

U.S. Health Reform—Monitoring and Impact

Perspective from Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org.

EXECUTIVE SUMMARY

Changes in federal and state policy have caused turmoil in the individual health insurance market in the last several years. For policymakers and other stakeholders, it is important to understand how these changes have affected consumers' access to affordable, high-quality coverage. Health insurance brokers sell almost half of all Affordable Care Act (ACA) marketplace policies, as well as many non-ACA-compliant products, such as short-term plans. Thus, brokers are a critical resource for understanding the impact of policy changes on consumers' health insurance experiences.

In this study, we assess market trends in seven states—Colorado, Georgia, Iowa, Mississippi, New Hampshire, Texas, and Utah—through a review of insurer participation, premiums, and enrollment data and through structured interviews with health insurance brokers.

Findings

Consistent with national trends, the individual market appears to be stabilizing in our seven study states. At least as many insurers are participating in each state's marketplace as did in 2018, and five of the seven states have more participating insurers in 2020. Marketplace plan selections have also remained stable in our study states, with increases in five states and small, single-digit reductions in the other two. After a few years of significant hikes, average benchmark premiums in our study states have been moderating.

Brokers Report Improved Competition and Products in ACA Marketplaces but Continued Concern over Narrow Networks

Brokers universally welcomed the additional insurer competition in their state marketplaces. In at least a few cases, the new insurers built their networks using different providers, giving consumers new choices of both insurers and providers. At the same time, individual market insurers are continuing to offer only health maintenance organization–style products, and brokers expressed frustration about the lack of plans with preferred provider organization networks.

Incentives to Serve Individual Market Consumers Have Improved but Are Still Limited

Several brokers have either stopped marketing their services to individual market consumers or have discontinued selling marketplace plans altogether. Though brokers cited several factors for this trend, the precipitous decline in compensation for selling ACA-compliant individual policies has been a significant factor. However, several brokers noted that some insurers have increased their compensation slightly as insurer competition has increased. Conversely, brokers across our study states reported that compensation for selling short-term plans and other products that do not comply with the ACA is significantly more generous than that for selling ACA-compliant plans.

Coverage Affordability Remains a Top Concern

Several brokers reported that declines in average benchmark premiums resulted in net premium *increases* for their clients eligible for ACA subsidies. Brokers noted that these enrollees, though still protected from the full cost of the premium, had to pay more for their coverage than they did the prior year.

because their subsidy amount decreased. However, brokers' unsubsidized clients were generally happy about, though often confused by, the decline in their premiums. At the same time, brokers reported that premiums for people remaining in transitional policies have been rising faster than premiums for ACA-compliant coverage in recent years.

Better Prices and Products in the Employer Group Market Limit Use of Health Reimbursement Arrangements and Attract Sole Proprietors

The Trump administration has touted Individual Coverage Health Reimbursement Arrangements (ICHRA) as mechanisms to encourage employers that have not heretofore offered a health benefit to workers to do so. Brokers reported that few to no employers have taken up individual coverage health reimbursement arrangements.

Brokers in three of our study states—Iowa, Utah, and Texas—reported that their clients have benefited from the relaxation of rules prohibiting the self-employed from purchasing small-group market health plans. Several brokers noted that they work to offer clients that option whenever possible.

Brokers Hold Mixed Views on the Value of Alternative Coverage Options

Despite federal rules designed to expand their sale, short-term plans have been slow to get off the ground, according to brokers in our study states, and few of the brokers with whom we spoke had positive opinions of short-term plans. Several noted these plans' risks for clients with preexisting conditions, but others thought they were a good option for healthy people who could not afford ACA-compliant coverage.

Health care sharing ministries (HCSMs) are another form of coverage that does not have to comply with the ACA's

consumer protections. Though brokers reported that HCSMs have been actively marketing to consumers in their states, most were reluctant to sell HCSM coverage, primarily because it is not insurance.

Several brokers also expressed concerns about association health plans, which the Trump administration has promoted as a more affordable alternative to ACA-compliant insurance. Many brokers described very negative experiences with association health plans that existed before the ACA.

Companies selling fixed indemnity plans, which provide a fixed dollar amount for specified health care services, often market their products as cheaper substitutes for comprehensive, ACA-compliant insurance. The brokers we interviewed almost universally criticized these products, citing their caps on benefits and skimpy coverage.

Conclusion

Brokers in our study generally felt positive about moderating premiums and the introduction of new participating insurers in the individual market. However, though they applauded signs of stabilizing and even healthier markets, many noted that premiums are still unaffordable for many consumers, and they criticized the lack of broader network options. Many brokers expressed interest in the new ICHRAs but reported that where legally permissible, they direct individual market clients to the group market to take advantage of better rates and products, not the other way around.

Though the brokers in our study generally appreciated the availability of alternative coverage options, such as short-term plans and HCSMs, many refuse to sell products they view as overly risky for consumers, despite the higher compensation brokers receive for selling those products.

