U.S. Health Reform—Monitoring and Impact

Views From the Market: Insurance Brokers' Perspectives on Changes to Individual Health Insurance

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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

The Affordable Care Act (ACA) ushered in a range of consumer protections designed to make it easier for individuals to obtain affordable, adequate health insurance in the individual market. In many states, however, individual market consumers have faced increasingly limited plan choices, relatively narrow provider networks, and rising unsubsidized premiums. In the past year, policy decisions made by Congress and the Trump administration have exacerbated trends. Such policy decisions include the repeal of the individual mandate penalty, cuts to ACA-related outreach funding and enrollment assistance, and the encouragement of alternative coverage options that are exempt from the ACA's consumer protections, such as short-term limited duration insurance (short-term plans) and association health plans (AHPs).

In this brief, we examine brokers' evolving role in the individual market, consumer purchasing decisions, and brokers' observations about how the market and consumers are responding to recent federal policy adjustments to the ACA. Key observations include the following:

- Brokers' compensation for selling ACA-compliant individual market health insurance has declined, leading brokers to reduce their participation in the market. Brokers cited reduced or eliminated commissions and the amount of time it takes to help someone through the enrollment process, particularly those eligible for premium assistance.
- Healthy, higher-income consumers are being pushed out of the individual market. The ACA appears to have spurred increased demand for coverage among those previously uninsured, but significant premium increases in our study states combined with fewer plan options and limited provider networks resulted in a decline in enrollment in ACA-compliant coverage among higher-income and healthier consumers.
- Healthy consumers are considering less-expensive products with fewer benefits and less consumer protections over ACA-compliant individual market insurance, particularly short-term plans and health care sharing ministries (HCSMs). Short-term plans and HCSMs do not need to comply with the ACA's consumer protections, often exclude preexisting conditions and often do not cover benefits such as maternity, mental health services, or prescription drugs. Brokers also report interest in direct primary care arrangements (DPCAs) and fixed indemnity plans.
- Brokers in some states have moved significant numbers of individual clients into ACA-compliant small group coverage, when possible. Small-group market plans in these states tend to have lower premiums and wider provider networks than ACA marketplace options. Some brokers are also interested in the potential growth of AHPs, and brokers in Iowa showed particular enthusiasm about the future Iowa Farm Bureau plan.
- Most broker respondents across our study states report receiving higher commissions for selling non-ACA-compliant coverage options, such as short-term plans, fixed indemnity plans, and HCSMs. Brokers also reported extensive efforts by HCSMs to offer trainings to educate them about their coverage model and direct-to-consumer marketing of HCSMs and short-term plans.

Brokers expect that consumers will face a more expensive ACA-compliant individual market and that they will increasingly shift healthy non-subsidy eligible consumers to alternative coverage options. Brokers predict the shift will be driven by enrollment in short-term plans and AHPs because of federal regulatory changes. At the same time, the marketing of other alternative products, including HCSMs and direct primary care arrangements, is increasing. Consequently, brokers predict that enrollment in individual health insurance products will become smaller and sicker.

INTRODUCTION

The Affordable Care Act (ACA) ushered in a range of consumer protections designed to make it easier for individuals to obtain affordable, adequate health insurance in the individual market. The ACA's requirement to maintain health insurance combined with these consumer protections and financial help for low- to moderate-income individuals helped to expand enrollment in the individual market from 10.3 million people in 2013 to approximately 18.7 million in 2016.[1]

In many states, however, individual market consumers have faced increasingly limited plan choices, relatively narrow provider networks, and rising unsubsidized premiums. In the past year, policy decisions made by Congress and the Trump administration have exacerbated these trends.[2] Such policy decisions include the repeal of the individual mandate penalty, cuts to ACA-related outreach funding and enrollment assistance, and the encouragement of alternative coverage options that are exempt from the ACA's consumer protections, such as short-term plans and AHPs.[3] These policy decisions are expected to encourage healthy consumers to drop insurance coverage or gravitate toward cheaper alternatives. These trends will likely lead to a smaller, sicker pool of enrollees in ACA-compliant plans, which in turn will further increase premiums and potentially reduce plan choices in that market.[4]

Through a review of market trends in six states and structured interviews with insurance brokers and agents who sell health coverage to individuals, this brief explores brokers' evolving role in the individual market, consumer purchasing decisions, and brokers' observations about how the market and consumers are responding to recent policy adjustments to the ACA. We find that companies and organizations selling products that do not comply with the ACA are increasing their marketing presence and broker compensation while financial incentives to sell ACA-compliant plans have been declining. Many brokers are prepared to embrace new coverage options, particularly for clients who are healthy and do not qualify for financial assistance under the ACA. At the same time, the brokers in our study recognize that these products can carry financial risks for consumers and for the future stability of the ACA-compliant individual market.

BACKGROUND

The ACA reformed the individual health insurance market with the goal of making insurance affordable, adequate, and accessible, particularly for consumers with pre-existing conditions. The market was transformed through three key pillars of the law: First, insurers could no longer deny coverage or charge higher rates based on a consumer's health. Second, the individual mandate required most consumers to maintain health insurance coverage or pay a tax penalty. Third, income-based tax credits reduce premiums for eligible enrollees and cost-sharing reduction subsidies lower the cost of care for lower-income people. The ACA also established health insurance marketplaces through which consumers could obtain premium and cost-sharing subsidies and compare and shop for plans.

