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BACKGROUNDER

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Five Steps Policymakers Can Take to Permit the Sale and Renewal of Affordable Alternatives to Obamacare Policies

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Abstract

Policymakers should provide consumers more freedom to choose the insurance coverage that is best for their families. A useful first step: rescinding an Obama Administration–imposed federal rule that improperly limits the sale and renewal of short-term limited-duration (STLD) health insurance policies. While this will afford consumers some relief, Congress should go further by supporting Trump Administration efforts to provide access to more affordable insurance by replacing Obamacare with a solution that returns resources and flexibility to the states. Taken together, these steps provide policymakers concrete options that would do much to help consumers find affordable alternatives to Obamacare policies.

The Trump Administration has proposed to remove federal restrictions on the sale of short-term, limited duration (STLD) health insurance policies, products that offer broader choices of providers and lower premiums for people in good health than Obamacare policies.[1] Current federal rules, which took effect just weeks before President Barack Obama left office, impose severe limits on STLDs. Those rules restrict STLD coverage to 90 days and prohibit their renewal—even if consumers want to keep their policies *and* insurers are willing to extend them.[2] President Trump, Health and Human Services (HHS) Secretary Alex Azar, and Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma all have expressed support for rescinding that rule and clarifying that consumers can renew STLD policies.

This paper describes STLDs and discusses why many consumers see them as an attractive alternative to Obamacare coverage. It also recommends that the Trump Administration rescind Obama-era

Key Points

- Short-term limited-duration insurance plans provide many consumers with the choice of a policy they can afford—offering a lifeboat enabling them to escape Obamacare's sinking ship.
- An Obama Administration rule inappropriately prevents access to these plans by taking their regulation away from the states and subjecting them to impermissible federal oversight.
- The Trump Administration should finalize its proposed rule to repeal the Obama Administration rule and replace it with the previous rule that stood for 20 years.
- Congress should support the Trump Administration's proposal to repeal and replace Obamacare by providing resources and restoring more regulatory flexibility to the states.
- Taken together, these steps provide policymakers concrete options that would do much to help consumers find affordable alternatives to Obamacare policies.

This paper, in its entirety, can be found at **http://report.heritage.org/bg3310**

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restrictions on STLDs. Those restrictions are inconsistent with federal statute. The Trump Administration also should be clear that such policies can be renewed. Additionally, Congress should support efforts to provide affordable alternatives to Obamacare policies by returning to efforts to replace Obamacare with a solution that returns resources and regulatory authority to the states.

What Are Short-Term Limited-Duration Policies?

Federal law defines STLDs not by what they are, but by what they are not: "individual health insurance coverage." This definition is crucial because that statutory definition has the effect of excluding STLD policies from all federal insurance regulations—including those added by Obamacare that apply only to "individual health insurance coverage."[3]

Federal statute unambiguously excludes STLD policies from the definition of "individual health insurance coverage" and, consequently, exempts them from federal regulation. To wit:

> The term individual health insurance coverage means health insurance coverage offered to individuals in the individual market, *but does not include short-term limited duration insurance*.[4]

In 1996 Congress created a safe harbor from federal regulation for STLDs but did not define them. That task was left to HHS, which defined STLDs as coverage that lasts "for less than 12 months."[5] That duration includes any extensions that a policyholder elects without the issuer's consent.[6]

That definition remained unchanged for 20 years. Just before President Obama left office in January 2017, his Administration implemented a new, more stringent definition of STLDs, improperly imposing federal requirements designed to restrict their sale and prohibit their renewal. The Trump Administration has proposed to reinstate the earlier definition and is seeking public comment on whether the policies can be extended or renewed.[7]

Are STLDs Unregulated?

No. Although Congress exempted STLDs from federal regulation, these plans remain subject to state regulation. Nothing in the Trump Administration's proposed rule would change the authority of states to regulate STLD plans.

States, unlike the federal government, have extensive experience regulating insurance products—including STLDs. The federal government preserved this authority when it passed the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA subjected "individual health insurance coverage" to federal regulation but exempted STLDs from this definition. That exemption, which has continued unamended, ensures that states are the regulators of these plans.

States play a crucial role in regulating STLDs and ensuring they do not create further instability in individual markets. Laws pertaining to the regulation of STLDs vary greatly by state. Six states have gone so far as to prohibit their sale, according to the Urban Institute, citing an unpublished Georgetown University study.[8] Two additional states would limit STLD policy expansion, even if the Trump Administration were to adopt a less aggressive federal regulatory approach than did its predecessor.

