CATO BRIEFING PAPER

December 5, 2025 Number 192

Universal, Permanent Health Insurance Relief

Obamacare for Those Who Want It, Choice for Those Who Don't

By Michael F. Cannon

Obamacare is not serving consumers as supporters promised. Premiums will rise an average 26 percent in 2026. Obamacare's regulations are reducing health insurance quality and rationing care. Supporters incorrectly blame these effects on insurers. Obamacare has provided health care to some individuals who otherwise would not have had access, at the cost of making coverage worse and more expensive for far more consumers.

Both former President Barack Obama and President Donald Trump offered relief when Obamacare made coverage unaffordable and rationed care. Congress should make the relief the two presidents pioneered both universal and permanent. Congress should free all individuals and employers to purchase Obamacare-exempt health plans available in US territories (Obama) and codify an agency rule that clarified that short-term health plans may offer certain consumer protections (Trump). Obamacare would remain for those who want it, and Congress would be free to adjust it.

INTRODUCTION

As a presidential candidate and as president, Barack Obama promised that the Patient Protection and Affordable Care Act (PPACA), or Obamacare, would "preserve the right of Americans who have insurance to keep their doctor and their plan," reduce health insurance premiums by $2,500 per family, and end discrimination against the sick.[1] Instead, Obamacare threw millions of consumers out of higher-quality, affordable health plans.[2] Premiums have grown at three times the rate of inflation, rising an average 26 percent for 2026.[3] Obama himself once described premium increases of that magnitude as "jaw-dropping."[4]

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

Worst of all, Obamacare's regulations are reducing health insurance quality and rationing care for the sick. Michael Geruso, an economist formerly with the Council of Economic Advisors during the Biden administration, has found that Obamacare's regulations effectively require insurers to engage in "backdoor discrimination" against the sick that "undoes intended protections for preexisting conditions." This results in "economically sizeable" losses for patients with expensive illnesses to the point that even "healthy consumers cannot be adequately insured."[5] Geruso and his coauthors studied the rationing of drug treatments. Other forms of backdoor discrimination against the sick include increasingly fewer options for choice of doctors and hospitals.[6] Democrats blame these effects on insurers, but Geruso says that the effects of Obamacare's regulations are "beyond any insurance carrier's ability to control."[7] Obamacare has provided health care to individuals who otherwise would not have had access, at the cost of making coverage worse and more expensive for far more Americans.

Obamacare largely hides its excessive premiums from consumers by placing the burden on taxpayers. Since 2014, Obamacare has granted premium subsidies to enrollees who earn 100–400 percent of the federal poverty level, or between $32,150 and $128,600 for a family of four.[8] In 2020, the average subsidy covered 83 percent of the premium.[9] Enrollees earning more than 400 percent of the federal poverty level faced the entire hidden-tax-laden premium.

In 2021, Congress created temporary "enhanced" premium subsidies for Obamacare enrollees, providing larger subsidies to enrollees between 100 and 400 percent of the poverty level and, for the first time, subsidizing enrollees earning above that threshold. Subsidies became available to households earning up to $600,000 per year. Some households earning $500,000 per year became eligible for subsidies of $7,000.[10] Congress reauthorized the enhanced subsidies in 2022. By 2025, taxpayers picked up 88 percent of the premium for enrollees who received a subsidy.[11] Nearly one-third of enrollees pay nothing toward their Obamacare premiums.[12]

Critics allege that the enhanced subsidies have led to widespread fraud.[13] They claim that fully insulating millions of consumers from their premiums enables unscrupulous brokers to collect hefty fees for enrolling consumers in Obamacare plans, often without the enrollee's informed consent.[14]

Congress set the enhanced subsidies to expire on December 31, 2025. When that occurs, families of four earning between $129,000 and $600,000 would no longer receive a premium subsidy. They would face the full cost of Obamacare's health insurance regulations. Overall, enrollees would face the same share of the premium—80 percent across all enrollees—that they did in 2020.[15] Democrats worry that many enrollees would then find Obamacare so unappealing that seven million individuals might drop their Obamacare plans.[16]