Following these reforms, enrollment in the individual market increased 81.5 percent between 2013 and 2016.[5] The total number of people enrolled through the ACA's marketplaces increased slightly between 2017 and 2018, from 10.3 million to 10.6 million,[6] but total enrollment across the individual market appears to have declined significantly in 2018.[7] This enrollment decline was preceded by a series of changes to federal policy and practices related to the individual market, including steep cuts to enrollment assistance and marketplace advertising programs, a cut in the annual enrollment period from 12 to 6 weeks, and discontinuation of cost-sharing reduction payments to insurers.

Further reductions in enrollment are expected beginning in 2019 because of new rules designed to expand the availability of short-term plans and AHPs. Short-term plans are not required to comply with any ACA consumer protections, while AHPs are exempt from the ACA's essential health benefit standard and restrictions on premium rating variation.[8] Short-term plans are currently limited to a contract duration of under three months, but regulations finalized in August will

allow a contract duration of 364 days and allow contracts to be extended for up to three years so that people could easily enroll in short-term plans in lieu of ACA-compliant individual market coverage.[9] A final rule issued in June allows AHPs to be considered large-group coverage for regulatory purposes and therefore exempt from ACA rules that apply to the individual and small-group markets. This rule also loosens the conditions under which employers can join together under an AHP.[10] Finally, the Tax Cuts and Jobs Act of 2017 nullified the individual mandate by eliminating its penalty effective in 2019. Insurers are generally responding to these shifts in federal policy and practice by raising premiums.[11]

It is in this evolving individual market that insurance brokers and agents (hereafter "brokers") have continued to serve consumers who are seeking to buy coverage for themselves and their families. Before the ACA, consumers relied heavily on brokers to help them navigate a complex medical underwriting process and to compare plans in a market that lacked a uniform, consumer-friendly platform to compare insurance options. For this service, insurers compensated brokers through commissions based on either a percentage of the premium or a flat "per member per month" (PMPM) dollar amount. With the advent of the ACA's marketplaces and grant-funded in-person assistance programs, the process for enrolling in coverage has changed. However, many consumers still rely on brokers to learn about and secure health coverage both inside and outside the ACA marketplaces. In 2017, 42 percent of all enrollments in the federally facilitated marketplace were completed with the assistance of a broker.[12]

APPROACH

Because they assist consumers in buying health coverage, brokers offer a unique perspective on how recent federal policies are affecting consumer purchasing trends and insurers' market behavior. The information in this brief is based on structured interviews with one national web broker and 22 brokers in Georgia, Iowa, New Hampshire, Mississippi, Texas, and Utah. These states were chosen because their individual insurance markets have experienced recent instability and to reflect geographic diversity. Each of these states had higher than average premium rate increases as well as a loss of plan options between 2017 and 2018. Specifically, each of the six states saw premium increases from 24 percent to 52 percent for gold plans and had at least one insurer that exited the ACA-compliant individual market (table 1).[13] Given these market conditions, consumers in these states may be more likely to seek out brokers for assistance and more willing to look beyond the ACA-compliant individual market for less expensive coverage options. We conducted our interviews between April and June 2018.

Table 1: Premium Changes and Consumer Choices in Six States, 2017-2018

State	% Change in Average Gold Premium[a]	# of Insurers in State Marketplace		% Enrollees with 2 or fewer insurers		Existence of on-exchange PPO	
		2017	2018	2017[b]	2018	2017[d]	2018
Georgia	40.7%	5	4	45%	100%	Yes	No
Iowa	40.9%	4	1	43%	100%	Yes	Yes
New Hampshire	51.5%	4	3	0%	12%	No	No
Mississippi	48.9%	2	1	100%	100%[c]	Yes	No
Texas	24.6%	10	8	37%	34%	No	No
Utah	32.1%	3	2	21%	100%	No	No

[a] Average individual market-wide gold plan premium change. We use gold plans as the basis for comparing premiums rather than silver because termination of cost-sharing reduction payments in 2017 resulted in inflated premiums for silver plans in most of the states in our study where insurers loaded the cost of the cost-sharing reductions into silver plan rates.

[b] Some participating insurers do not offer plans in each geographic rating area within a state, leaving marketplace enrollees in those rating areas with fewer insurers available.

[c] Mississippi dropped from two to one statewide insurer.

[d] A PPO is a "preferred provider organization." Generally, PPO plans offer coverage for services received from out-of-network providers. Plans that do not offer out-of-network benefits include "health maintenance organizations" (HMOs) and "exclusive provider organizations" (EPOs).

