CATO
POLICY
ANALYSIS

March 14, 2024 Number 970

Biden Short-Term Health Plans Rule Creates Gaps in Coverage

Rule Would Deny Care after Patients Fall Ill

By Michael F. Cannon

EXECUTIVE SUMMARY

Congress exempts "short-term limited duration insurance" (STLDI) from the Affordable Care Act (ACA or Obamacare) and all other federal health insurance regulations. As a result, STLDI provides affordable, comprehensive coverage to millions who are ineligible for other options or find them unaffordable. Consumers who miss Obamacare's enrollment periods can buy STLDI plans that cover them until the next enrollment period. Alternatively, they can renew their STLDI plans.

In 2023, the Biden administration proposed to require both that insurers terminate all STLDI plans after four months and that insurers not offer renewals. The proposal would cause STLDI enrollees who fall ill to lose their coverage within four months, leaving them uninsured for up to 12 months. Estimates suggest it would cause 500,000 people to lose comprehensive health insurance. A similar requirement stripped health insurance from 61-year-old Jeanne Balvin between hospitalizations for diverticulitis, leaving her with $97,000 in medical bills.

In *King v. Burwell*, the Supreme Court held, "Congress passed the Affordable Care Act to improve health insurance markets." This proposal conflicts with that goal. The Biden administration admits it would expose patients to "an increased risk of higher out-of-pocket expenses and medical debt, reduced access to health care, and potentially worse health outcomes."

Federal regulators lack statutory authority to implement this proposal. They should abandon it and reaffirm their current interpretation of the statute, including their finding that current STLDI rules can improve Obamacare's performance. Furthermore, Congress should codify current STLDI rules, and states should exempt STLDI from all health insurance regulations.

MICHAEL F. CANNON is the Cato Institute's director of health policy studies.

INTRODUCTION

Since 1996, Congress has exempted "short-term limited duration insurance" (STLDI) from all federal health insurance regulations. As a result, STLDI provides affordable, comprehensive coverage to millions who are ineligible for other options or find them unaffordable. This flexibility enables STLDI to provide coverage to individuals in situations that policymakers could not foresee.

For all but two of the subsequent 28 years, Congresses and presidents of both parties allowed STLDI plans to last 12 months and allowed enrollees to renew their STLDI plans. Beginning in 2016, federal regulators required insurers to cancel all STLDI plans three months after purchase. Regulators rescinded that requirement after two years.

> "The Departments acknowledge that their proposal would expose STLDI enrollees to 'an increased risk of higher out-of-pocket expenses and medical debt, reduced access to health care, and potentially worse health outcomes.'"

On July 12, 2023, the Departments of Health and Human Services, Labor, and Treasury (the Departments) issued a Notice of Proposed Rulemaking (NPRM) that effectively proposes to reinstate that requirement. The Departments proposed to limit the maximum length of new STLDI plans to four months, prohibit renewals, and prohibit enrollees from purchasing consecutive plans from the same insurer.[1]

The Departments claim their objective is to protect patients with preexisting conditions and to protect consumers from low-quality coverage. Yet the rule they have proposed would do the exact opposite. Longer contract periods and renewals increase health plan quality by increasing enrollees' ability to pool their medical expenses with others and by enabling continuous coverage. By prohibiting these features, the Departments would be requiring STLDI issuers to offer *lower*-quality coverage.

The Departments are fully aware that they are pursuing high-quality coverage by mandating low-quality coverage. They *acknowledge* that their proposal would take coverage away from sick patients, could increase overall the number of uninsured, and would therefore expose STLDI enrollees to "an increased risk of higher out-of-pocket expenses and medical debt, reduced access to health care, and potentially worse health outcomes."[2] They acknowledge that their proposal is so dangerous it requires a warning label.

The fact that the Departments nevertheless issued this proposal indicates their goal is not to protect *patients* but to protect *Obamacare*, even at the cost of harming patients. Their objection to STLDI is not that it is low-quality but that it is of sufficiently high quality that millions of consumers are choosing it as a reasonable alternative to Obamacare. STLDI is too good, so the Departments are trying to make it bad. It is too comprehensive, so the Departments want to make it less comprehensive. The NPRM reveals the Departments' actual purpose is to boost Obamacare enrollment by punishing consumers who make what the Departments—*not* Congress—believe to be the "wrong" choice.

The Departments have announced their intention to take final action on this NPRM—to implement it in its current form, implement it with alterations, or scuttle it—by April 2024.[3]

A DESPERATE NEED FOR HEALTH INSURANCE CHOICE

Consumers desperately need the options STLDI provides. Government intervention has priced medical care and health insurance out of reach for millions, reduced choice, and reduced the quality of health insurance and medical care.[4] The federal tax code and state income tax codes implicitly penalize workers unless they enroll in employer-sponsored health insurance. Those penalties also make employer plans more expensive.[5] In 2023, as total worker compensation rose by 4 percent, the average premium for employer-sponsored family coverage rose by 7 percent to $24,000—roughly one-quarter of median family income.[6]

Twenty-eight percent of workers either do not receive an offer of employer-sponsored health insurance or are otherwise ineligible for it. They must purchase coverage with after-tax dollars (the implicit penalty).[7] The average benchmark Obamacare premium (i.e., one of the lower-cost plans) for a 40-year-old individual in 2024 is $5,724, a still-high 13 percent of median nonfamily income.[8] Average

benchmark premiums range from $4,020 in New Hampshire (9 percent) to $11,400 in Vermont (25 percent).[9] For 2024, half of insurers who participate in Patient Protection and Affordable Care Act (ACA or Obamacare) Exchanges submitted premium increases of 6 percent or more; a quarter submitted increases of 10 percent or more; one in ten submitted increases of 16 percent or more (Figure 1).[10]

Obamacare's premium subsidies shield many, though not all, enrollees from at least a portion of those premiums. Those subsidies have cost taxpayers more than government officials projected. In 2021, the average cost of covering a previously uninsured person through Obamacare's Exchanges was three times the initial projections ($20,739 versus $6,850).[11] Obamacare premiums were so expensive that in some cases Congress offered "enhanced" taxpayer subsidies of $12,000 to families earning up to $212,000 a year.[12]

Government intervention reduces health insurance choice. The federal tax code penalizes workers who do not enroll in a health plan their employer chooses.[13] Obamacare reduces choice by narrowing both the variety of health insurance plans and the number of insurers in the market. Since Congress enacted Obamacare, the median number of issuers per state has fallen by two-thirds (Figure 2).[14]

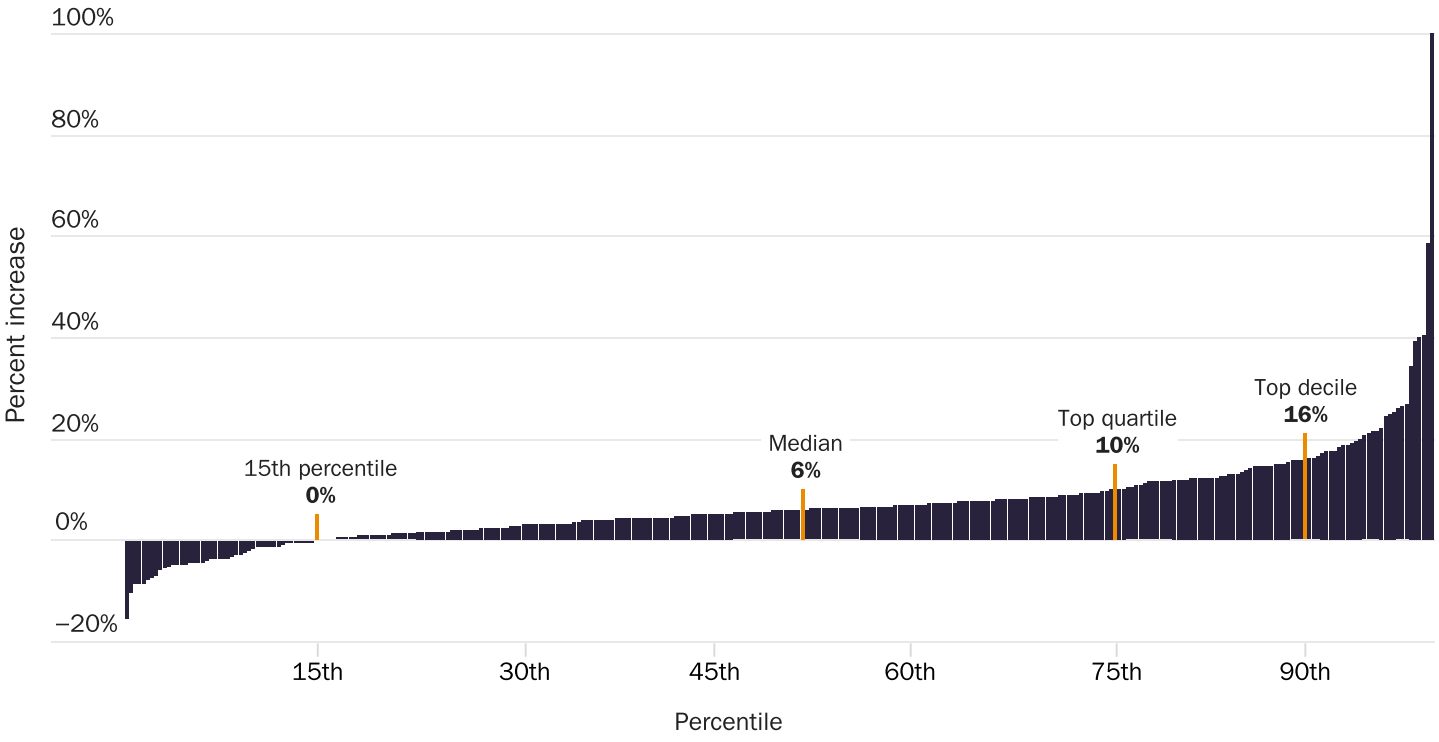
Furthermore, government intervention reduces health insurance quality. Those implicit tax penalties force workers into health insurance that is low in quality because it ends when their job does.[15] Biden economic adviser Michael Geruso has found that Obamacare's supposedly quality-enhancing preexisting-conditions provisions encourage "backdoor discrimination" that erodes coverage for the sick.[16] This unintended consequence of those provisions has proven so harmful, notes Geruso, that under Obamacare even "healthy consumers cannot be adequately insured."[17]

The fact that Congress exempts STLDI from those and other regulations allows STLDI to offer a broader choice of plans, provider networks, enrollment dates, and contract lengths than Obamacare, at premiums that are often 60 percent lower. It frees consumers to choose coverage that is either less or *more* comprehensive than Obamacare. It allows STLDI to reduce the number of uninsured consumers and the burden of uncompensated care. It allows STLDI to provide a benchmark to measure the negative impact

Figure 1

Obamacare plans continue to grow less affordable

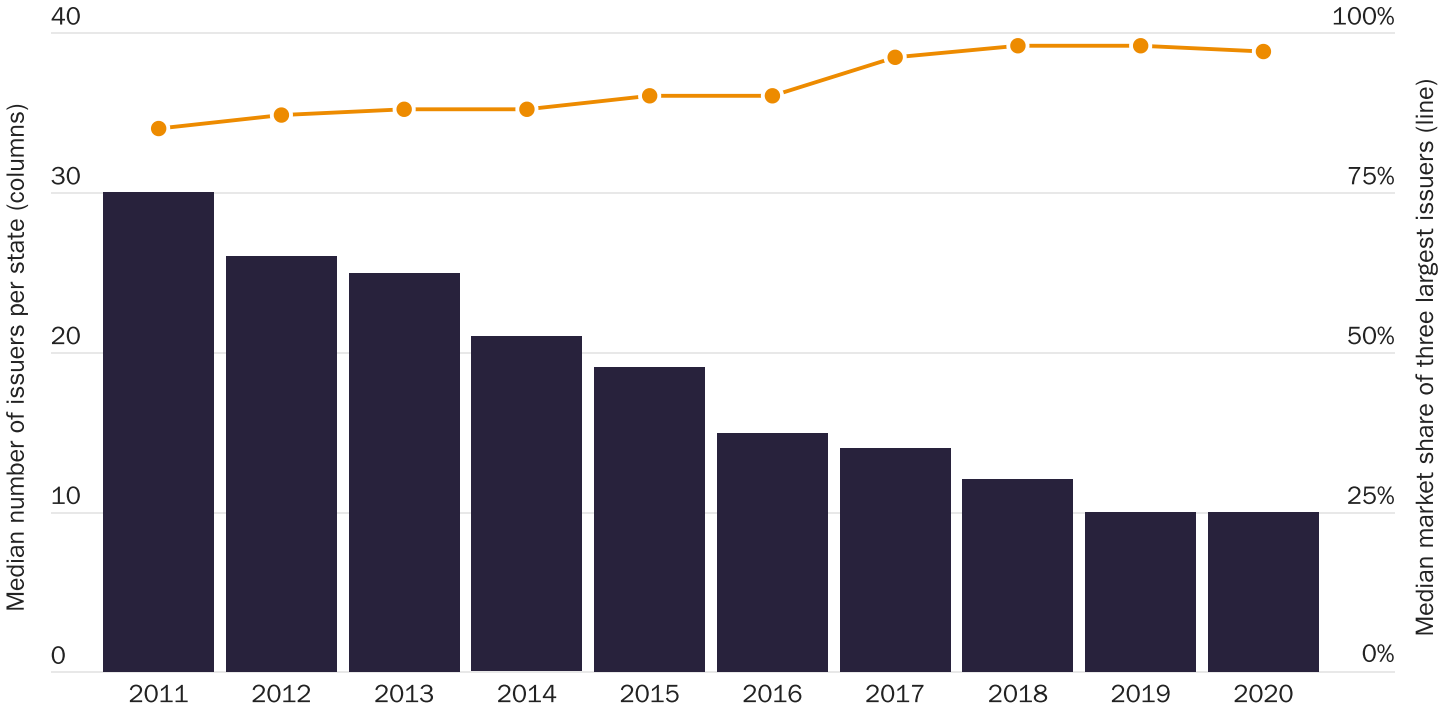
Distribution of premium-increase requests Obamacare issuers submitted to regulators for 2024



Source: "Rate Review," HealthCare.gov.

Figure 2

Individual health insurance market: competition falling and concentration increasing



Source: John E. Dicken et al., "Private Health Insurance: Markets Remained Concentrated through 2020, with Increases in the Individual and Small Group Markets," Government Accountability Office, November 2022.

of government regulation on premiums and quality in Obamacare plans. It makes STLDI the only coverage available to millions during Obamacare's closed-enrollment periods. Congress allows STLDI issuers to sell "renewal guarantees" that provide still-greater protection.

JEANNE BALVIN

The story of Arizona resident Jeanne Balvin illustrates how government intervention increases health insurance premiums and reduces health insurance quality.

Consumer Reports explains that in 2017, the lowest-cost Obamacare plan that 61-year-old Balvin could find had an unaffordable monthly premium of $744 (i.e., $8,928 per year) and a $6,000 deductible. Balvin instead enrolled in a STLDI plan from UnitedHealthcare with a monthly premium of $274 and a $2,500 deductible.[18]

When Balvin required emergency surgery and hospitalization for diverticulitis, UnitedHealthcare paid its share of the bill promptly and in full. After that hospitalization—but before two more hospitalizations for the same condition—federal regulators required UnitedHealthcare to cancel Balvin's plan. Balvin lost her coverage and was ineligible to enroll in an Obamacare plan for six months. Requiring her insurer to cancel her plan after just three months left Balvin with $97,000 in medical bills.[19]

Government intervention increased every price Balvin faced: the prices for the medical care she had to purchase herself, the premiums for the Obamacare plans she declined, and premiums for the STLDI plan she purchased (by increasing prices for the items those plans cover).[20] It further increased the premiums for those Obamacare plans by subjecting them to regulations from which Congress exempts STLDI plans.

Government intervention reduced the quality of Balvin's insurance. Absent regulation, Balvin and UnitedHealthcare would have been free to enter a health insurance contract that would have protected Balvin throughout her diverticulitis treatment. Instead, government regulators required UnitedHealthcare to cancel Balvin's STLDI plan after three months. Government regulation exposed Balvin to medical underwriting after she fell ill. Government turned an *insured* medical condition into an *uninsured* and *uninsurable* preexisting condition.