Democrats' solution is to make the enhanced subsidies permanent, including for households earning up to $600,000 per year. The Congressional Budget Office (CBO) estimates that this option would cost $488 billion over the next decade—$440 billion in subsidies plus $48 billion in debt-service payments.[17] The new spending would come on top of the nearly $700 billion taxpayers have already spent subsidizing Obamacare plans and the $1.3 trillion that current law will spend over the next decade under current law.[18]

Fortunately, Congress can provide relief to consumers without destabilizing or expanding Obamacare.

A BETTER WAY TO PROVIDE RELIEF

Consumers have a fundamental human right to make their own health care and health insurance decisions. A commonsense corollary is that if government regulation is making health insurance unaffordable or leads to rationing care, then consumers have a right to relief from those regulations.

This principle has a bipartisan pedigree. Obama appealed to that right when he promised that Obamacare "would preserve the right of Americans who have insurance to keep their doctor and their plan."[19] Presidents from both political parties have provided health insurance relief to victims of overregulation. Those efforts can serve as the basis for providing relief to consumers currently buckling under the weight of Obamacare.

President Obama Provides Relief from Obamacare

Barack Obama was the first president to provide health insurance relief from Obamacare. In 2013, the National

Association of Insurance Commissioners warned that in US territories, Obamacare's regulations would cause "higher premiums, less competition, and more Americans without health insurance coverage."[20] In 2014, the *Washington Post* reported that officials in American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the US Virgin Islands "have been warning for years that [Obamacare] would destroy their insurance markets."[21]

President Obama listened. In 2014, the Obama administration issued guidance clarifying that Obamacare's costliest regulations—guaranteed issue, community-rating price controls, essential health benefits mandates, single-risk pool requirements, medical loss ratio requirements, and rate review—would not apply in US territories.[22]

The health insurance relief that Obama provided to US territories continues to this day. One result is that individuals and employers in US territories have greater freedom to choose health insurance plans than do residents of the 50 states.

President Trump Provides Relief from Obamacare

Donald Trump offered health insurance relief to consumers in all 50 states and all six territories. Since 1996, Congress has exempted "short-term, limited duration insurance" (STLDI) from nearly all federal health insurance regulations.[23] Congress and President Obama continued the tradition when they exempted short-term plans from all Patient Protection and Affordable Care Act (i.e., Obamacare) regulations. In 2018, the Trump administration issued a final rule clarifying what does and does not qualify as STLDI.

The rule clarified that federal law allows issuers of short-term plans to offer the following consumer protections:

- Initial contract terms of up to 12 months,
- Extensions of up to 24 additional months for a total duration of 36 months, and
- Renewal guarantees that permit policyholders who develop expensive illnesses to re-enroll at the same low premiums as if they had not developed those illnesses.

On the legal status of renewal guarantees, the Trump administration wrote, "The ability to purchase such instruments, which are essentially options to buy new policies in the future, is at present permitted under federal law. . . . Anyone . . . can purchase such instruments under current federal law."[24] In other words, Congress left insurers and consumers free to sell and purchase a product that turns short-term health insurance into long-term health insurance.

According to the CBO, Trump's health insurance relief enabled consumers to purchase "a comprehensive major medical policy" at premiums "as much as 60 percent lower than premiums for the lowest-cost bronze [Exchange] plan."[25] The Kaiser Family Foundation reports that such plans "can cost two-thirds or less than the lowest-cost . . . Bronze plans."[26]

Those plans were not subject to Obamacare regulations that erode coverage for the sick. As a result, they were often higher quality than Exchange plans on some dimensions, including "lower deductibles or wider provider networks."[27] Trump's rule freed consumers to purchase 36 months of contractual protection, and even longer contractual protection via renewal guarantees, whereas Exchange plans offer only 12 months of contractual protection.