Source: Authors' calculations based on data from the Kaiser Family Foundation, Urban Institute, and healthcare.gov. Semanskee A, Cox C. Insurer participation on the ACA marketplaces, 2014–2017. Menlo Park, CA: Kaiser Family Foundation; 2017. http://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2017. Published June 1, 2017. Accessed June 2018; Holahan, J., Blumberg, L., Wengle, E. Changes in Marketplace Premiums, 2017 to 2018. Washington, DC: Urban Institute. Published March 21, 2018. https://www.urban.org/research/publication/changes-marketplace-premiums-2017-2018. Accessed June 2018; 2017 QHP Landscape Individual Market Medical Excel. Healthcare.gov, August 2017. https://data.healthcare.gov/dataset/2017-QHP-Landscape-Individual-Market-Medical-Excel/t99m-dgwg. Accessed June 2018; QHP PY2018 Medi- Indi-Land. Healthcare.gov, April 2018. https://data.healthcare.gov/dataset/QHP-PY2018-Medi-Indi-Land/hd64-a3rh. Accessed June 2018.

Because insurance markets differ across states, we cannot extrapolate the findings in our six states to the nation. Further, although all the brokers interviewed sell coverage in the individual market (including ACA-compliant insurance), most did not concentrate on sales to low- or moderate-income people eligible for the ACA's financial assistance. However, our findings highlight key purchasing and other market trends that may be applicable in other states experiencing high premiums and new, alternative insurance options in the individual marketplace.

FINDINGS

Compensation for Selling ACA-compliant Individual Health Insurance Market Has Declined, Giving Rise to New Business Models

Several of our respondents have reduced their individual market clientele over the years, and some are no longer marketing themselves to potential individual market customers. As one Texas broker put it, "We've lost all of our individual [market brokers]," noting that exceptions are insurance agents with many clients still enrolled in plans that existed before 2014 (called "grandmothered" or "grandfathered" policies) as well as brokers who primarily serve group market clients but are occasionally asked to help with a spouse or part-time employee who is not eligible for the employer's plan.[14]

Brokers cited several reasons why they had reduced their engagement with the individual market. After the ACA was enacted, many insurers reduced or eliminated the commissions they paid to brokers.[15] This is critical because, in general, brokers derive their income strictly from commissions. For example, a Mississippi broker told us his individual market commissions dropped from $30 PMPM to $8; a New Hampshire broker estimated that she made 70 percent less on individual market commissions than she did 10 years ago. Some brokers blamed this in part on the ACA's medical loss ratio standard, which requires that insurers issue rebates to enrollees if the insurer spends more than 20 percent of its premium revenue on administrative expenses, including broker commissions.[16]

Marketplace commissions have also declined in recent years because some insurers have exited the market or pulled back from aggressive efforts to build market share. Commissions for special enrollments (for people who qualify to enroll outside of the annual open enrollment period) have all but disappeared, largely because insurers have been concerned about the health risk of the people seeking coverage midyear. As one Georgia broker described it, "Brokers have been upset at carriers for the last few years. 'Let's keep cutting your commissions, put more work on you…' It hasn't been a great feeling for the broker community."

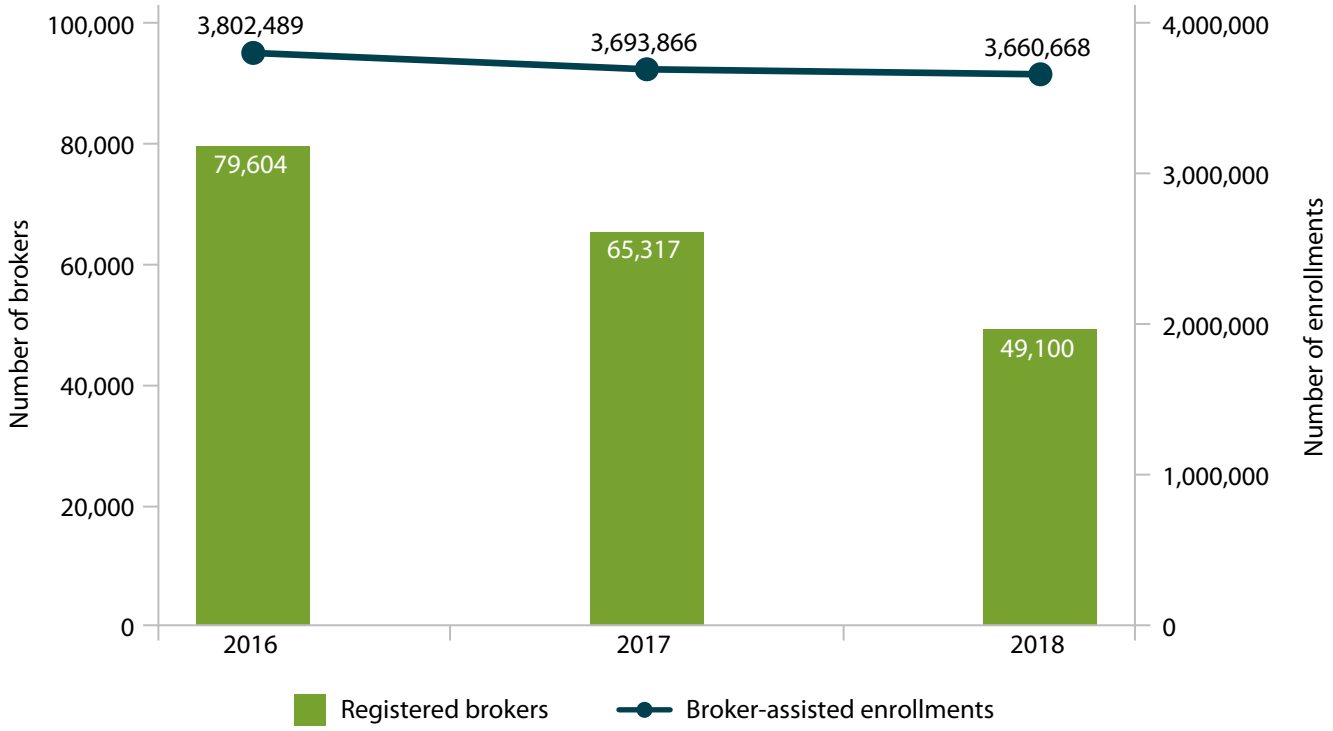
In two of our study states, brokers successfully lobbied to restrict insurers' attempts to cut or eliminate commissions. For example, Georgia's legislature enacted a bill requiring insurers to pay commissions if they had previously submitted premium rate filings that included broker commissions.[17] In Utah, the insurance department advised insurers it would be considered discriminatory not to pay commissions for special enrollments.[18] Shortly thereafter, a broker told us, Utah insurers restored their commissions.