REGULATORS PUSH LOW-QUALITY COVERAGE

All those price-increasing, quality-reducing government interventions remain in place—except for one. In 2018, federal regulators eliminated the three-month limit for STLDI plans.

In 2023, the Departments of Health and Human Services, Labor, and the Treasury (the Departments) proposed to reinstate the heart of the 2016 rule that so dramatically reduced the quality of Balvin's health insurance. The Departments proposed to cancel all short-term plans after four months and to prohibit renewals. Like Balvin, enrollees who fall ill would (1) lose their coverage within four months, (2) be unable to renew or purchase a new short-term plan, and (3) be unable to enroll in Obamacare until the following January. As the old rule did to Balvin, this proposal would strip coverage from sick patients and leave them uninsured for up to 12 months. Estimates suggest that the Departments' plans to cancel all short-term health insurance plans and prohibit renewals would increase the number of uninsured by 500,000.[21]

The remainder of this policy analysis discusses why STLDI is an essential option for consumers, why policymakers should reject the Departments' proposal, and how policymakers should instead make health insurance more secure for sick patients.

"SHORT-TERM LIMITED DURATION INSURANCE"

Short-term plans provide affordable, comprehensive coverage to 2–3 million US residents who are ineligible for other coverage options or find those options unaffordable.[22] STLDI offers a broader choice of plans, provider networks, enrollment dates, and contract lengths than Obamacare plans. It does so at significantly lower premiums and negotiates lower prices for medical services than Obamacare plans. Consumers may enroll at any time of year. STLDI plans can last up to 36 months (i.e., they can cover enrollees until the next Obamacare enrollment period). STLDI reduces the number of uninsured and therefore reduces the amount of uncompensated care. Federal law allows insurers to sell "renewal guarantees" that make STLDI coverage even more secure. STLDI can accomplish these things because Congress and most states exempt it from Obamacare and other regulations that produce high-cost, low-quality coverage.

Comprehensive

Short-term plans offer comprehensive health insurance. The nonpartisan Congressional Budget Office (CBO) writes that, thanks to current rules, 95 percent of STLDI plans are a "comprehensive major medical policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals." In essence, STLDI plans "resemble a typical nongroup insurance plan offered before 2014, when many [Obamacare] regulations . . . took effect."[23] In that sense, current STLDI rules honor President Obama's promise to people with pre-Obamacare individual-market plans that "if you like your health plan, you can keep it" and Joe Biden's 2019 pledge, "If you have private insurance, you can keep it."[24]

> "The nonpartisan Congressional Budget Office writes that, thanks to current rules, 95 percent of STLDI plans are a 'comprehensive major medical policy.' In many ways, STLDI is more comprehensive than Obamacare."

In many ways, STLDI is *more* comprehensive than Obamacare. The CBO writes that STLDI "may exclude some benefits that [Obamacare] plans must cover [but] may have lower deductibles or wider provider networks" than Obamacare plans.[25]

For 9–10 months of the year, STLDI offers more comprehensive coverage than *all* Obamacare plans. Consumers may purchase STLDI throughout the year, and coverage can take effect as soon as one day after an enrollee applies. By contrast, federal law generally prevents consumers from enrolling in Obamacare plans for 9–10 months of the year.[26] Consumers may purchase Obamacare plans only during narrow "open" or "special"

enrollment periods. Even then, there can be a lag of up to two months before Obamacare coverage takes effect. Outside of those narrow enrollment windows and lagged start dates, Obamacare denies health insurance to *everyone*. The Departments fret that "STLDI generally is not subject to the Federal consumer protections and requirements for comprehensive coverage."[27] Yet for 9–10 months of the year, Obamacare doesn't offer insurance purchasers those protections, either. During that period, Obamacare is the farthest thing from comprehensive coverage because it offers potential enrollees no coverage at all: zero essential health benefits, an annual coverage limit of $0, and unlimited out-of-pocket exposure.[28] STLDI provides coverage where Obamacare denies coverage. It covers those Obamacare leaves behind.

> "For 9–10 months of the year, Obamacare is the farthest thing from comprehensive coverage because it offers potential enrollees no coverage at all."

Unlike Obamacare, STLDI can provide as much coverage as consumers are willing to purchase. Biden adviser Michael Geruso and colleagues found that, even if Obamacare enrollees wish to purchase more comprehensive coverage for multiple sclerosis and other conditions than Obamacare plans offer, Obamacare regulations make it impossible for insurers to provide that coverage.[29] STLDI can provide even more comprehensive and secure coverage than it does today (see below).

Affordable

The CBO finds that for many consumers, comprehensive STLDI carries premiums that are "as much as 60 percent lower than premiums for the lowest-cost bronze [Obamacare] plan."[30] Figures 3 and 4 show where the lowest-cost bronze Obamacare plan premium falls in relation to the range of available STLDI premiums. STLDI even gives consumers the choice of paying more than they would pay for the lowest-cost Obamacare bronze plan.

At least part of this affordability edge is that STLDI plans negotiate lower prices for services than Obamacare plans. One study found that STLDI plans negotiated prices 11.4 percent lower than the national average, versus 6.3 percent–9.1 percent for Obamacare plans. STLDI likewise outperformed Obamacare plans relative to local-average prices.[31]

Choice

STLDI makes health insurance affordable, and as comprehensive as consumers want it to be, by providing consumers only as much coverage as they want. While Obamacare empowers government to make tradeoffs between affordability and comprehensiveness, STLDI allows consumers to strike that balance for themselves.

The STLDI market gives consumers a wide range of options when it comes to the overall amount of coverage they purchase, as well as how much coverage they purchase for particular medical goods and services such as preventive care, mental health, substance abuse, and prescription drugs. Tables 1–4 show that STLDI plans in major cities have a wide range of annual out-of-pocket limits, including limits as low as $1,000. In most markets, STLDI plans offer up to $5 million in lifetime coverage. Premiums are broadly consistent with the CBO's findings that STLDI premiums are often 60 percent less than the lowest-cost Obamacare plans.[32]

As Figure 5 shows, the broad range of available STLDI plans allows consumers to choose whether and to what extent they will purchase coverage for such items as preventive care, mental health, substance abuse, and prescription drugs. Apparently no STLDI plans provide coverage for uncomplicated pregnancies, but many consumers consider that a feature rather than a shortcoming (see the section "The Departments Create a Problem for 'Maria'").

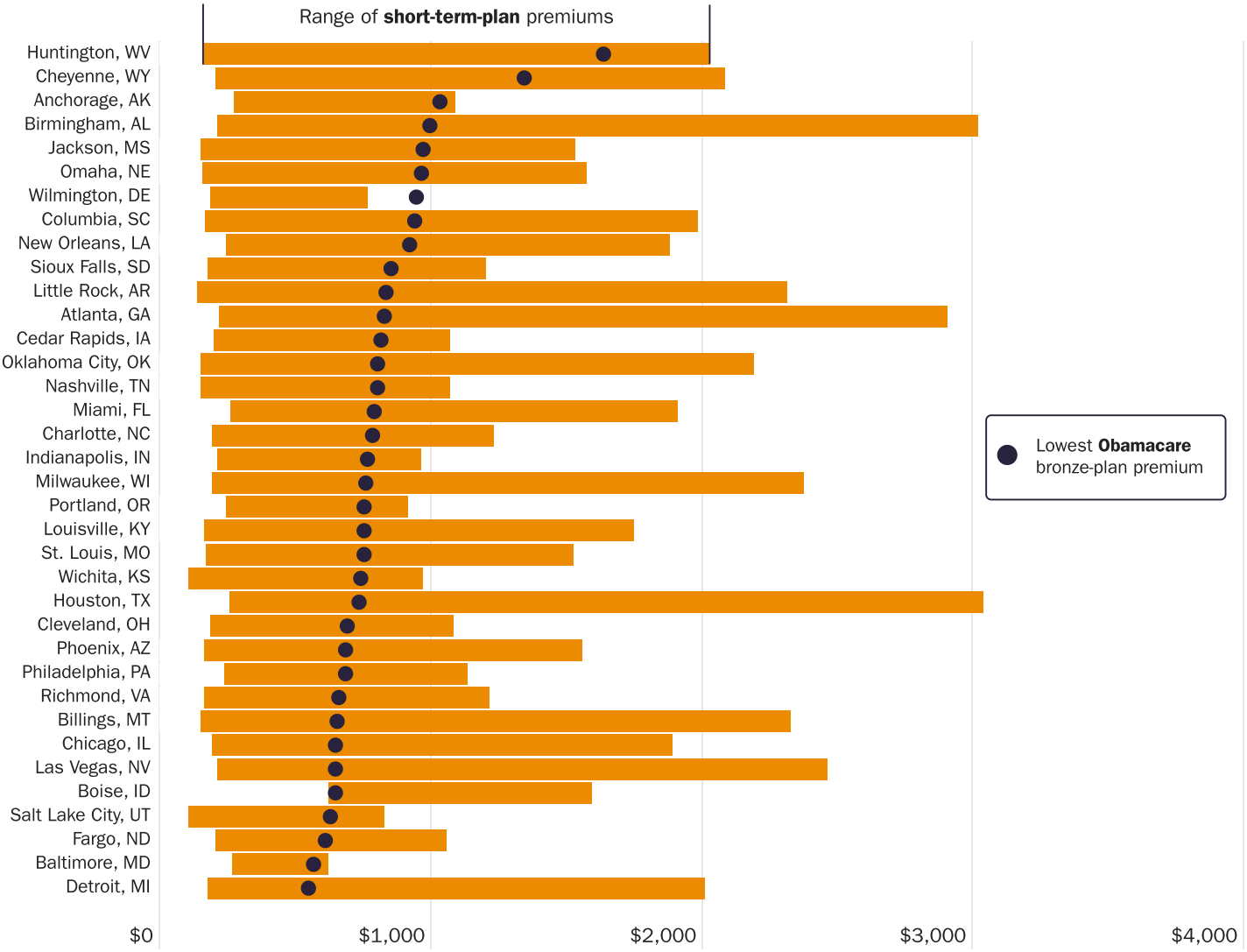
Secure Coverage

STLDI provides secure temporary health insurance to many consumers. Current federal rules allow initial contract terms of up to 12 months, which enables STLDI to cover enrollees until the next Obamacare "open" enrollment period. In 2020, the US Court of Appeals for the Washington,

Figure 3

Short-term-plan premiums are often lower than lowest Obamacare premium

Monthly premiums for a 64-year-old female, dollars



Sources: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, for Obamacare-compliant plan premiums; and eHealthInsurance and Agile Health Insurance for short-term-policy premiums and features.

DC, Circuit held, "Allowing STLDI policies to run for just under one year ensures that individuals can always purchase a policy to fit their need for temporary coverage."[33] For millions, STLDI is the only health insurance option available between Obamacare enrollment periods.

Federal law also allows STLDI to provide secure *primary* coverage, including more secure coverage than it currently provides. The DC Circuit has held that Congress "did not foreclose" the option of consumers using STLDI as their primary health insurance, that "even under the 2016 Rule, many individuals were purchasing STLDI as their primary insurance," and that "nothing in [federal law] prevents insurers from renewing expired STLDI policies."[34]

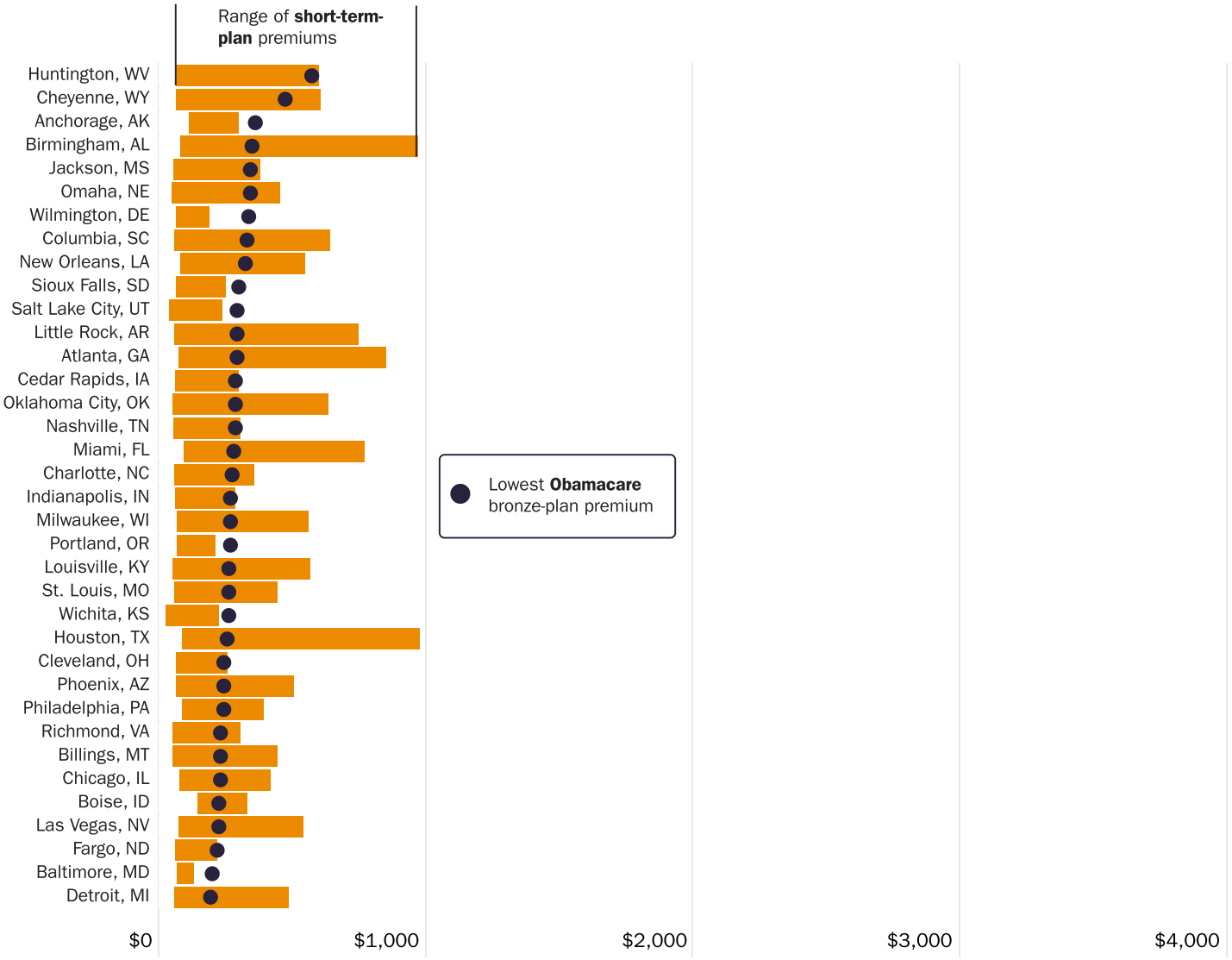
Consistent with federal statute, current STLDI rules allow enrollees to renew their initial 12-month contract for an additional 24 months, for up to a total of 36 months. The longer the contract term, the more protection health insurance provides. A 36-month term provides three times the protection of a 12-month term against losing one's coverage or having one's premiums increase due to an illness. Even in the current NPRM, which seeks to dismantle these rules, the Departments acknowledge "the current regulations . . . promote continuous enrollment in coverage."[35]

Federal rules further allow consumers to purchase the right to enroll in a new STLDI plan, without additional underwriting, after their 12- or 36-month policy expires.[36]

Figure 4

Short-term-plan premiums are often lower than lowest Obamacare premium

Monthly premiums for a 27-year-old male, dollars



Sources: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, for Obamacare-compliant plan premiums; and eHealthInsurance and Agile Health Insurance for short-term-policy premiums and features.

"Renewal guarantees" are an insurance product that protects consumers from coverage cancellations, exclusions, or higher premiums following a change in their health status. Insurers had sold renewal guarantees for decades prior to Obamacare taking effect in 2014.[37] The Departments allowed many of those renewal guarantees to continue operating after 2014.[38] Twenty-five states even approved standalone renewal guarantees for sale.[39] Figure 6 shows that, due to renewal guarantees, the pre-Obamacare individual market did a better job of providing secure health insurance—and thus reducing the problem of preexisting conditions—than employer-sponsored insurance.