Trump's final rule enabled a market similar to those in other countries. Advanced countries including Germany and Chile allow residents to purchase voluntary long-term health insurance at affordable, actuarially fair premiums. As under Trump's rule, voluntary long-term health insurance in those countries coexists alongside compulsory government-run systems. According to economist Hanming Fang and colleagues, voluntary long-term health insurance in Germany "achieves welfare that is close to 96 percent of the welfare under the optimal contract."[28] Indeed, consumers would benefit to the extent that voluntary long-term health insurance supplants compulsory government-run systems. Fang and colleagues wrote that adding long-term health insurance to the US health sector "would be superior to the *status quo*, but inferior to a system of long-term contracts over the entire lifecycle."[29]

The courts upheld Trump's clarification of federal law. In *Association for Community Affiliated Plans, v. Treasury* both the US District Court for the District of Columbia and the US Court of Appeals for the DC Circuit ruled that Trump's rule was a reasonable and valid interpretation of the statute.[30]

In particular, the DC Circuit ruled that unlimited renewal guarantees are permissible under current law—and always have been. "Nothing in [federal law] prevents insurers from renewing expired STLDI policies," the court wrote. "Indeed, from 1997 to 2016, renewals were allowed with the insurer's consent."[31]

Nevertheless, then-President Joe Biden rescinded Trump's rule in 2024. The Biden administration decreed: Insurers could not sell short-term plans with terms longer than four months; consumers could not purchase consecutive short-term plans from the same insurer; and insurers could not offer renewal guarantees. Biden's 2024 final rule stripped consumer protections from short-term plans and left enrollees who fell ill with no coverage for up to 12 months.[32] The Trump administration has announced that it "intend[s] . . . to undertake notice-and-comment rulemaking to consider the need for amendments" to Biden's 2024 rule and that it "do[es] not intend to prioritize enforcement actions for violations" of that rule.[33]

HEALTH INSURANCE RELIEF DID NOT UNDERMINE OBAMACARE

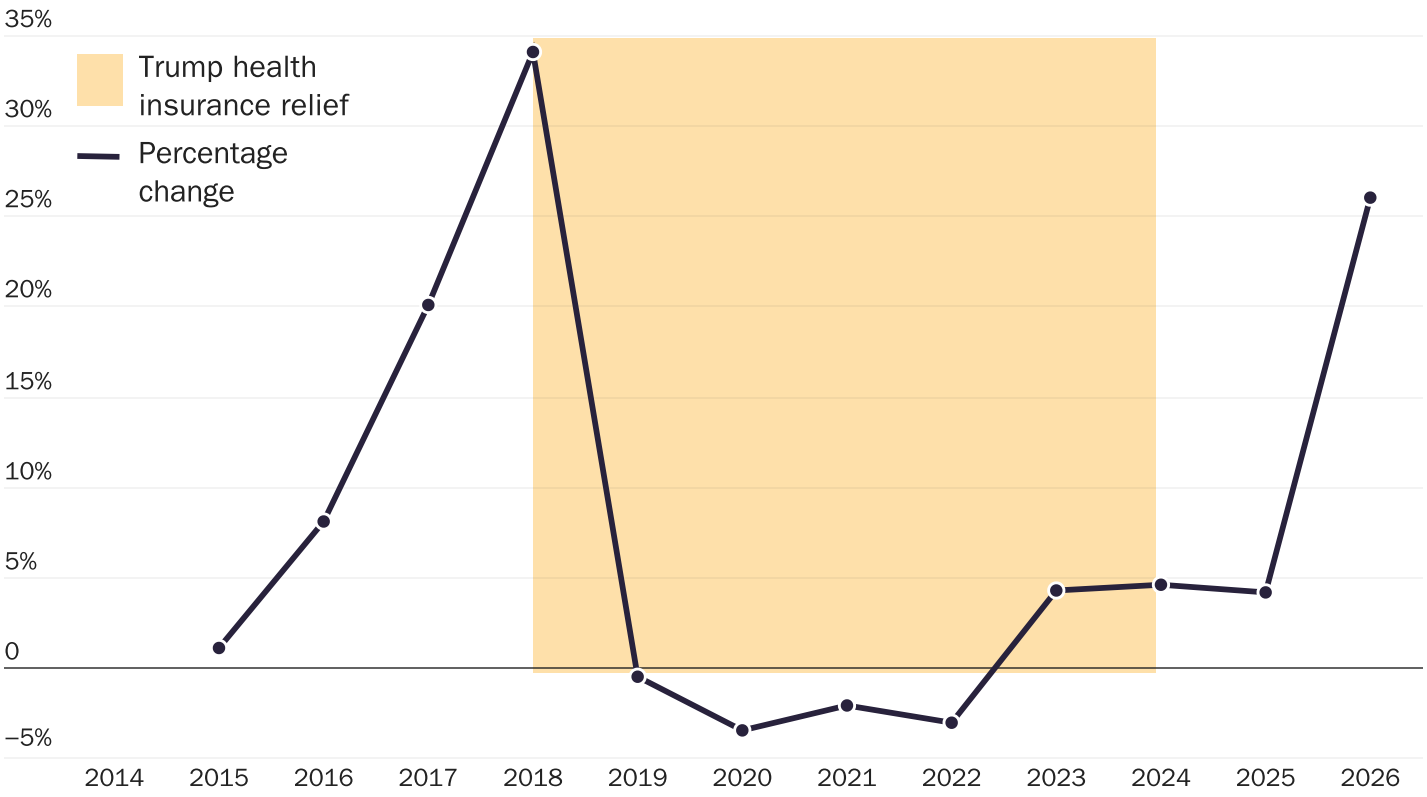
Critics predicted that Trump's health insurance relief would undermine Obamacare. The opposite appears to be true. Obamacare thrived under the Trump rule.

