



July 2023

PRIVATE HEALTH COVERAGE

Information on Farm
Bureau Health Plans,
Health Care Sharing
Ministries, and Fixed
Indemnity Plans

GAO Highlights

Highlights of [GAO-23-106034](#), a report to congressional requesters

Why GAO Did This Study

Alternatives to health insurance—including Farm Bureau health plans, HCISM memberships, and fixed indemnity plans—are generally not required to report information to federal regulators. Policymakers thus lack a clear understanding of how these plans and memberships operate, their role in the insurance market, and the scope of their potential effects on individual consumers and workforces.

GAO was asked to review plan features, enrollment, and marketing associated with alternatives to health insurance. This report describes, among other issues, the features of selected Farm Bureau health plans, HCISM memberships, and fixed indemnity plans and the marketing practices used by sellers of the selected plans and memberships.

For this report, GAO reviewed documentation for nine plans and memberships selected for diversity in features and sellers. GAO also interviewed eight of the nine sellers of these plans and memberships and 23 stakeholders and stakeholder groups. These stakeholders included seven state departments of insurance and eight national organizations, including the National Association of Insurance Commissioners. GAO also reviewed documents detailing marketing practices associated with alternatives to health insurance.

View [GAO-23-106034](#). For more information, contact John E. Dicken at (202) 512-7114 or dickenj@gao.gov.

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PRIVATE HEALTH COVERAGE

Information on Farm Bureau Health Plans, Health Care Sharing Ministries, and Fixed Indemnity Plans

What GAO Found

States are the primary regulators of health insurance plans, which are also subject to certain federal standards and minimum requirements, including those established by the Patient Protection and Affordable Care Act (PPACA). Certain types of health coverage arrangements (referred to as alternatives to health insurance) are generally not subject to these federal and state requirements for health insurance. Alternatives to health insurance include:

- Farm Bureau health plans—plans sold in six states to members of Farm Bureaus.
- Health care sharing ministry (HCISM) memberships—memberships in organizations whose members agree to live by a statement of beliefs or ethics and contribute monthly to pay for the medical costs of other members.
- Fixed indemnity plans—plans that pay a fixed dollar amount on a per-period or per-incident basis. Certain plans may resemble the design of a health insurance plan, such as providing separate payment amounts for a variety of medical services.

GAO found that the benefits and other features of nine selected health plans and memberships varied, and state insurance officials stated that these plans tend to contain few consumer protections. These plans and memberships generally are not required to adhere to the requirements and consumer protections imposed by PPACA on individual health insurance plans, such as the requirement to cover the 10 essential health benefits. GAO's analysis of documentation for these health plans and memberships found that they all included some coverage for hospital services and office visits for illness or injury, while coverage varied for routine examinations, prescription drugs and other types of services. While all of the plans and memberships reviewed disclosed that they are not health insurance, officials from four state insurance departments reported that these types of plans contain few, if any, of the consumer protections found in plans that are required to comply with PPACA.

GAO also found that sellers of the selected plans and memberships used a variety of marketing practices. These practices included focusing on factors such as affordability, suitability, choice, and values. For example, marketing materials associated with all nine of the reviewed plans and memberships advertised that they offered lower premiums or monthly contributions than other health coverage options. Further, regulators have identified misleading marketing practices associated with some alternatives to health insurance in recent years. In August 2022, for example, the Federal Trade Commission took action against a health care company for misleadingly selling several health coverage products, including fixed indemnity products. The company agreed to a proposed court order that required it to pay \$100 million in consumer refunds, among other stipulations.

GAO received technical comments on a draft of this report from the Department of Labor and the Department of Health and Human Services and incorporated them as appropriate.

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Abbreviations

ARPA	American Rescue Plan Act of 2021
CMS	Centers for Medicare & Medicaid Services
DOL	Department of Labor
HCSM	Health Care Sharing Ministry
NAIC	National Association of Insurance Commissioners
PPACA	Patient Protection and Affordable Care Act

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July 26, 2023

The Honorable Robert C. “Bobby” Scott
Ranking Member
Committee on Education and the Workforce
House of Representatives

The Honorable Mark DeSaulnier
Ranking Member
Subcommittee on Health, Employment, Labor, and Pensions
Committee on Education and the Workforce
House of Representatives

Certain types of health coverage arrangements generally do not have to adhere to federal and state requirements for health insurance, including requirements established by the Patient Protection and Affordable Care Act (PPACA). These coverage arrangements—which we refer to as alternatives to health insurance—may advertise lower upfront costs and greater flexibility to consumers than traditional health insurance options.¹ However, according to government and private industry stakeholders, they may pose risks to consumers because they may lack the protections imposed by PPACA requirements, such as guaranteed coverage for maternity and mental health benefits. Because comprehensive information is not reported to regulators about these alternatives to health insurance, policymakers may lack a clear understanding of how they operate, their role in the insurance market, and the full scope of their potential effects on individual consumers and workforces.

As of 2023, there were several different types of products being sold as alternatives to health insurance in the United States, including Farm

¹In this report, we use the term “alternatives to health insurance” to refer to alternatives to comprehensive health insurance plans that are required to comply with PPACA and other federal regulations for health insurance.

Bureau health plans, health care sharing ministry (HCSM) memberships, and certain fixed indemnity plans.²

You asked us to examine plan features, enrollment, and marketing associated with alternatives to health insurance. In this report we describe:

1. the features and consumer protections associated with selected Farm Bureau health plans, HCSM memberships, and fixed indemnity plans;
2. what is known about the number and characteristics of individuals and groups who participate in Farm Bureau health plans, HCSM memberships, and fixed indemnity plans; and
3. the marketing practices of selected sellers of Farm Bureau health plans, HCSM memberships, and fixed indemnity plans and regulators' views on the marketing practices of these types of products.

To describe what features and consumer protections are associated with selected Farm Bureau health plans, HCSM memberships, and fixed indemnity plans, we analyzed documentation for nine selected individual plans and memberships:

- two Farm Bureau health plans,
- five HCSM memberships, and
- two fixed indemnity plans.

We selected these products to represent each of these three alternatives to health insurance, as well as diversity in estimated enrollment size and plan and membership features. We reviewed documentation describing these products that we obtained from sellers' websites or from the sellers

²Fixed indemnity plans pay a fixed dollar amount on a per-period or per-incident basis. While several different types of fixed indemnity plans exist, this report focuses on fixed indemnity plans that are sold on the individual market and may resemble the design of a health insurance plan, such as providing separate payment amounts for a variety of medical services, provider networks, and deductibles. Other alternatives to PPACA-compliant health insurance include short-term plans, a form of health coverage traditionally designed to fill temporary gaps in health insurance, among others. See GAO, *Private Health Insurance: Limited Data Hinders Understanding of Short-Term Plans' Role and Value during the COVID-19 Pandemic*, [GAO-22-104683](#) (Washington, D.C.: May 31, 2022) for more information on short-term plans.

themselves. We interviewed eight of the nine sellers about the features and consumer protections found in their products.³

We also interviewed officials from the Centers for Medicare & Medicaid Services (CMS)—an agency within the Department of Health and Human Services—and the Employee Benefits Security Administration—an agency within the Department of Labor (DOL) about the federal oversight, if any, of Farm Bureau health plans, HCSM memberships, and fixed indemnity plans.

In addition to CMS, DOL, and the sellers of the selected plans and memberships, we interviewed 23 stakeholders and stakeholder groups, including officials from seven selected state insurance departments, officials from two state attorneys' offices, three individual policy researchers and one policy research group consisting of three policy researchers, and eight national organizations that have conducted work relevant to this topic.⁴ We selected the state insurance departments to achieve variation in geographic region, the extent to which the three types of alternatives to health insurance are regulated in the states, and other unique factors such as specific reporting or disclosure requirements. We identified other stakeholders through background research, our literature search, and through recommendations from other stakeholders.⁵ Specifically, the policy researchers we interviewed had written about or studied alternatives to health insurance from calendar year 2018 through 2022. We identified them through the literature search described below and other background research efforts and selected them to achieve variation across the group with respect to expertise with each type of alternative to health insurance, organizational affiliation, and policy perspective. Stakeholders also included one industry expert with firsthand

³One major seller of a fixed indemnity plan identified by a stakeholder declined to be interviewed by us, although we obtained and analyzed a detailed plan document for this work. We interviewed another seller of a fixed indemnity plan that did not provide us with a detailed plan document; therefore, we did not analyze their plan for this work. Further, after interviewing another seller of fixed indemnity plans and reviewing one of their products, we determined their plan did not fit the type of fixed indemnity product we examined for this work. Therefore, we did not analyze this plan's documentation in this report.

⁴The states selected for this study are California, Colorado, Massachusetts, Nebraska, Tennessee, Texas, and Virginia.

⁵Organizations included, among others, the National Association of Insurance Commissioners (NAIC), the American Academy of Actuaries, America's Health Insurance Plans, and the National Association of Benefits and Insurance Professionals.

experience selling fixed indemnity plans and officials from one state-based health insurance exchange.

We also conducted a literature search of publications on Farm Bureau health plans, HCSM memberships, and fixed indemnity plans.⁶ We reviewed literature on these three types of alternatives to health insurance published from 2017 through mid-2022 to learn about 1) the number and characteristics of individuals who participate, 2) the risks and benefits of these plans or memberships, 3) the extent to which they are marketed to certain individuals and groups, and 4) typical features of these plans or memberships. We used this literature search for background information purposes, as well as to assist in identifying stakeholders to interview.

To describe what is known about the number and characteristics of individuals and groups who participate in Farm Bureau health plans, HCSM memberships, and fixed indemnity plans, we reviewed any publicly available information on the websites of sellers of Farm Bureau health plans, HCSMs, and fixed indemnity plans pertaining to their enrollment. Some sellers also provided us with enrollment estimates. We reviewed background literature obtained through our literature search. We also interviewed sellers of these three types of alternatives to health insurance, state insurance departments, policy researchers, and other stakeholders as outlined above about enrollment in these alternatives to health insurance, trends in enrollment over time, and information on the characteristics of those enrolled, including age, income, and health status.