Renewal guarantees would allow STLDI enrollees who fall ill to keep their plans and keep paying healthy-person premiums, indefinitely. In 2018, the Departments wrote, "The ability to purchase such instruments, which are essentially options to buy new [STLDI] policies in the future, is at present permitted under federal law, and [current rules do] nothing to forbid . . . such transactions. . . . Anyone . . . can purchase such instruments under current federal law."[40] In their latest proposal, the Departments acknowledge that many STLDI enrollees *want* to renew their plans.[41]

Despite the freedom to sell this consumer protection,

Table 1

Obamacare Exchange plans versus short-term health insurance plans in select cities, 27-year-old male

City	Monthly premium for lowest-cost bronze Exchange plan (unsubsidized)	Range of monthly premiums for short-term plans	Range of out-of-pocket cost-sharing maximums for short-term plans	Range of policy coverage caps for short-term plans
Phoenix, AZ	$238	$60.98–$353.28	$1,000–$25,000	$100,000–$5 million
Los Angeles, CA	$231	NA	NA	NA
Denver, CO	$205	NA	NA	NA
Miami, FL	$276	$91.21–$588.16	$1,000–$25,000	$100,000–$5 million
Atlanta, GA	$289	$75.54–$582.54	$1,000–$25,000	$100,000–$5 million
Chicago, IL	$226	$71.86–$293.35	$1,000–$25,000	$100,000–$5 million
St. Louis, MO	$262	$54.80–$301.67	$1,000–$25,000	$100,000–$5 million
Columbus, OH	$256	$58.68–$250.07	$1,000–$25,000	$100,000–$2 million
Houston, TX	$256	$86.57–$679.66	$1,000–$25,000	$100,000–$5 million
Virginia Beach, VA	$246	$49.17–$302.20	$1,000–$20,000	$100,000–$5 million

Sources: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, for Obamacare-compliant plan premiums; and eHealthInsurance and Agile Health Insurance for short-term-policy premiums and features.

Table 2

Obamacare Exchange plans versus short-term health insurance plans in select cities, 27-year-old female

City	Monthly premium for lowest-cost bronze Exchange plan (unsubsidized)	Range of monthly premiums for short-term plans	Range of out-of-pocket cost-sharing maximums for short-term plans	Range of policy coverage caps for short-term plans
Phoenix, AZ	$238	$62.78–$364.85	$1,000–$25,000	$100,000–$5 million
Los Angeles, CA	$231	NA	NA	NA
Denver, CO	$205	NA	NA	NA
Miami, FL	$276	$95.58–$722.53	$1,000–$25,000	$100,000–$5 million
Atlanta, GA	$289	$85.88–$602.00	$1,000–$25,000	$100,000–$5 million
Chicago, IL	$226	$74.05–$302.88	$1,000–$25,000	$100,000–$5 million
St. Louis, MO	$262	$57.25–$312.00	$1,000–$25,000	$100,000–$5 million
Columbus, OH	$256	$61.24–$266.10	$1,000–$25,000	$100,000–$2 million
Houston, TX	$256	$98.96–$702.38	$1,000–$25,000	$100,000–$5 million
Virginia Beach, VA	$246	$54.60–$308.50	$1,000–$20,000	$100,000–$5 million

Sources: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, for Obamacare-compliant plan premiums; and eHealthInsurance and Agile Health Insurance for short-term-policy premiums and features.

the demand that existed for it prior to Obamacare, and the demand that likely continues today, no insurers appear to be selling renewal guarantees in the STLDI market. It's not hard to see why. Congress heavily subsidizes Obamacare's competing approach to shielding the sick from medical underwriting—community-rating price controls. Insurers also likely foresaw the Departments' current efforts to prohibit renewals. Though the Departments have no statutory authority to prohibit renewal guarantees, STLDI issuers understandably decided not to risk investing resources in a product that regulators are nevertheless trying to prohibit.

Table 3

Obamacare Exchange plans versus short-term health insurance plans in select cities, 64-year-old male

City	Monthly premium for lowest-cost bronze Exchange plan (unsubsidized)	Range of monthly premiums for short-term plans	Range of out-of-pocket cost-sharing maximums for short-term plans	Range of policy coverage caps for short-term plans
Phoenix, AZ	$680	$183.36–$1,702.78	$1,000–$25,000	$100,000–$5 million
Los Angeles, CA	$661	NA	NA	NA
Denver, CO	$588	NA	NA	NA
Miami, FL	$789	$279.94–$1,969.20	$1,000–$25,000	$100,000–$5 million
Atlanta, GA	$828	$284.17–$3,182.58	$1,000–$25,000	$100,000–$5 million
Chicago, IL	$647	$220.36–$2,072.66	$1,000–$25,000	$100,000–$5 million
St. Louis, MO	$750	$177.47–$1,667.70	$1,000–$25,000	$100,000–$5 million
Columbus, OH	$732	$178.30–$1,220.58	$1,000–$25,000	$100,000–$2 million
Houston, TX	$732	$269.40–$3,331.20	$1,000–$25,000	$100,000–$5 million
Virginia Beach, VA	$704	$170.12–$1,374.36	$1,000–$20,000	$100,000–$5 million

Sources: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, for Obamacare-compliant plan premiums; and eHealthInsurance and Agile Health Insurance for short-term-policy premiums and features.

Table 4

Obamacare Exchange plans versus short-term health insurance plans in select cities, 64-year-old female

City	Monthly premium for lowest-cost bronze Exchange plan (unsubsidized)	Range of monthly premiums for short-term plans	Range of out-of-pocket cost-sharing maximums for short-term plans	Range of policy coverage caps for short-term plans
Phoenix, AZ	$680	$161.57–$1,281.67	$1,000–$25,000	$100,000–$5 million
Los Angeles, CA	$661	NA	NA	NA
Denver, CO	$588	NA	NA	NA
Miami, FL	$789	$260.64–$1,711.12	$1,000–$25,000	$100,000–$5 million
Atlanta, GA	$828	$214.24–$2,064.42	$1,000–$25,000	$100,000–$5 million
Chicago, IL	$647	$193.92–$1,371.94	$1,000–$25,000	$100,000–$5 million
St. Louis, MO	$750	$165.40–$1,089.34	$1,000–$25,000	$100,000–$5 million
Columbus, OH	$732	$157.15–$1,078.25	$1,000–$25,000	$100,000–$2 million
Houston, TX	$732	$251.03–$2,230.97	$1,000–$25,000	$100,000–$5 million
Virginia Beach, VA	$704	$157.20–$1,213.87	$1,000–$20,000	$100,000–$5 million

Sources: "Health Insurance Marketplace Calculator," Kaiser Family Foundation, for Obamacare-compliant plan premiums; and eHealthInsurance and Agile Health Insurance for short-term-policy premiums and features.

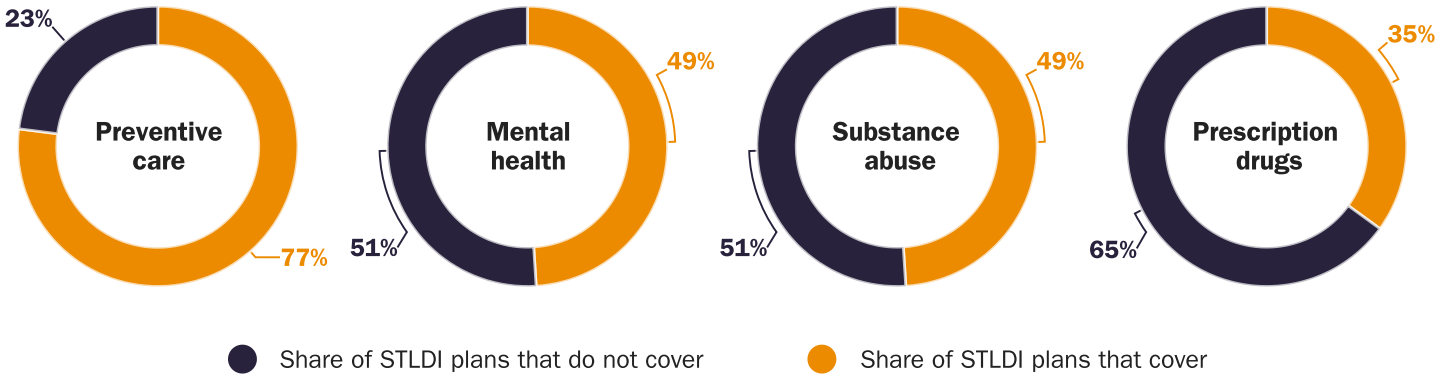
WHO BENEFITS FROM STLDI?

A majority of STLDI enrollees are women. The average age of STLDI enrollees is 34.[42] Yet STLDI can benefit consumers who want broader choice than what employers and Obamacare offer, who face high Obamacare premiums, who receive little or no assistance with those premiums (e.g., some immigrants), or who object to certain types of coverage that Obamacare requires them to purchase (e.g., religious objections to contraceptives coverage). In contrast to Obamacare, which generally bars consumers

Figure 5

Short-term plans free consumers to choose what coverage they purchase

Percentage of short-term plans that cover various types of medical expenses

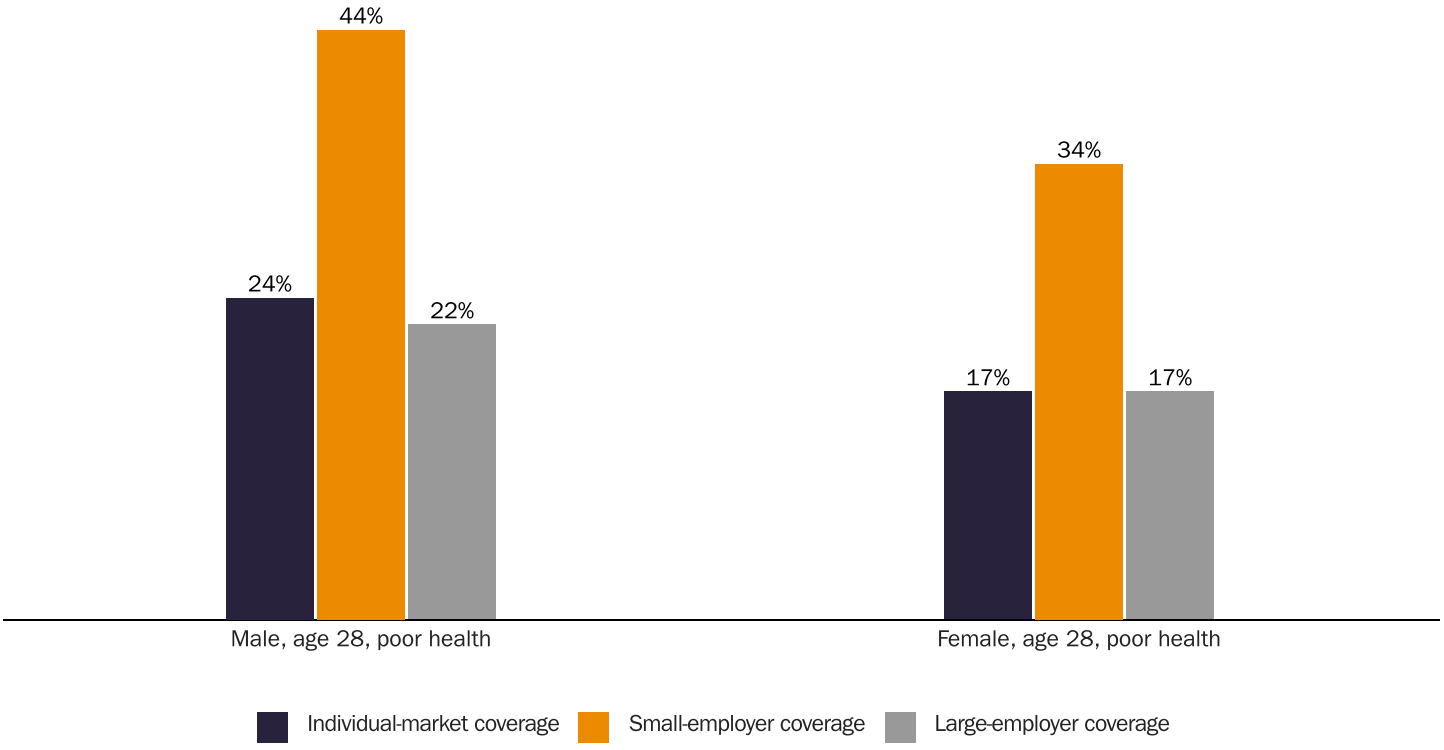


Sources: eHealthInsurance; and Agile Health Insurance.
Notes: Percentages are weighted averages across the 36 states that offer short-term health plans; STLDI = short-term limited duration insurance.

Figure 6

For enrollees in poor health, individual-market coverage is similarly or more secure than employer coverage

Probability of uninsurance after a year of continuous coverage by coverage type, 2000–2004, percent



Source: Mark V. Pauly and Robert D. Lieberthal, "How Risky Is Individual Health Insurance?," *Health Affairs* 27, no. 1 (2008).
Note: Assumes family income of $50,000 annually, expecting a 4 percent increase in income.

from purchasing coverage for 9–10 months out of each year, consumers can purchase STLDI at any time. It can thus be a lifeline to consumers who miss Obamacare's restrictive "open" or "special" enrollment periods. STLDI is especially important as a lifeline in situations that can be difficult for policymakers to foresee. Finally, STLDI with renewal guarantees can even benefit Obamacare enrollees and taxpayers.

The Departments Create a Problem for "Maria"

One example of a situation that would have been difficult for policymakers to foresee and where STLDI can be a lifeline is "Maria," a semi-fictionalized person. People like Maria can benefit from STLDI several times over.

In 2023, Maria entered a convent as a postulant (i.e., to study to become a Catholic nun). The convent does not sponsor health insurance for postulants, so Maria's only option for health insurance is to purchase it herself.

Maria's income is low enough to qualify for Medicaid—but she is an immigrant whose status makes her ineligible. If she is lawfully present in the United States, she would be eligible for a premium subsidy to purchase an Obamacare plan. But let's assume that, like many immigrants, Maria is not lawfully present. In that case, she would be ineligible for a premium subsidy. Were she to purchase an Obamacare plan, she would have to pay the entire premium herself.

Maria *is* subject to the regulations that increase Obamacare premiums. As a result, the lowest-cost bronze plan available to her carries an annual premium of $4,821. That's at least 32 percent of her income.[43] It is nearly four times the amount that the Affordable Care Act defines as affordable: 8.39 percent of household income, or at most $1,264 in Maria's case.[44]

Therefore, according to Congress, STLDI is the only affordable coverage option Maria has. She can choose from plans with annual premiums ranging from $1,100 to $5,300 and deductibles ranging from $1,000 to $10,000. Importantly for Maria, STLDI allows her to avoid coverage for maternity and contraceptives—neither of which she needs, one of which violates her religious beliefs, and each of which would threaten her ability to afford coverage.[45]

Obamacare Enrollees and Taxpayers

Obamacare enrollees and other taxpayers can benefit from STLDI even if they never enroll. One way is with renewal guarantees that turn STLDI into "renewable term health insurance"[46] that can reduce Obamacare premiums and premium subsidies.

Renewal guarantees give enrollees a contractual right to keep their health insurance, and to keep paying healthy-person premiums, after they get sick. By giving high-cost STLDI enrollees a health insurance option that is potentially more affordable than Obamacare, they would allow those patients to stay out of Obamacare risk pools and thereby reduce Obamacare premiums and premium subsidies.

> "Obamacare enrollees and other taxpayers can benefit from STLDI even if they never enroll. The Departments have written that 'renewal guarantee products . . . could reduce Exchange premiums and spending.'"

Were Congress or the Departments to offer STLDI issuers the certainty of knowing that they can have renewal guarantees well into the future, the STLDI market could give enrollees who fall ill a lower-cost insurance option than Obamacare plans. The Departments have written that "renewal guarantee products will serve to strengthen individual market pools and could reduce Exchange premiums and spending."[47]

STLDI can also benefit taxpayers by reducing the need for government subsidies for uncompensated care. When STLDI plans expand coverage to the uninsured, the problem of uncompensated care gets smaller.