In 2018, the Trump administration predicted that long-term health insurance with renewal guarantees "will serve to strengthen individual market pools and could reduce Exchange premiums and spending."[34] Consistent with that prediction, Figure 1 shows that in the first four years of Trump providing health insurance relief, benchmark Exchange premiums *fell*. In the two remaining years that Trump's rule was in place, premiums grew at a moderate pace (4–5 percent). Over the six years that Trump's rule was in place (2018–2024), there was zero net growth in benchmark Exchange premiums.

Even if Trump's rule was not responsible for restraining Obamacare premiums, it did not cause them to skyrocket as critics predicted. Figure 1 shows that premiums shot

Figure 1

Annual percentage change in weighted average benchmark Exchange premium, 2014–2026



Sources: KFF, "Percent Change in Average Marketplace Premiums by Metal Tier, Timeframe," 2025.
Notes: Data reflect premiums for the second-lowest-cost silver (benchmark) plan for a 40-year-old in each county, which authors weighted according to county-level plan selections. In some state-run Exchanges, the premium data for some years are at the rating-area level or zip level, and therefore weighting may not reflect intra-county plan selections.

upward only after the Biden administration rescinded Trump's final rule, with cumulative growth of 31 percent in 2025 and 2026.[35]

Figure 2 shows that during the same period, Exchange enrollment grew from 12 million in 2018 to 21 million in 2024.

IMPLEMENTING BIPARTISAN HEALTH INSURANCE RELIEF

President Obama and President Trump both recognized the importance of providing relief when regulation renders coverage unaffordable and rations care. Other countries' markets show that voluntary long-term health insurance improves consumer welfare. Experience further shows that Obamacare's health insurance Exchanges can operate and even thrive alongside at least Trump's health insurance relief—and likely Obama's as well. Congress should follow their lead and make the health insurance relief they pioneered both universal and permanent.