Some of our broker respondents also told us that although they service unsubsidized individual market consumers, they no longer support any ACA marketplace enrollments. Several brokers who had assisted consumers with ACA marketplace enrollments early on became frustrated with the glitch-prone platforms associated with the rollout of healthcare.gov, although they noted the site has improved considerably in recent years. Many brokers said they were not sufficiently reimbursed for the amount of time it takes to help someone through the enrollment process, particularly if it involved helping with applications for premium assistance. "I can't keep my lights on if that's what I spend my day doing… You spend all your time going through hoops to determine the subsidy, which has nothing to do with insurance," said one Texas broker. A New Hampshire broker told a similar tale, also expressing considerable frustration with clients losing coverage and "slipping through the cracks and nobody can tell you why…We are spending hours trying to get someone back on their plan."

Further, brokers' early attempts to partner with federally funded ACA enrollment assisters (called "navigators") were unsuccessful because the marketplace would give only one entity "credit" for the enrollment. Brokers need that credit to receive their commissions; navigators need it to ensure future grant funding. Not surprisingly, once navigators had assisted someone with an eligibility determination, they were reluctant to hand him or her over to a broker for plan selection.

Recent data from the U.S. Department of Health and Human Services (HHS), which runs the federally facilitated ACA marketplace, confirm an overall decline in the number of brokers assisting marketplace customers (figure 1). Between 2016 and 2018, the number of brokers registered with the

Figure 1. Trends in the ACA Marketplaces: Broker Activity, 2016-2018



Source: "The Exchanges Trends Report." Washington, DC: Centers for Medicare and Medicaid Services, July 2018. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-3.pdf.

federal marketplace declined approximately 40 percent.[19] However, HHS has worked to generate greater enrollment in the marketplaces through web-based brokers by making the process easier and more efficient. Perhaps as a result, the overall numbers of broker-assisted enrollments have declined only slightly, suggesting that the brokers who remain are working with a high volume of consumers.[20]

A minority of our broker respondents focus primarily on the individual market, particularly the web broker. "We're an e-commerce company at heart, so we're able to scale our business," the web broker noted. "We're committed to the individual market." For brick-and-mortar brokers, their ability to survive in the post-ACA landscape appears to depend on strong sales of non-ACA insurance products, such as Medicare Advantage and Medicare supplemental products, as well as alternatives to traditional health insurance coverage (such as short-term plans). Some brokers reported that they had shifted to charging consumers "consulting fees" for their services, particularly for special enrollments for which some insurers do not provide a commission.

Increased Premiums and Fewer Plan Choices Push Health, Higher-Income Consumers Out of the Individual Market

As noted, the number of people insured through the individual market has increased significantly as a result of the ACA's individual market reforms. Further, the ACA appears to have spurred increased demand and appreciation for coverage among those previously uninsured. As one broker in Georgia put it, "because of the explosion of people having insurance that didn't have it in the past, the psychology now is to have health insurance." However, brokers across our study states report that significant premium increases in the individual market over the past two years have pushed consumers ineligible for subsidies to look beyond ACA plans for lower-cost coverage. As this combines with other concerns, such as fewer plan options and limited provider networks, brokers in our study states report that enrollment in ACA-compliant individual market plans by higher-income and healthier consumers has declined.

Although most consumers shopping in the individual market are eligible for premium subsidies and therefore largely

insulated from rate hikes, millions of consumers pay the full premium.[21] These unsubsidized consumers are finding the significant rate hikes in our study states a major obstacle to purchasing ACA-compliant coverage. As one broker in Texas, where individual market premiums for gold plans increased an average of 24.6 percent between 2017 and 2018, explained, the top concern among clients shopping for coverage in the individual market now is "premium, premium, premium. [Individual market policies] are way too expensive." Sharing a sentiment heard from brokers in all the study states, a broker in New Hampshire, where consumers faced an average 51.5 percent increase in individual market gold premiums in 2018, noted that most non–subsidy eligible individuals have simply been "priced out." One broker in Texas noted that a family could easily end up with a monthly premium over $2000 for a policy with a high deductible. Explaining the challenge of selling to potential customers when the premium is so high, the same broker said "you could pay a [house] mortgage with the cost of private health insurance today."