WHY STLDI WORKS

All this is possible because Congress and most states exempt STLDI plans from regulations that increase premiums and reduce the quality of health insurance.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 imposed regulations on the individual health insurance market. It inserted those regulations into the Public Health Service Act (PHSA).[48] HIPAA expressly exempted "short-term limited duration insurance" from those new regulations. At that time, the Departments allowed STLDI plans to have an initial contract period of up to 12 months.[49]

In the intervening 28 years, Congress has clearly manifested its desire to preserve the STLDI exemption and

has expressed zero desire to reduce the initial contract term. Congress has repeatedly amended the PHSA to impose additional regulations on buyers and sellers of health insurance. Examples include:[50]

- The Mental Health Parity Act of 1996 (Pub. L. 104–204, September 26, 1996) mandates that certain consumers purchase coverage for certain types of mental health care.
- The Newborns' and Mothers' Health Protection Act (Pub. L. 104–204, September 26, 1996) mandates that certain consumers purchase a certain level of coverage for maternity and neonatal care.
- The Women's Health and Cancer Rights Act (Pub. L. 105–277, October 21, 1998) mandates that certain consumers purchase coverage for post-mastectomy breast reconstruction.
- The Genetic Information Nondiscrimination Act of 2008 (Pub. L. 110–233, May 21, 2008) prohibits certain types of medical underwriting.
- The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. 110–343, October 3, 2008) mandates that certain consumers purchase certain levels of mental health and drug-abuse treatment coverage.
- Michelle's Law (Pub. L. 110–381, October 9, 2008) requires workers with employer coverage to purchase coverage for certain student dependents who lose their student status.
- The Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111–3, February 4, 2009) requires employer-sponsored health plans to suspend enrollment restrictions for certain workers and dependents who lose eligibility for government programs.
- The Patient Protection and Affordable Care Act (Pub. L. 111–148, March 23, 2010) imposes a sweeping set of health insurance price controls, mandates, and other regulations.
- The No Surprises Act (Division BB of the Consolidated Appropriations Act, Pub. L. 116–260, December 27, 2020) requires certain consumers to purchase coverage that uses government-imposed rules to determine the prices the insurers pay out-of-network providers.

In every case, Congress chose both to preserve the STLDI exemption and to exempt STLDI plans from the new regulations.[51]

Congress has *never* curtailed the STLDI exemption. It has never sought to shorten STLDI contract lengths. On the contrary, Congresses and presidents of both political parties accepted the 12-month contract length. Nor has Congress ever sought to prohibit consumers from purchasing multiple consecutive STLDI plans from the same issuer.

For all but two of the 28 years since Congress created the STLDI exemption, a 12-month initial contract term has been the rule. The only exception occurred from 2016 to 2018, when the Departments required STLDI issuers to cancel all STLDI plans after just three months.

In 2016, the Obama administration shortened the maximum STLDI contract term length to three months. Even then, the US Court of Appeals for the DC Circuit held that "from 1997 to 2016, renewals were allowed with the insurer's consent."[52]

> "In 2018, the Departments clarified that federal law neither prevents consumers from purchasing consecutive STLDI plans nor prevents issuers from selling renewal guarantees that shield sick enrollees from medical underwriting."

In 2018, the Departments reversed themselves. They reestablished an initial contract term of 12 months. For the first time, they gave meaning to the statutory phrase "limited duration" by allowing issuers and consumers to extend the initial contract up to a total of 36 months. The Departments further clarified that federal law neither prevents consumers from purchasing consecutive STLDI plans ("Nothing in [federal law] . . . precludes the purchase of separate [STLDI] contracts that run consecutively, so long as each individual contract is separate and can last no longer than 36 months") nor prevents issuers from selling standalone renewal guarantees that shield sick enrollees from medical underwriting when they purchase a new STLDI plan ("The ability to purchase . . . options to buy

new [STLDI] policies in the future . . . is at present permitted under federal law, and this rule does nothing to forbid or permit such transactions").[53] The Departments wrote that federal law allows consumers to purchase "renewal guarantees" that would allow them to "maintain coverage under [STLDI] policies for extended periods of time to protect themselves against financial vulnerabilities, such as developing a costly medical condition."[54] In the current NPRM, the Departments acknowledge that after the 2018 rule change, "the number of individuals covered by STLDI sold to individuals more than doubled between 2018 and 2019 . . . and further increased . . . in 2020," an indication that STLDI makes affordable what Obamacare does not.[55]

"The US Court of Appeals for the DC Circuit found 'Congress *hoped* that most individuals would purchase ACA-compliant plans as their primary insurance. . . . But it did not foreclose other options.'"

These rules have withstood a court challenge from private insurance companies that sell Obamacare plans. Those issuers claimed the current STLDI rules harmed their revenues by providing consumers a more attractive option.[56] The insurers petitioned federal courts to reinstate the three-month limit because allowing STLDI plans to meet consumers' needs would injure Obamacare plans by causing them to lose customers.[57] Both a district court and the US Court of Appeals for the DC Circuit rejected the Obamacare insurers' arguments and upheld the current STLDI rules. The DC Circuit found the current rules "perfectly reasonable" and held that they had "only modest effects on the government Exchanges."[58] The DC Circuit rejected the argument that Congress did not intend to allow consumers to use STLDI as their primary health insurance:

> Congress expressly elected *not* to set up a Hobson's choice between purchasing ACA-compliant insurance and forgoing coverage altogether. . . . To be sure, Congress *hoped* that most individuals would purchase ACA-compliant plans as their primary insurance, and it provided incentives to encourage them to do so. . . . But it did not foreclose other options.[59]

Again, the court affirmed that "nothing in [federal law] prevents insurers from renewing expired STLDI policies."[60]

States Violate the Right to Purchase STLDI Plans

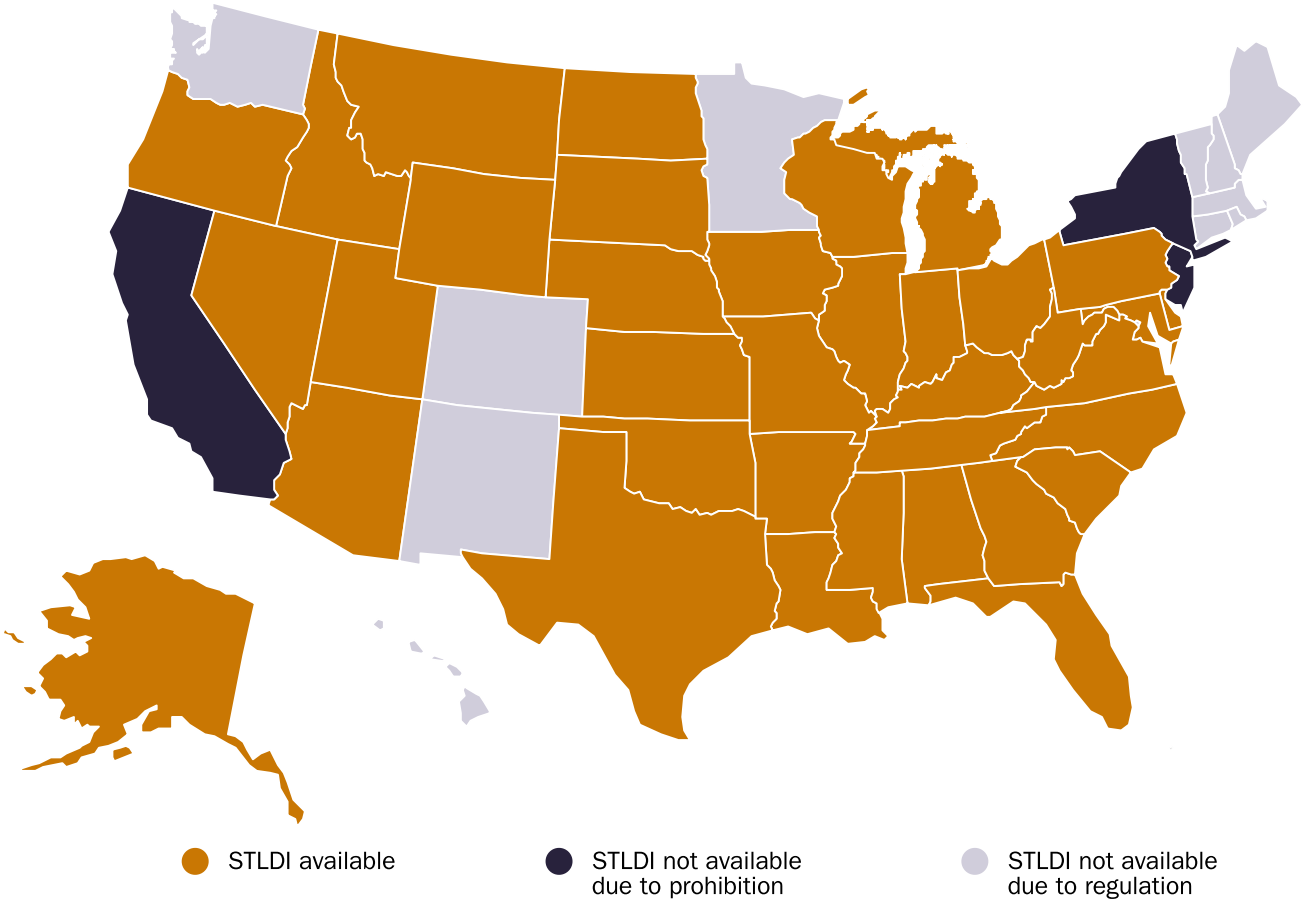
Currently, STLDI is available in only 36 states (Figure 7). While many states preserve as much freedom to purchase STLDI as federal law does, some states impose restrictions akin to what the Departments propose, and a few prohibit STLDI outright. States where STLDI is not available in 2023 (and the regulations they impose on STLDI) are as follows:[61]

- California (prohibits STLDI)
- Colorado (limits STLDI to six months, prohibits renewals)
- Connecticut (limits STLDI to six months, prohibits renewals, requires STLDI to cover all Obamacare benefits)
- District of Columbia (limits STLDI to three months, prohibits renewals)
- Hawaii (limits STLDI to three months, prohibits renewals for most consumers)
- Maine (prohibits renewals after 24 months, prohibits online/mail/phone sales)
- Minnesota (limits STLDI to six months, prohibits renewals after one year)
- New Hampshire (limits STLDI to six months, prohibits renewals, prohibits consecutive plans beyond 18 months)
- New York (prohibits STLDI)
- New Jersey (prohibits STLDI)
- Massachusetts (requires STLDI to be guaranteed-issue)
- New Mexico (limits STLDI to three months, prohibits renewals and consecutive plans)
- Rhode Island (effectively prohibits STLDI)
- Vermont (limits STLDI to three months, prohibits renewals and consecutive plans)
- Washington (limits STLDI to three months, prohibits renewals and consecutive plans)

Figure 7

Fourteen states and the District of Columbia either ban STLDI or regulate it out of existence

Short-term limited duration insurance (STLDI) availability by state



Source: "Short-Term Health Insurance Availability by State," Healthinsurance.org.
Note: Not all states where STLDI is available allow consumers full flexibility.

Three states—California, New Jersey, and New York—explicitly ban STLDI; eleven other states and the District of Columbia effectively have regulated it out of existence.[62] Those 14 states and DC account for 32 percent of the US population.[63] In some states, limits like those the Departments have proposed appear to be enough to have driven all insurers from the market.

Three- or six-month limits and prohibitions on renewals do not necessarily destroy a state's STLDI market. Ohio allows one-year plans and consecutive plans but prohibits renewals, and Michigan limits STLDI to six months and prohibits both renewals and consecutive plans. STLDI in some form is still available in both states.[64] It is nevertheless clear that such regulations have the potential to collapse this market.

Every year, in every state, some consumers will inevitably not enroll in health insurance during Obamacare's enrollment period, either because they forgot, never got around to it, or found those plans unaffordable. Laws that prohibit STLDI, regulate it out of existence, or limit STLDI terms to less than 12 months condemn those consumers to go without health insurance for up to one year. Even where time limits and prohibitions on renewals do not destroy the STLDI market, those restrictions create gaps in health insurance identical to the one into which Jeanne Balvin fell.

A Reprieve from State Regulation

Fortunately, some states allow some freedom to avoid the costly regulations they impose on STLDI enrollees. Just as Congress exempts STLDI from federal regulation, a 2019 study of 34 STLDI plans notes that "many states have exempted policies issued by out-of-state associations from

some or all [regulation], including benefit mandates and rate and form filing requirements. In those states, the association is then regulated by the state of approval, rather than the state in which the consumer purchases coverage."[65]

Out-of-state associations are a significant source of affordable coverage, largely due to regulatory exemptions. The same 2019 study found that, of 34 STLDI plans it studied, 28 were plans that insurers sell through such associations. "For instance, in Florida, Iowa, and Mississippi, a short-term plan offered by UnitedHealthOne specifies that, in most cases, coverage will be determined by the policy approved under Arkansas law," it noted.[66]

Furthermore, a 2020 House Energy and Commerce Committee Democratic staff study found that:

> UnitedHealth Group is the parent company of Golden Rule Insurance Company (Golden Rule). Golden Rule offers STLDI plans in 31 states, either through individual policies or through non-employer associations. . . .
>
> Pivot Health (Pivot) offers STLDI plans in 30 states as individual policies and through associations. Pivot offers STLDI plans underwritten by Companion Life, and the products range in duration from 90 to 364 days. . . .
>
> Everest offered STLDI plans through non-employer associations in 18 states in plan year 2018. The company sells STLDI plans through out-of-state associations in six states that do not exert jurisdiction over out-of-state association group policies. This includes Alabama, Arizona, Georgia, Ohio, Pennsylvania, and Wisconsin. In these states, Everest sells STLDI plans that are filed with and approved by Delaware and Illinois.
>
> NHIC [National Health Insurance Company] offers STLDI plans through non-employer associations in 21 states. In Arizona and Michigan, NHIC sells STLDI plans that are approved in another state.[67]

According to the study, association-based STLDI plans enrolled 2.2 million individuals in 2019, making associations a leading vehicle for accessing affordable coverage.[68]

THE DEPARTMENTS' PROPOSAL

On July 12, 2023, the Departments of Health and Human Services, Labor, and the Treasury (the Departments) proposed to limit the maximum length of new STLDI plans to four months, to prohibit renewals, and to prohibit enrollees from purchasing consecutive plans from the same insurer:

> Taking into account the potential risk to individuals who enroll in STLDI, the increased availability of affordable comprehensive coverage options, the potential impact on the individual market risk pools, and consumer challenges in differentiating STLDI from individual health insurance coverage, the Departments propose to reinterpret the phrase "short-term" to refer to a contract term of no more than 3 months. . . . [and] to reinterpret the phrase "limited-duration" to mean that the maximum permitted duration for STLDI is no longer than 4 months in total.[69]

"The Departments," they write, "are no longer of the view that permitting the longer duration for STLDI is in the best interests of consumers."[70]

"The reasons the Departments offer for these changes range from insufficient to disingenuous."

The reasons the Departments offer for these changes range from insufficient to disingenuous. Previous sections ("A Desperate Need for Health Insurance Choice" and "The Departments Create a Problem for 'Maria'") explain that the need to preserve current STLDI rules remains great because Obamacare plans remain unaffordable for millions. Other sections explain that the Departments' proposal would reduce rather than increase risk pooling by leaving half a million people without coverage ("Regulators Push Low-Quality Coverage") and would harm Obamacare's risk pools by increasing adverse selection ("Obamacare Enrollees and Taxpayers"). This section addresses the disingenuity of purporting concern for the risks STLDI enrollees face while simultaneously proposing to increase those risks. The next section addresses the Departments' justification for intentionally increasing those risks.

Increasing Risks for STLDI Enrollees

The Departments' proposal would pose serious dangers to consumers. Consider their impact on Maria. So long as she remains healthy, Maria could continue to use STLDI plans as her primary source of insurance. As she can today, she could keep purchasing a series of consecutive STLDI plans, albeit from different insurers. She would have to apply for insurance every four months and her premiums would be higher (and her plans' medical loss ratios lower) because insurers would incur greater costs from having to process applications and underwrite enrollees more frequently. Otherwise, the proposal would not affect her.