INTRODUCTION

Changes in federal and state policy have buffeted the market for individual health insurance in the last several years. Such market shocks include Congress's repeal of the penalty for failing to maintain insurance coverage, the expansion of short-term and association health plans (AHPs) as cheaper alternatives to coverage that meet Affordable Care Act (ACA) standards, and the introduction of Individual Coverage Health Reimbursement Arrangements (ICHRA) through which employers fund employee accounts for purchasing individual health insurance. At the same time, states have taken increasingly diverse approaches to regulating the individual market; some have worked to maintain or expand robust enrollment in ACA plans, while others have facilitated the sale of short-term plans or other

alternative options, such as Farm Bureau health plans and health care sharing ministry (HCSM) memberships.

Policymakers and other stakeholders need to understand how these changes have affected consumers' access to affordable, high-quality coverage. Currently, almost half of ACA marketplace plans are sold through an insurance broker¹; many short-term, AHP, Farm Bureau, and HCSM products are also sold through brokers. Thus, brokers are a critical resource for understanding the impact of policy changes on consumers' experiences with individual market coverage. Through a review of market trends in seven states and structured interviews with brokers who sell insurance products to individuals, we assess how consumers are affected by the evolving policy environment.

APPROACH

This study assesses trends in premiums, insurer participation, and enrollment in seven states—Colorado, Georgia, Iowa, Mississippi, New Hampshire, Texas, and Utah.² We chose these states to reflect geographic diversity and because they had all experienced recent individual market instability or policy changes. In addition to scanning market trends, we conducted structured interviews with 18 insurance brokers across the seven states between January 9 and February 10, 2020.

Insurance markets differ across states, making it difficult to extrapolate the findings from our seven study states to

the nation. All the brokers interviewed for this study sell insurance in the individual market, and many sell both ACA-compliant and alternative (non-ACA-compliant) health coverage options. Most primarily serve people in their communities and generate customers largely through referrals, instead of actively marketing themselves to individual market clients. Many of the brokers primarily serve people whose income makes them unlikely to qualify for Medicaid or significant premium tax credits (PTCs), though by necessity, these brokers have become adept at navigating consumers through determining eligibility for subsidies.

BACKGROUND

The ACA reformed the individual health insurance market with the goal of making insurance more affordable, adequate, and accessible. In the two years after ACA implementation, enrollment in the nongroup market increased 81.5 percent, from 12.5 million people in 2013 to 21.2 million people in 2016.³ However, that number declined to 18.9 million by 2018.^{3,4} Most people leaving the individual market have had incomes above 400 percent of the federal poverty level and thus were ineligible for ACA subsidies.⁵

One critical ACA implementation decision contributed to early market instability: in 2013, the Obama administration gave states the power to exempt certain health plans issued after March 2010 but before 2014 (called transitional plans) from many of the ACA's consumer protections. Consequently,

insurers in most states could retain enrollees that had passed the insurer's underwriting standards and were healthier, on average, than those signing up for ACA-compliant plans.⁶

More recently, an improved economy and federal policy changes, such as the deep cuts to marketplace advertising and consumer assistance budgets, repeal of the individual mandate penalty, and promotion of short-term plans, have likely contributed to the decline in individual market enrollment. Evidence suggests that the sale and marketing of other cheaper, non-ACA-compliant products, such as HCSMs, fixed indemnity products, and Farm Bureau plans (available in three states), have also grown, though no national enrollment numbers for these products are available (Table 1).⁷

Table 1. Alternative Coverage Options in the Individual Market

Type	Description
Transitional plans	Individual health insurance policies purchased between March 23, 2010, and January 1, 2014. At state option, insurers are permitted to renew existing enrollees. These plans are exempt from many ACA consumer protections, including the ban on health status underwriting.
Short-term, limited-duration insurance	Insurance products originally designed to fill temporary gaps in coverage but now allowed to be sold in most states for 364 days' worth of coverage, which can be renewed for up to three years. Generally, consumers must pass medical underwriting to enroll in the plan, and the plans do not cover preexisting conditions. In most states, 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. Federal rules adopted in 2018 would allow association health plans (AHPs) to be sold to employers of all sizes, including the self-employed. Such rules would treat the AHP as a large employer group plan for the purpose of federal law, rendering the AHP exempt from ACA consumer protections that otherwise apply to individual and small-employer health insurance. Though the federal rules are on hold pending the outcome of litigation, AHPs could have a significant impact on the individual market if they become widely available.
Health care sharing ministries	Entities that ask their members to adhere to a set of religious beliefs and contribute funds to pay for other members' qualifying medical expenses. Health care sharing ministry coverage is not insurance and does not have to meet any ACA consumer protections.
Fixed indemnity plans	Policies that generally pay a fixed dollar amount per health care service, regardless of the actual cost of the service. They are not considered health insurance under federal or state laws and do not have to meet any ACA consumer protections.
Farm Bureau plans	Health plans sponsored by Farm Bureau associations that have been exempted from state insurance regulation. As such, they are exempt from the ACA consumer protections. They are currently available in Iowa, Nebraska, and Tennessee.

