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Applicability of Federal Requirements to Selected Health Coverage Arrangements: An Overview

Introduction

A majority of individuals in the United States have private health insurance coverage. In general, health plans sold in the private health insurance market (i.e., individual coverage, small- and large-group coverage, and self-insured plans) must comply with applicable federal and state health insurance requirements.

The federal requirements are codified in 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). They relate to how coverage is offered and issued, the benefits it must cover, and how it is priced, among other issues. Such requirements include the prohibition of preexisting condition exclusions and requirements to cover certain benefits, such as maternity care.

However, not all private health coverage arrangements comply with federal health insurance requirements. This includes *exempted health coverage arrangements* and *noncompliant health coverage arrangements*, as discussed below. This document provides an overview of such arrangements.

This document is adapted from the CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*. See the report for further description of each arrangement, explanation of each arrangement's current status and history with respect to complying with federal health insurance requirements, and relevant statutory and regulatory citations. The report also includes information about whether and how the arrangements are subject to state regulatory authority and provides enrollment estimates (where available).

Applicability of Federal Health Insurance Requirements to Selected Arrangements

Some health coverage arrangements that consumers may purchase from private health insurers or other private organizations do not comply with some or all federal health insurance requirements. The arrangements listed in **Table 1** can be divided into two broad categories, as termed for purposes of this document:

- **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.
- **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.

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

Health Coverage Arrangement	Applicability of Federal Health Insurance Requirements
Exempted Health Coverage Arrangements	
Group Health Plans Covering Fewer Than Two Current Employees	Exempt from complying with all requirements
Excepted Benefits	
Short-Term, Limited-Duration Insurance	
Student Health Insurance Coverage	Exempt from complying with some or all requirements
Self-Insured, Nonfederal Governmental Plans	Exempt from complying with some requirements
Grandfathered Plans	
Transitional Plans	
Noncompliant Health Coverage Arrangements	
Health Care Sharing Ministries	Does not necessarily comply with federal health insurance requirements
Farm Bureau Coverage	

Source: CRS analysis of federal statute and regulations.

Notes: This table is adapted from Table 1 in CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*. See that table for more detail and citations.

Exempted Health Coverage Arrangements

Most of the arrangements identified in **Table 1** are exempt from compliance with some or all federal health insurance requirements. The exemptions are described in federal statute, regulations, or guidance.

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. This includes *retiree-only plans*, provided they cover fewer than two current employees. The exemption was established in the Health Insurance Portability and Accountability Act (HIPAA; P.L. 104-191), which was enacted in 1996.

Excepted Benefits

In general, health plans in their provision of *excepted benefits* are exempt from all federal health insurance requirements (when specified conditions are met). A diverse collection of insurance benefits can be considered excepted benefits, including auto liability insurance, limited-scope dental and vision benefits, specific disease coverage, and supplemental Medicare plans (i.e., Medigap

plans). The exemption for excepted benefits was established under HIPAA.

Short-Term, Limited-Duration Insurance

Short-term, limited-duration insurance (STLDI) is 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 last longer than 36 months, taking into account renewals or extensions. Additionally, the contract and application materials for the coverage must display a notice as specified in federal regulations indicating that the coverage does not have to comply with federal requirements.

STLDI is exempt from complying with all federal health insurance requirements. STLDI's exemption status is based on STLDI's exclusion from the definition of *individual health insurance coverage* when the term was defined under HIPAA. Its maximum duration has been changed twice via rulemaking, most recently in 2018.

Student Health Insurance Coverage

Student health insurance coverage is 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.

Fully insured student health insurance coverage is exempt from complying with some federal health insurance requirements. The Department of Health and Human Services (HHS) established the exemption in response to Section 1560(c) of the Patient Protection and Affordability Act (ACA; P.L. 111-148, as amended), which provides that nothing in Title I of the ACA should be construed to prohibit institutions of higher education from offering student health insurance plans. HHS also stated that it lacks authority to regulate self-insured student health plans.

Self-Insured, Nonfederal Governmental Plans

A *nonfederal governmental plan* is a governmental group health plan that is not sponsored by the federal government. Entities that may sponsor nonfederal governmental plans include states, counties, school districts, and municipalities.

If a sponsor of a nonfederal governmental plan offers a self-insured plan, the sponsor may elect to exempt the plan from specified federal requirements. The exemption was established under HIPAA and modified under the ACA.

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*. For as long as a plan maintains its grandfathered status, it is exempt from specified federal health insurance requirements established under the ACA. For example, a grandfathered plan offered in the individual market is exempt from certain specified ACA requirements with which a non-grandfathered plan offered in the individual market must comply. Any type of plan could be grandfathered.

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).

Transitional Plans

The Centers for Medicare & Medicaid Services (CMS) issued guidance in November 2013 that established *transitional plans* (or *grandmothered plans*). Pursuant to the guidance, state insurance commissioners could choose whether to enforce compliance with specified ACA requirements that were to go into effect in 2014 in their individual and small-group markets. If they chose not to, CMS also would not enforce compliance and issuers could renew coverage for enrollees that was effectively exempt from complying with some federal health insurance requirements established under the ACA.

Subsequent guidance has extended the availability of transitional plans; currently, states may allow transitional plans to continue through 2020.

Noncompliant Health Coverage Arrangements

Certain arrangements do not necessarily comply 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. In general, HCSM members are expected to follow a set of religious or ethical beliefs and contribute a payment regularly (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.

HCSMs maintain that they are not providing insurance. However, the federal government does not appear to have defined HCSMs for regulatory or exemption purposes. HCSMs do not necessarily comply with federal health insurance requirements.

Farm Bureau Coverage

The American Farm Bureau Federation is a national organization that was established in 1919 to advocate for the financial and political interests of farmers, ranchers, and others associated with agriculture. There are local farm bureau offices in all 50 states and in Puerto Rico (but not in the District of Columbia). Membership in a local farm bureau is open to anyone who pays the membership fee. Each state farm bureau provides member benefits, which can include offering health coverage to its members.

As of the date of this document, three states—Iowa, Kansas, and Tennessee—have enacted laws that allow 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, if specified requirements are met. 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.

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