1. *Federal Register*, Vol. 83, No. 35 (February 21, 2018), pp. 7437–7447.
2. *Federal Register*, Vol. 81, No. 210 (October 31, 2016), pp. 75316–75327. The rule took effect on December 30, 2016.
3. 42 U.S. Code 300gg–91(b)(1). Congress created this definition in 1996 in § 102 of the Health Insurance Portability and Accountability Act (HIPAA), Public Law 104–191.
4. 42 U.S. Code 300gg–91(b)(5) (emphasis added).
5. CMS created the "less than 12 months" standard in an interim final rule issued in April 1997. See *Federal Register*, Vol. 62, No. 67 (April 8, 1997), pp. 16894–16976. It issued a slightly revised definition in the final rule, published in December 2004. See *Federal Register*, Vol. 69, No. 250 (December 30, 2004), pp. 78719–78799. It was codified at 45 Code of Federal Regulations § 144.103 (2010).
6. A consumer might, for example, purchase a 90-day policy that the issuer would allow to be renewed automatically. The consumer could exercise this option three times (coverage for 360 days), but not a fourth, since that would extend the length of the policy beyond 12 months.
7. *Federal Register*, Vol. 83, No. 35.
8. Linda J. Blumberg, Matthew Buettgens, and Robin Wang, "The Potential Impact of Short-Term Limited Duration Policies on Insurance Coverage, Premiums and Federal Spending," Urban Institute, February 2018, p. 5, https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf (accessed April 23, 2018). The six states that prohibit STLD expansion are Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington. The two that would limit STLD expansion are Michigan and Nevada.

If finalized, the Trump Administration's rule would return to the original definition in place since 1997 and reserve regulatory authority over STLDs to states. States would remain free to bar the sale of STLDs altogether, to limit the duration and renewability of the coverage, to apply state health insurance mandates to the coverage, or to increase oversight of marketing and product forms and rate filings.[9]

Why Do Some Consumers Prefer STLDs?

While Obamacare has resulted in coverage increases among low-income households and those with chronic illness, its regulations have made coverage too expensive for many Americans who once could afford it. ACA-compliant plans have been priced out of the reach of many individuals who do not have employer-based coverage and do not qualify for federal subsidies. Many of these individuals are having to choose between paying for a policy that costs as much as their mortgage and exposing themselves to the financial risks of being uninsured.

Average premiums in the individual market more than doubled between 2013 and 2017 and, in some states, *tripled*.[10] As a result of rapid increases in premiums and the consolidation of the non-group market, the number of people with individual health coverage began to shrink in 2016.[11] ACA-compliant plans are far too costly for many consumers, leading them to flee the non-group market; at the end of 2015, there were 17.6 million individuals in the non-group market. By the end of 2017, the market had thinned by 14 percent, with only 15.2 million individuals remaining.[12]

Currently, more than half the counties nationwide and eight states have only one insurer offering coverage on the exchange.[13] This equates to roughly 26 percent of exchange enrollees effectively having no choice among insurers in their market.[14] Many Americans trapped in the broken Obamacare market continue to find that these plans do not provide the coverage they need at a price they can afford.

While STLD plans are not ACA-compliant, individuals who have left the individual market self-report that they prefer and are happy with short-term coverage plans. According to a survey by eHealth, only 5 percent of respondents said they were unhappy with the coverage provided; nearly seven in 10 (69 percent) said they were satisfied with the coverage offered by their short-term plans.[15]

Short-term plans offer an affordable alternative to Obamacare plans for millions of Americans facing skyrocketing health care costs and very limited coverage options. As short-term plans do not have to comply with federal health insurance regulations (i.e., guaranteed issue, guaranteed renewability, bans on pre-existing condition exclusions, and required essential health benefits coverage), they are far more affordable than the plans offered on the Obamacare exchange. The eHealth survey found that 76 percent of respondents reported "the affordability of their short-term plans was one of the things they liked most about their coverage."[16]

Ease of Enrollment. The ease of enrollment for short-term plans also appeals to consumers. Enrollment in ACA-compliant plans is generally limited to the