Although brokers made clear that high premiums were often the determining factor in whether or not non-subsidy eligible consumers purchased individual coverage, some noted that limited plan options on the marketplaces and narrow networks were also relevant. In each of the study states, the dwindling number of plan choices was met with concern from potential customers, especially if the remaining plans had a limited network. In southern Georgia, for example, Centene, a former Medicaid-only plan, stepped into the marketplace to offer coverage after Blue Cross Blue Shield exited. Centene was relatively unknown among higher-income customers and offered access to different providers than those in Blue Cross Blue Shield of Georgia's network. Georgia customers were frustrated not only with Centene's high premiums but also that their "doctors are not in the network, they have [to] drive far [for a participating provider] and they have no alternative plan choice." Brokers in several states also reported that the remaining ACA-compliant plans offer only health maintenance organization (HMO)-style products, meaning they offer no coverage for out-of-network care. They noted many of their clients seek a broader choice of providers and are ultimately frustrated with their options.

Despite these concerns, brokers have some higher-income customers still willing to purchase health insurance in the individual market, although they generally have a greater health risk. One broker in Texas pointed out that "if [a customer] has medical conditions, they are stuck between a rock and a hard place and will pay the [high premium]." This, they suggested, would lead to adverse selection against the individual market, in turn leading to even higher premiums and further limitations on plan choice in the long run. Meanwhile, brokers report that many healthy people question the need to pay high premiums for comprehensive health insurance before giving up and either looking toward alternative coverage arrangements or forgoing insurance entirely.

Healthy Consumers Are Choosing Less-Expensive Products with Fewer Benefits over Individual Market Insurance

Brokers are increasingly selling alternative coverage products, primarily to people ineligible for the ACA's subsidies. Many of these products do not have the same consumer protections as ACA-compliant individual market insurance, such as short-term plans, HCSMs, fixed indemnity plans, and DPCAs. Brokers also noted that AHPs could become a more widely available option in the future. (Table 2 provides an overview of these coverage options.) To determine the best option for each client, brokers "dig into personal information," including health status. Brokers repeatedly mentioned that most of these products are only an option for healthy consumers, but other characteristics, such as family size, income, and potential for future employment, also effect the choice of product. Brokers in two of our study states reported that some insurers are allowing self-employed individuals to switch from ACA-compliant individual market policies to ACA-compliant small business coverage (small-group coverage).

Recognizing that many alternative coverage products do not provide comprehensive coverage and do not have the same consumer protections as ACA-compliant individual market coverage, some brokers require clients to sign disclosure statements attesting that they are aware of these plans' limitations before enrolling. Another broker from Texas is "very cautious about [selling] those types of coverage" that are not insurance or that have limitations, noting "people don't understand insurance." Other brokers told us that they want to maintain long-term relationships with their clients, particularly for future Medicare sales, and do not want to be blamed if a customer later finds their coverage insufficient.

Short-Term Limited Duration Insurance

Short-term plans were mentioned most often by brokers as an alternative to individual market coverage, with one broker from Mississippi saying they are the "most common remedy for people priced out of the individual market." All brokers interviewed sell short-term plans (except for the brokers in New Hampshire, who were unable to identify a short-term insurer selling locally).[22] Short-term plans were originally designed to fill short gaps in coverage, such as when someone is between school and job-based coverage. Some brokers note positive aspects of short-term plans, such as

Table 2: Non-ACA Compliant Alternative Coverage Options

Type	Description
Short-term plans	Health plans designed to fill temporary gaps in coverage. Generally, short-term plans are available only to consumers who can pass medical underwriting. Typically, they provide minimal benefits and financial protection for those who become sick or injured. These policies do not have to meet any of the ACA's consumer protections. A recent final federal regulation extended the maximum duration of short-term plans from under 90 days to under 12 months with the ability to renew or extend contracts to up to three years.
Association health plans	Health insurance plans sponsored by an employer-based association, such as a professional or trade group. New federal rules allow association health plans (AHPs), a type of Multiple Employer Welfare Arrangement (MEWA), to be sold to employers of all sizes, including sole proprietors and the self-employed, and treats some AHPs offering coverage to self-employed and small employers as a large employer group plan for the purpose of federal law, rendering the plans exempt from ACA consumer protections that otherwise apply to individual and small-employer health insurance.
Health care sharing ministries	Entities whose members share a common set of religious beliefs and contribute funds to pay for the qualifying medical expenses of other members, but do not guarantee payment. HCSM coverage does not have to meet any of the ACA consumer protections. Enrollment in a HCSM exempts an individual from the individual mandate penalty for 2018.
Direct primary care arrangements	A contract between a primary care provider (PCP) and a patient, under which the PCP agrees to provide primary care services in exchange for a monthly fee paid by the patient. Unless state law treats the arrangement as health insurance, DCPAs do not have to meet any of the consumer protections of the ACA.
Fixed indemnity plans	Health plans designed to wrap around other coverage and cover enrollee cost-sharing such as deductibles, co-payments, and co-insurance. Fixed indemnity plans pay a set dollar amount for covered services that are often significantly lower than the cost of services. These policies do not have to meet any of the consumer protections of the ACA.