To describe the marketing practices of selected sellers of Farm Bureau health plans, HCSM memberships, and fixed indemnity plans and regulators' views on the marketing practices of these types of products, we reviewed marketing materials associated with the nine plans and memberships we analyzed, such as advertisements on the sellers'

⁶The search was done in several scholarly databases, including ones focused health care and economic issues. Thirty-five citations were provided to the team, of which 10 were used. The databases searched were: ABI/INFORM Professional Advanced, AgeLine, BIOSIS Previews, British Library Inside Conferences, Business Continuity & Disaster Recovery Reference Center, Business Source Corporate Plus, CINAHL Plus, EBSCOhost eBook Collection, EconLit, Embase, EMCare, Finance Source, Google Scholar, H.W. Wilson Index to Legal Periodicals and Books, Harvard Think Tank Search, HeinOnline, Index to Legal Periodicals, Leadership & Management Source, MEDLINE, Newswires, PAIS International, Risk Management Reference Center, SciSearch, Scopus, Social SciSearch, SSRN, and Web News.

websites. We also reviewed government publications detailing misleading marketing associated with alternatives to health insurance. We interviewed sellers of the selected products in our review about their marketing practices. We also interviewed state insurance department officials and other stakeholders, including the National Association of Insurance Commissioners (NAIC), about the general marketing practices of sellers of these alternatives to health insurance. Stakeholders included officials from two state attorneys' offices who had taken actions against sellers of alternatives to health insurance for misleading marketing since 2020.

We conducted this performance audit from May 2022 to July 2023, in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

States are the primary regulators of private health insurance.⁷ Health insurance plans are also subject to certain federal standards and minimum requirements, most notably those established in PPACA.⁸ However, the alternatives to health insurance discussed in this report—Farm Bureau health plans, HCSM memberships, and fixed indemnity plans—are generally either exempted from PPACA's requirements (fixed indemnity plans that meet the requirements to qualify as an excepted benefit) or otherwise are generally not subject to PPACA's requirements (Farm Bureau health plans and HCSM memberships). Instead, the requirements applicable to these alternatives to health insurance vary depending on the type of arrangement, state law, and federal law.

⁷Among other activities, state insurance departments assess the financial solvency of insurance companies—or the ability for a company to cover claims—and conduct market conduct examinations, in which regulators review an insurance company's marketing and sales behavior to identify misleading or unfair practices. States have also established guaranty funds, which are associations that are set up to pay claims of insurers that become insolvent.

⁸Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

Alternatives to Health Insurance and Applicable Requirements

- **Farm Bureau health plans.** These plans are only available to Farm Bureau members, though an individual does not necessarily need to be affiliated with the agricultural industry to become a member.⁹ According to Farm Bureau officials, as of March 2023, six states have enacted laws allowing 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: Tennessee, Iowa, Kansas, South Dakota, Texas, and Indiana.¹⁰ These laws may impose minimum requirements for these plans, including restrictions on waiting periods exceeding certain timeframes, requirements for disclaimers that the plans are not insurance, restricting sale of the plans exclusively to Farm Bureau members and their families, and requirements for actuarial filings demonstrating the Farm Bureau's financial solvency.
- **HCSM memberships.** These memberships are offered by organizations whose members agree to live by a statement of religious or ethical beliefs and contribute monthly to pay for the medical costs of other members.¹¹ Rather than indemnifying risk as an insurer would, a typical HCSM oversees the voluntary sharing of medical costs between members. According to the Commonwealth Fund, as of 2018, thirty states specifically have exempted HCSMs from their health insurance regulations.¹² These laws may require HCSMs to meet certain requirements to operate in their state,

⁹The American Farm Bureau Federation is a national agricultural advocacy organization with offices in all 50 states and Puerto Rico.

¹⁰The first state to enact such a law did so in 1993. The five other states have done so more recently, between 2018 and 2021.

¹¹Traditionally, HCSMs are health sharing organizations based on adherence to a religion or a set of religious beliefs. In recent years, HCSMs that do not require members to attest to a statement of faith have also formed. These HCSM memberships may be structured similarly to traditional HCSM memberships but may have members attest to a set of ethical rather than religious beliefs. PPACA exempted members of eligible HCSMs from the individual mandate to maintain minimum essential health coverage. For an individual to qualify for an exemption from the individual mandate based on membership in an HCSM, the HCSM had to meet several requirements, including being established before 1999. According to CMS officials, CMS maintained a list of HCSMs that met the PPACA definition and were therefore approved for exemption purposes until late 2016, when the process for obtaining an exemption as a member of an HCSM was delegated to the Internal Revenue Service. In addition, the penalty for failing to maintain minimum essential coverage was reduced to \$0 effective in 2019.

¹²See JoAnn Volk, Emily Curran, and Justin Giovanelli, *Health Care Sharing Ministries: What Are The Risks to Consumers and Insurance Markets?* (New York, N.Y.: Commonwealth Fund, 2018).

including being a tax-exempt nonprofit and adding a written disclosure that the facilitating of medical cost sharing is not insurance.

According to an HCSM trade group, there are nine HCSMs with open membership that require members to attest to a statement of faith as of May 2023. HCSMs currently operate or have operated in most states.¹³ (See app. I for more information on the ownership and operations of HCSMs). Several states have taken action to obtain more information on the HCSMs operating in their state. For example, Colorado enacted a law in 2022 requiring HCSMs to annually submit data on their operations in the state, including how much they collect in payments and how much they pay out for claims.¹⁴

- **Fixed indemnity plans.** These plans pay a fixed dollar amount on a per-period or per-incident basis, regardless of the amount of expenses incurred. Historically, they were used as a form of income replacement during illness or hospitalization, but certain fixed indemnity plans may resemble the design of a health insurance plan; for example, employing provider networks, deductibles, or separate payment amounts for a variety of medical services. Fixed indemnity plans are permitted to be sold in the individual market as independent, non-coordinated excepted benefits—that is, not subject to federal health insurance requirements—when they meet certain requirements. In the individual market, these requirements include providing a notice prominently displayed in the application materials informing potential policyholders that the coverage is not a substitute for major medical coverage.¹⁵ According to NAIC, states generally regulate fixed indemnity plans as excepted benefits, and each state insurance department must ensure that fixed indemnity plans sold in its state adhere to the state’s requirements. For example, one seller of

¹³In 2016, CMS reported that there were 108 HCSMs operating in the United States. Many HCSMs are localized to small religious communities or organizations, and memberships are exclusively offered to members of that community. Enrollment in these HCSMs is unknown and likely low according to an HCSM trade group with which we spoke.

¹⁴§ 10-16-107.4, C.R.S. (2022).

¹⁵42 U.S.C. § 300gg-91(c)(3)(B); 45 C.F.R. § 148.220(b)(4). In addition to requirements under PPACA, excepted benefits are not subject to other federal consumer protections and requirements that apply to health insurance coverage, including certain requirements under the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191; the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343; and division BB of the Consolidated Appropriations Act, 2021, which includes the No Surprises Act, Pub. L. No. 116-260 (2020).

fixed indemnity plans we spoke with told us they have been approved to sell these plans in 18 states as of March 2023.

PPACA-Compliant Plans and Applicable Requirements

Unlike the alternatives to health insurance described above, health insurance plans sold on the individual market are generally subject to minimum requirements and consumer protections established in PPACA. For the purposes of this report, we refer to these plans as “PPACA-compliant plans.”¹⁶ For example, beginning in 2014, PPACA required the following of such plans.

- **Guaranteed issue.** Plans must generally accept every applicant who applies for health coverage, as long as the applicant agrees to the terms and conditions of the insurance offer.
- **Guaranteed renewability.** Plans must generally renew coverage at the option of the enrollee.
- **Coverage of 10 essential health benefits.** These benefits are ambulatory patient services (outpatient services), emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services (including oral and vision care).
- **Prohibition of lifetime or annual dollar benefit limits.** Plans are prohibited from imposing lifetime or annual dollar benefit limits on expenses relating to the ten essential health benefits.
- **Coverage of pre-existing conditions.** Plans are prohibited from excluding coverage for pre-existing conditions, or imposing waiting periods for benefits related to these conditions.
- **Rating restrictions.** Plans can adjust premiums based only on certain factors, such as geographic area, age, and tobacco use, and amounts by which rates may vary is limited in certain circumstances.¹⁷

¹⁶In this report we use the phrase “PPACA-compliant plans” to mean plans that must meet federal requirements for individual health insurance coverage. We did not evaluate the legal compliance of any plans for purposes of this report.

¹⁷See Pub. L. No. 111-148, § 1201, 124 Stat. 119, 154-61 (codified, as amended, at 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3, 300gg-6). Rating restrictions prohibit insurers in the individual market from adjusting an individual’s health insurance premiums based on an individual’s health status.

Additionally, beginning in 2011, PPACA-compliant plans were required to spend at least 80 percent of their premium revenue on medical claims and certain other non-claims costs, such as quality improvement activities. These are known as medical loss ratio requirements.

PPACA also established health insurance marketplaces—or exchanges—through which consumers can shop for private health insurance plans.¹⁸ Some consumers who purchase health insurance on a PPACA exchange may also be eligible for subsidies to help offset the cost of their premiums. The American Rescue Plan Act of 2021 (ARPA) expanded eligibility for subsidies to higher income individuals and increased subsidies for lower income individuals beginning in 2021.¹⁹ In 2022, the Inflation Reduction Act extended these premium subsidies through 2025.²⁰

Individuals who do not enroll in PPACA-compliant plans, but instead enroll in the alternatives to health insurance discussed in this report, are not included in PPACA individual market risk pools, which comprise the population that buys PPACA-compliant plans in each state. To the extent that individuals purchase health insurance alternatives instead of PPACA exchange plans, this could influence the cost of premiums set by companies that sell PPACA-compliant plans and the amount of federal subsidies disbursed under PPACA. For example, if relatively healthy individuals choose alternatives to health insurance instead of PPACA-compliant plans, leaving fewer healthy individuals purchasing PPACA-compliant plans, it could result in higher premiums for PPACA-compliant plans and, in turn, higher federal spending on subsidies.