Conversely, the federal government adopted rules in 2019 that could expand enrollment in individual market health insurance. Beginning January 1, 2020, employers are allowed to offer employees an Individual Coverage Health Reimbursement Arrangement (ICHRA) in lieu of a group health plan. The ICHRA is a tax-exempt account, funded by the employer, that can be used to reimburse employees' premiums for individual market, ACA-compliant coverage.⁸ Employees offered an ICHRA may not qualify for premium subsidies for marketplace coverage, unless they can demonstrate that after-ICHRA premiums for the lowest-cost silver-level marketplace plan available would exceed a specified percentage of their household income (currently 9.78 percent), adjusted annually. How popular ICHRAs will be with employers is unclear.

Though the proportion of consumers using brokers to enroll in a marketplace plan has grown, the number of brokers selling individual market coverage has declined significantly.⁹ Insurers have reduced brokers' compensation for selling individual market policies since enactment of the ACA, because they were pressured to reduce administrative and

marketing costs. Further, many insurers suffered significant financial losses on marketplace plans from 2014 to 2016, causing them to reduce brokers' commissions even further.⁹ At the same time, evidence shows that companies marketing alternative coverage products, such as short-term plans, HCSMs, and fixed indemnity plans, offer significantly higher commissions than those available for ACA plans to encourage brokers to sell these products.¹⁰

Consistent with National Trends, Studied Markets Are Stabilizing

Nationally, marketplace plan premiums have declined for two consecutive years (2019 and 2020), while insurer participation in the marketplaces has increased.¹¹ This follows a tumultuous 2017–18 enrollment period, where many states experienced large, double-digit—sometimes even triple-digit—percent increases in state average benchmark premiums for the 2018 plan year (Table 2). Our seven study states have generally followed these national trends. All seven states have at least as many insurers participating in their marketplace as they had in 2018, and five of the seven states have more participating insurers in 2020 (Table 2).

Table 2: Marketplace Participation, Changes in Average Benchmark Premiums, and Marketplace Plan Selections, 2018–20

State	Number of Insurers Participating in the Marketplace			Percent Change in Benchmark Premium		Marketplace Plan Selections*			Percent Change in Plan Selections	
	2018	2019	2020	2018-19	2019-20	2018	2019	2020	2018-19	2019-20
Colorado	7	7	8	16	-24	165,777	169,762	167,000	2	-2
Georgia	4	4	6	-4	14	480,912	458,437	464,061	-5	1
Iowa	1	2	2	-11	-4	53,217	49,210	54,596	-8	11
Mississippi	1	1	2	-5	-2	83,649	88,542	98,868	6	12
New Hampshire	3	3	3	-18	5	49,573	44,581	44,496	-10	0
Texas	8	8	8	2	1	1,126,838	1,087,240	1,117,882	-4	3
Utah	2	3	5	-4	-7	194,118	194,570	201,272	0	3

Sources: Premium data are authors' calculations based on data taken from Helathcare.gov premium data files and Connect for Health Colorado for all three years, found at <https://www.healthcare.gov/health-and-dental-plan-datasets-for-researchers-and-issuers/> and <https://planfinder.connectforhealthco.com/>.

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*Notes: Plan selections reflect the number of consumers who have selected a marketplace plan during the annual open enrollment period (November 1–December 15 in most states). Marketplace selections for 2020 are rounded to the nearest thousand, whereas previous years include exact numbers of plan selections.

Nationally, marketplace enrollment has stayed generally constant in 2020.¹² Among our study states, two had minor declines in plan selections this year (0.02 percent in New Hampshire and 2 percent in Colorado). The remaining states all saw increases in plan selections in 2020. Further, premium trends in our study states have been moderating after a few years of significant hikes. All study states but Georgia experienced either a decline or only a slight increase in benchmark premiums in 2020.

State-level policy and market conditions can affect the overall stability of the individual market. Colorado's establishment of a reinsurance program in 2019 helped lower premiums, and Colorado's and New Hampshire's decisions to limit the sale

of underwritten short-term plans may have helped stem the flow of healthy marketplace enrollees into those products.¹³ Conversely, Iowa deciding to allow the renewal of transitional policies in 2013, and the state's dominant individual market insurer (Wellmark) deciding to retain most of its membership in those plans has resulted in a smaller, sicker ACA-compliant market in that state.¹⁴ Iowa arguably doubled down on this policy in 2018 by exempting plans sold by the state's Farm Bureau from state and federal insurance standards, including protections for people with preexisting conditions. Iowa's Farm Bureau plans are underwritten, meaning they screen out consumers with health issues. Though it is too soon to tell if the Farm Bureau plans will siphon off a significant share of healthy enrollees from the individual market, they could do so.