lower premiums and greater variation in benefit design. As a Texas broker observed, "you get more options, with regard to deductibles." Some short-term plans also have broad provider networks that are not available in the individual market in any of our study states. However, short-term plans exclude many benefits, don't cover pre-existing conditions, restrict enrollment to people who can pass a questionnaire about their health status, and often drop enrollees from their plans if they later become sick (a practice known as post-claims underwriting).[23] Consequently, brokers generally provide short-term plans as an option only "if you are young and healthy," a Mississippi broker explained.

Even before the Trump administration implements its final rule extending short-term plans, many brokers are able to offer clients almost a full year of short-term coverage. For example, consumers in several of our study states may simultaneously purchase four 90-day plans with staggered effective dates. Brokers like this option because in many of the plans, consumers only go through a health screen before the first contract, so if they get sick or injured after enrollment, they are still covered for the entire year. On the other hand, the plan deductible restarts with each 90-day contract. With a $5000 deductible, this could mean a potential out-of-pocket expense of $20,000 over the course of the year. In another example, a broker in Utah reported that consumers "jump from carrier to carrier" to tack together a year of coverage through different short-term plans.

A few brokers said they only sell short-term plans in limited situations because "nothing replaces comprehensive coverage." A Texas broker said "I can barely stomach selling

short-term plans, but sometimes it's the only option." Brokers seem to have two views of these products when it comes to catastrophic health events. A different Texas broker sells short-term plans as "an opportunity to provide you at least catastrophic coverage," but an Iowa broker said "all it takes is that a catastrophic thing happens" to show these plans' shortcomings. In the end, one broker in Utah referred to her pitch to clients on short-term plans as "here's something, it's better than nothing."

Health Care Sharing Ministries

Health care sharing ministries are the second most common alternative offered by brokers to clients who find ACA-compliant plans unaffordable. HCSMs are religious organizations that are not regulated as insurance, but enrollment in HCSMs exempt individuals from the individual mandate to maintain insurance.[24] Members make a monthly payment, often described as a "share," that goes toward the medical expenses of other members and the administrative costs of the ministry. A broker knows of five HCSMs available in Texas that are "ACA compatible," meaning they fulfill the individual mandate. Although HCSMs are primarily defined as not being insurance, brokers informed us that HCSM sponsors are increasingly seeking to partner with them to sell memberships, and the marketing materials are often designed to make the arrangement appear similar to traditional insurance.

Brokers in our study take a range of approaches to HCSMs. Some actively promote their sale, others sell memberships only when clients inquire, and some simply provide educational information to interested clients. For example, the web-broker we interviewed does not display HCSMs on its site but does have a partnership with one national HCSM and will refer customers to it upon request as a "back-pocket" option. Similarly, a New Hampshire broker does not offer HCSM plans "unless the client is about to walk away" and go without any coverage.

Many brokers are reluctant to sell HCSMs because they are not insurance. Brokers are licensed by their state to sell insurance products and carry "errors and omissions" (E&O) insurance, which protects them if they are later sued by a client for inadequate advice or negligence. But traditional E&O insurance only protects brokers if they are selling an insurance product, which HCSMs explicitly are not. Several respondents in our survey have refused to sell HCSM memberships for this reason. "It's not worth the risk," a Texas broker told us. Some brokers can sell HCSMs without liability concerns because they have broader E&O insurance covering them as consultants or because they purchase E&O insurance created by HCSMs to encourage brokers to sell their plans. However, other brokers are simply uncomfortable with a noninsurance product. A Texas broker who does not sell HCSM plans said "as an evangelical Christian, I find them an affront to Christianity" and expressed concern that "they're built on a house of cards with no guarantee of payment." Brokers selling HCSM plans say they make efforts to "heavily educate our clients that it is not insurance and has pre-existing condition" exclusions. An Iowa broker tells clients "there's no assurance they will pay," and that there are "holes in benefits," such as not covering preventive services.

Consumers are interested in HCSMs because they are a much less expensive option and, in some instances, because the consumers hold political opposition to "Obamacare plans." The demographics of those interested include "young invincibles" as well as, according to one broker, people nearing the Medicare eligibility age who are not eligible for subsidies, small business owners, and families with many children. Although HCSMs are mostly sold to those ineligible for subsidies, one broker noted that the people purchasing HCSM plans are not wealthy. Similar to short-term plans, brokers note that HCSMs are primarily an option for people who are healthy.