9. Christina Lechner Goe, "Non-ACA-Compliant Plans and the Risk of Market Segmentation: Consideration for State Insurance Regulators," National Association of Insurance Commissioners, March 2018, http://healthyfuturega.org/wp-content/uploads/2018/03/Non-ACA-Compliant-Plans-and-the-Risk-of-Market-Segmentation.pdf (accessed April 23, 2018).
10. U.S. Department of Health and Human Services, "HHS Report: Average Premiums More Than Doubled Since 2013," May 23, 2017, https://www.hhs.gov/about/news/2017/05/23/hhs-report-average-health-insurance-premiums-doubled-2013.html (accessed April 23, 2018). The report notes that premiums tripled in Alabama, Alaska, and Oklahoma.
11. Edmund F. Haislmaier and Drew Gonshorowski, "2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed," Heritage Foundation *Issue Brief* No. 4743, July 26, 2017, https://www.heritage.org/health-care-reform/report/2016-health-insurance-enrollment-private-coverage-declined-medicaid.
12. Figures based on data reported in state insurer regulatory filings and compiled by the National Association of Insurance Commissioners. Accessed through the Mark Farrah Associates subscription data service at http://www.markfarrah.com (accessed April 23, 2018).
13. Edmund F. Haislmaier, "2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink," Heritage Foundation *Issue Brief* No. 4813, January 25, 2018, Table 1, http://report.heritage.org/ib4813.
14. Ashley Semanskee et al., "Insurer Participation on ACA Marketplaces, 2014–2018," The Kaiser Family Foundation, November 10, 2017, https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/ (accessed April 23, 2018).
15. "5 Reasons Americans Are Crazy for Short-Term Insurance," eHealth, June 3, 2015, https://resources.ehealthinsurance.com/affordable-care-act/5-reasons-americans-crazy-short-term-insurance (accessed April 23, 2018).
16. Ibid.

annual open season. Enrollment outside that defined enrollment period is only available to those who experience a major life event. Unless you get married or divorced, move to a new area or lose your health coverage outside the open enrollment period, you could go without insurance until the next open enrollment period begins.[17] Unlike Obamacare plans, short-term plans are not bound by an enrollment period, and individuals can purchase plans in accordance with their needs.

Preference for Short-Term Coverage Benefits. For individuals in need of coverage for a transient time period, short-term plans provide an appropriate coverage option. Survey results from eHealth show that 47 percent of respondents reported they purchased a short-term plan because they only needed temporary coverage before they acquired health benefits through their employer or other means.[18]

Further, some people, especially the young and healthy, do not need or want comprehensive benefit plans. Instead, these individuals prefer catastrophic coverage for unexpected health care costs. When eHealth asked individuals what they liked most about their short-term plan, 32 percent responded that short-term coverage offered "the benefits they value most in a health insurance plan." The study noted that while short-term plans often do not provide the extensive benefits that federal and state laws require in traditional individual-market plans, they do offer the necessary coverage to safeguard them in the event of unforeseen medical expenses. Such short-term coverage is perfectly suitable for many individuals in the market who cannot afford and do not need comprehensive coverage.

Why Did the Obama Administration Change the STLD Rules?

Alerted by an April 2016 *Wall Street Journal* article that some consumers found STLDs to be an affordable alternative to Obamacare policies, the Obama Administration sprang into action.[19] In June 2016, it proposed a stringent set of rules to restrict the sale of these policies—rules that are without basis in federal law.[20]

The *Journal* piece noted that sales of the policies had increased since Obamacare's implementation, in part because of lower premiums and in part because, unlike many Obamacare plans, STLDs offer "broad access to doctors." A spokesman for one insurer who sells the plans said that his company was "aiming to make it easier to renew the policies."

Citing the article, federal regulators expressed concern that "in some instances individuals are purchasing this coverage as their primary form of health coverage."[21] They further noted that "some issuers are providing renewals of the coverage that extend the duration beyond 12 months."[22] They accomplished this by "automatically renewing [STLD] policies or having a simplified reapplication process."[23]

Such extensions and renewals are completely consistent with the regulatory definition of STLDs that had been in place at that point for nearly two decades. While the term of each insurance contract was less than 12 months, federal rules did not prohibit insurers from establishing expedited procedures or selling riders that allowed consumers to purchase STLDs once their old ones expired. Indeed, federal regulators could not lawfully impose limitations on such practices, since the statute exempts STLDs from the definition of "individual health insurance coverage."

The preamble to the Obama Administration rule also cited concerns that STLDs "may not provide meaningful health coverage" because the statute exempts them from a federal regulatory regime without which, in the judgment of the Obama Administration, insurance is meaningless.[24] Moreover, they worried that "healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for ACA-compliant coverage."[25] Issuers

17. 45 Code of Federal Regulations § 155.420(d) (2013).
18. "5 Reasons Americans Are Crazy for Short-Term Insurance."
19. Anna Wilde Mathews, "Sales of Short-Term Health Policies Surge," *Wall Street Journal*, April 10, 2016, https://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539 (accessed April 23, 2018).
20. *Federal Register*, Vol. 81, No. 112 (June 10, 2016), p. 38020.
21. Ibid., p. 38032. The reference to the *Wall Street Journal* article is in footnote 34.
22. Ibid.
23. Ibid.
24. Ibid.
25. Ibid.

of STLDs could thus compete with issuers of Obamacare policies by offering consumers a broader choice of doctors at an affordable price.