FINDINGS

Brokers Report Improved Competition and Products in ACA Marketplaces but Continued Concern over Narrow Networks

The widespread moderation in premiums for ACA coverage primarily owes to insurers' increased financial stability in the marketplaces, as well as increased competition from new market entrants.⁵ Most of our study states had new insurers enter the individual market this year, and no states lost an insurer. Brokers universally welcomed the additional competition, but many observed that the new companies had not yet worked to educate brokers about their products or ingratiate themselves with the broker community. However, some brokers were pleased to offer consumers new options, particularly because insurers in their markets exclusively offer health maintenance organization (HMO) or exclusive provider organization products, with no out-of-network coverage. (See text box.) Brokers noted that at least a few new insurers built their networks using different providers, giving consumers new choices of both insurers and providers. An Iowa broker suggested that "bad press" for Wellmark led it to reenter the market with a plan covering 98 percent of doctors in the state, presumably to woo customers away from its marketplace competitor. Conversely, the lack of any competition in some Georgia counties strengthened those counties' sole insurer, Ambetter. "Their network grew substantially because they were the only game in town," reported a broker. Doctors "understood it's either take them or leave them because it's the only insurance [people have]," said a broker who also noted that a new insurer entering into the market prompted Ambetter to improve some of its plans by reducing deductibles.

Preferred provider organization: A health plan that contracts with a network of providers. Enrollees pay less in cost sharing if they use providers in that network but can see providers outside the network at an additional cost.

Health maintenance organization: A health plan that only covers care from providers under contract. The plan generally will not cover out-of-network care except in an emergency and will require a referral to see a specialist.

Exclusive provider organization: A health plan that covers only services provided by in-network providers. It generally will not cover out-of-network care except in an emergency.

Despite these improvements, brokers in our study found that many consumers disliked not having preferred provider organization (PPO) products available to them, particularly those transitioning from employer-sponsored insurance

to a marketplace plan. "You can't go anywhere because the networks are so small," observed a New Hampshire broker. A Texas broker noted that many of her clients would rather pay significantly higher premiums through a COBRA policy than transition to a narrow-network HMO product. Brokers also mentioned that many plans exclude the marquee regional hospital system in their areas.

Incentives to Serve Individual Market Consumers Have Improved but Are Still Limited

The brokers in our study reported limited incentives for selling ACA-compliant individual market products. Several have either stopped actively marketing their services to individual market consumers (instead operating only through referrals) or chosen to discontinue selling marketplace plans altogether. Some reported that they only work with individual market clients at the request of an employer client, or to help a Medicare Advantage client obtain a policy for a family member. "I have all these referrals," said one broker, "but I lose money on most of them. ... [Working with individual market consumers] is just not a good business plan." Brokers identified four primary reasons the individual market was unattractive for them.

- First, keeping up with constantly changing public policies at the state and federal levels is challenging.
- Second, helping consumers receive a determination of eligibility for ACA marketplace subsidies can be a long and complicated endeavor, particularly for those with multiple family members or sources of income.
- Third, technical issues with the marketplace platform have been challenging, including glitches in the system's ability to record when a broker has assisted someone (and thereby enabling the broker to be paid).
- Lastly, brokers almost universally cited the precipitous decline in commissions from insurance companies since ACA enactment.

One broker noted that before the ACA, it was common to receive 10 percent of the premium for selling and servicing a plan. Thus, for a plan with a \$1,500 per month premium, the broker would receive \$150 per month for the life of the policy. Today, many insurers have switched to a per member, per month flat rate, which this broker said ranged from \$6 to \$18 in his market. Other brokers reported commissions averaging 1 to 2 percent of a plan's premiums. However, more recently, brokers in a few of our study states reported that insurers have begun increasing their commissions slightly, perhaps in response to increased competition from other insurers.

As one Utah broker observed, insurers have “actually increased commissions over the past couple of years ... and they’re all now paying commissions for [special] enrollments,” which insurers had previously eliminated.

By contrast, brokers across our study states reported that compensation for selling short-term plans, HCSMs, and fixed indemnity plans is more generous than that for selling ACA plans. Fixed indemnity insurers offered one broker as much as a 25 percent commission to sell their plans. Another broker reported that short-term-plan insurers were offering commissions between 15 and 28 percent. HCSMs tend to offer similarly generous compensation, with brokers reporting commissions between 15 and 30 percent. This partly owes to alternative health insurance plans not being subject to the medical loss ratio regulations required of ACA-compliant plans. By law, at least 80 percent of premium dollars for ACA-compliant plans must be spent on medical care, limiting the size of broker commissions.

Coverage Affordability Remains a Top Concern

Though average premiums either declined or increased only modestly in 2020, brokers reported that this trend had disparate impacts on marketplace enrollees, depending on whether they were eligible for PTCs. In each study state where premiums declined, all brokers reported that their subsidized clients were slightly worse off in 2020 than they had been in previous years, because the PTC amount they receive is pegged to the price of the benchmark plan. As that price declines, so, too, do PTCs. Brokers noted that subsidized enrollees, though still protected from the full cost of the premium, still had to pay more for their coverage than they did the prior year. People with subsidies “got hit the hardest,” said a Colorado broker. “Especially bronze [plan enrollees] with a subsidy ... their rates went up ... and we had to explain how the subsidies went down. ... From their standpoint, it makes no sense,” the Colorado broker continued. Table 3 illustrates how the net premium paid by enrollees can vary based on the price of the benchmark silver plan.