> "As they did to Jeanne Balvin, the Departments are proposing to strip health insurance from STLDI enrollees who fall ill—and *only* enrollees who fall ill—and leave them uninsured for up to 12 months."

Were Maria to fall ill, however, the proposal's effects would be catastrophic. She could not continue to use STLDI plans as her primary source of insurance. On the contrary, she would (1) lose her coverage within four months, (2) be unable to renew her plan or purchase a new STLDI plan (due to medical underwriting that she could otherwise avoid), and (3) be ineligible to enroll in Obamacare until the following January. As they did to Jeanne Balvin, the Departments are proposing to strip health insurance from STLDI enrollees who fall ill—and *only* enrollees who fall ill—and leave them uninsured for up to 12 months, with all the attendant health and financial risks.

Such is the situation most STLDI enrollees would face. But remember, our undocumented postulant, Maria, would also be ineligible for Obamacare premium subsidies. So, after facing up to 12 months with a costly illness and no insurance, she would then either have to spend *at least* 32 percent of her income on an Obamacare plan (not including cost-sharing) or face *more than* 12 months without insurance. In all likelihood, Maria would become one of the 500,000 people who would lose coverage entirely under this proposal.[71] Without health insurance, those half-million people would reduce the overall amount of risk pooling and add to the cost of uncompensated care.

Maria could prevent that from happening by purchasing STLDI under current rules—if the Departments would just let her.

Eliminating Consumer Protections

The Departments' proposal would make legal health insurance products worse by requiring them to provide *less* protection to consumers. A 36-month health insurance contract term provides nine times as much protection as a 4-month term. (One would expect the Departments to mandate the former, not the latter.) Similarly, renewal guarantees make access to health care more secure by protecting the sick from canceled coverage and large out-of-pocket expenses. Rather than promote renewal guarantees as a way of protecting the sick, which Congress has done (see below), the Departments are mandating that insurers *cancel* coverage for the sick and expose them to large out-of-pocket expenses.

Putting Consumers in Harm's Way

The Departments are fully aware that they are proposing to expose consumers to greater risk and of the severity of those risks. They are fully aware, as they write in the current NPRM, that "the current regulations . . . promote continuous enrollment in coverage."[72]

The Departments and other regulators foresaw the impact that limiting STLDI plans to less than one year would have on consumers. In 2016, when the Departments were considering limiting STLDI contract terms to three months, the National Association of Insurance Commissioners, an association of state insurance regulators, warned that limiting STLDI terms to less than one year would leave many enrollees sick and uninsured:

> Short term, limited duration insurance has long been defined as a policy of less than 12 months both by the states and the federal government. The proposed rule provides no data to support the premise that a three-month limit would protect consumers or markets.

> In fact, state regulators believe the arbitrary limit proposed in the rule could harm some consumers. For example, if an individual misses the open enrollment period and applies for short-term, limited duration coverage in February, a 3-month policy would not provide coverage until the next policy year (which will start on January 1). The only option would be to buy another short-term policy at the end of the three months, but since the short-term health plans nearly always exclude pre-existing conditions, if the person develops a new condition while covered under the first policy, the condition would be denied as a preexisting condition under the next short-term policy. In other words, only the healthy consumers would have coverage options available to them; unhealthy consumers would not.
>
> This is why we do not believe this proposal will actually solve the problem it is intended to address. If the concern is that healthy individuals will stay out of the general pool by buying short-term, limited duration coverage there is nothing in this proposal that would stop that. If consumers are healthy they can continue buying a new policy every three months. Only those who become unhealthy will be unable to afford care, and that is not good for the risk pools in the long run.[73]

In 2020, the DC Circuit noted that canceling STLDI plans after just a few months would lead consumers "to be denied a new policy based on preexisting medical conditions."[74] The Departments are aware that Jeanne Balvin was one of the victims of the 2016 rule.[75]

The Departments explicitly acknowledge these risks. They write that if consumers are "unable to renew STLDI at the end of the coverage period," that "increas[es] the risk of periods during which they are uninsured."[76] They write, "Those individuals who become uninsured could face an increased risk of higher out-of-pocket expenses and medical debt, reduced access to health care, and potentially worse health outcomes."[77] All in a day's work for federal regulators.

The Departments gingerly acknowledge that their proposal "could also lead to an increase in the number of individuals without some form of health insurance coverage."[78] The Departments neither estimate how many people would lose coverage as a result of the proposal, nor cite the CBO's readily available and authoritative estimate of 500,000 additional uninsured. Removing those people from health insurance pools ipso facto reduces risk pooling.

The Departments believe (correctly) that the risks to which they seek to expose STLDI enrollees are so severe that they merit a warning label. The NPRM proposes to require all STLDI marketing and plan materials to carry a "Notice to Consumers." That warning label states, in part:

> When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.[79]

The Departments are essentially warning STLDI enrollees that they may end up like Jeanne Balvin. (The proposed warning label does not inform consumers that the Departments themselves are unnecessarily exposing STLDI enrollees to those completely avoidable risks.)

"If a regulation degrades the quality of the underlying product to the point where it requires a warning label in 14-point type, its authors really should not be regulating anything."

From one perspective, it is refreshingly honest for the authors of a regulation that would throw sick and vulnerable consumers out of their health insurance plans to give those consumers advance warning. From another perspective, if a regulation would eliminate consumer protections and degrade the quality of the underlying product to the point where it requires a warning label in 14-point type, its authors really should not be regulating anything.

Yet the Departments go further still. The NPRM even contemplates stripping coverage from the sick *without* warning. "The Departments seek comments," they write, "on whether all STLDI policies [should] end upon the effective date of the final rules," which the Departments plan to issue in April 2024, "or some other date," such as "January 1, 2025."[80] In other words, even though "the current regulations . . . promote

continuous enrollment in coverage,"[81] the Departments are open to impairing the obligation of existing contracts and throwing enrollees out of STLDI plans after just one month. The NPRM betrays no interest in ensuring such consumers could obtain new coverage.

THE DEPARTMENTS' RATIONALE FOR EXPOSING STLDI ENROLLEES TO AVOIDABLE RISKS

The Departments offer two rationales for intentionally exposing consumers to greater risk. Both are deceptive and disingenuous. Together, they reveal the Departments' purpose: to encourage more people to enroll in Obamacare plans by harming STLDI enrollees who make the "wrong" choice.

"Hide the Premium"

First, the Departments estimate that the proposal would reduce Obamacare premiums by 0.5 percent and thereby reduce federal spending on Obamacare premium subsidies by 0.2 percent ($120 million per year).[82] The Departments hypothesize that exposing STLDI enrollees to greater risk would encourage healthy consumers to enroll in Obamacare instead and thereby reduce Obamacare premiums. Yet the proposal would not reduce Obamacare's cost but hide it.

It is an economic fallacy to claim that current STLDI rules "increas[e] overall premium costs" in Obamacare plans or that curtailing STLDI would reduce the cost of Obamacare plans.[83] Compelling STLDI enrollees into Obamacare plans might reduce Obamacare *premiums*, but it would have no effect on the program's *cost*. Obamacare's community-rating price controls deliver hidden subsidies to the sick in the form of health insurance at lower premiums than insurers would otherwise charge. Those same price controls finance those subsidies by imposing a hidden tax on the healthy, in the form of higher premiums than insurers would otherwise charge. The Departments admit that the people they seek to force out of the STLDI plans and into Obamacare plans "might incur higher premium[s]."[84]

Spreading the burden of those hidden taxes across additional healthy consumers has no impact on the cost of those hidden subsidies. Instead, it merely hides those taxes and transfers from public view. The Departments estimate that the proposal "would reduce gross [Obamacare] premiums by approximately 0.5 percent" and therefore "would reduce Federal spending on [Obamacare premium subsidies] by $120 million" in 2027.[85] Under current rules, that $120 million portion of Obamacare's cost appears in the federal budget as spending. Congress must finance it by either taxing or borrowing $120 million, which also appears in the federal budget. The Departments' proposal would *not* eliminate that $120 million of compulsory spending. It would cause those transfers to disappear from the federal budget, only to reappear as $120 million in higher health insurance premiums for healthy consumers.

> "The Departments admit that the people they seek to force out of the STLDI plans and into Obamacare plans 'might incur higher premium[s].'"

The result is not greater efficiency but greater opacity. The reason Obamacare's architects employed hidden taxes and transfers was that transparent taxes and transfers would threaten Obamacare's political viability.[86] The Departments' proposal would not reduce Obamacare's costs, but it would reduce political accountability for those costs.

That's if it reduces Obamacare premiums at all. It could increase them by encouraging more sick than healthy STLDI enrollees to switch. Healthy consumers could remain in the STLDI market for as long as they remain healthy by purchasing consecutive four-month plans. The only STLDI enrollees who would have to switch are those who fall ill. Those patients would make Obamacare's risk pools sicker and thus increase Obamacare premiums. Renewal guarantees would tend to reduce Obamacare premiums by keeping those high-cost patients out of Obamacare's risk pools, but the Departments' proposal does not consider those effects.

Distinguishing STLDI by Crippling It

The Departments' second rationale is that their proposal would "define and more clearly distinguish STLDI . . . from

comprehensive coverage."[87] By "comprehensive coverage," they mean Obamacare plans.[88] The proposal "would help ensure consumers are better able to distinguish between the two types of coverage and therefore make better informed coverage purchasing decisions."[89] This rationale is likewise deceptive and disingenuous.

The proposal would not distinguish STLDI from Obamacare plans in the sense of providing consumers better or more information. If that were the case, the Departments would merely require STLDI issuers to disclose features that make STLDI plans different from Obamacare plans. In fact, the Departments already require such disclosures, in capital letters and 14-point type.[90] If the Departments consider the existing requirements insufficient, they could add to them.

"The Departments fear that consumers might choose STLDI because it is too 'similar' to Obamacare coverage. The Departments' solution is to make STLDI less comprehensive."

The proposal would distinguish STLDI from Obamacare plans in the sense of arbitrarily *creating differences* between the two. The reason the Departments want to create these differences is significant.

The Departments fear that consumers might choose STLDI because it is too "similar" to Obamacare coverage. STLDI plans have "terms that are similar in length to a 12-month policy year for [Obamacare] coverage." Again, in the Departments' words, "the current regulations . . . promote continuous enrollment in coverage."[91] From the Departments' perspective, STLDI plans have *too few* gaps in coverage. They provide too much protection. They are too comprehensive. It is from the dystopia of affordable, comprehensive coverage that the Departments wish to save STLDI enrollees.

The Departments' solution is to make STLDI *less like* Obamacare: "The Departments are now of the view that interpreting 'short-term' in a manner that prevents STLDI from having terms that are similar in length to a 12-month policy year for [Obamacare] coverage is the most important tool for consumers to distinguish between STLDI and [Obamacare] coverage."[92] The Departments write, "These proposed rules would encourage enrollment in [Obamacare] coverage and lower the risk that STLDI [is] viewed or marketed as a substitute for [Obamacare] coverage," and would accomplish that goal by "increasing regulation of issuers offering STLDI."[93] STLDI is too good, therefore the Departments must make it bad. It is too comprehensive, therefore the Departments must make it less comprehensive by creating gaps in coverage where there were none.

The Departments are not *informing* consumers' choices. They are punishing consumers who make what the Departments (not Congress) believe to be the wrong choice. They are punishing STLDI issuers not for offering low-quality coverage but for offering *high*-quality coverage.

AN UNREASONABLE PROPOSAL

The Departments lack the legal authority to implement this proposal. They have no authority to limit short-term plans in a manner that creates gaps in coverage. They lack authority to regulate renewal guarantees in any way at all, much less to ban them. Nor is either step necessary or appropriate to carry out the Departments' responsibilities.

No Authority to Create Gaps in Coverage

The Departments have authority to interpret (and reinterpret) ambiguous statutes so long as their interpretation is reasonable. The relevant passage from the PHSA is ambiguous indeed: other than the words "short-term limited duration insurance," Congress has provided no direct guidance on how to implement this exemption. The task of defining which characteristics health plans must have to qualify for this regulatory exemption therefore falls to the Departments.

The interpretation of "short-term limited duration insurance" that the Departments propose is not reasonable. Canceling all STLDI plans after four months and prohibiting renewals conflicts with and undermines Congress's express goals in regulating health insurance, as well as the goals Departments state in interpreting federal law. Decades of congressional legislation clearly indicate that:

1. Congress wants consumers to have access to STLDI plans that are exempt from federal health insurance regulation.
2. Congress's primary goals with respect to health insurance regulation are to reduce gaps in health insurance, reduce the number of uninsured, and shield the sick from medical underwriting.
3. Since the enactment of Obamacare, Congress has moved away from negative incentives (i.e., penalties) and toward positive incentives (subsidies) to induce consumers to enroll in Obamacare plans.

Canceling STLDI plans after four months and prohibiting renewals conflicts with each of these elements of Congress's plan.

"The Departments' proposal conflicts with Congress's purpose by creating gaps in health insurance."

The Departments' proposal conflicts with Congress's regulatory scheme in multiple ways. First, it incorrectly treats the STLDI exemption as an aberration or a lesser part of federal law. Congress placed the STLDI exemption on an equal footing with Obamacare and all other provisions of federal law. The same lawmaking process that created the remainder of the PHSA also created the STLDI exemption. That exemption predates most federal health insurance regulations, including Obamacare. The DC Circuit held in 2020 that the STLDI exception is "[an] exception *Congress* created" and "Congress expressly elected *not* to set up a Hobson's choice between purchasing Obamacare-compliant insurance and forgoing coverage altogether. . . . It did not foreclose other options."[94]

Second, the Departments' proposal conflicts with Congress's purpose and regulatory scheme by creating gaps in health insurance. Congress's primary purpose throughout decades of legislating has been to reduce gaps in health insurance; reduce the number of uninsured; and reduce discrimination against the sick, in particular by shielding the sick from medical underwriting. A few examples suffice to make the point:

- In 1985, Congress passed the Consolidated Omnibus Budget Reconciliation Act, or COBRA, which sought to reduce gaps in health insurance by allowing certain workers to remain on their employer's health plan for up to 36 months after leaving their job.[95]
- In 1996, Congress passed the Health Insurance Portability and Accountability Act, whose primary purpose was to protect sick patients from gaps in coverage as they transitioned from one health plan to another. Where such gaps existed, Congress shortened or eliminated them. HIPAA did so by limiting the ability of employers and insurers to deny coverage to such patients or to exclude coverage for those patients' preexisting conditions. It limited the amount of time during which large employers' group health plans could exclude preexisting conditions from coverage.[96] It prohibited such plans from denying coverage or charging higher premiums to an employee on the basis of the employee's or a dependent's health status.[97] It imposed mandatory guaranteed renewability for certain large-employer group health plans.[98] It mandated renewal guarantees in the individual market.[99] It required individual-market carriers to issue policies to certain individuals who were transitioning from employer-based plans.[100] HIPAA preserved state regulations that went even further to shield sick enrollees from exclusions, denials, cancellation, or re-underwriting.[101]
- The ACA went to great lengths in the hopes of eliminating gaps in coverage and shielding the sick from medical underwriting, including mandating renewal guarantees in the individual and employer markets and banning medical underwriting.[102]

Existing STLDI rules are consistent with Congress's intent because, as the Departments acknowledge, "the current regulations . . . promote continuous enrollment in coverage."[103] By contrast, canceling STLDI plans after four months and prohibiting renewals flies in the face of everything Congress has tried to achieve in health insurance. In no instance has Congress tried to create gaps and expose sick patients to underwriting, as the Departments are now doing. Even when Obamacare's community-rating price controls prevented enrollment in such plans for 9–10 months

of the year, Congress left in place an insurance option that could fill those gaps (i.e., STLDI plans with 12-month contract terms). The Departments would mandate the very practice of stripping coverage from the sick and exposing them to underwriting that Obamacare seeks to end.