The Obama Administration was transparent in its intention to quash this competition. Although the statute exempts STLDs from federal regulation, the agency attempted to use its authority to define them as a pretext to regulate them. Specifically, it proposed to limit duration of the coverage to 90 days and to prevent extensions "*with or without* the issuer's consent."[26] The rule changed the definition, it said, "to address the issue of short-term limited duration insurance being sold as a type of primary coverage" by limiting their duration and prohibiting their renewal.[27]

The CMS rule failed to note two important things. First, STLDs are exempt from federal "market reforms" because Congress exempted them from those "reforms." Congress reserved authority to regulate STLDs to the states, as discussed above. That includes any contracts, riders, or expedited procedures that facilitate renewal of these policies. The CMS cannot use its legal authority to define STLDs to usurp the states' authority to regulate them.

Second, while Obamacare's system of mandates and subsidies has created government-abetted monopolies and duopolies in most individual health insurance markets, the CMS lacks legal authority to protect these anti-competitive arrangements by regulating the sale of plans that Congress has forbidden them to regulate.[28]

What Has the Trump Administration Proposed on STLDs?

The Trump Administration moved in February to provide more affordable health coverage options to millions of Americans through a proposed rule that would limit the federal government's regulatory authority over short-term limited-duration plans. The rule, proposed in February 2018 pursuant to the President's Executive Order discussed below, would reinstate the STLD regulations that were in effect for 20 years.[29]

Specifically, the rule would define STLDs as coverage that lasts for less than 12 months, including any extensions elected by the policyholder without the issuer's consent. The rule thus repeals the 90-day limitation established under the existing regulation and the stipulation that this period may not be extended "with or without the issuer's consent."

If You Like Your STLD, Can You Keep It?

In proposing to reinstate the pre-2017 definition of STLDs, the Trump Administration is seeking public comment on whether these plans can be renewed, something the Obama-era regulation improperly prohibits.

The President and senior HHS officials clearly favor letting consumers who like their policies keep them. The President signaled his intentions in an executive order directing the Secretaries of Labor, Treasury, and HHS to "consider allowing such insurance [to] be renewed by the consumer."[30] More recently, HHS Secretary Alex Azar has stated, "We'd like to see the ability to give people the option of renewability in whatever form we can have it."[31]

CMS Administrator Seema Verma expressed a similar sentiment in a March 2018 letter to Idaho Governor Butch Otter (R).[32] Idaho is seeking to permit the sale of "state-based health benefit plans" that would not be subject to federal regulation. In her letter, Verma suggested that these plans were, in fact, subject

26. Ibid., p. 38033 (emphasis added).
27. Ibid., p. 38032.
28. Seventeen states and the District of Columbia have only two insurers selling through their exchanges. Edmund Haislmaier, "2018 Obamacare Health Insurance Exchanges: Competition and Choice Continue to Shrink," Heritage Foundation *Issue Brief* No. 4813, January 25, 2018, https://www.heritage.org/health-care-reform/report/2018-obamacare-health-insurance-exchanges-competition-and-choice-continue.
29. *Federal Register*, Vol. 83, No. 35. p. 7437.
30. Donald J. Trump, "Promoting Healthcare Choice and Competition Across the United States," Executive Order No. 13813, October 12, 2017, https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/ (accessed April 23, 2018).
31. Joyce Frieden, "HHS Chief Wants to Lighten Data Collection Burdens," Medpage Today, March 8, 2018, https://www.medpagetoday.com/publichealthpolicy/healthpolicy/71646 (accessed April 23, 2018).
32. Seema Verma, CMS Administrator, letter to Governor Butch Otter (R-ID) and Dean L. Cameron (Idaho insurance commissioner), March 8, 2018, https://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Otter.pdf (accessed April 23, 2018).

to federal regulation. She closed the letter by calling on the Governor to consider modifying the proposal.[33]

> We believe that, with certain modifications, these state-based plans could be legally offered under the [Public Health Service Act] exception for *short-term limited duration plans*. I encourage you to continue to engage in a dialogue with my staff regarding this and other potential options.[34]

Consistent with this policy preference, the preamble to the Trump Administration proposed rule sought public comment on "whether any processes for expedited or streamlined reapplication for [STLD] insurance that would simplify the reapplication process and minimize the burden on consumers may be appropriate."[35]

The Obama-era rule that the CMS proposes to repeal, as we have seen, improperly prohibits such practices. It does so in an attempt to regulate products that Congress has exempted from federal regulation. Such regulation is impermissible; the CMS has no statutory authority to regulate STLDs, much less ban state-approved processes that provide for their extension or renewal. The CMS cannot use its authority to define STLDs as an artifice to restrict their sale or renewal.