Table 3. State Average Lowest-Cost Bronze and Benchmark Monthly Premiums for a 40-Year-Old Nonsmoker, 2019–20 (in dollars)

State	Lowest-Cost Bronze, 2019	Benchmark, 2019	Lowest-Cost Bronze, 2020	Benchmark, 2020	Lowest-Cost Bronze 2019, after APTC ^a	Lowest-Cost Bronze 2020, after APTC
Colorado	363	496	292	374	0	53
Georgia	338	457	342	438	13	39
Iowa	442	731	367	689	0	0
Mississippi	455	521	422	484	66	73
New Hampshire	303	402	303	405	33	34
Texas	297	419	279	415	11	0
Utah	287	539	286	481	0	0

Source: Authors’ calculations based on data from Healthcare.gov and Connect for Health Colorado.

Notes: APTC = advanced premium tax credits.

^a Advanced premium tax credits were calculated for a person with income at 200 percent of the federal poverty level.

However, brokers in these states reported that consumers ineligible for subsidies were generally pleased that their rates went down, though some were surprised and confused. “More clients were questioning why their rates went down ... because that doesn’t usually happen,” one broker said.

Across all seven states, brokers reported that many of their clients cannot afford ACA coverage, particularly those ineligible for subsidies. In addition to the high premiums, brokers pointed to the high cost sharing in these plans, particularly deductibles and annual out-of-pocket maximums, which has increased steadily each year. “People feel like they’re paying a lot and not

getting any benefit if they don’t meet the deductible,” noted one broker. A New Hampshire broker reported that her clients “just gasp” when she informs them of the deductibles and out-of-pocket maximums for ACA plans.

At the same time, brokers reported that premiums for people remaining in transitional policies have been rising in recent years, faster than premiums for ACA-compliant coverage. Though those products were originally underwritten and tended to have healthier enrollees, the healthier selection resulting from that underwriting has worn off as enrollees have gotten older and acquired health conditions. (These

plans are prohibited from selling coverage to new enrollees.) Brokers reported that some insurers of those products have been hiking up premiums in response, driving more of these enrollees into the ACA marketplaces.

Better Prices and Products in the Employer Group Market Limit Use of ICHRAs and Attract Sole Proprietors

ICHRAs Are Slow to Take Hold but Could Become More Popular

The Trump administration has touted ICHRAs as mechanisms to encourage employers that have not heretofore offered a health benefit to their workers to do so, as well as to help employers that can no longer afford to offer a health benefit.⁸ The ICHRA enables employers who do not offer a group plan to fund employees' health reimbursement arrangement (HRA) accounts with a predetermined amount to reimburse them for the cost of premiums for an individual market plan. ICHRAs may be conceptually appealing to employers because they shift their liability for health coverage from a percentage of the cost, where annual cost growth may be unpredictable, to a defined dollar amount, where the employer can determine how much it wants to contribute each year.

The ICHRA is different from another HRA called the qualified small employer HRA, or QSEHRA, which Congress authorized in 2016. The QSEHRA, as its name suggests, is only available to small employers. Employees with a QSEHRA can combine those funds with ACA PTCs to reduce their premium costs, if eligible.¹⁵ Conversely, employees with an ICHRA, if eligible for PTCs, must use either the HRA account or the PTCs; the two funding sources cannot be combined.

Brokers across all our study states reported that few to no employers have taken up the new ICHRAs. "We haven't really had anyone come and say, 'This is a good way to go,'" reported an Iowa broker. Another broker called employers' interest in the option "minimal." However, a few brokers thought the ICHRA could become an attractive option for employers, particularly for those who fear their renewal every year because they "don't know if it's going to be a 2 percent or 30 percent [cost increase]," said one broker.

This slow adoption can be attributed to several factors, including the insufficient lead time for brokers to learn about these arrangements, the complicated nature of the product and potential compliance risks for employers, the lack of PPO products in the individual market, and the inability to combine HRA funds with APTCs. Additionally, several brokers noted that, in a robust economy, employers are unlikely to risk alienating employees with unwelcome benefit changes.

Federal rules authorized ICHRAs in June 2019, but ICHRAs were not available until January 1, 2020. Though the federal government has attempted to educate employers and brokers

about this new vehicle for funding employee benefits, many brokers did not feel ready to adequately advise employers on a potential shift. "I had [an employer] ask me about the [ICHRAs] in December. ... He was ready to offer, but I wasn't ready to advise him; I don't know all the guidelines to abide by," said one broker. Other brokers pointed to the complicated tax and Employee Retirement Income Security Act of 1974 compliance obligations associated with offering ICHRAs, as well as the operational complexity and need for extensive employee education. "There's increased fees for someone to administer the HRA," noted one broker, "and at the end of the year, you still have to go through reporting and tracking of employees to make sure they had the right coverage at the right time. ... It's enough to drive someone crazy."