¹⁸PPACA requires plan sold on the exchanges to be generally marketed in four tiers—Bronze, Silver, Gold, and Platinum—which allows consumers to compare the relative benefit value of each plan.

¹⁹Pub. L. No. 117-2, § 9661, 135 Stat. 4, 182 (codified as amended at 26 U.S.C. § 36B).

²⁰Pub. L. No. 117-169, § 12001, 136 Stat. 1818, 1905 (2022).

Benefits and Other Features of Selected Plans and Memberships Varied and Officials Say These Product Types Generally Have Few Consumer Protections

Plans and Memberships Reviewed Generally Covered Hospital Stays and Certain Office Visits, but Coverage for Preventative Screenings, Prescription Drugs and Other Types of Services Varied

Our analysis of documentation for our nine selected health plans and memberships (two Farm Bureau health plans, five HCISM memberships, and two fixed indemnity plans) found that these plans and memberships varied in their features.²¹ While all of these plans and memberships included some coverage for hospital services and offices visits for illness or injury, their coverage for routine examinations, preventative screenings, prescription drugs and other types of services varied. For example, both of the Farm Bureau health plans we reviewed covered routine wellness office visits, while three of the five HCISM memberships we reviewed did not. Both of the fixed indemnity plans we reviewed covered these visits, although the benefits varied depending on the level of coverage selected by the enrollee.²²

The nine plans and memberships we reviewed varied in their use of waiting periods, as some had waiting periods to access certain benefits, such as for wellness services or maternity benefits.²³ For example, one

²¹Unlike Farm Bureau plans and fixed indemnity plans, officials from all of the HCISMs we spoke with told us they do not use terms commonly associated with insurance—such as coverage, premiums, plans, or plan documentation—in an effort to distinguish themselves from health insurance products. In this report, we endeavor to use the terms HCISM may use when describing their memberships that may generally align with these common terms, including sharing, monthly contributions, memberships, and sharing guidelines.

²²Wellness visits are required to be included in health insurance plans under PPACA as one of the 10 essential health benefits.

²³Waiting periods are periods of time in which enrollees are not able to access benefits or make claims or sharing requests related to all or certain services. PPACA-compliant plans in the individual market do not impose waiting periods, though the date on which coverage takes effect may vary depending on when an individual enrolls in a plan.

fixed indemnity plan had a 30-day waiting period for wellness services in most states and two HCSM memberships had 60- or 90-day waiting periods for coverage of medical expenses other than accidents, injuries, or acute illnesses. Additionally, one Farm Bureau and all five HCSM memberships we reviewed had waiting periods for maternity services. Enrollees in these plans and memberships are fully responsible for any costs relating to these services that occur during these waiting periods, according to plan documents and HCSM guidelines that we reviewed. For example, one HCSM's sharing guidelines state that if a member is diagnosed with cancer during the waiting period, any expenses related to the diagnosis and treatment of that cancer are ineligible for sharing. See figure 1 for more examples of the variation in features among the plans and memberships that we reviewed.

Figure 1: Benefits and Features of Nine Selected Farm Bureau Health Plans, Health Care Sharing Ministry (HCSM) Memberships, and Fixed Indemnity Plans in 2022

Benefits and Features	Farm Bureau Health Plans (two plans)		HCSMs (five HCSM memberships) ^a					Fixed Indemnity Plans (two plans) ^b	
Coverage for hospital services	✓	✓	✓	✓	✓	✓	✓ ^c	✓	✓
Coverage for office visits for injury or illness	✓	✓	✓ ^d	✓	✓	✓	✓	✓	✓ ^c
Coverage for routine check-up/exam	✓	✓	—	—	✓ ^c	✓ ^c	—	✓ ^c	✓
Coverage for preventative screenings ^e	✓	✓	—	—	✓ ^c	✓ ^c	✓	✓ ^c	✓
Coverage for prescription drugs	✓	✓	✓ ^{d,f}	✓ ^f	✓ ^f	—	✓ ^f	✓	✓ ^d
Coverage for maternity services	✓ ^{c,d}	✓	✓ ^{c,d}	✓ ^c	✓ ^c	✓ ^c	✓ ^c	—	—
Coverage for mental health services	✓	✓	—	—	—	—	✓ ^g	—	✓ ^c
Immediate coverage of pre-existing conditions	—	✓	—	—	—	—	—	—	—
No per-incident, annual, or lifetime benefit maximums ^h	✓	—	—	—	—	—	—	—	—

The plan we reviewed contains the feature
 The plan contains the feature with one of the restrictions below
 The plan does not contain the feature

Source: GAO analysis of plan documentation (data); GAO (icons). | GAO-23-106034

^aThe health care sharing ministries (HCSM) from which we gathered information did not use insurance terms, such as plan or premium, when describing their HCSM memberships.

^bAlthough one of the fixed indemnity plan sellers declined to speak with us, we obtained and analyzed a detailed plan document for their product.

^cBenefits are subject to a waiting period.

^dNot available for all plan tiers or membership levels.

^eTests, such as colonoscopies or mammograms that screen individuals for possible health issues.

^fIncident-related prescription drugs only; maintenance drugs excluded.

^gSubject to annual benefit maximum.

^hThe maximum dollar amount that a plan or membership will pay for a discrete incident, in a calendar year, or for the covered person's lifetime, respectively.

While some of the benefits and associated waiting periods of the plans and memberships we reviewed varied, documentation for these plans and memberships indicated that most denied or delayed coverage for pre-existing medical conditions and imposed benefit limits. Specifically, documentation we reviewed suggested that plans and memberships may deny coverage of certain claims or medical costs that would otherwise be covered because of restrictions on covering pre-existing conditions or because an individual exceeded a benefit limit set by the seller.

Denials for and restrictions on pre-existing conditions.

Documentation for both Farm Bureau health plans, both fixed indemnity plans, and one HCSM membership that we reviewed indicated that they may deny coverage to applicants based on their health history in some instances, leaving those with certain pre-existing conditions unable to access coverage through these plans and memberships.²⁴ Further, once an applicant is accepted, documentation for all but one of the plans and memberships we reviewed showed that they excluded or delayed coverage for pre-existing conditions.²⁵ For example:

- One HCSM membership excluded costs due to “active” pre-existing conditions, or conditions that need treatment other than routine medications, from being eligible to be shared by the HCSM.

²⁴Officials from another HCSM told us that they will deny applicants if they report tobacco use or substance abuse in the 12 months prior to applying.

²⁵PPACA-compliant plans are required to cover pre-existing conditions, including pregnancies. The one plan in our selection that does offer immediate coverage for pre-existing conditions told us they will deny coverage to individuals with certain pre-existing conditions.

-
- The other HCSM memberships we reviewed contained 12- to 36-month waiting periods before they would partially or fully share costs associated with pre-existing conditions.²⁶
 - One Farm Bureau had a 6- month waiting period for coverage of pre-existing conditions, while both fixed indemnity plans we reviewed had 12- month waiting periods.²⁷

Under these alternatives to health insurance, individuals with pre-existing conditions would be responsible for any costs related to those conditions during these waiting periods.²⁸

Benefit limits. Of the nine plans and memberships we reviewed, eight had dollar benefit limits of some kind. These limits were either per-incident, annual, or lifetime limits, which represent the maximum dollar amount a plan or membership would pay for a discrete incident, in a calendar year, or for the covered individual's lifetime, respectively.²⁹ For example, one HCSM membership we reviewed had a per-incident limit of \$125,000. Some plans and memberships had multiple types of benefit limits. For example, one fixed indemnity plan we reviewed had both an annual and a lifetime benefit limit. Once these benefit limits are reached, individuals are fully responsible for any medical costs that subsequently occur.

The plans and memberships that we reviewed also differed in other aspects of their features, including the use of provider networks, the approaches they use to pay for services, the factors that influence

²⁶These costs would otherwise be eligible for sharing if they were not associated with a pre-existing condition.

²⁷The Department of Health and Human Services estimated in 2017 that as many as 51 percent of non-elderly Americans – 133 million individuals – had a pre-existing condition that could have resulted in a denial of coverage or elevated premium rates in the individual health insurance market prior to the enactment of PPACA. See Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* (Jan. 5, 2017). Non-elderly individuals are defined as individuals age 0 to 64 who did not have Medicare coverage in any month.

²⁸Two HCSMs had processes for members to voluntarily make additional donations to cover the medical costs of others that would otherwise be ineligible for sharing, including for pre-existing conditions.

²⁹PPACA-compliant plans are prohibited from imposing lifetime or annual dollar benefit limits on expenses relating to the 10 essential health benefits.

premiums or monthly contributions, and the use of plan tiers or membership levels.

Provider networks and discounts. The nine plans and memberships we reviewed differed in their use of provider networks.³⁰ Some of the alternatives we reviewed provided discounts for using network providers, consistent with the use of provider networks in some PPACA-compliant health insurance plans. For example:

- While both Farm Bureau plans we reviewed used provider networks, one offered out-of-network benefits only for emergency services.
- One HCSM membership and one fixed indemnity plan we reviewed had optional provider networks. In those arrangements, enrollees using in-network providers could receive reduced or discounted medical bills.

The other five plans and memberships did not have provider networks. However, one HCSM's membership guidelines stated that although they have no required provider network, they had "HCSM friendly" providers with whom they have "established pre-determined discount agreements." Four HCSMs that did not have established provider networks encouraged individuals to compare prices and choose providers who offered services at lower costs. For example, officials from one of these HCSMs told us that members receive access to an online tool that allows them to compare provider rates in their area.

Payment Systems. The plans and memberships varied in the payment systems they used to cover medical costs. Both of the Farm Bureau health plans we reviewed processed medical bills directly from providers, which is how PPACA-compliant health insurance plans typically operate. According to HCSM officials, the five HCSMs we reviewed operated by either facilitating medical cost sharing directly from member to member, or by collecting contributions from members and distributing them to other members or to providers (see app. I for more information on how HCSMs share medical costs). Both of the fixed indemnity plans we reviewed paid a fixed amount, regardless of the actual cost of the service and whether the service was covered by any other insurance plan or form of health coverage.

