, and guidance.

Notes: The requirements listed in this table do not comprise a comprehensive list of all federal health insurance requirements and standards that apply to all health plans.
A checkmark in the table indicates that the grandfathered or transitional plan must comply with the requirement. The *N.A.* indicates that the requirement does not apply to the specified market segment, regardless of whether the plan is a grandfathered or transitional plan. The use of *Exempt* in the table indicates that the grandfathered or transitional plan is exempt from complying with the requirement.

a. See the "Grandfathered Plans" section of this report for information about grandfathered plans.

b. See the "Transitional Plans" section of this report for information about transitional plans.

c. A fully insured health plan is one in which the plan sponsor purchases health coverage from a state-licensed issuer; the issuer assumes the risk of paying the medical claims of the sponsor's enrolled members.

d. Self-insured plans refer to health coverage that is provided directly by the organization sponsoring coverage for its members. Such organizations set aside funds and pay for benefits directly. Under self-insurance, the organization bears the risk for covering medical claims. In general, the size of a self-insured employer does not affect the applicability of federal health insurance requirements.

e. Consumers who are not associated with a group can obtain health coverage by purchasing it directly from an issuer in the individual (or non-group) health insurance market.

f. States may elect to define large groups as groups with more than 50 individuals or more than 100 individuals. The definition of a small group is a group with either 50 or fewer individuals or 100 or fewer individuals, depending on a state's definition of a large group.

g. Before the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended), this prohibition (or nondiscrimination requirement) applied only to group plans. The ACA renumbered and amended the prohibition to apply to individual plans in addition to group plans. The general grandfathering rule at 45 C.F.R. §147.140(c) states that the nondiscrimination requirement and other provisions "as added or amended by the Patient Protection and Affordable Care Act, do not apply to grandfathered health plans." However, 45 C.F.R. §147.110 indicates that 45 C.F.R. §147.140 provides for exemption of grandfathered individual market plans from such provisions.

h. The nondiscrimination requirement codified at 42 U.S.C. §300gg-16 (and incorporated by reference in the Employee Retirement Income Security Act of 1974 and the Internal Revenue Code) applies to fully insured plans, including transitional plans (but not grandfathered plans). The nondiscrimination requirement for fully insured plans is not in effect as of the date of this report, but the requirement for self-insured plans is in effect.

i. As discussed in this table's note (f), states may choose to define their small-group market as groups of 50 or fewer or 100 or fewer individuals for purposes of the application of the requirements listed in this table. However, the state definition does not matter with respect to the application of the mental health parity requirements. The definition of small group for purposes of the mental health parity requirements is a group with 50 or fewer individuals, regardless of how a state defines small group. See Internal Revenue Service (IRS), Department of the Treasury; Employee Benefits Security Administration, Department of Labor (DOL); Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS), "Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program," 78 *Federal Register* 68239, November 13, 2013, p. 68248.

j. In this case, the checkmark applies only to self-insured large-group plans. The mental health parity requirements are not applicable to small-group plans, including those that are self-insured.

k. This is the requirement for individual and small-group plans to cover the essential health benefits (EHB); the EHB are defined at 42 U.S.C. §18022(b).

l. Wellness program requirements for group health plans were established under both the Health Insurance Portability and Accountability Act (HIPAA; P.L. 104-191) and the ACA. Per the preamble of the final rule "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans," "[w]hile section 1251 of the Affordable Care Act provides that certain amendments made by the Affordable Care Act (including the amendments to PHSA section 2705(j)) do not apply to grandfathered health plans, the Departments believe that the provisions of these final regulations are authorized under both HIPAA and the Affordable Care Act. This approach is intended to avoid inconsistency across group health coverage and to provide grandfathered plans the same flexibility to promote health and prevent disease as non-grandfathered plans." See IRS, Department of the Treasury; Employee Benefits Security Administration, DOL; CMS, HHS, "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans," 78 *Federal Register* 33157, June 3, 2013, p. 33167.

m. This is the requirement for individual and small-group plans to limit annual out-of-pocket spending; the limit is defined at 42 U.S.C. §18022(c).

n. This is the requirement for individual and small-group plans to comply with actuarial value requirements; the requirements are defined at 42 U.S.C. §18022(d).

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