Most brokers suggested that the biggest impediment to employers shifting to ICHRAs is the disparity in the quality and affordability of products between the group and individual markets. "The coverage is better in the group market," one broker said, "and premiums are higher in the individual space." Adopting ICHRAs would be a "step down" for employees, another broker noted. Specifically, brokers pointed to group plans continuing to have broader, PPO-style networks, whereas the individual market offers almost exclusively HMO, or closed-network, plan options. "It might work in other places with PPO options [in the individual market]," said one broker, "but here in Texas? Not at all." Others noted that, like premiums, deductibles in the individual market tend to be higher than those offered in the group market. Until coverage options are equal in both markets, most brokers did not think employers would be willing to shift their employees to ICHRAs.

According to some brokers, employers' interest in ICHRAs has been dampened by the inability to combine their ICHRA contributions with APTCs for marketplace coverage. One reported "a decent number" of employers asking about ICHRAs but deciding against it after learning that employees would lose eligibility for APTCs. As one broker put it, for employees whose income would qualify them for APTCs, "it's not a good option. ... You can't pay for subsidized premiums with [the ICHRA]." This broker preferred QSEHRAs, at least for employers who qualify.

Brokers also cited the robust economy and employers' fear of change as reasons for slow take-up of ICHRAs. "We've mentioned it to [our employer clients]," said a Georgia broker, but "they don't want to go through all the trouble to do it. They ... don't like change." Another broker suggested that employers were waiting for other employers to go first: "They want to see other employers who have done it."

However, a few brokers noted that ICHRAs could be a good option for some employers, such as those that offer a traditional group plan to full-time employees but do not offer a health benefit to part-time employees. In that context, one broker said, offering an HRA to those part-time employees “makes complete sense.” Another noted that for self-funded employer clients with sicker-than-average employees, the “ICHRA is something they’ll have to consider” because it offloads the financial risk of an employee group with above average health care costs to the individual market.

Flexibility for the Self-Employed to Enroll into a Group Market Plan Is Helping Some Find More Affordable, Generous Coverage

Brokers in three of our study states—Iowa, Utah, and Texas—reported that their clients have benefited from the relaxation of rules prohibiting the self-employed from purchasing small-group market health plans. Brokers in Iowa told us that if a self-employed person creates a limited liability company and issues his or herself a W-2, a local insurer could then enroll the person in a group plan. In Utah, married couples can qualify for a group plan if they are both owners of a company, though the broker noted that flexibility varies by insurer. The same is true in Texas: One broker mentioned husband and wife clients who were early retirees. They had income from a rental property, so by incorporating themselves as a business, they qualified for a group plan. “They’re saving \$700 per month in premiums,” the broker said. In addition to saving on premiums, brokers noted that qualifying individuals can benefit from the broader provider networks available in the group market. “We try to rescue people from the individual market,” said one broker, “especially if they’re just over 400 percent [of the federal poverty level].”

Brokers Hold Mixed Views on the Value of Alternative Coverage Options

Short-Term Plans Have Not Taken Hold in Some States

Short-term, limited duration (STLD) plans were originally designed to fill temporary gaps in coverage, such as when someone is between jobs. Trump administration rules published in 2018, now adopted in most states, allow insurers to offer STLD plans lasting up to 364 days, and the rules allow consumers to renew STLD plans for up to three years. Because they do not generally cover preexisting conditions, do not have to provide comprehensive health benefits, and can deny enrollment outright based on health status, these plans are offered at a lower cost than ACA-compliant plans.

Despite federal rules designed to expand the sale of STLD plans, brokers in several study states reported that STLD plans have been slow to get off the ground. In Colorado and New Hampshire, STLD plans are limited to six months,

reducing their attractiveness as a substitute for ACA coverage.¹⁶ In the remaining five states, STLD plans can last for up to one year and be renewed for up to three years. However, brokers in these states report that few insurers have developed STLD products that align with the federal policy changes. In Mississippi, a broker told us that the STLD industry “basically shut down” after the ACA and that no insurers have yet started to offer the longer-duration coverage now permitted. In a few cases, the state department of insurance had only recently approved insurers’ longer-term STLD plans; Iowa had only approved them as of January 2020.¹⁷ Consequently, brokers reported limited experience selling the product.

A few brokers we spoke with held positive opinions about STLD plans. One broker in Texas said he was “trying to grow that [line of business] aggressively” for people who are healthy and looking for low-cost, catastrophic coverage, partly because he could earn significantly higher commissions for STLD plans (15–20 percent, compared with commissions for ACA plans, which in his case ranged from 3–5 percent). Meanwhile, a New Hampshire broker called STLD plans “wonderful” because they are “actual insurance,” adding, however, that she only offers them “as plan B, if there’s no other choice, and when folks are ready to walk out the door.” A Georgia broker allowed that networks for STLD plans can be quite broad, pointing to Anthem Blue Cross Blue Shield, which offers its full ACA network to STLD plan enrollees.