Third, the Departments' proposal conflicts with Congress's regulatory scheme by employing a tactic that Congress disfavors. Since 2010, Congress has moved away from negative incentives (i.e., penalties) and toward positive incentives (subsidies) to induce consumers to enroll in Obamacare plans. In 2017, Congress eliminated the financial penalties that Obamacare's "individual mandate" had previously imposed on taxpayers who fail to enroll in "minimum essential coverage." In 2021 and 2022, Congress opted for subsidies rather than penalties to induce consumers to enroll in Obamacare plans.

"The Departments would mandate the very practice of stripping coverage from the sick and exposing them to underwriting that Obamacare seeks to end."

The Departments propose to penalize consumers who enroll in STLDI rather than Obamacare by exposing them to greater financial and health risks. They then propose to require issuers of the "wrong" health plans to advertise those penalties. Federal law grants the Departments no warrant to impose a backdoor mandate to purchase health insurance, or to wield a sword Congress has sheathed.

Fourth, the proposal is neither necessary nor appropriate. The Departments note, correctly, that they "have authority to promulgate regulations as may be necessary or appropriate to carry out . . . Federal consumer protections and requirements for comprehensive coverage."[104] There is nothing necessary or appropriate, however, about letting patients like Jeanne Balvin face $97,000 in unpaid medical bills or go without medical care so that the Departments can hide less than half a percentage point of Obamacare's cost from voters.

Finally, the Departments' proposal conflicts with the executive order from which it sprang. The Departments note, "Executive Order 14009 also directed Federal agencies to examine policies or practices that may undermine protections for people with preexisting conditions and that may reduce the affordability of coverage."[105] STLDI provides protection for patients with preexisting conditions by shielding them from canceled coverage and medical underwriting for up to 36 months and by eliminating gaps in coverage. It makes coverage more affordable by allowing consumers to avoid coverage they do not wish to purchase and hidden taxes they do not want to pay. The Departments' proposal undermines the protections that STLDI provides against preexisting conditions and reduces the affordability of coverage.

No Authority to Regulate Renewal Guarantees

The Departments have no authority to regulate renewal guarantees at all, much less to ban them. Renewal guarantees lie outside the Departments' legal authority. If the Departments finalize their proposal to prohibit renewal guarantees in this market, that final rule would be vulnerable to a legal challenge.

The Departments' authority to regulate health insurance stems from the PHSA's definition of health insurance:

> The term "health insurance coverage" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.[106]

That definition cabins the word "insurance" when it appears in the exemption for STLDI:

> 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.[107]

The Departments have room to interpret "short-term" and "limited duration" because the statute does not define those terms. Since the statute clearly defines "insurance," the

Departments must adhere to Congress's definition.

The PHSA's definition of "health insurance" does not include renewal guarantees, therefore the Departments have no authority to regulate them. The statute defines health insurance as providing "benefits consisting of medical care" or payments for medical care. Renewal guarantees provide neither. They provide a different type of benefit that protects enrollees against a different type of risk.

"If renewal guarantees do not provide 'benefits consisting of medical care,' the Departments do not have authority to regulate them, much less ban them."

A renewal guarantee protects the consumer against the risks that her insurer will drop or re-underwrite her when her current policy expires. The benefits a renewal guarantee provides are: (1) an offer of a new health insurance contract and (2) lower premiums, in the sense of protecting her from underwriting that would otherwise increase her premiums. Renewal guarantees pay for no medical care whatsoever.

The Departments have recognized that renewal guarantees do not provide benefits in the form of medical care. In 2018, the Departments wrote that "one of the nation's largest health insurance issuers received regulatory approval from 25 states to offer renewal guarantees as a standalone product" in 2008 and 2009. The Departments acknowledged such products are not health insurance but "essentially options to buy new policies in the future" (which "is at present permitted under federal law").[108]

If renewal guarantees do not provide "benefits consisting of medical care," the Departments do not have authority to regulate them, much less ban them. If the Departments finalize their proposal to prohibit renewal guarantees, that ban would be vulnerable to a legal challenge for exceeding the Departments' authority.

Like creating gaps in STLDI, prohibiting renewal guarantees would conflict with Congress's consistent purpose in regulating health insurance, would conflict with Executive Order no. 14009, and is neither necessary nor appropriate to carry out the Departments' responsibilities. Banning renewal guarantees would reduce protections for people who develop expensive medical conditions, the affordability of STLDI plans for those patients, and the affordability of Obamacare plans.

No Evidence of Congressional Intent

The Departments have identified no statutory authority or other support for their position that the STLDI exemption is a lesser part of federal law or that Congress granted them the power to create gaps in health insurance coverage. That is because there is none.

The Departments declare, for example, that "STLDI's role [is that] of serving as temporary coverage for individuals transitioning between other types of comprehensive coverage."[109] This is pure invention with zero statutory support. Congress has never articulated a desire for, much less imposed, such a limitation on such plans. On the contrary, the US Court of Appeals for the DC Circuit held that "nothing in HIPAA prevents insurers from renewing expired STLDI policies. Indeed, from 1997 to 2016, renewals were allowed with the insurer's consent."[110] Not even the Departments claim that STLDI renewals, which resumed in 2018, are contrary to statute.

The Departments claim that "Congress' intent [was] to provide uniform minimum protections to consumers in every State."[111] Again, the DC Circuit rejected this theory of congressional intent, holding that "Congress expressly elected *not* to set up a Hobson's choice between purchasing ACA-compliant insurance and forgoing coverage altogether."[112] The fact that Congress "did not foreclose other options" shatters the Departments' depiction of Congress's intent.[113]

Indeed, the Departments themselves do not seem to believe their own theory of congressional intent. If they truly believed Congress intended to make Obamacare's regulatory standards uniform, then why are they avowedly trying to make STLDI even less like Obamacare plans than it already is? Why aren't they proposing to subject STLDI to Obamacare regulations? Alternatively, why aren't they proposing to prohibit all STLDI for falling short of those "uniform minimum protections"? The reason is that the Departments lack the authority to do either. The fact that the Departments proposed neither option strongly indicates that they know Congress did *not* make Obamacare's

regulations the uniform standard for all health insurance.

The Departments' depiction of Congress's intent in creating and preserving the STLDI exemption leans heavily into the passive voice: STLDI "is primarily designed," "was not intended," and "was initially intended."[114] Just as the passive voice presents a verb without an actor, the Departments present a claim about congressional intent without any supporting evidence.

> "The Departments claim one goal of their proposal is to protect consumers from 'misleading or aggressive sales and marketing tactics.' The NPRM directly conflicts with this goal."

Obamacare advocates may wish Congress had relegated STLDI to a narrower role in the marketplace or that STLDI were less attractive to consumers than it is. Yet the Departments need more than wishes before they can limit the freedom of producers and consumers. They need clear statutory authority, or at least a reasonable interpretation of ambiguous statutory authority. They have neither.

Aggressive and Deceptive Marketing

A proposal so contrary to Congress's intent and to the interests of consumers could not receive so much undeservedly favorable media attention without some aggressive and misleading marketing of its own.[115]

The Departments claim one goal of their proposal is to protect consumers from "misleading or aggressive sales and marketing tactics that obscure the differences between comprehensive coverage and STLDI," tactics to which "underserved populations may be particularly vulnerable."[116] The NPRM directly conflicts with this goal over and over by aggressively misleading consumers and the public about STLDI, Obamacare plans, and the Departments' proposal:

- It is false and misleading to claim, as the Departments propose to warn consumers, that STLDI "isn't comprehensive health insurance."[117] Nonpartisan authorities such as the CBO affirm that 95 percent of STLDI plans provide comprehensive coverage. In many respects, STLDI plans provide *more* comprehensive coverage than Obamacare plans.
- It is false and misleading for the Departments to describe Obamacare plans as categorically providing "comprehensive health insurance." Some Obamacare requirements have the effect of making Obamacare plans more comprehensive. Others, in particular Obamacare's community-rating price controls, have the effect of making Obamacare plans less comprehensive in terms of network breadth, prescription drug coverage, and other coverage dimensions, as well as by prohibiting enrollment for most of the year.[118] It is false and misleading to claim Obamacare plans provide comprehensive coverage and STLDI plans do not, when nonpartisan authorities such as the CBO find that STLDI plans often provide coverage more comprehensive than Obamacare, including having "lower deductibles or wider provider networks."[119]
- Similarly, it is false and misleading for the Departments to advertise, and to require STLDI issuers to advertise, that under Obamacare plans "the most you have to pay out-of-pocket for essential health benefits in a year is limited" or that "you will have access to all essential health benefits." Those guarantees apply only within Obamacare's narrow provider networks. If a patient requires care from an out-of-network provider—for example, MD Anderson Cancer Center, which no Obamacare plans include in their networks[120]—there is no limit to what the patient could pay out of pocket. With broader networks, many STLDI plans cover MD Anderson.[121] If a patient cannot find an in-network provider, she may not be able to access all essential services. It is false and misleading for the Departments to claim otherwise.
- It is misleading for the Departments to complain that "STLDI policies can discriminate against individuals with serious illnesses or preexisting conditions, including individuals with mental health and substance use disorders, older consumers, [and] women" without also mentioning that the economics literature—including empirical work by Biden economic adviser Michael Geruso—shows that

Obamacare's preexisting-conditions "protections" discriminate against those exact groups.[122]

- It is misleading and disingenuous to write, "The Departments are concerned about additional costs to consumers who enroll in STLDI . . . and incur medical expenses that are not covered by such coverage" without expressing any concern about the same phenomenon that Geruso has documented in Obamacare. Geruso and his colleagues write that the erosion in coverage due to Obamacare's community-rating price controls "can be economically sizable," costing patients thousands of dollars per year.[123]
- It is misleading to claim, and to require STLDI issuers to tell their customers, that STLDI "has fewer protections than comprehensive insurance options you can find on HealthCare.gov."[124] For those purchasing coverage outside Obamacare's narrow enrollment periods (i.e., generally 9–10 months of the year), *every STLDI plan is more comprehensive than Obamacare*. This would remain true under the Departments' proposal.
- It is misleading for the Departments to warn consumers that STLDI "may deny you coverage if you have a preexisting condition" or "might not cover or might limit coverage for preexisting conditions" when the Departments' proposal *requires* STLDI to do so more often (i.e., every four months versus just once at enrollment).[125]
- It is disingenuous to decry and to purport to protect consumers from "practices . . . common in the STLDI market, which could leave them without any coverage in a health crisis" when the Departments are themselves exposing consumers to "higher out-of-pocket expenses and medical debt, reduced access to health care, and potentially worse health outcomes."[126]
- It is false and misleading for the Departments to claim the NPRM would "improve the comprehensiveness of coverage and protect consumers from low-quality coverage" when in fact the *only* impact it would have would be to make coverage *less* comprehensive by *reducing* quality.
- The Departments claim the NPRM would "protect" consumers from STLDI "that provide [sic] little to no coverage and can discriminate against those with pre-existing conditions" when in fact it would require STLDI to offer *less* coverage and engage in *more* discrimination against patients with preexisting conditions.[127]
- After writing at length about "the Federal requirements that are the subject of this rulemaking," the Departments disingenuously claim, "These proposed rules . . . would not impose requirements on STLDI. Rather, they would define STLDI." The NPRM would, among other things, require STLDI issuers to: cancel all STLDI plans after four months, *not* cover medical expenses that they otherwise would, and inform consumers of the risks the foregoing requirements would create.
- It is misleading for the Departments to cite the availability of "enhanced" but temporary Obamacare subsidies as an argument for discarding the 2018 rules that make STLDI coverage more comprehensive and secure.[128] Those subsidies expire after 2025; the Departments have no way of knowing whether Congress will reauthorize them. It is inappropriate to expose consumers to greater financial risk on the presumption that Congress will someday provide consumers an alternative.
- It is misleading to use consumers' ignorance about the availability of Obamacare premium subsidies as a basis for undermining the Departments' competitors without mentioning that ignorance is evidence of failure on the part of the Departments' marketing campaigns.[129]
- Finally, it is misleading for the Departments to warn consumers, and to require STLDI issuers to warn their customers, that STLDI "is temporary insurance" and to expose STLDI enrollees to the risks of "higher out-of-pocket expenses and medical debt, reduced access to health care, and potentially worse health outcomes" without also informing consumers that the Departments are solely responsible for those features and risks.[130]

The Departments' capricious analysis and description of these health insurance markets produced a proposal that jeopardizes consumers' health and fortunes.

What explains these rampant deceptions is that the Departments are not neutral observers. The Departments' reputations, and those of their employees, rise and fall with the success of Obamacare. The Departments are essentially marketers of Obamacare plans who wield power over their competitors.[131] Rather than impartial regulators who seek to help consumers distinguish between apples and pears, they are *sellers* of apples who are misleading consumers about the quality of their apples while adding worms to the competition's pears. The Departments are frank about their desire to prevent STLDI from competing with Obamacare plans:

- The Departments acknowledge that one of their goals is "to prevent or otherwise mitigate the potential for direct competition between STLDI and [Obamacare] coverage."[132]
- The Departments requested public input on how they might block competition from STLDI plans by "limit[ing] . . . marketing and/or sale of STLDI during [Obamacare's] open enrollment period."[133]
- The Departments propose to require STLDI issuers to advertise Obamacare plans, including providing phone numbers and website addresses of government agencies that sell Obamacare plans.[134]

Allowing the Departments to craft rules and warning labels for STLDI is akin to allowing STLDI issuers to craft rules and warning labels for Obamacare plans.

The problem that the Departments seek to redress is not that STLDI offers inadequate coverage but that it offers a perfectly reasonable alternative to what the Departments offer, and consumers are choosing the alternative that is better for them. For better or worse, Congress has left STLDI free to compete with Obamacare. The Departments should respect Congress's design.

CONCLUSION

Year-long, renewable STLDI plans are providing affordable, comprehensive coverage to millions of consumers in situations policymakers could not foresee. The Departments' proposal to limit short-term plans is not an attempt to protect consumers. It is the opposite: an attempt to punish consumers who choose a perfectly legal and valid product that competes with the product the Departments favor. The Departments' proposal would reduce the consumer protections it purports to increase. It would increase the number of uninsured by 500,000 and expose already-sick patients to canceled coverage, lack of insurance, and avoidable financial and health risks.

The Departments acknowledge their purpose is to make a legal, valid health insurance product less comprehensive in a manner that poses significant risks to consumers. The fact that the Departments believe consumers would be better off in Obamacare plans neither changes nor justifies the fact that they are seeking to punish consumers who reasonably disagree.

"The Departments should abandon this proposal as inconsistent with Congress's purpose. The Departments should reaffirm their current interpretation of the governing statute."

The Departments' proposal to limit short-term plans clearly conflicts with and undermines both Congress's and the Departments' own stated goals. It directly conflicts with Congress's clear and consistent purpose every time Congress has legislated in this area (i.e., to make health insurance more secure for the sick by shielding them from coverage cancellations and medical underwriting). Congress mandates renewal guarantees; the Departments would prohibit them. Congress prohibits stripping coverage from the sick and leaving them uninsured; the Departments would mandate it.

In *King v. Burwell*, the Supreme Court held, "Congress passed the Affordable Care Act to improve health insurance markets."[135] This proposal directly conflicts with that goal by making health insurance worse.

The Departments should abandon this proposal as inconsistent with Congress's purpose. The Departments should reaffirm their current interpretation of the governing statute, which they already acknowledge "promote[s] continuous enrollment in coverage"[136] with longer contract

terms and renewal guarantees and makes health insurance more affordable. The Departments should reaffirm their prior finding that STLDI with renewal guarantees can improve Obamacare's performance by giving patients who develop high-cost conditions a lower-cost coverage option, which can reduce Obamacare premiums. The Departments should go further by affirming that Congress has granted them no authority to regulate renewal guarantees.

Congress and state legislators should not wait for the Departments to do the right thing. Congress should codify current STLDI rules and clarify that the Departments have no authority to regulate renewal guarantees. States that subject STLDI to arbitrary limits or general health insurance regulation should exempt it from all such measures. Then let the best approach to providing secure access to health care win.

NOTES

1. 88 Fed. Reg. 44596 (July 12, 2023).

2. 88 Fed. Reg. 44644 (July 12, 2023).

3. Department of Labor, "Short-Term Limited Duration Insurance; Update," Office of Information and Regulatory Affairs, 2023.