The Trump Administration should make clear in its final rule that, to the extent consistent with state regulation, insurers should be able to offer consumers the option to renew their STLD policies.

How Will Renewable STLDs Affect the Individual Health Insurance Market?

Some supporters and many opponents of the Trump Administration's rule suggest that it would have a large effect on individual markets. The idea is that many healthy people with ACA-compliant coverage would drop their policies and buy STLDs instead. Because these policies—unlike Obamacare policies—are medically underwritten, people in reasonably good health can expect to pay relatively low premiums that reflect their relatively low medical risk. In its February 2018 proposed rule, the CMS notes that the average unsubsidized monthly premium for ACA-compliant coverage in 2016 was $393, compared with an average of $124 for an STLD policy.[36]

In the unlikely event these lower premiums precipitated an exodus of younger, healthier people from Obamacare policies to STLDs, premiums for ACA-compliant policies would be higher than if the federal government retains the current restrictions on STLDs.

There is a good deal of evidence, however, that young and healthy people who are ineligible for premium subsidies have not purchased ACA-compliant policies in any great number. During the 2016 open enrollment period, 2.15 million adults ages 26–34 selected a plan on the health insurance exchanges.[37] That represents only about one-third of the 6.24 million adults in that age group who were uninsured in 2016.[38] To the extent that the Trump Administration rule will affect behavior among young adults,

33. Although the letter has been portrayed as closing the door to Idaho's proposal, Verma clearly left the door open, inviting Otter to recast the non-ACA-compliant policies as STLDs.
34. Verma, letter to Governor Otter (emphasis added).
35. *Federal Register*, Vol. 83, No. 35, p. 7440.
36. *Federal Register*, Vol. 83, No. 35, p. 7442. These figures are not directly comparable, since insurers must issue ACA-compliant products at that price to all applicants. Because STLDs are medically underwritten, issuers can charge applicants higher premiums based on their medical conditions or deny them policies outright.
37. "Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report," ASPE *Issue Brief*, March 11, 2016, Table A1, p. 24, https://aspe.hhs.gov/pdf-report/health-insurance-marketplaces-2016-open-enrollment-period-final-enrollment-report (accessed April 23, 2018). The number of "plan selections" substantially overstates the number of people who were actually covered by exchange-based insurance. Many who select a plan or who are re-enrolled by their insurer fail to pay their premiums—and thus either never effectuate their coverage or forfeit it during the course of the year. The CMS reported that 12.2 million individuals had "selected plans" during the 2017 open season; by June 30, only 10.1 million actually had health insurance coverage, a decline of 2.1 million. See "First Half of 2017 Average Effectuated Enrollment Report," CMS, December 13, 2017, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-12-13-2.html (accessed April 23, 2018).The same pattern prevailed in prior years. HHS reported that 12.7 million people selected a plan during the 2016 open enrollment period. But average monthly effectuated enrollment during 2016 was just over 10 million. See "2017 Effectuated Enrollment Snapshot," CMS, June 12, 2017, p. 8, https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf (accessed April 23, 2018).
38. U.S. Census Bureau, "Health Insurance in the United States: 2016—Tables," Table 2, https://www.census.gov/data/tables/2017/demo/health-insurance/p60-260.html (accessed April 23, 2018).

STLDs seem far more likely to attract uninsured young adults than those who already have ACA-compliant policies.

The CMS has repeatedly noted that relatively few people are enrolled in STLDs. In its October 2016 final rule, which inappropriately restricted access to STLDs, it estimated that 148,000 people had STLDs in December 2015, compared with 108,800 in December 2013.[39] While that is a large percentage increase, it represents less than 1 percent of the 17.7 million people with individual coverage in December 2015.[40]

The CMS also noted that "a large majority of [STLD] insurance plans are sold as transitional coverage...and typically provide coverage for less than three months."[41] It stated that "only a small fraction of consumers...purchase such policies for longer periods."[42] As a result, the CMS concluded that its regulation "will have no effect on the majority of consumers who purchase [STLD] coverage and issuers of those policies."[43]

Similarly, the CMS estimates that its February 2018 proposal to rescind the Obama Administration's restrictions on STLDs would have only a marginal effect on enrollment in ACA-compliant policies. The CMS estimates that 100,000–200,000 people would shift from Obamacare individual policies to STLDs if the rule became final.[44] Thus, the Administration does not foresee an exodus of young and healthy people from ACA-compliant policies resulting from its proposal.