More often, however, brokers expressed reservations regarding STLD plans. “I’m apprehensive to sell them; I don’t want someone to get into a limited plan and then ... develop cancer,” said one Iowa broker. “[Short-term plans] don’t fit everyone, and a \$1 to \$2 million lifetime benefit isn’t much in today’s costs,” added a Texas broker. One broker also highlighted how STLD plans can result in adverse selection against ACA-compliant plans. In her state, where STLD plans can only last six months, she advises relatively healthy clients to sign up for an ACA-compliant plan at the start of the year, obtain any needed medical services during that time, and then switch to a short-term plan for the second half of the year. For people struggling to pay the monthly premiums on ACA plans “that’s a game plan if their health holds out,” she said.

Several brokers said they missed the *shorter*-duration plans. An Iowa broker shared, “I wish that 90-day policies were still an option. I don’t like having a [policy with a] \$20,000 [benefit] maximum for 364 days.” A Mississippi broker described the shorter STLD plans as an “excellent stop-gap for short-term situations at an affordable cost,” adding, “that product was a lifesaver for a lot of people.”

Broker Interest in Health Care Sharing Ministries Is Limited, Despite Generous Commissions

HCSMs are another alternative that can be sold to people who have missed the open enrollment period or are not interested in purchasing ACA-compliant coverage. However, HCSMs are not considered insurance under federal or state laws, and paying for an HCSM membership provides no guarantee that medical claims will be paid. HCSM coverage does not have to meet any of the ACA consumer protections and seldom covers preventive care or preexisting conditions.

Brokers reported that HCSMs have been actively marketing to consumers in their states. These include Alera and Trinity HealthShare in New Hampshire, Altrua HealthShare in Utah and Iowa, and Medi-Share in Georgia and Iowa. An Iowa broker who sells Medi-Share memberships praised the ministry: “They’ve been in business since 1993 and have 400,000 lives [nationally] and have never not paid a qualified claim. I’m not concerned about Medi-Share. . . . They’re the real deal.”

Beyond this, however, brokers in our study states were mostly reluctant to sell HCSM coverage, primarily because it is not insurance. As we found in our previous work,¹⁸ brokers are licensed by their state to sell insurance products and carry “errors and omissions” (E&O) insurance to protect them from lawsuits by clients for inadequate advice or negligence. Traditional E&O insurance does not cover HCSMs, and brokers choosing to sell HCSMs must either bear the added cost of a separate E&O policy or risk legal exposure. “As an agent, I don’t want to sell a product where someone will fall through a gap. And when something goes wrong, they’re mad at me,” explained one Iowa broker. A Colorado broker said, “People ask about [HCSMs], but I tell them they’re maybe not the safest route to go. If you want insurance, you should be buying insurance . . . and not something you can be cancelled from.” In Georgia, a broker told us, “A lot of Christian plans come to me, but you need a separate E&O contract for it, and I’m just not comfortable enough with it. If I won’t buy it, I’m not going to try and sell it. And I consider myself a Christian.” A Texas broker has prepared a flier with a Wikipedia definition of HCSM and links to ministries available in the state. “I give this to people who are interested in them, and then advise them to pursue it on their own,” she said, adding, “It doesn’t matter what you tell people, you have no control over what they remember or what they think you said. People remember what they choose to remember.” Another Texas broker said, “I want to know at the end of the day that my client’s claims will get paid, and the HCSMs just don’t guarantee that.” Brokers described how HCSMs market aggressively and offer higher commissions than ACA-compliant plans. But as one Georgia broker put it, “That’s still not enough [for the risk involved].”

Brokers Report Concerns about Association Health Plan Scams and “Death Spirals”

Federal rules adopted in 2018 would allow an association of employers—or the self-employed—to join together under an AHP and be considered a single employer. This designation would allow AHPs to be regulated as large employer plans, exempting them from many of the ACA standards and protections that apply to small-employer and individual market plans.

Though the federal rules were enjoined by a federal district court in 2019, meaning the AHPs formed under the rules had to stop marketing their products, many brokers interviewed for this study expected AHPs to “take off” if that court ruling is overturned on appeal. The brokers in our study did not report having any clients that had joined the new version of AHPs, but many of them reported experiences with AHPs that existed before the ACA, much of them negative. Brokers spoke about AHPs’ “long and sordid history” in the individual market and how many AHPs are little more than insurance scams. For more legitimate AHPs, several brokers reported that many in their states had failed or become insolvent. A broker in Mississippi observed, “The problem is that they inevitably collapse in a death spiral. Everyone loves them initially, but as claims come in, premiums increase, healthy individuals jump off for greener pastures, the sick remain, and you go broke.” A Texas broker shared similar sentiments: “You pool sole proprietors together and get better rates, and initially all is lovely. Until there are claims. Then rates go up, healthy people say, ‘Wait a minute’ and pull out, and sick people can’t go anywhere. Pools get smaller and sicker and premiums get higher. [AHPs] died an ugly death in Texas in the past. They’re a good sound bite for politicians, but they don’t work.”