4. See Shirley Svorny, "Medical Licensing: An Obstacle to Affordable, Quality Care," Cato Institute Policy Analysis no. 621, September 17, 2008; Shirley Svorny, "Liberating Telemedicine: Options to Eliminate the State-Licensing Roadblock," Cato Institute Policy Analysis no. 826, November 15, 2017; Shirley Svorny and Michael F. Cannon, "Health Care Workforce Reform: COVID-19 Spotlights Need for Changes to Clinician Licensing," Cato Institute Policy Analysis no. 899, August 4, 2020; Jeffrey A. Singer and Michael F. Cannon, "Drug Reformation: End Government's Power to Require Prescriptions," Cato Institute White Paper, October 20, 2020; Michael F. Cannon and Jacqueline Pohida, "Would 'Medicare for All' Mean Quality for All? How Public-Option Principles Could Reverse Medicare's Negative Impact on Quality," *Quinnipiac Health Law Journal* 25, no. 2 (Spring 2022); Michael F. Cannon, "Market Concentration in Health Care: Government Is the Problem, Not the Solution," Cato Institute Briefing Paper no. 139, July 19, 2022; and Michael F. Cannon, *Recovery: A Guide to Reforming the US Health Sector* (Washington: Cato Institute, 2023).

5. Michael F. Cannon, "End the Tax Exclusion for Employer-Sponsored Health Insurance: Return $1 Trillion to the Workers Who Earned It," Cato Institute Policy Analysis no. 928, May 24, 2022.

6. Brett Christie, "2023 US Total Compensation Increases Averaged 4.1%," *Workspan Daily*, May 5, 2023; Gary Claxton et al., *Employer Health Benefits: 2023 Annual Survey* (San Francisco: Kaiser Family Foundation, 2023), p. 6; Gloria Guzman and Melissa Kollar, *Income in the United States: 2022* (Washington: Government Publishing Office, September 2023), p. 3; and author's calculations. Data for 2022 are the most recent data available.

7. Gary Claxton et al., *Employer Health Benefits: 2023 Annual Survey* (San Francisco: Kaiser Family Foundation, 2023), pp. 50, 66; and author's calculations.

8. "Average Marketplace Premiums by Metal Tier, 2018–2024," State Health Facts, Kaiser Family Foundation, October 2023; Gloria Guzman and Melissa Kollar, *Income in the United States: 2022* (Washington: Government Publishing Office, September 2023), p. 3; and author's calculations. Data for 2022 are the most recent data available.

9. "Average Marketplace Premiums by Metal Tier, 2018–2024," State Health Facts, Kaiser Family Foundation, October 2023; and Gloria Guzman and Melissa Kollar, *Income in the United States: 2022* (Washington: Government Publishing Office, September 2023), p. 3. Data for 2022 are the most recent data available.

10. "Rate Review," HealthCare.gov.

11. Daniel Cruz and Greg Fann, "The Shortcomings of the ACA Exchanges: Far Less Enrollment at a Much Higher Cost," Paragon Health Institute, September 2023, p. 9.

12. Brian Blase, "Expanded ACA Subsidies: Exacerbating Health Inflation and Income Inequality," Galen Institute, updated June 11, 2021, p. 13.

13. Michael F. Cannon, "End the Tax Exclusion for Employer-Sponsored Health Insurance: Return $1 Trillion to the Workers Who Earned It," Cato Institute Policy Analysis no. 928, May 24, 2022.

14. John E. Dicken et al., "Private Health Insurance: Markets Remained Concentrated through 2020, with Increases in the Individual and Small Group Markets," Government Accountability Office, November 2022.

15. Michael F. Cannon, "End the Tax Exclusion for Employer-Sponsored Health Insurance: Return $1 Trillion to the Workers Who Earned It," Cato Institute Policy Analysis no. 928, May 24, 2022.

16. Michael Geruso, "Screening in Exchanges: Some Facts and Findings from Geruso, Layton, Prinz (2016)," Presentation at Penn LDI HIX Conference, September 2017, p. 3.

17. Michael Geruso, Timothy Layton, and Daniel Prinz, "Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges," *American Economic Journal: Economic Policy* 11, no. 2 (May 2019): 64–107. See also Michael F. Cannon, "Is Obamacare Harming Quality? (Part 1)," *Health Affairs Forefront* (blog), Health Affairs, January 4, 2018; Michael F. Cannon, "How to Ensure Quality Health Coverage (Part 2)," *Health Affairs Forefront* (blog), Health Affairs, January 5, 2018; and Michael F. Cannon, "Obamacare Makes Discrimination against Those with Preexisting Conditions Even Worse," *Washington Examiner*, December 7, 2020.

18. Donna Rosato, "Short-Term Health Insurance Isn't as Cheap as You Think," *Consumer Reports*, October 2, 2018.

19. Donna Rosato, "Short-Term Health Insurance Isn't as Cheap as You Think," *Consumer Reports*, October 2, 2018.

20. See, for example, Michael F. Cannon, "End the Tax Exclusion for Employer-Sponsored Health Insurance: Return $1 Trillion to the Workers Who Earned It," Cato Institute Policy Analysis no. 928, May 24, 2022; and Michael F. Cannon, *Recovery: A Guide to Reforming the US Health Sector* (Washington: Cato Institute, 2023).

21. "H.R. 1010, To Provide That the Rule Entitled 'Short-Term, Limited Duration Insurance' Shall Have No Force or Effect," Congressional Budget Office Cost Estimate, April 25, 2019.

22. 88 Fed. Reg. 44638 (July 12, 2023) (1.9 million); and House of Representatives Committee on Energy and Commerce, Subcommittee on Health, Subcommittee on Oversight and Investigations, "Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans Is Putting Americans at Risk," June 2020, p. 6 (3 million).

23. Alice Burns et al., "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans," Congressional Budget Office, January 2019, p. 6.

24. Angie Drobnic Holan, "Lie of the Year: 'If You Like Your Health Care Plan, You Can Keep It,'" PolitiFact, December 12, 2013; and Jon Greenberg, "'If You Like Your Plan, You Can Keep It.' Biden's [sic] Invokes Obama's Troubled Claim," PolitiFact/KFF Health News, July 30, 2019.

25. Alice Burns et al., "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans," Congressional Budget Office, January 2019, p. 6.

26. 42 U.S.C. § 300gg–1 (2010); and 45 C.F.R. § 155.410 (2021).

27. 88 Fed. Reg. 44638 (July 12, 2023).

28. For a lighthearted take on how Obamacare denies people health insurance for most of the year, see Zoltan Kaszas, "I Can't Get Health Insurance," YouTube video, June 14, 2023.

29. Michael Geruso, "Screening in Exchanges: Some Facts and Findings from Geruso, Layton, Prinz (2016)," Presentation at Penn LDI HIX Conference, September 2017, p. 3.

30. Alice Burns et al., "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans," Congressional Budget Office, January 2019, p. 6.

31. Daria Pelech and Karen Stockley, "How Price and Quantity Factors Drive Spending in Nongroup and Employer Health Plans," *Health Services Research* 57, no. 3 (June 2022): 624–33.

32. Tables 1–4 show that many STLDI plans have premiums that are much more than 60 percent lower than the lowest-cost bronze ACA plan. Presumably, the 5 percent of STLDI plans that have the lowest premiums are not comprehensive coverage. That still leaves plenty of room for comprehensive STLDI plans with dramatically more affordable premiums than ACA plans.

33. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020).

34. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020).

35. 88 Fed. Reg. 44618 (July 12, 2023).

36. 83 Fed. Reg. 38212 (August 3, 2018).

37. Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks* (Washington: AEI Press, 1999); and Sherry Glied, *Revising the Tax Treatment of Employer-Provided Health Insurance* (Washington: AEI Press, 1994), pp. 19, 35 (endnote 76: "In testimony before the Senate Subcommittee on the

Health of the Elderly, Special Committee on Aging, April 28, 1964, J. F. Follman, Jr., director of information of the Health Insurance Association of America, testified that 72 of 200 members of the HIAA wrote individual policies guaranteed renewable for life").

38. Michael Cohen et al., "Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market," Wakely Consulting Group, 2018 ("Individuals in transitional plans did not undergo underwriting").

39. Reed Abelson, "UnitedHealth to Insure the Right to Insurance," *New York Times*, December 2, 2008. Those states are Alabama, Arizona, Arkansas, Delaware, Illinois, Indiana, Iowa, Louisiana, Maryland, Michigan, Mississippi, Missouri, Nebraska, New Mexico, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, West Virginia, Wisconsin, and Wyoming. See also "UnitedHealthcare's Golden Rule Unveils Innovative Solution to Guarantee Future Insurability for Individuals, Families When They Need It," Business Wire, December 4, 2008.

40. 83 Fed. Reg. 38222 (August 3, 2018).

41. 88 Fed. Reg. 44613 (July 12, 2023).

42. Daria Pelech and Karen Stockley, "How Price and Quantity Factors Drive Spending in Nongroup and Employer Health Plans," *Health Services Research* 57, no. 3 (June 2022): 624–33.

43. Were Maria to earn less than 100 percent of the poverty level for a single adult in 2024 (i.e., $15,060), an Obamacare plan premium would consume more than 32 percent of her earnings. "HHS Poverty Guidelines for 2024," Assistant Secretary for Planning and Evaluation, Department of Health and Human Services.

44. 26 C.F.R. § 601.105 (2023).

45. Michael F. Cannon, "How Do You Solve a Problem like Maria's? Rescind Biden's Short-Term Plans Proposal," *Cato at Liberty* (blog), Cato Institute, August 4, 2023.

46. Chris Pope, *Renewable Term Health Insurance: Better Coverage Than Obamacare* (New York: Manhattan Institute, May 2019).

47. 83 Fed. Reg. 38234 (August 3, 2018).

48. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (August 21, 1996).

49. 62 Fed. Reg. 16894 (April 8, 1997).

50. 88 Fed. Reg. 44596–97 (July 12, 2023).

51. The sole instance the Departments cite of Congress imposing burdens on STLDI issuers argues against the changes they propose in the NPRM. In 2020, Congress required issuers of STLDI plans "to disclose the direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage to the enrollees in such coverage as well as to report it annually to HHS." The law imposing that requirement was the Consolidated Appropriations Act of 2021, Pub. L. No. 116-260, 134 Stat. 1182 (December 27, 2020); and 88 Fed. Reg. 44598 (July 12, 2023). This de minimis regulation indicates that Congress knew how to regulate STLDI plans when it wanted, and that Congress has repeatedly chosen not to impose the sorts of burdens and penalties the Departments seek to impose.

52. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020).

53. 83 Fed. Reg. 38220, 38222 (August 3, 2018).

54. 83 Fed. Reg. 38222 (August 3, 2018).

55. 88 Fed. Reg. 44638 (July 12, 2023).

56. The insurer-plaintiffs complained they "will be injured directly by [STLDI] products that will be priced lower than [their] policies" and therefore "will . . . lose customers to competing companies offering STDLI [sic] policies." One insurer predicted "a large exodus" of "at least 10,000 members . . . which would reduce its revenue by $50-100 million" relative to what it had been when regulators allowed STLDI plans to last only three months. Complaint at 16, 17, *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, No. 1:18-cv-02133 (DDC September 14, 2018).

57. Michael F. Cannon, "In a Win for Consumers, a Court Ruling Affirms the Legality of Short-Term Health Insurance Plans," *The Hill* (blog), July 24, 2020.

58. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020).

59. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020). Emphases in original.

60. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020).

61. Louise Norris, "Proposed Rule Would Limit Duration of Coverage under Short-Term Health Plans to 4 Months," Healthinsurance.org, August 22, 2023; and "Duration and Renewals of 2023 Short-Term Medical Plans by State," Healthinsurance.org, last updated September 6, 2023.

62. Louise Norris, "Proposed Rule Would Limit Duration of Coverage under Short-Term Health Plans to 4 Months," Healthinsurance.org, August 22, 2023; and "Duration and Renewals of 2023 Short-Term Medical Plans by State," Healthinsurance.org, last updated September 6, 2023.

63. "Annual Estimates of the Resident Population for the United States, Regions, States, District of Columbia and Puerto Rico: April 1, 2020 to July 1, 2023," Census Bureau, December 2023; and author's calculations.

64. Louise Norris, "Proposed Rule Would Limit Duration of Coverage under Short-Term Health Plans to 4 Months," Healthinsurance.org, August 22, 2023; and "Duration and Renewals of 2023 Short-Term Medical Plans by State," Healthinsurance.org, last updated September 6, 2023.

65. Emily Curran, Dania Palanker, and Sabrina Corlette, "Short-Term Health Plans Sold through Out-of-State Associations Threaten Consumer Protections," *To the Point* (blog), Commonwealth Fund, January 31, 2019.

66. Emily Curran, Dania Palanker, and Sabrina Corlette, "Short-Term Health Plans Sold through Out-of-State Associations Threaten Consumer Protections," *To the Point* (blog), Commonwealth Fund, January 31, 2019.

67. House of Representatives Committee on Energy and Commerce, Subcommittee on Health, Subcommittee on Oversight and Investigations, "Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans Is Putting Americans at Risk," June 2020 ("Everest Reinsurance Company [Everest] is a Delaware-domiciled insurance company, operating as a state-licensed carrier across the United States. Everest offers plans in 26 states, including as individual policies in 8 states and through associations in 18 states. Everest offers STLDI plans with plan duration of up to 364 days. Everest Re Group, Ltd is the holding company, and is domiciled in Bermuda").

68. House of Representatives Committee on Energy and Commerce, Subcommittee on Health, Subcommittee on Oversight and Investigations, "Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans Is Putting Americans at Risk," June 2020.

69. 88 Fed. Reg. 44609–10 (July 12, 2023).

70. 88 Fed. Reg. 44609 (July 12, 2023).

71. "H.R. 1010, To Provide That the Rule Entitled 'Short-Term, Limited Duration Insurance' Shall Have No Force or Effect," Congressional Budget Office Cost Estimate, April 25, 2019.

72. 88 Fed. Reg. 44618 (July 12, 2023).

73. John M. Huff et al., "Short-Term Duration Comment Final—Aug 2016," Public Submission: Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, Comment ID IRS-2016-0021-0146, submitted to the IRS August 9, 2016, and posted by the IRS August 15, 2016.

74. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020).

75. The author apprised the Departments of Balvin's experience in 2023. Michael F. Cannon, "20230911 Cannon Michael F Comments on STLDI NPRM," Public Submission: Comment on CMS-2023-0116-0001, Comment ID CMS-2023-0116-13421, submitted to the Centers for Medicare & Medicaid Services (CMS) September 11, 2023, and posted by the CMS September 12, 2023.

76. 88 Fed. Reg. 44606 (July 12, 2023).

77. 88 Fed. Reg. 44644 (July 12, 2023).

78. 88 Fed. Reg. 44644 (July 12, 2023).

79. 88 Fed. Reg. 44615 (July 12, 2023).

80. 88 Fed. Reg. 44619 (July 12, 2023).

81. 88 Fed. Reg. 44618 (July 12, 2023).

82. Figures are for 2027. 88 Fed. Reg. 44645 (July 12, 2023); Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People under 65: 2022 to 2032," June 2022, p. 17; and author's calculations.

83. 88 Fed. Reg. 44599 (July 12, 2023).

84. 88 Fed. Reg. 44644 (July 12, 2023).

85. 88 Fed. Reg. 44645 (July 12, 2023).

86. Michael F. Cannon, "Grubergate Part 1: 'The Stupidity of the American Voter,'" opinion, *Forbes*, November 30,

2014 (Quoting Obamacare architect Jonathan Gruber: "If . . . you made explicit that healthy people pay in and sick people get money, it would not have passed. . . . Lack of transparency is a huge political advantage. And basically—you know, call it the stupidity of the American voter, or whatever—but basically that was really, really critical to get anything to pass").

87. 88 Fed. Reg. 44608 (July 12, 2023).

88. The NPRM attempts to delineate between STLDI on the one hand and "comprehensive" coverage on the other, by which the Departments mean Obamacare plans. This study's "Short-Term, Limited Duration Health Insurance/ Comprehensive" section shows that that delineation is inaccurate and misleading because STLDI is frequently more comprehensive than Obamacare coverage. To avoid confusion, this study hereinafter edits the NPRM's references to "comprehensive coverage" to read "[Obamacare] coverage."