³⁰A provider network is a list of the doctors, hospitals, and other health care providers contracted to provide medical care to plan members.

Factors influencing premium rates or monthly contributions. The plans and memberships we reviewed also differed in the factors they used to determine premium rates or monthly contributions, including their use of health status and gender as factors.³¹ Officials from both Farm Bureaus told us they used health status, age, family size, and tobacco use to determine premiums, with one also using gender.³² Sharing guidelines from three HCSMs stated that family size is used to set monthly contribution amounts, with two of the three also using age. Officials from the other two HCSMs we reviewed stated that they also use age and family size, with one also using a member's state of residence. Additionally, although only one of the HCSMs we reviewed used tobacco use as a factor to determine monthly contributions, the other four HCSMs required members to abstain from using tobacco, with one excluding health issues related to tobacco use from sharing. One fixed indemnity plan document states that they use health status, age, gender, and family size, while officials from the other seller of these plans that we interviewed told us they use health status, age, and family size.

Plan tiers and membership levels. All of the plans and memberships that we reviewed offered multiple tiered options. These tiers differ in several ways, including by monthly premiums or contributions, benefit levels, or deductibles.³³ For example, one fixed indemnity plan we reviewed had twelve plan options that a consumer could choose from, each with different levels of benefits. One HCSM membership offered Gold, Silver, and Bronze membership levels, each with differing amounts that enrollees must pay before the HCSM will begin sharing their medical bills.³⁴ Additionally, this HCSM also restricted some services, such as

³¹PPACA-compliant plans are prohibited from considering health status or gender in setting premiums. PPACA-compliant plans may adjust premiums based only on geographic area, age, tobacco use, and family size, but the amount by which rates may vary based on those factors is limited.

³²Officials from one of these Farm Bureaus told us they charge a family rate regardless of the size of the family or number of dependents.

³³All of the HCSMs we reviewed specified an amount of money that members must pay towards their own medical costs before the HCSM will share their medical costs, similar to the insurance concept of a deductible. Depending on the HCSM membership, this amount is either on a per-incident or annual amount.

³⁴Two stakeholders we spoke with told us that some alternatives to health insurance may resemble PPACA exchange plans in how they are structured, including in offering tiers with terms similar to PPACA exchange plans, which are marketed in four categories: Bronze, Silver, Gold, and Platinum. In addition, catastrophic plans may be offered in the individual market. However, HCSM memberships are not required to follow PPACA standards of coverage for the tier levels.

maternity benefits or emergency transportation benefits, for members in the Gold membership level.

Selected Plans and Memberships All Disclose They Are Not Health Insurance; State Officials Say Alternatives to Health Insurance Generally Have Few Consumer Protections

Example of a Health Care Sharing Ministry (HCSM) Membership Disclosure

"NOTICE: [HCSM] is not insurance or an insurance policy nor is it offered through an insurance company. Whether anyone chooses to assist you with your medical bills will be totally voluntary, as no other member will be compelled by law to contribute toward your medical bills. As such, [HCSM] should never be considered to be insurance. Whether you receive any payments for medical expenses and whether or not [HCSM] continues to operate, you are always personally responsible for the payment of your own medical bills. [HCSM] is not subject to the regulatory requirements or consumer protections of your particular State's Insurance Code or Statutes."

Source: HCSM membership guidelines. | GAO-23-106034

The plan documents and HCSM membership guidelines for all nine products we reviewed contained some form of a written disclosure that the product was not health insurance. For example, one Farm Bureau plan document stated that their coverage is "not required to comply with certain federal or state market requirements for health insurance, principally those in the Affordable Care Act [PPACA]." One HCSM's membership guidelines contained a disclosure stating that they do not offer an insurance product and that neither members nor the HCSM are under a legal obligation to pay the costs of the medical bills of other members (see sidebar for an example of a full HCSM disclosure). A disclosure on a fixed indemnity plan document stated that the product provides limited benefits, that it is a supplement to health insurance, and that it is not a substitute for minimum essential coverage as defined by PPACA.

However, some literature we reviewed and stakeholders we interviewed stated that written disclosures may not be an adequate means of educating consumers about the limitations or risks of alternatives to health insurance. Some literature we reviewed found that some individuals believed they had purchased insurance through an HCSM, despite the fact that the HCSM products contained a written disclosure that the product was not insurance.³⁵ Further, officials from one state insurance department told us these disclosures are not adequate to protect consumers from the risks of alternatives to health insurance because they may be presented in a way that lessens the impact of the disclosure. Additionally, three stakeholders we interviewed told us they did not think written disclosures were an adequate means of educating consumers about this coverage because many consumers do not read the disclosures or do not understand them because of a general lack of knowledge about health insurance. For example, an industry expert on fixed indemnity plans told us that these plans may have a disclosure stating that they do not cover all 10 essential health benefits required by PPACA, but this may not be helpful because many consumers are not

³⁵Relias Media, "It Is Not Insurance, It Just Looks Like It: 'We Make Them Self-Pay'" (Morrisville, N.C.: Relias Media, Aug. 1, 2019), accessed June 22, 2022, <https://www.reliasmedia.com/articles/144751-it-is-not-insurance-it-just-looks-like-it-we-make-them-self-pay> and JoAnn Volk, Emily Curran, and Justin Giovanelli, *Health Care Sharing Ministries: What Are the Risks to Consumers and Insurance Markets?* (New York, N.Y.: Commonwealth Fund, 2018).

familiar with those benefits. Further, one policy research group also told us that consumers who purchase alternatives to health insurance over the phone may make payments without ever seeing a written disclosure.

According to four state insurance department officials we interviewed, alternatives to health insurance generally include few, if any, consumer protections, which are practices or regulations that safeguard the interests of consumers. These plans and memberships are not required to adhere to, and may lack, the types of consumer protections that apply to PPACA-compliant, state-regulated health insurance plans. For example:

- sellers of plans and memberships may impose limitations on coverage for pre-existing conditions or implement annual lifetime dollar limits on certain benefits (see fig. 1 and discussion above), and
- sellers of plans and memberships generally are not subject to the same state oversight of financial solvency and market conduct as health insurance companies, such as requirements that consumers are charged fair and reasonable prices and protections against insurers that fail to operate in ways that are legal and fair to consumers.³⁶

However, although they are not required to do so, some sellers told us they have adopted some consumer protections similar to a PPACA-compliant, state-regulated health insurance plan. For example, officials from one Farm Bureau told us they hold funds in reserve in order to maintain financial solvency and avoid a situation where they cannot pay claims associated with their health plans.

Officials from three of the seven state insurance departments we interviewed told us that HCSM memberships do not guarantee that medical bills for covered benefits will be paid.³⁷ Membership guidelines from all of the HCSM memberships we reviewed also stated that all member contributions are completely voluntary and that members are ultimately responsible for any unpaid medical bills. According to some literature we reviewed, HCSMs leave their members at risk of being financially responsible for paying for medical care for conditions either not

³⁶Although state regulators can exercise oversight over fixed indemnity plans, as excepted benefits they are not subject to the same standards as PPACA-compliant plans.

³⁷Since HCSMs are not regulated as health insurance, they are not subject to state financial solvency requirements for insurers.

covered, covered only up to a benefit limit, or if the HCSM has inadequate funds to cover the benefits.³⁸

The absence of a guarantee that medical costs will be paid could leave consumers with significant medical bills to pay on their own.³⁹ Further, unlike companies that sell health insurance plans, HCSMs are generally not required by states to meet financial reporting standards to ensure they have sufficient funds to pay members' medical costs.⁴⁰ Therefore, if an HCSM ceases operations, it could also leave members responsible for unpaid medical bills. For example, during bankruptcy proceedings, a court document revealed that one HCSM likely had over \$100 million in unpaid, eligible claims.⁴¹

Additionally, alternatives to health insurance are not required to meet PPACA's medical loss ratio requirements.⁴² Medical loss ratio requirements are a key consumer protection because they cap profits for companies that sell health insurance and ensure more of the enrollees' money is spent on medical care, according to the Commonwealth Fund.⁴³

³⁸See Kevin Lucia, Justin Giovannelli, Sabrina Corlette et al., *State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market* (New York, N.Y.: Commonwealth Fund, 2018) and Partnership to Protect Coverage, "Under-Covered: How "Insurance-Like" Products Are Leaving Patients Exposed" (Mar. 2021), accessed May 16, 2023, https://nami.org/NAMI/media/NAMI-Media/Public%20Policy/Undercovered_Report_03252021.pdf.

³⁹Enrollees in PPACA-compliant plans may also be liable for unpaid medical bills to the extent that they incur costs that are not covered by their plan.

⁴⁰Large- and medium-sized insurers and insurance groups are required to regularly file an assessment with state insurance regulators of their own current and future risk that could have an impact on an insurer's ability to meet its policyholder obligations, including paying insurance claims. Since state insurance regulators do not supervise HCSMs, they are exempt from this reporting requirement.

⁴¹In contrast, unpaid claims from a state-regulated insurance company that became insolvent would be covered by a state guaranty fund.

⁴²Medical loss ratios are the percentage of premium dollars that private insurers must spend on their enrollees' medical care claims and activities to improve health care quality as opposed to what they spend on administrative costs and fees, as well as profits earned. PPACA requires individual and small group health plans to have a minimum medical loss ratio of 80 percent and large group health plans to have a minimum loss ratio of 85 percent.

⁴³Mark A. Hall and Michael J. McCue, *How the ACA's Medical Loss Ratio Rule Protects Consumers and Insurers Against Ongoing Uncertainty* (New York, NY: Commonwealth Fund, July 2019).