These estimates are firmly rooted in data drawn from insurance company regulatory filings. Table 1 below aggregates those data.

Table 1 shows the number of STLD policies sold from 2006–2017 and the number of people who were covered under those policies. Since more than one person can be covered by the same policy (e.g., a husband and wife), the number of covered lives always is greater than the number of policies.

TABLE 1

National Association of Insurance Commissioners Data on STLD Plans

Year	Covered Lives	Policies Sold
2006	93,944	71,922
2007	75,098	56,530
2008	93,572	75,182
2009	98,289	81,488
2010	108,435	86,903
2011	78,881	56,822
2012	72,855	55,093
2013	108,771	80,399
2014	144,350	111,983
2015	148,118	119,675
2016	160,638	134,424
2017	122,415	97,150

SOURCE: Data compiled by Mark Farrah Associates, http://www.markfarrah.com (accessed April 23, 2018).

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The data confirm the CMS's assessment that STLDs were always a relatively small segment of the individual market. At their peak in 2016, 160,638 people had such policies. STLD coverage thus represented 0.9 percent of the individual market.[45] In 2017, when the Obama Administration rule took effect, that figure fell to 0.8 percent.

39. *Federal Register*, Vol. 81, No. 210, p. 75322. The preamble erred in saying that 80,400 *people* were enrolled in December 2013. That actually refers to the number of *policies* in force in that month. Table 1 below provides more complete data on number of STLD policies and enrollees by year.
40. Haislmaier and Gonshorowski, "2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed."
41. *Federal Register*, Vol. 81, No. 210, p. 75322.
42. Ibid.
43. Ibid. That is, of course, an odd statement for the CMS to make. Elsewhere in the preamble, as we have noted, the CMS suggests that consumer purchase and renewal of these policies threatened the government-abetted ACA monopolies and duopolies. Here it announces that its regulatory overreach would have little effect.
44. *Federal Register*, Vol. 83, No. 35, p. 7443.
45. Figures based on data reported in state insurer regulatory filings and compiled by the National Association of Insurance Commissioners. Accessed through the Mark Farrah Associates subscription data service, *supra*, note 12.

Though enrollment in STLDs never was large, it did double between 2012 and 2014—the year Obamacare was fully implemented—and rose steadily through 2016. In 2017, when the rule limiting their duration to 90 days took effect, the number enrolled in STLDs fell, but not below pre-Obamacare levels.

The data show that under either federal definition of STLDs (pre– or post–Obama Administration rulemaking), they have comprised a relatively inconsequential share of the individual market. This provides at least historical evidence that reinstating the pre-existing federal definition would not greatly disrupt the individual market. The CMS estimate that the rule would result in 100,000–200,000 enrollees in ACA-compliant plans migrating to STLDs seems, if anything, on the high end of the range of possibilities. Adding 200,000 STLD enrollees in 2019 would take enrollment to a level more than double its 2016 peak.

Nevertheless, some believe that restoring the earlier federal definition would have a profound effect on individual health insurance markets. A February 2018 study by the Urban Institute, for example, estimated that the rule would result in around 4.3 million people enrolling in STLDs, 2.1 million of whom would switch from ACA-compliant policies.[46] That would indeed be a tectonic shift. The 4.3 million estimate is nearly 27 times as large as the STLD market at its 2016 peak.

The shift of 2.1 million from individual Obamacare policies to STLDs would be especially consequential, since medically underwritten policies are most attractive to healthy young adults. The total number of people ages 18–34 who selected an exchange-based policy during the most recent open season was 3.1 million.[47] If past trends are any indication, that figure greatly overstates the number of young adults who will pay their premiums and therefore actually *have* exchange-based coverage. Moreover, as we have seen, eight states either prohibit the sale of STLDs or have regulations in place that would prevent their expansion, further reducing the number of young adults who might abandon exchange-based coverage in favor of STLDs.

Finally, the study's estimate of the behavioral effects of the STLD rule is *in addition to* the effects of the individual-mandate repeal. That policy change, according to the study, would reduce the number of people with individual coverage in 2019 by 5.5 million.[48] That represents people who, according to the Urban Institute model, will refuse to buy ACA-compliant policies in 2019 because they would no longer be subject to tax penalties for remaining uninsured.

Those 5.5 million people, who would be disproportionately young and healthy, far exceed the total number of young adults who selected exchange-based coverage during the most recent open enrollment period. It is difficult to see how an *additional* 2.1 million largely young and healthy people would abandon ACA-compliant coverage for STLDs.

It is certainly possible that the Urban Institute's assessment of the coverage effects of the STLD rule is correct—but the estimate appears to lie on the frontiers of plausibility.