89. 88 Fed. Reg. 44610 (July 12, 2023).

90. 83 Fed. Reg. 38223 (August 3, 2018).

91. 88 Fed. Reg. 44618 (July 12, 2023).

92. 88 Fed. Reg. 44610 (July 12, 2023).

93. 88 Fed. Reg. 44646, 44639 (July 12, 2023).

94. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020). Emphases in original.

95. Ryan J. Rosso, "Health Insurance Continuation Coverage under COBRA," Congressional Research Service, updated August 13, 2021.

96. 29 U.S.C. § 1181.

97. 29 U.S.C. § 1182(a); and 29 U.S.C. § 1182(b).

98. 29 U.S.C. § 1183.

99. 42 U.S.C. § 300gg–42. Even so, markets were providing renewal guarantees before Congress mandated them. See Mark Pauly and Bradley Herring, *Pooling Health Insurance Risks* (Washington: AEI Press, 1999), p. 18 (Such protection "was actually quite common even when it was not required by regulation . . . with more than three-quarters of nongroup policies in the late 1980s containing some type of guaranteed renewability").

100. 42 U.S.C. § 300gg–41.

101. 42 U.S.C. § 300gg–62.

102. 42 U.S.C. § 300gg–2; and 42 U.S.C. § 300gg–41.

103. 88 Fed. Reg. 44618 (July 12, 2023).

104. 88 Fed. Reg. 44598 (July 12, 2023).

105. 88 Fed. Reg. 44607 (July 12, 2023).

106. 42 U.S.C. § 300gg–91.

107. 42 U.S.C. § 300gg–91.

108. 83 Fed. Reg. 38222 (August 3, 2018); citing Reed Abelson, "UnitedHealth to Insure the Right to Insurance," *New York Times*, December 2, 2008. The author alerted the Departments to these issues in 2018. Michael F. Cannon, "20180423 Cannon, Michael Comments on STLDI Rule," Public Submission: DC, Comment ID CMS-2018-0015-9086, submitted to the CMS April 23, 2018, and posted by the CMS May 16, 2018.

109. 88 Fed. Reg. 44611 (July 12, 2023).

110. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020).

111. 88 Fed. Reg. 44649 (July 12, 2023).

112. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020). Emphases in original.

113. *Association for Community Affiliated Plans, et al. v. United States Department of the Treasury, et al.*, 966 F.3d 782 (DC Cir. 2020). Emphases in original.

114. 88 Fed. Reg. 44598, 44610–11 (July 12, 2023).

115. See, for example, Catherine Rampell, "Biden Is Quietly Reversing Trump's Sabotage of Obamacare," opinion, *Washington Post*, July 11, 2023.

116. 88 Fed. Reg. 44608 (July 12, 2023).

117. 88 Fed. Reg. 44615 (July 12, 2023).

118. National Academies of Sciences, Engineering, and Medicine, *Health-Care Utilization as a Proxy in Disability Determination* (Washington: National Academies Press, 2018), pp. 47, 48 ("Narrow networks existed before the implementation of the ACA, but they have grown more

common as a result of it" and "jeopardize the ability of consumers to obtain needed care in a timely manner"); Noam Bauman et al., "Hospital Networks: Updated National View of Configurations on the Exchanges," McKinsey & Company, June 1, 2014, p. 5; Avalere, "2020 Exchange Plan Networks Are the Most Restrictive since 2014," December 11, 2019 (Broad provider networks accounted for 80 percent of individual-market plans in 2013, when networks reflected consumer preferences, but only 21 percent of Exchange plans in 2020); Alice Burns et al., "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans," Congressional Budget Office, January 2019, p. 6 (Obamacare provider networks are often less comprehensive than STLDI networks); Michael Geruso, Timothy Layton, and Daniel Prinz, "Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges," *American Economic Journal: Economic Policy* 11, no. 2 (May 2019): 64–107 (Community-rating creates drug-coverage gaps that cost patients thousands of dollars per year; even "currently healthy consumers cannot be adequately insured"); and Beatriz Duque Long, Carl Schmid, and Andrew Sperling, letter to Sylvia Mathews Burwell, "Re: 2017 Qualified Health Plan Review and 2018 Notice of Benefit and Payment Parameters Rule & Letter to Issuers," August 24, 2016 (Coalition of 150 patient groups identified narrowing coverage for cancer, cystic fibrosis, hepatitis, HIV, and other illnesses that "completely undermines the goal of the ACA").

119. Alice Burns et al., "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans," Congressional Budget Office, January 2019, p. 6.

120. "Insurance Plans," University of Texas MD Anderson Cancer Center, revised February 23, 2023 ("MD Anderson and our physicians are not included as a 'Participating Provider' for any 'Individual' insurance plans on or off the marketplace in Texas [i.e., ACA plans]. . . . Plans that offer out-of-network benefits may be accepted at MD Anderson if they meet our requirements. If not, enrollees would be responsible for all charges [i.e., self-pay]").

121. Brian Blase et al., "Paragon Leads Comment Letter Opposing Biden Admin's Misguided Proposed Rule Limiting Short-Term Health Plans," Paragon Health Institute, September 7, 2023.

122. 88 Fed. Reg. 44600 (July 12, 2023); Michael Geruso, Timothy Layton, and Daniel Prinz, "Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges," *American Economic Journal: Economic Policy* 11, no. 2 (May 2019): 64–107 (discrimination against patients with substance abuse disorder); and Joann Weiner, "Older Women Bear the Brunt of Higher Insurance Costs under Obamacare," *Washington Post*, June 24, 2014 (discrimination against older women: "Total expected premiums and out of pocket expenses rose [in 2014] by 50 percent for women age 55 to 64—a much larger increase than for any other group—for policies on the federal exchanges relative to prices that individuals who bought individual insurance before health care reform went into effect. . . . Premiums for the second-lowest silver policy are 67 percent higher for a 55 to 64-year-old woman than they were pre-ACA. . . . '[Older women] are being averaged in with younger women who have much higher expenses associated with childbearing and with older men who didn't take care of themselves. Community rating redistributes against the relatively healthy'").

123. Michael Geruso, Timothy Layton, and Daniel Prinz, "Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges," *American Economic Journal: Economic Policy* 11, no. 2 (May 2019): 64–107.

124. 88 Fed. Reg. 44617 (July 12, 2023).

125. 88 Fed. Reg. 44617 (July 12, 2023); and 88 Fed. Reg. 44615 (July 12, 2023).

126. 88 Fed. Reg. 44646 (July 12, 2023); and 88 Fed. Reg. 44644 (July 12, 2023).

127. Department of Health and Human Services, "Statement of Regulatory Priorities for Fiscal Year 2024."

128. 88 Fed. Reg. 44605 (July 12, 2023) ("[T]he availability of the enhanced subsidies allay[s] the accessibility and affordability concerns expressed by the Departments in the preamble to the 2018 final rules regarding the availability of affordable options for comprehensive coverage").

129. 88 Fed. Reg. 44607 (July 12, 2023).

130. 88 Fed. Reg. 44615 (July 12, 2023); and 88 Fed. Reg. 44644 (July 12, 2023).

131. Phil McCausland, "Biden Administration Invests $50 Million in HealthCare.gov Ad Campaign," NBC News, March 31, 2021.

132. 88 Fed. Reg. 44613 (July 12, 2023).

133. 88 Fed. Reg. 44646 (July 12, 2023).

134. 88 Fed. Reg. 44615, 44616 (July 12, 2023) ("The Departments are of the view that the notice [that STLDI issuers must affix to their plans] must also provide resources where consumers can access additional information about . . .

other health coverage options. . . . The Departments propose to add language to the notice to help consumers identify where and how they might be able to enroll in [Obamacare] coverage. The Departments propose to add a website link and telephone number for *HealthCare.gov* to the notice as reliable resources for consumers. . . . [T]he Departments would state that STLDI sold through associations include a link to the website of the [Obamacare] Exchange. . . . The proposed revised notice would also remind consumers that if they are eligible to enroll in employment-based coverage they should contact their employer or family member's employer about the health coverage offered by the employer").

135. *King v. Burwell*, 135 S. Ct. 2480, 2495 (2015).

136. 88 Fed. Reg. 44618 (July 12, 2023).

RELATED PUBLICATIONS FROM THE CATO INSTITUTE

Recovery: A Guide to Reforming the US Health Sector by Michael F. Cannon (Washington: Cato Institute, October 2023)

The Original Sin of US Health Policy by Michael F. Cannon, Visual Feature (July 24, 2023)

Market Concentration in Health Care: Government Is the Problem, Not the Solution by Michael F. Cannon, Briefing Paper no. 139 (July 19, 2022)

End the Tax Exclusion for Employer-Sponsored Health Insurance by Michael F. Cannon, Policy Analysis no. 928 (May 24, 2022)

Drug Reformation: End Government's Power to Require Prescriptions by Jeffrey A. Singer and Michael F. Cannon, White Paper (October 20, 2020)

Health Care Workforce Reform: COVID-19 Spotlights Need for Changes to Clinician Licensing by Shirley Svorny and Michael F. Cannon, Policy Analysis no. 899 (August 4, 2020)

RECENT STUDIES IN THE CATO INSTITUTE POLICY ANALYSIS SERIES

969. **State Fiscal Health and Cost-Saving Strategies** by Marc Joffe (February 20, 2024)

968. **Bold International Tax Reforms to Counteract the OECD Global Tax** by Adam N. Michel (February 13, 2024)

967. **Containing Medicaid Costs at the State Level** by Marc Joffe and Krit Chanwong (February 6, 2024)

966. **Curbing Federal Emergency Spending Government Spending Grows with Excessive and Wasteful Emergency Designations** by Romina Boccia and Dominik Lett (January 9, 2024)

965. **Taiwan's Urgent Need for Asymmetric Defense** by Eric Gomez (November 14, 2023)

964. **Trade and Investment Are Not a Balancing Act** by Norbert J. Michel (November 7, 2023)

963. **Misperceptions of OPEC Capability and Behavior: Unmasking OPEC Theater** by David Kemp and Peter Van Doren (November 2, 2023)

962. **Are Public School Libraries Accomplishing Their Mission? Public School Libraries Do Not Appear to Stock a Balance of Views** by Neal McCluskey (October 17, 2023)

961. **Pariah or Partner? Reevaluating the US-Saudi Relationship** by Jon Hoffman (September 20, 2023)

960. **Expand Access to Methadone Treatment: Remove Barriers to Primary Care Practitioners Prescribing Methadone** by Jeffrey A. Singer and Sofia Hamilton (September 7, 2023)

959. **Sweden during the Pandemic: Pariah or Paragon?** by Johan Norberg (August 29, 2023)

958. **Terrorism and Immigration: A Risk Analysis, 1975–2022** by Alex Nowrasteh (August 22, 2023)

957. **Corking Russian Gas: Global Economic and Political Ramifications** by Scott Semet (August 17, 2023)

956. **A Link Tax Won't Save the Newspaper Industry: The Journalism Competition and Preservation Act Will neither Promote Competition nor Preserve Newspapers** by Paul Matzko (August 14, 2023)

955. **Freeing American Families: Reforms to Make Family Life Easier and More Affordable** by Vanessa Brown Calder and Chelsea Follett (August 10, 2023)

954. **Tax Expenditures and Tax Reform** by Chris Edwards (July 25, 2023)

953. **2022 Arms Sales Risk Index** by Jordan Cohen and A. Trevor Thrall (July 18, 2023)

952. **Adverse Effects of Automatic Cost-of-Living Adjustments to Entitlement and Other Payments** by John F. Early (June 22, 2023)

951. **Indian Nationalism and the Historical Fantasy of a Golden Hindu Period** by Swaminathan S. Anklesaria Aiyar (June 21, 2023)

950. **Why Legal Immigration Is Nearly Impossible: US Legal Immigration Rules Explained** by David J. Bier (June 13, 2023)

949. **Global Inequality in Well-Being Has Decreased across Many Dimensions: Introducing the Inequality of Human Progress Index** by Chelsea Follett and Vincent Geloso (June 8, 2023)

948. **The High Price of Buying American: The Harms of Domestic Content Mandates** by James Bacchus (June 6, 2023)

947. **The Future of the WTO: Multilateral or Plurilateral?** by James Bacchus (May 25, 2023)

946. **Course Correction: Charting a More Effective Approach to US-China Trade** by Clark Packard and Scott Lincicome (May 9, 2023)

945. **The Right to Financial Privacy: Crafting a Better Framework for Financial Privacy in the Digital Age** by Nicholas Anthony (May 2, 2023)

944. **Balance of Trade, Balance of Power: How the Trade Deficit Reflects US Influence in the World** by Daniel Griswold and Andreas Freytag (April 25, 2023)

943. **Streamlining to End Immigration Backlogs** by David J. Bier (April 20, 2023)

942. **Transforming the Internal Revenue Service** by Joseph Bishop-Henchman (April 11, 2023)

941. **Central Bank Digital Currency: Assessing the Risks and Dispelling the Myths** by Nicholas Anthony and Norbert Michel (April 4, 2023)

940. **Uncle Sucker: Why US Efforts at Defense Burdensharing Fail** by Justin Logan (March 7, 2023)

939. **A Shaky Foundation: The Myth of Authoritarian Stability in the Middle East** by Jon Hoffman (December 20, 2022)

938. **Keeping North Carolina's Housing Affordable: A Free Market Solution** by Michael D. Tanner (December 7, 2022)

937. **How Guest Workers Affect Illegal Immigration: Mexican Visas and Mexican Border Apprehensions, 1943–2022** by David J. Bier (December 1, 2022)

936. **The Black Hole of National Security: Striking the Right Balance for the National Security Exception in International Trade** by James Bacchus (November 9, 2022)

935. **Reining in the Unreasonable Executive: The Supreme Court Should Limit the President's Arbitrary Power as Regulator** by William Yeatman (November 1, 2022)

934. **Jawboning against Speech: How Government Bullying Shapes the Rules of Social Media** by Will Duffield (September 12, 2022)

933. **The Self-Imposed Blockade: Evaluating the Impact of Buy American Laws on US National Security** by Colin Grabow (August 16, 2022)

932. **Revising the Bank Secrecy Act to Protect Privacy and Deter Criminals** by Norbert Michel and Jennifer J. Schulp (July 26, 2022)

931. **How to Pick a President: A Guide to Electoral Count Act Reform** by Andy Craig (June 28, 2022)

930. **Unfair Trade or Unfair Protection? The Evolution and Abuse of Section 301** by Scott Lincicome, Inu Manak, and Alfredo Carrillo Obregon (June 14, 2022)

929. **Drug Paraphernalia Laws Undermine Harm Reduction: To Reduce Overdoses and Disease, States Should Emulate Alaska** by Jeffrey A. Singer and Sophia Heimowitz (June 7, 2022)

928. **End the Tax Exclusion for Employer-Sponsored Health Insurance: Return $1 Trillion to the Workers Who Earned It** by Michael F. Cannon (May 24, 2022)

927. **False Alarm over the Retreat of the Himalayan Glaciers** by Swaminathan S. Anklesaria Aiyar and Vijay K. Raina (May 3, 2022)

926. **Biden and Trade at Year One: The Reign of Polite Protectionism** by James Bacchus (April 26, 2022)

925. **The (Updated) Case for Free Trade** by Scott Lincicome and Alfredo Carrillo Obregon (April 19, 2022)

924. **Universal Preschool: Lawmakers Should Approach with Caution** by Colleen Hroncich (March 29, 2022)

923. **The National Flood Insurance Program: Solving Congress's Samaritan's Dilemma** by Peter Van Doren (March 2, 2022)

922. **Competition and Content Moderation: How Section 230 Enables Increased Tech Marketplace Entry** by Jennifer Huddleston (January 31, 2022)

921. **How Wealth Fuels Growth: The Role of Angel Investment** by Chris Edwards (September 29, 2021)

CITATION

Cannon, Michael F. "Biden Short-Term Health Plans Rule Creates Gaps in Coverage: Rule Would Deny Care after Patients Fall Ill," Policy Analysis no. 970, Cato Institute, Washington, DC, March 14, 2024.