Information on medical loss ratios is generally not available for alternatives to health insurance, according to two stakeholders we interviewed. Instead, available data may include the proportion of member contributions spent on medical bills versus that which is spent on administrative expenses such as staff salaries and advertising, or a simple loss ratio, which represents the ratio of expenses or losses to premiums earned. For example, one Farm Bureau we spoke with told us their health plans operated with a loss ratio of between 85 and 90 percent. Four HCSMs we interviewed reported a range of 57 percent to 94 percent in the proportion of member contributions spent on medical needs versus on administrative expenses.⁴⁴

Limited Information Is Available on Enrollment in and Characteristics of Enrollees in Alternatives to Health Insurance

Enrollment

Information is limited about overall enrollment in Farm Bureau health plans, HCSM memberships, and fixed indemnity plans. Officials from most of the seven state insurance departments we spoke with told us they do not collect data on alternatives to health insurance.⁴⁵ Documents we reviewed as well as sellers and stakeholders we interviewed provided anecdotal estimates of enrollment and trends in enrollment in these three

⁴⁴The sellers of fixed indemnity plans that we spoke to did not share any information on their loss ratios. They told us they had no data to share, and that they were direct sellers of the plans, which were underwritten by third party carriers. States may set loss ratio requirements for fixed indemnity plans. For example, officials from one state insurance department told us they require these plans to have a loss ratio of at least 55 percent. Issuers may submit loss ratio information in NAIC's System for Electronic Rate and Form Filings.

⁴⁵Several states have taken action to obtain more information on the HCSMs operating in their state. For example, Massachusetts began requiring HCSMs to file enrollment data with the state annually in 2020. A Colorado law required HCSMs operating within the state to file similar enrollment information beginning in 2022.

types of alternatives to health insurance, but information availability varied by each type.⁴⁶

- **Farm Bureau health plans.** According to Farm Bureau officials, total national enrollment in Farm Bureau health plans was approximately 130,000 as of March 2023, with one state's Farm Bureau accounting for over 75 percent of this enrollment.⁴⁷
- **HCSM memberships.** According to HCSM documentation and HCSM officials, total national enrollment in the nine open HCSMs that required members to attest to a statement of faith was approximately 1.2 million as of March 2023.⁴⁸ The HCSM with the highest enrollment told us they had approximately 392,000 members, and the HCSM with the lowest enrollment told us they had fewer than 5,000 members. Four stakeholders, including officials from two of seven state insurance departments and one seller, also highlighted the growth of HCSMs that do not require members to attest to a statement of faith, the total number of which was unknown. While total national enrollment in these HCSMs was also unknown, one reported about 40,000 individual members on its website in October 2022.
- **Fixed indemnity plans.** Comprehensive enrollment data on fixed indemnity plans were not available. The two sellers of fixed indemnity plans we interviewed told us these products were a relatively small part of their overall product line. One seller of these plans told us they had 6,000 enrollees across 18 states as of March 2023. Another told us they began selling their fixed indemnity products in 2021, and said they had sold about 1,100 of these products as of March 2023.

⁴⁶All of the sellers we spoke with told us they only enroll individuals or families and do not work with employers to offer their product as employee health coverage, though officials from one Farm Bureau health plan and all five HCSMs acknowledged there may be limited instances of employers facilitating or contributing to monthly payments for this coverage. For example, officials from one HCSM we spoke with estimated that a little over 1,000 of their members were enrolled through employers, the majority of which were entities with between two and ten employees. Officials from this HCSM told us they believed a small minority of employers subsidized part of the HCSM's membership costs.

⁴⁷Enrollment in individual state Farm Bureau health plans ranged from 832 to around 100,000 as of March 2023.

⁴⁸According to an HCSM trade group, there were nine HCSMs with membership open to the public that required members to attest to a statement of faith in 2023. CMS reported that there were a total of 108 HCSMs operating in the United States in 2016, the majority of which were private, community-based HCSMs. Enrollment in these organizations is unknown and likely low according to an HCSM trade group we spoke with.

Despite a lack of comprehensive data, literature we reviewed as well as sellers and stakeholders we interviewed indicated that enrollment in alternatives to health insurance may have grown between the enactment of PPACA in 2010 and 2020. Specifically, consumer interest in lower-cost alternatives to health insurance may have been greater when premiums were higher and there was less stability in the PPACA exchanges in the mid-2010s, according to literature we reviewed and one seller and stakeholder we interviewed.⁴⁹ Further, officials from one HCSM told us that enrollment in HCSMs may have been higher during this period because HCSM membership could exempt an individual from PPACA's requirement to maintain minimum essential coverage.⁵⁰

However, enrollment in alternatives to health insurance may have declined in 2021 and 2022. Specifically, according to two sellers and two stakeholders, expanded subsidies through ARPA may have made PPACA-compliant plans purchased through the exchanges more affordable for many consumers.⁵¹ This may have decreased enrollment in alternatives to health insurance in 2021 and 2022. For example, officials from one Farm Bureau we spoke with told us enrollment in their health plans has been relatively consistent since they began offering the plans in 2019, but that enrollment declined slightly in 2021 and 2022 due to subsidy expansions. Officials from an HCSM trade group we spoke with estimated that there has been an overall reduction of 100,000 to 150,000 enrollees in HCSMs due to these expanded subsidies. One of the sellers of a fixed indemnity plan we spoke with also told us these expanded subsidies likely affected their sales, but could not quantify the effect.

The lack of comprehensive enrollment data for Farm Bureau health plans, HCSM memberships, and fixed indemnity plans makes it difficult to assess their effect—if any—on premiums for health insurance plans, including PPACA exchange plans. Research by the Commonwealth Fund

⁴⁹See Sabrina Corlette, Erik Wengle, Ian Hill, Olivia Hoppe, *Perspective from Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks* (Washington, D.C.: Urban Institute, April 2020).

⁵⁰As previously noted, the penalty for failure to comply with this requirement was reduced to \$0 beginning in 2019.

⁵¹ARPA expanded eligibility for subsidies to individuals with higher incomes and increased subsidies for lower income individuals. Pub. L. No. 117-2, § 9661, 135 Stat. 4, 182 (codified as amended at 26 U.S.C. § 36B). In 2022, the Inflation Reduction Act extended these subsidies through 2025. Pub. L. No. 117-169, § 12001, 136 Stat. 1818, 1905 (2022).

and Urban Institute has suggested that alternatives to health insurance could draw healthy consumers out of state PPACA exchange plans, which could negatively affect risk pools and potentially increase premiums for health insurance plans sold on the PPACA exchanges.⁵² Officials from one of the seven state insurance departments we spoke with told us that they believed HCSMs were negatively affecting their state's PPACA risk pool because enrollment in HCSMs was relatively high compared to PPACA exchange enrollment, and they believed enrollees in HCSMs were younger and healthier than the general population. Officials from another state insurance department told us that alternatives to health insurance did not currently affect their risk pools, but said that they were concerned about the growth of certain HCSMs that might target young and healthy consumers in the state.

However, officials from five state insurance departments, a seller, and a stakeholder told us they could not estimate the effect these alternatives had on PPACA risk pools and premiums because of a lack of data, or stated that these alternatives likely have little to no effect. For example, officials from one state insurance department told us that enrollment in these alternatives is too small to affect the risk pools in their state. Officials from the American Academy of Actuaries told us that alternatives to health insurance do not appear to have a negative effect on risk pools. They estimated that enrollment in HCSMs and Farm Bureau health plans combined likely amounted to less than two percent of the overall health coverage market. Further, officials from the Farm Bureau with the largest health plan enrollment told us that market research they have conducted suggests that their plans do not have an effect on their state's PPACA exchange or risk pool, and stated that very few of their customers leave a PPACA exchange plan to purchase a Farm Bureau health plan. They told us most of their customers are either uninsured or they are leaving employers offering group health insurance to work in the agricultural industry.

Characteristics of Enrollees

Most of the literature we reviewed as well as stakeholders and sellers we interviewed reported that little is known about the demographic and personal characteristics of enrollees in alternatives to health insurance,

⁵²A health insurance risk pool is a group of individuals whose medical costs are combined to calculate premiums; each state has a risk pool associated with its individual exchange. See JoAnn Volk, Emily Curran, and Justin Giovanelli, *Health Care Sharing Ministries: What Are The Risks to Consumers and Insurance Markets?* (New York, N.Y.: Commonwealth Fund, 2018) and Kevin Lucia, Sabrina Corlette, Dania Palanker, and Olivia Hoppe, *Views from the Market: Insurance Brokers' Perspectives on Changes to Individual Health Insurance* (Washington, D.C.: Urban Institute, 2018).

such as age, income, and pre-existing condition status. However, some of the sellers, state insurance departments, and other stakeholders we interviewed provided anecdotal information.

- **Health status.** Six stakeholders stated that enrollees in alternatives to health insurance tend to have better health status than the general population. According to three of these stakeholders, this may be because many of these alternatives use underwriting—the practice of determining cost or eligibility for health coverage based on health status. Healthier individuals may also be more likely to enroll in coverage with less robust benefits, according to some literature we reviewed. Officials from two HCSMs provided information on the proportion of their enrollees with at least one pre-existing condition; one told us that 40 to 50 percent of its applicants have at least one pre-existing condition; the other told us 23 percent of its members have a pre-existing condition.⁵³
- **Employment.** Two sellers and two stakeholders we interviewed said that enrollees in alternatives to health insurance tended to be self-employed or employed in the gig economy because these consumers lack an offer of employer sponsored insurance.⁵⁴ Sixteen percent of Americans have earned money from an online gig platform as of 2021, and they tended to have lower incomes than other American adults, according to the Pew Research Institute.⁵⁵ However, eight sellers told us they did not collect employment or income information from their enrollees. The only seller that provided information related to their members' income was one HCSM. Officials from this HCSM

⁵³A 2017 issue brief from the Department of Health and Human Services estimated that up to 51 percent of non-elderly Americans have a pre-existing condition. See Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act* (Washington, D.C.: January 2017).

⁵⁴The Bureau of Labor Statistics defines a gig as a single project or task for which a worker is hired, often through a digital marketplace, to work on demand. Department of Labor, Bureau of Labor Statistics, "Working in a Gig Economy," *Career Outlook* (Washington, D.C.: May 2016), accessed May 11, 2023, <https://www.bls.gov/careeroutlook/2016/article/what-is-the-gig-economy.htm>.