46. Blumberg, Buettgens and Wang, "The Potential Impact of Short-Term Limited Duration Policies on Insurance Coverage, Premiums and Federal Spending." The study estimates that an additional 0.4 million people would shift from Medicaid and employer-sponsored coverage to STLDs. The Urban Institute's baseline estimate appears to be greatly inflated. It suggests that if the individual mandate and existing STLD rules were in effect in 2019, 19.5 million people would have "minimum essential coverage" in the individual market in 2019. That number strains credulity. The individual market has been shrinking since 2016, a trend that accelerated in 2017. In December 2015, 17.7 million people had individual coverage; by December 2017, that number had fallen to 15.2 million. Enrollment has consequently fallen below the December 2014 level, when 16.5 million people had individual coverage. (See note 12, *supra*.) The CMS's March 2018 report on the most recent open season suggests that the market has not rebounded. The report estimates the number of people who had either selected a plan or been automatically enrolled by their insurer in exchange-based coverage. This is an inflated count, since a substantial number of these people are unlikely to pay their premiums and therefore will not have insurance coverage. These numbers, however, showed a steady decline in enrollment over the previous two years. According to the report, only 11.8 million people selected a plan, fewer than both 2017 (12.2 million) and 2016 (12.7 million). Enrollment in exchange-based coverage appears to have fallen to 2015 levels, even before accounting for the difference between "plan selections" and actual insurance coverage. "Health Insurance Exchanges 2018 Open Enrollment: Final Report," CMS, April 3, 2018, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html (accessed April 23, 2018). Given these numbers, it seems unlikely that enrollment in ACA-compliant coverage would reach 19.5 million in 2019 under any circumstances.

47. Ibid., Table 2. Some additional individuals in this age group purchased ACA-compliant policies sold off the exchange. The CMS does not provide an estimate of how many people enrolled in off-exchange Obamacare policies.

48. Buettgens and Wang, Table 1, p. 7.

The study also assessed the impact of the proposed rule on the uninsured. It estimates that 1.7 million people who would have been uninsured would *gain coverage* through STLDs if the Trump Administration finalized its rule.[49]

The two studies thus present an estimate of the decline in ACA-compliant individual coverage that ranges from 0.1 million to 2.1 million people. If the Urban Institute is correct, the effect on ACA-compliant coverage would be seismic, resulting in substantially fewer covered lives, higher premiums, and—since the federal government will pay most or all of these premium increases on behalf of subsidized enrollees—higher federal spending.

If the estimate that 1.7 million who would otherwise be uninsured will purchase STLD policies is correct, then providing consumers with an affordable alternative to ACA-compliant coverage would benefit a substantial number of people.

This is a critical policy consideration. Speculation about the behavioral effects of permitting the sale and renewability of STLDs may or may not bear out. What is inarguable is that these plans provide many consumers with the choice of a policy they can afford, a lifeboat enabling them to escape Obamacare's sinking ship. The Trump Administration should not sink the lifeboats.

Recommendations

STLDs offer millions of consumers an affordable health insurance option. The Obama Administration improperly limited their availability and renewability. The Trump Administration should expeditiously reverse this rule and clarify that STLDs can be renewed. More specifically, policymakers should take the following steps:

1. **The Administration should finalize its proposed rule to repeal the Obama Administration rule and replace it with the previous rule that stood for 20 years.** The existing rules restricting the duration of STLDs and prohibiting their renewal have no legal basis. The statute does not permit the federal government to impose regulations on STLDs, much less to prohibit guaranteed renewability riders, expedited renewal processes, or other mechanisms permissible under state law. The federal government erred in assuming it had that authority—and it should correct that error.

2. **The Administration, in its final rule, should clarify that federal law does not prohibit renewal of these policies.** The Obama Administration rule improperly imposed federal restrictions on renewing STLD policies. The Trump Administration requested public comment on whether the federal government should continue to prohibit expedited and streamlined reapplication processes or otherwise place burdens and limitations on consumers who want to renew or extend their STLD coverage. The Administration should make clear in its final rule that these restrictions do not apply, since Congress has placed STLDs beyond the reach of federal regulators.

3. **The Administration should finalize the STLD regulations expeditiously to allow insurers to begin marketing and consumers to start buying them.** The proposed rule does nothing more than to reinstate a definition that applied from 1996 until the Obama Administration's improper rule took effect in January 2017. This change is neither groundbreaking nor radical. While the agency needs time to review and respond to public comments, it should not unnecessarily delay finalizing the regulation. It should complete this process well in advance of the 2019 open enrollment period to permit insurers, consumers, and state regulators ample time to adjust to these changes.