Direct Primary Care Arrangements

One coverage alternative that appears to be garnering growing interest is the direct primary care arrangement, in which a customer pays a monthly fee for access to primary or urgent care providers. DPCAs are not considered insurance in most states. The model varies and can include a fee covering unlimited access to a set of services without additional costs, or it may cover some services (such as telehealth) without costs and office visits with a small copayment. Brokers in Texas and Utah have seen a "growth of direct primary care outfits." According to brokers interviewed, one organization in Utah has a monthly fee providing access to urgent care services for $10 a visit. Brokers report that DPCAs are primarily marketing to employer groups, but some have seen signs that they are expanding into the individual market. Many DPCAs do not yet have a system to pay broker commissions. The brokers that are familiar with the arrangements have some concerns that "you're totally exposed" for hospital services and other health care needs not covered by the providers. For example, one broker in Utah says a local DPCA "will write prescriptions but won't fill them," meaning the member fee covers the cost of the office visit where a patient gets a prescription, but it does not cover the cost of the drug itself. Some brokers will pair a DPCA with other products, such as a high-deductible plan or prescription program, and one in Utah will "push [clients] to go to a health plan too for hospitalizations."

Fixed Indemnity Insurance

A handful of brokers report selling fixed indemnity insurance, but most offer it as a wrap-around plan to cover some of the cost-sharing associated with comprehensive health insurance. Fixed indemnity insurance pays a set fee directly to the enrollee after accessing a health service, such as $75 for an office visit and $1,000 per day in the hospital. The reimbursements are usually well below the actual cost of services. The web broker reported that some insurers created fixed indemnity products instead of short-term plans because of the Obama administration's limits on short term products. Many brokers interviewed say they stay away from these plans. "It's not the protection you need," said a broker in Utah; "if you read the fine print, it's worthless," observed a broker in Texas. Some brokers sell them bundled with other products, including short-term plans, HCSMs, and limited-benefit association plans. Again, because of health underwriting, fixed indemnity plans are an option attractive only to healthy clients (mostly younger people but also those ages "45 to 65 in great health," according to a broker in Georgia).

Association Health Plans and the Iowa Farm Bureau

Association health plans have not yet become a recognized alternative to ACA-compliant coverage, but some brokers see them as part of a suite of future options thanks to recent Trump administration policies. AHPs are plans sold to members of an association and, under new regulations, will be treated like large-group plans even when sold to small businesses and the self-employed.[25]

Some brokers expressed caution about AHPs, noting past experiences with insolvencies and financial troubles. Others are ready to embrace them as a new option for consumers. For example, an Iowa broker has plans to create an association for small businesses that would enroll the self-employed as an alternative to individual market coverage. Additionally, the brokers interviewed in Iowa are eager for the entry of the Farm Bureau plan. This plan is not a traditional AHP but is expected to be sold in 2019 after enactment of a state law exempting it from insurance regulation (including the ACA's consumer protections).[26] The state law included language requiring broker involvement, and brokers expect commissions to be higher than the current $10 PMPM offered for ACA-compliant individual market policies. Details of the new Farm Bureau plans have not yet been released, but they will be permitted to deny coverage or charge more for people with pre-existing conditions. And they will likely not cover all of the benefits required of ACA-compliant plans.

Small-Group Coverage

Finally, a growing trend in some states is to convert people from the ACA-compliant individual market to the small-group market. Brokers cited two primary reasons for this trend. First, premiums for coverage in the small-group market have become more affordable than those for individual market policies (the opposite was true in 2014, when the ACA's marketplaces were first launched).[27] For example, a Texas broker has found small-group plans "identical" to individual plans that are "25 percent cheaper." Second, the plans' provider networks are often broader in the small-group market than in the individual market. Further, small employers do not have to wait for an annual open enrollment period. They can enroll at any time during the year.

Brokers in several of our study states noted that some small employers that had shifted their employees to individual coverage during the early years of the ACA are now switching back to group plans. In Iowa and Texas, brokers have been able to enroll self-employed people without employees and married couples into some insurers' small-group plans. A broker in Iowa said their agents "wrote one-thousand brand new never-been-a-group groups" in the fourth quarter of 2017, with an average size of two.

According to the web broker, Iowa and Texas may be outliers, asserting it is just "a couple of states and a handful of carriers" that are allowing individuals and married couples to enroll in small group plans. In most cases, insurers require group plan enrollees to have at least one common-law employee that is not a child or spouse of the owner.

Higher Compensation and Marketing for Alternatives to ACA-Compliant Plans

Most broker respondents across our study states report that insurers selling non-ACA-compliant coverage options, such as short-term plan insurers, fixed indemnity insurers, and HCSMs, are attempting to increase sales with commissions that are more generous than those offered by major medical insurers. Brokers note that even though these products have lower premiums, the overall compensation they receive by selling them often still exceeds their compensation for individual market ACA-compliant plan enrollments. "The share that I get as a broker, even on a smaller dollar amount, is still better than the individual market," said a Georgia broker. In Texas, brokers are offered a 10 percent commission for selling HCSM memberships and between one and three percent for ACA-compliant coverage. An Iowa broker estimated that short-term plan sellers are offering commissions as much as five times the amount offered by ACA-compliant insurers. Brokers further noted that it often takes much less time and effort to enroll people in these products than in ACA-compliant plans. However, this difference in commissions was not universal. Brokers in Utah and Mississippi, for example, estimated that commissions for short-term and fixed indemnity sales were lower than for ACA-compliant plans.