⁵⁵Monica Anderson, Colleen McClain, Michelle Faverio, and Risa Gelles-Watnick, *The State of Gig Work in 2021* (Washington, D.C.: Pew Research Center, 2021).

told us they conducted a survey of their members in 2020 and found that 42 percent had income below 200 percent of the poverty line.⁵⁶

- **Coverage preference.** Two sellers we spoke with stated that consumers who select alternatives to health insurance may be those interested in health coverage that does not have a provider network. One policy researcher told us these consumers may want to purchase coverage outside of the open enrollment period for PPACA exchange plans.⁵⁷
- **Personal Values.** Five sellers and two stakeholders we interviewed stated that certain consumers are drawn to alternatives to health insurance for personal or values-based reasons. For example, officials from both Farm Bureaus we interviewed emphasized the importance of the Farm Bureau's closeness to the rural and agricultural communities of its health plan members. Further, some literature we reviewed suggested that many HCSM members value the faith-based community of like-minded individuals provided by their membership, and find that this factor overcomes limitations, such as delays in payment, associated with this form of coverage. For example, this literature suggested that some enrollees in HCSMs appreciate that, unlike with health insurance, their monthly contributions will not be spent on health care costs incurred by individuals who abuse drugs or alcohol or otherwise live an unhealthy lifestyle because of the membership requirements of HCSMs.⁵⁸

⁵⁶Individuals or families with income above 100 percent but below 200 percent of the poverty line would generally meet the income eligibility requirements to receive subsidies for coverage purchased through the exchanges, or, depending on the state in which they reside, some individuals and families below 200 percent of the poverty line may be eligible to enroll in the Medicaid program. For 2022, the poverty line was \$13,590 for individuals and \$27,750 for a family of four.

⁵⁷Consumers can enroll in health insurance coverage through PPACA exchanges during the annual open enrollment period, the timing of which varies but generally occurs between November and January. Outside of open enrollment, individuals may use special enrollment periods to sign up for coverage if they experience a triggering event, such as losing coverage from another source, like Medicaid or an employer.

⁵⁸See Schwartz, "Paying for Something Bigger: The Sentiment of Sociality and Health Care Sharing Ministries in the United States," *Anthropological Quarterly*, vol. 93, no. 4 (2020): 625-652 and Schwartz, "Freed from Insurance: Health Care Sharing Ministries and the Moralization of Health Care," *Social Science and Medicine*, vol. 268 (2021).

Selected Sellers Used a Variety of Marketing Strategies and Regulators Described Concerns about Marketing Practices of Alternatives to Health Insurance

Sellers of the selected Farm Bureau health plans, HCSM memberships, and fixed indemnity plans we reviewed marketed these plans and memberships using a variety of strategies, including advertising lower premiums or monthly contributions than other health coverage options. While officials from the seven state insurance departments did not identify inappropriate or misleading marketing practices related to the nine plans and memberships we reviewed, all of these officials told us they were concerned about inappropriate marketing practices in the market for alternatives to health insurance, especially related to misleading marketing online.

Selected Sellers Marketed Their Plans and Memberships as Lower-Cost Health Coverage, in Addition to Other Strategies

Sellers of the selected Farm Bureau health plans, HCSM memberships, and fixed indemnity plans we reviewed used a variety of strategies to market their products, according to marketing materials we reviewed. These practices included focusing on factors such as affordability, suitability, choice, and values, among other things.

Price and affordability. Marketing materials associated with all nine of the Farm Bureau health plans, HCSM memberships, and fixed indemnity plans we reviewed advertised that these plans and memberships offered lower premiums or monthly payments than other health coverage options, such as PPACA-compliant plans. For example, one Farm Bureau advertised on its website that consumers could save 50 percent on their health coverage with one of their health plans, and one HCSM's website referred to the membership as a "faith-based healthcare cost solution for Christians."

Suitability for the self-employed. Marketing materials associated with three of these plans focused specifically on consumers without an offer of employer-sponsored insurance, such as the self-employed or those employed in the gig economy. For example, officials from both Farm Bureaus told us that these plans are well suited for individuals who are leaving a job with employer-sponsored insurance to farm full-time. Additionally, sellers of one fixed indemnity plan advertised it through their website as a "flexible insurance plan" that was affordable for "entrepreneurs, freelancers, and the self-employed" as of March 2023.

Greater provider choice. Marketing materials associated with these plans and memberships also frequently advertised that they give

consumers greater freedom over their choice of health care provider than PPACA-compliant plans. For example:

- Four plans and memberships advertised that members could see the provider of their choice, unlike PPACA-compliant plans that may require members to see a provider within a network.⁵⁹
- One seller of a fixed indemnity plan we interviewed told us that networks offered by some insurers are a source of frustration for consumers, especially those seeking coverage for mental health services.
- One Farm Bureau advertised in their marketing materials that enrollees in their health plans would have coverage at all hospitals in the state and could stay with their preferred doctor.
- One HCSM advertised its membership as “health care set free” from insurance and that, as a member, you “have the freedom to choose the health care provider that works best for you.”

HCSMs’ values-based community. Documentation for four of the HCSM memberships we reviewed shows that the HCSMs emphasized the faith-based community aspect of their memberships in their marketing. Two specifically advertised the HCSM as a community of like-minded individuals, rather than simply a form of health coverage. Marketing materials from four of the HCSMs also referred to providing health coverage that adhered to religious values, and one advertised that members should join in order to be better stewards of their healthcare dollars. Further, an HCSM trade group we spoke with told us that many HCSM members prefer this coverage because they perceive that the money they would have spent on PPACA-compliant plans would be used for services that do not align with their values.

Solutions for employers. Marketing materials we reviewed from three HCSMs specifically targeted employers.⁶⁰ For example, one HCSM’s

⁵⁹According to three sellers and one stakeholder, this is often because the individual enrolled in the plan or membership is considered a self-pay patient. GAO has previously reported that providers may offer discounts to self-pay patients. See GAO, *Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care* [GAO-11-791](#) (Washington, D.C. Sept. 23, 2011).

⁶⁰A 2023 report by the Colorado Division of Insurance stated that five of the 16 HCSMs that submitted data to the state reported employer groups participating, and at least three additional HCSMs had marketing materials encouraging employers to offer the HCSM’s products to their employees.

website referred to their product as a “health care solution for employers” and noted that a college used this HCSM’s memberships to cover its 168 employees. Further, DOL officials and three of the stakeholders we interviewed told us that some HCSMs targeted employers in their marketing.⁶¹ One HCSM told us that as healthcare costs continue to rise for businesses and employees, many small and mid-sized businesses have found that facilitating employees’ membership in their HCSM allows the employees to save money have more options for their healthcare.⁶² However, according to officials from this HCSM, although employee membership contributions are facilitated through the employer, employees sign up for an individual membership with the HCSM.

The selected sellers marketed their products both online and through other advertising outlets. All nine sellers we spoke with advertised their plans or memberships on their websites. Eight of nine sellers we spoke with told us they also conducted some sort of digital advertising, which included paid advertisements on web search engines or social media websites. Other marketing strategies included the following:

- **Traditional media outlets.** Officials from two of the HCSMs we spoke with told us they market through secular outlets, with one conducting television advertisements.⁶³ One of these HCSMs told us they also marketed through Christian outlets, such as Christian radio stations. Officials from two other HCSMs we spoke with marketed only through Christian outlets, such as Christian magazines, but officials from one of these HCSMs told us they were considering expanding soon to

⁶¹According to DOL officials, DOL does not have enforcement jurisdiction over the alternatives to health insurance when they are sold as individual coverage, which is the focus of this report. However, officials told us DOL does have jurisdiction to enforce certain requirements if the alternatives are sold as private, employment-based health plans. Specifically, DOL officials told us if entities selling these alternatives are acting in a fiduciary capacity, for example, by setting their own compensation from plan assets, DOL can enforce the fiduciary provisions of the Employee Retirement Income Security Act.

⁶²They told us that in order to facilitate this option for employer groups, they use a list billing arrangement, which is a process that allows an insurer or HCSM to sell individual coverage through payroll deduction, by sending employers a bill listing the specific premiums or monthly contributions for employees who have enrolled.

⁶³Officials from one Farm Bureau told us they have used television advertisements to market their health plan on limited occasions. Officials from the other Farm Bureau and the two sellers of fixed indemnity plans we spoke with told us they did not advertise the product we reviewed for this work through television.

secular national media. Officials from four of the HCSMs we spoke with told us they conducted radio advertisements.

- **Online lead-generating entities.** Only one seller of a fixed indemnity plan told us they used online lead generators as a part of their marketing efforts for their plan.⁶⁴ Officials from one HCSM said they had recently stopped using lead generators because they were not satisfied with the quality of leads they received.

Alternatives to health insurance may be marketed and sold by internal sales representatives (who work for the seller of the plan or membership) or external sales representatives (who work independently from the seller and may sell products from a variety of companies).⁶⁵ Sellers we spoke with varied in their use of external sales representatives.

- **Farm Bureaus.** Officials from one of the two Farm Bureaus we spoke with told us they used both internal and external sales representatives to sell their health plans, and officials from the other Farm Bureau told us they used exclusively internal sales representatives.
- **HCSMs.** Officials from one of the five HCSMs that provided information stated that they used internal and external sales representatives to sell their memberships.⁶⁶ On their website, one HCSM we reviewed advertised opportunities for health insurance brokers to add the HCSM membership to their list of product offerings as of March 2023. Three HCSMs did not use external sales representatives to sell their products, but officials from one of these HCSMs told us they recently stopped using external sales representatives in March 2022.

⁶⁴Lead generators collect “leads,” or the contact information of potential customers for a product, often via a website. Lead generators may then share these leads with sales representatives who then contact the individual with solicitations of health insurance and alternatives to health insurance. However, according to NAIC, the company that issues the plan is ultimately responsible for the marketing associated with their product.