Fixed Indemnity Insurance Is Perceived as A “Desperation Product”

Companies selling fixed indemnity plans, which provide a fixed dollar amount for specified health care services, often market their products as cheaper substitutes for comprehensive, ACA-compliant insurance.^{7,19} The brokers we interviewed for this paper were almost universally critical of fixed indemnity products, citing their caps on benefits and skimpy coverage. One broker called them “desperation products.” Several brokers reported that they do not and never would sell such plans for some of the same reasons they will not sell HCSMs. One Mississippi broker expressed a commonly held view: “No matter what you tell [customers about the risks], no matter what documentation you give them, no matter what you have them sign, they still think everything is covered. And the moment they find out something is not covered, the first thing they say is, ‘You didn’t tell me that!’” Another broker noted that the brokers who sell fixed indemnity products “never stick around more than four months” because they do not want to face unhappy clients

who have discovered their policy does not cover much. “If you have a \$75,000 claim [on a fixed indemnity plan],” he said, “you’ll be [out of pocket] \$30,000 to \$40,000. ... Anyone can buy a cheap policy. It’s just not good insurance.”

Farm Bureau Plans in Iowa Are Not for People with Preexisting Conditions

In 2018, Iowa amended its state law to exempt health plans sold by the state Farm Bureau from state and federal insurance regulation, including the ACA’s consumer protections. Enrollees must annually apply for membership to the Farm Bureau (a \$30–\$40 fee), go through underwriting to identify and exclude preexisting conditions, pay premiums that run about one-third below those charged for an ACA-compliant plan, and receive their care through the Wellmark Blue Cross and Blue Shield statewide HMO network.

Though Iowa brokers reported thinking the Farm Bureau plans would “take off” once freed from ACA rules, the product had been difficult to sell thus far. “It started from zero, [Farm Bureau plans] didn’t have a pool to figure out what kind of risk they could bear, so were strict on underwriting,” said one broker. People who can meet the Farm Bureau’s underwriting standards are typically healthy and between ages 26 to 32 or 61 to 65, according to another broker. This interviewee went on to say, “But if you fail to disclose something, even by accident, they consider you fraudulent and can cancel your coverage at any time.” These factors have resulted in the Farm Bureau reportedly writing “less than 1,000 contracts” during its first year. Another broker summed it up this way: “I’m always apprehensive to sell something new unless they come in with some financial backing. The [Farm Bureau plan] is not insurance. As an insurance agent, my E&O doesn’t cover noninsurance products.”

CONCLUSION

In our 2018 study’s interviews with health insurance agents and brokers, we heard that significant premium increases and fewer plan options in the ACA-compliant market were pushing many healthy, unsubsidized consumers out of the individual market. Brokers further reported aggressive marketing of and increased consumer interest in alternative products, such as short-term plans and HCSMs. Brokers also reported receiving significantly higher commissions for selling these alternative products than they received for selling ACA-compliant plans. Many were pessimistic about the long-term stability of the individual market.

Two years later, the brokers in our current study generally spoke positively about moderating premiums in the individual market, as well as the introduction of new insurer participants. However, though they applauded signs of stabilizing and even healthier markets, many noted that premiums are still unaffordable for many consumers, particularly those with incomes just over 400 percent of federal poverty level. The high cost sharing and narrow networks associated with ACA plans also deter enrollment. Additionally, in markets that experienced premium decreases, brokers reported that many subsidized individuals (particularly those enrolled in bronze-level plans) experienced an unwelcome premium increase because of how the ACA’s PTCs are structured.

Many brokers expressed interest in the new ICHRAs, but to date there has been minimal take up among their employer

clients. Indeed, brokers in our study states reported that where legally permissible, they direct individual market clients to the group market to take advantage of better rates and products, not the other way around. Brokers identified several issues that inhibit the growth of ICHRAs, including a robust economy, more expensive and less attractive products in the individual market, employers’ resistance to change, the administrative and compliance burdens associated with these arrangements, and the inability to combine ICHRA funds with PTCs. However, several brokers predict that ICHRAs could become an important alternative option for some employers, especially those that wish to offer a benefit to a part-time or seasonal workforce or have sicker-than-average employees.

Though the brokers in our study generally appreciated the availability of alternative coverage options, such as STLD plans, Farm Bureau plans, HCSMs, and fixed indemnity products, they were highly cognizant of the risks these products pose for consumers, particularly those with preexisting conditions or who have an unexpected injury or illness after enrollment. Many brokers refuse to sell products they view as overly risky for consumers, despite the higher commission those plans offer. Though alternative coverage plans are considerably less expensive than ACA plans, these brokers were concerned about the reputational and even legal risks when clients discover the plans cover far less than they thought.

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