Brokers also reported extensive efforts by HCSMs to offer trainings to educate them about their coverage model, to "nurture and develop broker relationships," and to encourage them to sell memberships. One Utah broker observed that "they're very aggressive…now we are getting aggressively approached, and the commissions are higher." In contrast, a Georgia broker observed that when it came to the ACA-compliant plan representative based in his area: "I wouldn't know her if she walked in the door."

Broker respondents also report that short-term plan insurers and HCSMs are engaged in aggressive direct-to-consumer marketing. "[Short-term plan sellers] are on the radio all the time," said one Georgia broker. In a similar vein, an Iowa broker told us, "You can't listen to satellite radio and not hear the [HCSM's] commercials," and Texas brokers report these products are "highly marketed" on TV and radio. Other brokers observed increased amounts of web-based and telephonic marketing of these products to consumers.

Brokers also report an increase in engagement from DPCAs, with one reporting that they were heavily marketed at a recent broker conference as the "future of health care." A Texas broker noted that physician groups have begun "getting together with brokers and having discussions," but others noted that the DPCAs were primarily interested in employer group market sales rather than the individual market. A broker in Utah is eager to work with DPCA providers but has found their infrastructure for working with brokers to be limited. "We tried to work with a [DPCA provider], but he didn't have the back-end set up to work cleanly with brokers," she said. "If he figured it out, we would blow it up."

To date, brokers in our survey have not seen aggressive marketing by AHPs in anticipation of the now-final regulation. Several were dismissive of AHPs and did not think they would be viable; others were enthusiastic about their potential expansion.

Brokers Predict That Consumers Will Face a More-Expensive ACA-Compliant Individual Market

Brokers do not expect the future ACA-compliant individual market to become unstable, primarily because of the federal dollars funding premium subsidies. In 2019, with premiums expected to rise and the individual mandate undermined, they do expect expanded enrollment in alternative coverage options. Brokers predict the shift will be driven by enrollment in short-term plans and AHPs because of federal regulatory changes, although some brokers note that other arrangements, such as HCSMs, are ripe for further expansion. In Iowa, brokers expect the Farm Bureau to change enrollment patterns.

Most brokers are embracing the increased availability of some (if not all) non-ACA-compliant products. The national web broker and brokers in Iowa, Mississippi, New Hampshire, and Utah expressed support for extending short-term plans, noting that doing so would enable more people to enroll in short-term products. For example, a Utah broker commented, "I do hope they expand short-term plans up to a year…There are a lot of consumers that like it, and I'm not opposed to selling them if it works better for them." Other brokers are just looking for more products to offer consumers, such as one broker in New Hampshire who is hoping new "options come out of [the Trump administration's new policies]." A broker in Texas expects more "stacked arrangements," where insurers package together multiple products, such as short-term plans and fixed indemnity insurance, to market for the 2019 open enrollment season in lieu of an ACA-compliant plan and, if "the person is healthy, we will be recommending that." The web broker mentioned there is a carrier that recently introduced a short-term plan that covers some pre-existing conditions, but that coverage is limited to $25,000. Although brokers do not expect that recent regulatory changes will affect HCSMs, they still expect consumers will want to join them because of their low price point.

Brokers were less excited about AHPs, and in some instances they are concerned they would do more harm than good. A broker from Georgia said she expects "a ton of people in the marketplace will go into these plans" and "it will turn the market upside down." A Texas broker remarked on AHPs' history of fraud and financial insolvency, saying, "been there, done that."[28] Although one broker in Iowa is interested in starting an AHP, she also said "we don't want fly-by-night companies making these associations."

Most brokers recognize the alternative coverage options are a threat to the ACA-compliant risk pool and that they will increase premium rates for ACA-compliant plans. Several also expressed concerns about the level of financial liability their clients face when enrolling in these products, should they experience an unexpected medical event. But most brokers interviewed are also interested in offering a more affordable product with some level of financial protection, even if it is well below the protection from a comprehensive plan. A broker from Texas observed that the person leaving an ACA-compliant plan for a short-term plan is "that healthy person we need in the pool to help stabilize the rates." A couple of brokers from Iowa suggested the ACA-compliant individual market would effectively become a high-risk pool: "If we're back to underwriting, they cherry pick out of ACA…and then you end up back to where we started except the high-risk pool is funded by the federal government…"

CONCLUSION

All the brokers in our study sell some alternative coverage options to people who are ineligible for subsidies and looking for less expensive coverage. Many brokers expect these markets will grow, particularly for short-term plans and AHPs, in the wake of federal regulations designed to expand their sale. At the same time, the marketing of other alternative products to brokers, including health care sharing ministries and direct primary care arrangements, is increasing. Consequently, the individual health insurance market is expected to become smaller and sicker.

Consistent with other market projections, brokers in our study predict that premium rates will increase for ACA-compliant plans, pushing more healthy people into cheaper, less comprehensive alternatives.[29] This study focused on states with particularly fragile markets that had higher than average increases in premiums and a loss of insurers in recent years. But with the elimination of the individual mandate penalty and the expansion of alternative coverage options, many states that do not take steps to protect their ACA-compliant market could face similar instability.

ENDNOTES

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