⁶⁵Some of the sellers we spoke with told us that they provided training to their sales representatives about how to accurately explain their products when interacting with customers. For example, officials from three HCSMs told us that their sales representatives must go through a rigorous training program on how to explain how their HCSM membership differs from health insurance before they are able to sell their memberships.

⁶⁶Officials from the HCSM told us they require these individuals to be licensed to sell health insurance because they believe it would better qualify that individual to explain the differences between an HCSM membership and a PPACA-compliant plan to a consumer.

-
- **Fixed indemnity plans.** Both of the sellers of fixed indemnity plans that we spoke with said that, while consumers could enroll in their plans directly through their websites, they also used external sales representatives to sell these plans.

Some literature we reviewed as well as two sellers and two stakeholders we interviewed raised concerns about external sales representatives selling HCSM memberships alongside PPACA-compliant health insurance. Specifically, officials from two of five HCSMs we spoke with told us they were opposed to HCSMs using external sales representatives to sell HCSM memberships alongside health insurance because it made it difficult for consumers to understand that HCSM memberships are not insurance and are not an equivalent health coverage option.⁶⁷

Further, external sales representatives selling multiple types of coverage may have incentives to sell alternatives to health insurance instead of a PPACA-compliant plan. When external sales representatives sell a health plan or HCSM membership to a consumer, they are typically paid a percentage of the plan's premium or membership's monthly contribution as a commission. According to some literature we reviewed as well as a state insurance department and seller we spoke with, sales representatives may receive a higher percentage of the plan's premium as a commission for selling alternatives to health insurance than for selling PPACA exchange insurance.⁶⁸ In 2019, California's PPACA state exchange, Covered California, reported that HCSMs paid sales representatives substantially higher commissions for sales of HCSM memberships (15 to 20 percent of the monthly payment) compared to those paid by PPACA exchange insurers (2.6 percent of the monthly premium).⁶⁹ According to two brokers surveyed by Covered California in 2019, the higher commissions for HCSM memberships may provide an incentive for brokers to sell these products over a PPACA-compliant

⁶⁷Officials from one state insurance department and one state attorney general told us that at least one HCSM offered its members cash payments or discounted memberships for enrolling new members.

⁶⁸The commission a sales representative receives for the sale of a health plan is often a percentage of the plan's premium (e.g., 15 percent of the plan's premium). Therefore, for alternatives to health insurance with low premiums or monthly payments, the higher commission rate may not result in higher total compensation for the sale.

⁶⁹See Covered California, "Covered California Policy and Action Items" (Mar. 2019), accessed March 9, 2023, <https://board.coveredca.com/meetings/2019/03-14%20Meeting/PPT.Policy%20and%20Action.March%202019.3-14%20at%201150.pdf>.

plan.⁷⁰ However, since the amount a broker is paid is a percentage of the cost of the plan's premium, lower cost alternatives to health insurance—such as HCSM memberships—may not result in higher total compensation.

Regulators Described Concerns About and Identified Potentially Misleading Marketing Practices

Federal and state regulators have described concerns about and identified misleading marketing practices associated with alternatives to health insurance. All seven of the state insurance departments we spoke with told us they were concerned with misleading marketing of alternatives to health insurance, with three specifically discussing misleading marketing online. For example, officials from two state insurance departments told us they were concerned about the involvement of HCSMs operating in their state with online lead generators that may be providing misleading information to consumers.⁷¹ Officials from one of these state insurance departments told us they continue to get complaints from consumers saying that they were led to believe through these types of websites that HCSM memberships are the same as, or offer the same coverage as, health insurance. These officials told us they would like to monitor these websites for inappropriate sales practices regularly, but do not have enough resources. Further, officials from another state insurance department told us they frequently receive consumer complaints about misleading marketing associated with lead generators. They told us that in one complaint they received, a consumer asked the lead generator specifically for a PPACA-compliant plan and found out later the lead generator had signed them up for an HCSM membership.

According to officials from one of the state insurance departments we interviewed, an NAIC committee found that online lead generators were involved in misleading marketing related to the sale of health coverage products. (NAIC is a regulatory support organization for insurance regulators). We spoke with the state insurance officials who chaired

⁷⁰See Covered California, "Evaluating Agent Commissions" (Mar. 2019), accessed November 29, 2022, https://hbex.coveredca.com/toolkit/webinars-briefings/downloads/Commissions_Questions&Comments.pdf.

⁷¹None of the state insurance departments we spoke with described specific concerns about the marketing associated with the nine plans and memberships we reviewed for this work.

NAIC's Improper Marketing of Health Insurance Working Group.⁷² As a part of this effort, the working group collected information from insurance officials from multiple states, several of whom described cases of consumers in their state who thought they had purchased a PPACA exchange health insurance plan, but who had actually been sold a short-term plan or a fixed indemnity plan.⁷³

According to the state insurance officials who chaired the working group, the working group found that many of these cases stemmed from the use of lead generators that advertise on social media platforms or pay to get their websites listed at the top of web search engine results. They told us that these lead generators sometimes had names similar to the name of the federal PPACA exchange website, which may mislead consumers into thinking they are selling PPACA exchange health insurance plans. The officials told us that the working group found that in some cases, these online lead generators solicited and sold personal information from consumers looking for health insurance. After entering their information in the lead generator, these consumers were contacted repeatedly by sales representatives working through call centers trying to sell health coverage products. According to these state insurance officials, some sales representatives who purchased leads attempted to mislead consumers about these products over the phone. For example, sales representatives have falsely claimed that the product they were selling covered maternity or mental health benefits.

Federal agencies and state attorneys general have also identified and taken steps to address misleading marketing practices associated with alternatives to health insurance in recent years, including the following examples.

- In August 2022, the Federal Trade Commission took action against a health care company and its subsidiaries for misleadingly selling several health coverage products, including fixed indemnity products.

⁷²The state insurance officials who chaired this committee told us the committee consisted of state insurance officials from two NAIC committees. They told us they also involved federal agencies who may have investigated these practices, including the Federal Trade Commission, CMS, and DOL.

⁷³Short-term plans are a form of health coverage traditionally designed to fill temporary gaps in health insurance. They are exempt from individual health insurance regulations. For more information, see GAO, *Private Health Insurance: Limited Data Hinders Understanding of Short-Term Plans' Role and Value during the COVID-19 Pandemic*, [GAO-22-104683](#) (Washington, D.C.: May 31, 2022).

For example, the Federal Trade Commission alleged that written sales scripts used by the entity's sales representatives contained false or misleading statements, including that the plans "don't discriminate against any...pre-existing conditions," despite the fact that many plans either did not cover pre-existing conditions or incorporated waiting periods to access these benefits. The company agreed to a proposed court order that required it to pay \$100 million to provide consumer refunds and prohibited the company from lying about its products or charging illegal junk fees.⁷⁴

- In April 2022, a state court determined that three companies had engaged in unfair and deceptive practices related to the sale of health coverage products in that state, including HCSM memberships.⁷⁵ Specifically, the court found that the companies' sales representatives inappropriately presented the HCSM memberships as equivalent to health insurance, including using the term "insurance" and "premiums," which are typically associated with health insurance.

According to the state insurance officials who chaired NAIC's Improper Marketing of Health Insurance Working Group, the working group is revising NAIC's Unfair Trade Practices Act model to clarify what actions regulators can take when they become aware of misleading or inappropriate marketing of health coverage products.⁷⁶ Specifically, NAIC officials told us that NAIC members formed the working group in order to 1) coordinate with state and federal regulators to provide assistance in monitoring improper marketing of health coverage products and coordinate appropriate enforcement actions, as well as 2) review existing NAIC models and guidelines relevant to marketing of health coverage products to ensure they are updated to address current issues in the market.

⁷⁴Complaint, Fed. Trade Comm'n v. Benefytt Tech., et al., 8:22-cv-01794 (M.D. Fla. filed Aug. 8, 2022).

⁷⁵Decision and Order, Massachusetts v. Mega Life and Health Ins. Co., No. 0684CV04411-BLS1 (Suffolk Super. Ct. filed April 28, 2022).

⁷⁶According to NAIC, states may adopt their model laws in order to provide uniformity while balancing the needs of insurers operating in multiple jurisdictions with state judicial, legislative and regulatory frameworks. According to NAIC, the purpose of the Unfair Trade Practices Act model is to regulate trade practices in the business of insurance by defining all such practices in the state that constitute unfair methods of competition or deceptive acts or practices.

As of May 2023, NAIC officials told us the working group is focusing on revisions to NAIC's Unfair Trade Practices Act (NAIC model number 880). Specifically, officials told us they are revising the model to

- define a health insurance lead generator,
- define marketing-related activities of health insurance lead generators that constitute unfair trade practices, and
- prohibit health insurance lead generators from engagement in these unfair trade practices.

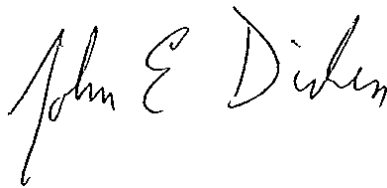
NAIC officials told us the working group reviewed stakeholder comments on the draft of the updated Unfair Trade Practices Act model in March 2023. They told us that as of May 2023, the working group plans to circulate an updated draft for public comment in summer 2023 and to conclude its work on the model act by the end of 2023.

Agency Comments

We provided a draft of this report to the Department of Health and Human Services and DOL. Both agencies provided technical comments, which we incorporated as appropriate.

As agreed with your offices, unless you publicly announce the contents of this report earlier, we plan no further distribution until 30 days from the report date. At that time, we will send copies to the Secretaries of Health and Human Services and Labor, and other interested parties. In addition, the report will be available at no charge on the GAO website at <https://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or DickenJ@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix II.



John E. Dicken
Director, Health Care

Appendix I: Ownership and Operations of Health Care Sharing Ministries Reviewed

The ownership and operating structure of health care sharing ministries (HCSM) are unique in key ways. Regulators have raised concerns about the business practices of certain HCSMs. An HCSM trade organization has taken steps to develop standards to help curb inappropriate practices.