4. **State regulators should permit the sale and renewal of these products.** As mentioned above, six states have rules in place that prohibit STLD policy expansions, and two others would significantly impede such expansions. These "consumer protection" rules "protect" consumers from buying products they want at a price they are willing

49. Ibid., p. 6.

50. Paige Winfield Cunningham, "Why Republicans Don't Talk About Repealing Obamacare Anymore," *Washington Post*, April 16, 2018, https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/04/16/the-health-202-why-republicans-don-t-talk-about-repealing-obamacare-anymore/5ad1012430fb046acf7bcc56/?utm_term=.30e8b8d029bf (accessed April 23, 2018).

to pay. The Urban Institute study estimates that 1.7 million people who would otherwise be uninsured in 2019 will instead have coverage under STLDs. None of these 1.7 million people live in the six states that prohibit their sale. Those states and the two others that restrict STLD expansion should remove these restrictions.

5. **Congress should repeal Obamacare and replace it with a solution that returns resources and regulatory authority to the states.** Obamacare continues to inflict high premiums, limited choice of doctors, and burdensome cost-sharing requirements on millions of people. Taxpayers are forced to finance higher and higher subsidies for a diminishing number of subsidy-eligible enrollees.

Resolving these problems will require more than making STLDs more broadly available. Conservative health care analysts have proposed that Congress scuttle Obamacare's Washington-centric regulatory regime in favor of a state-based approach to health care reform. Each state would take the lead in regulating its markets and designing programs that make coverage affordable to the poor and sick—without pricing healthy people out of the market.

Some states already are trying to move in that direction—even in the face of Obamacare's stultifying federal regulatory regime that hampers innovative state efforts to alleviate its adverse effects. Idaho and Iowa, as mentioned above, are among those seeking to permit the sale of policies that do not square with Obamacare's unnecessarily stringent rules. Legislation that provided federal formula grants to states, rather than federal entitlement payments to insurance companies, would empower these states and embolden others to reform their markets and establish consumer-centered programs.

Discouragement over last year's repeal effort seems to have convinced many in Congress to give up on health care reform.[50] But the window of opportunity has not yet closed. Repeal-and-replace legislation would not face some of the obstacles that doomed repeal efforts in 2017.

Congress has defanged perhaps the most ferocious enemy of health care reform by repealing the individual mandate. The Congressional Budget Office (CBO) has long believed that this tax on the uninsured induced millions of people who really do not want health insurance to buy it anyway. With that tax now gone, the CBO's dire predictions of 20 million or 25 million people "losing" coverage—which, for the most part, consisted of people the CBO believes would drop their policies once the government dropped the penalties—will be far less dire. A plausible case can be made that, fortified with federal resources and granted more flexibility, states could maintain or even increase the number of people with coverage by allowing insurers to sell policies consumers want at a price they are willing to pay.

Yuval Levin and Ramesh Ponnuru of the *National Review* succinctly summarized the case for Congress to advance state-based health care reform:

> This decentralizing and deregulatory approach to health policy offers a substantively and politically attractive path for Republicans. But whether it turns out to be more attractive than falling back into the role of pure critics of Democratic health reforms remains to be seen. The future of market-based health economics in America, and perhaps the political prospects of a recognizably conservative Republican party, may well depend on the answer.[51]

Conclusion

Rescinding a federal rule that improperly limits the sale and renewal of STLDs is a useful step toward providing consumers more freedom to choose the insurance coverage that is best for their families. Congress could go further by enacting legislation clarifying that STLDs are renewable. Such a step would prevent a future administration from restricting this choice. Senator John Barrasso (R–WY) has introduced a bill defining STLDs and clarifying that consumers can renew them.[52] The bill would prevent federal regulators from limiting access to STLDs.

Congress also should support Administration efforts to provide access to more affordable insurance by replacing Obamacare with a solution that

51. Yuval Levin and Ramesh Ponnuru, "A New Health Care Debate," *National Review*, March 29, 2018, https://www.nationalreview.com/magazine/2018/04/16/a-new-health-care-debate/ (accessed April 23, 2018).
52. S. 2507, Improving Choices in Health Care Coverage Act, 115th Cong., 2nd Sess.

returns resources and flexibility to the states.[53] Taken together, these steps provide policymakers concrete options that would do much to help consumers find affordable alternatives to Obamacare policies.

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53. The President's FY 2019 Budget called for the enactment of "legislation modeled closely after" the Graham–Cassidy bill, which proposed a state-centric approach to health care reform. The White House, Office of Management and Budget, *Budget of the United States Government, Fiscal Year 2019*, pp. 52 *et seq.*, https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf (accessed April 23, 2018).