Ownership

Four of the HCSMs we reviewed were 501(c)(3) nonprofit organizations.¹ Officials from the fifth HCSM we reviewed told us they had applied for but not yet received that designation from the Internal Revenue Service as of May 2023. As nonprofit organizations, these entities are not owned by individuals or groups but are run by a board of directors. Four of the five HCSMs we reviewed had conflict of interest policies in place regarding who may serve on the board or what activities a board member with a conflict of interest may participate in. For example, one conflict of interest policy for an HCSM we reviewed stated that any person in a position of influence who has a financial interest in an entity (such as a bill processing company) that the HCSM is pursuing a transaction with may not vote on whether the transaction goes forward.

Operations

Types of Cost-sharing. The HCSM memberships we reviewed differed in how they facilitated medical cost sharing among their members, specifically using either direct sharing or centralized sharing. (see fig. 2)

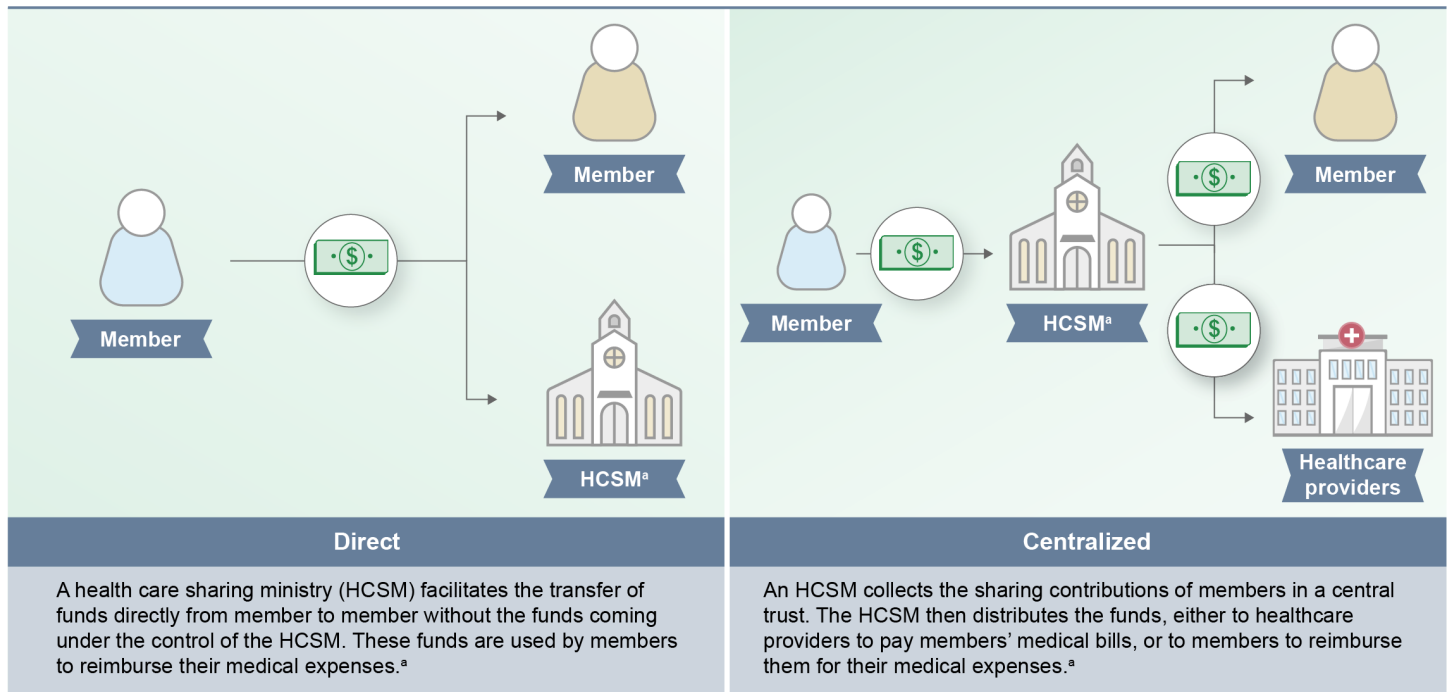
- **Direct sharing.** Officials from two of the five HCSM memberships we reviewed told us their HCSM facilitated payments directly from member to member. Officials from one of the HCSMs we reviewed that used this method told us that members either write a check or send funds electronically to other members, but that they leave it up to their members to determine how to provide the money to the other member. The other HCSM set up individual bank accounts for each member family, then instructs the bank to transfer funds from one account to another. To cover administrative expenses, one HCSM required members to send one month's contributions per year directly to the HCSM, while the other HCSM assessed a monthly administrative fee. Because contributions are facilitated from member to member, neither of the HCSMs that used this method paid medical

¹To be tax-exempt under section 501(c)(3) of the Internal Revenue Code, an organization must be organized and operated exclusively for exempt purposes set forth in section 501(c)(3), and none of its earnings may inure to any private shareholder or individual. According to the Internal Revenue Service, these organizations are commonly referred to as charitable organizations.

providers directly. Rather, members are told to act as self-pay clients for medical services.

- Centralized sharing.** Officials from the other three HCSM memberships we examined told us their HCSMs collected all member contributions before distributing funds to issue either reimbursements to members or payments to providers. For example, officials from one HCSM told us that they gather member contributions into an independently audited central trust fund.² These HCSMs typically take a portion of the contributions to cover administrative expenses. For example, officials from one HCSM told us that contributions are divided into dedicated sharing accounts and administrative accounts. The same HCSM's sharing guidelines stated that up to 40 percent of membership contributions may be used for administrative costs.

Figure 2. Health Care Sharing Ministries' Medical Cost Sharing Processes



Source: GAO analysis of HCSM documentation and literature (data); GAO (icons). | GAO-23-106034

^aHCSMs may take a portion of member contributions for administrative expenses.

²Officials from this HCSM told us that they choose to operate this way because they believe it promotes transparency to the HCSM's members about the spending of members' contributions.

Process for establishing monthly contributions. Officials from four of the five HCSM memberships we reviewed told us the monthly contribution amounts requested of HCSM members are set by the board of directors or other senior staff. Officials from the fifth HCSM told us that proposed increases in the monthly contribution amount are voted on by the membership of the HCSM after being proposed by the board. Officials from three of the five HCSMs we reviewed said that they do not currently use actuaries to set monthly contributions levels but rather will wait until it becomes apparent that the current contributions are not enough to meet the medical needs being shared before moving to raise the contribution amount. If there are insufficient funds to meet all shared needs, four of the five HCSMs we reviewed will prorate the amount each member receives for their shared needs until funds become available or the monthly contribution amount is raised.

Dispute Process. Four of the five of the HCSM memberships we reviewed had established dispute resolution processes in the case of a dispute between a member and the HCSM over the sharing eligibility of a medical need. For example, documentation we reviewed from one HCSM stated that they randomly choose a panel of seven to 13 members to help adjudicate the dispute. Another HCSM's documentation stated that they also used a member panel to resolve disputes, but only if the dispute is not resolved after two levels of internal review done by claims nurses employed by the HCSM. This HCSM also allows for mediation and legally binding arbitration if the member disagrees with the decision of the member panel.³

Efforts to Develop Accreditation Standards

Regulators have raised concerns about the business practices of some HCSMs, which has contributed to efforts to develop accreditation standards for HCSMs.⁴ Officials from an HCSM told us that in the wake of the increased public scrutiny of HCSMs after lawsuits surrounding a particular HCSM, there have been efforts to standardize HCSM business

³Additionally, the guidelines of four of the five HCSMs we reviewed state that members must agree to not sue either the HCSM or other members over any disputes.

⁴ For example, in March 2021, Liberty HealthShare entered into a settlement agreement with the Ohio Attorney General after an investigation led the Attorney General to believe that Liberty executives may have violated state law regarding the conduct of charitable organizations. Liberty denied any wrongdoing. Under the settlement, Liberty agreed to pay a civil fine, remove certain individuals from leadership positions, and refrain from contracting with certain third party vendors. Those vendors entered into a separate settlement agreement with the Ohio Attorney General in December 2021.

practices by developing an HCSM accreditation process.⁵ Specifically, an HCSM trade group told us they helped to create an independent organization dedicated to accredit HCSMs called the Health Care Sharing Accreditation Board. The board was established in 2020 and, as of May 2023, had accredited two HCSMs. The board's website states that it was created to "verify that HCSMs meet high standards of quality and ethical business practices." A consultant for the board provided GAO with a summarized list of the standards that it uses to assess the HCSMs seeking accreditation. The standards include requirements to undergo an annual external audit and make the results available to the public upon request, to have an independent board of directors, and to communicate clearly to members that there is no assumption of risk or promise to pay medical costs.

However, a policy research group and an official from one HCSM told us that there may be limitations associated with the accreditation process of the Health Care Sharing Accreditation Board, and the HCSM described an alternate accreditation process. For example, the policy research group said that because the HCSMs seeking accreditation were involved with establishing the accreditation board and its standards, the process may not be sufficiently independent. The policy research group also told us that, for this reason, the accreditation process may not ensure accountability and transparency of HCSMs. An HCSM official added that there was a lack of transparency around the accreditation process because the standards were not made publicly available. This official told us that the HCSM they represent recently received a different accreditation called a "Faith-Based Sharing Review." This accreditation was issued by an independent, third-party entity that has no affiliation with HCSMs and evaluates the financial stability of insurance companies as its core business. The standards for this accreditation have been made publicly available.

⁵Aliera, a for-profit corporation, founded Sharity Ministries (formerly Trinity Healthshare), a nonprofit corporation that purported to be a HCSM. Numerous lawsuits have alleged that Aliera sold unauthorized health plans and insurance through Sharity, which entered bankruptcy in 2021.

Appendix II: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Kristi Peterson (Assistant Director), Helen Sauer Young (Analyst-in-Charge), Thomas Friend, and Anna Lindholm made key contributions to this report. Also contributing were Laurie Pachter and Emily Wilson Schwark.

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