Universal Access to Obama's Relief for US Territories

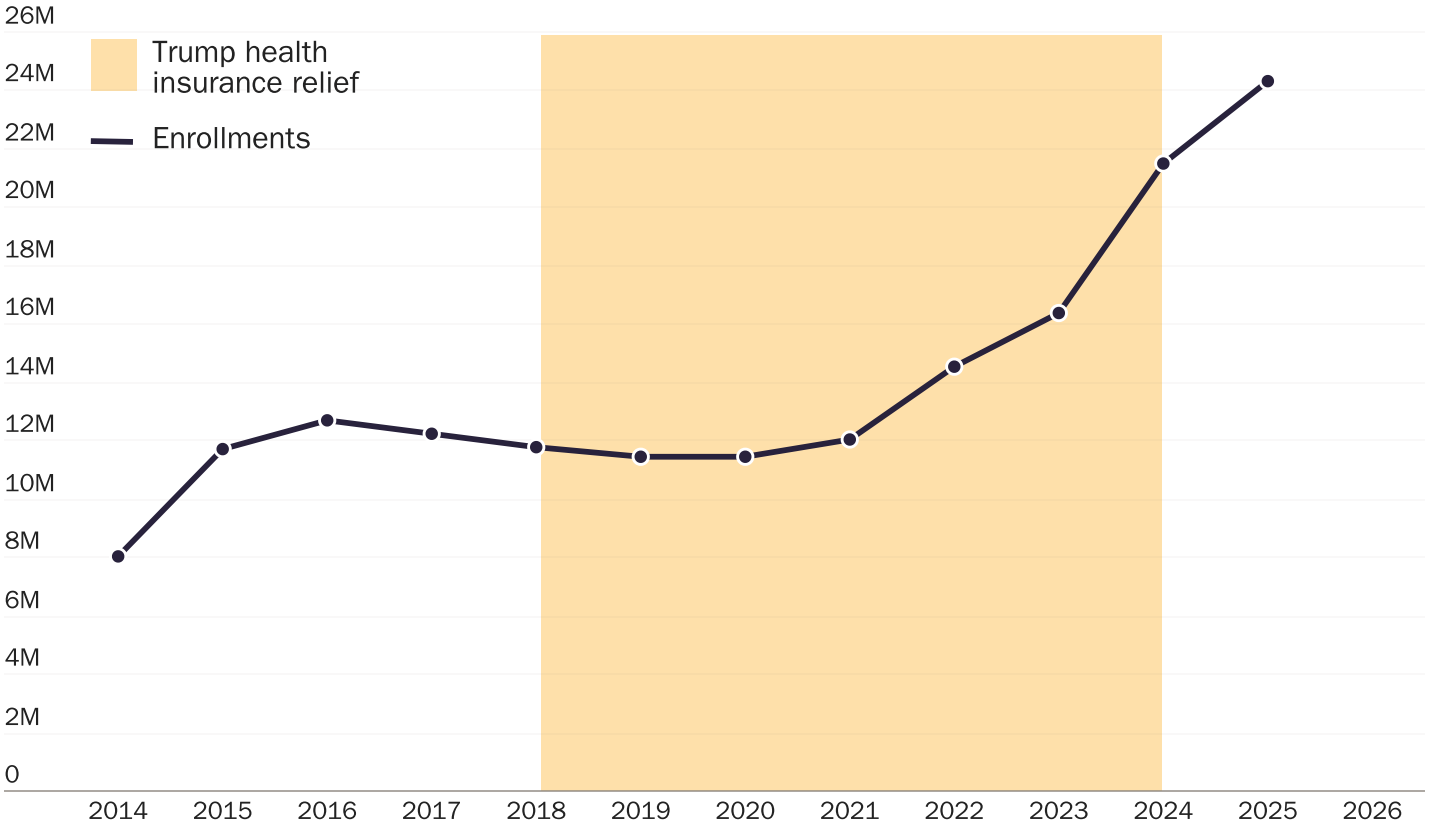
Congress can provide universal access, for all individual consumers and employers, to the same health insurance relief that President Obama granted residents of US territories.

How did Obama's relief operate? In 2010, the PPACA amended the Public Health Service Act (PHSA) in part by imposing numerous additional federal regulations on issuers and purchasers of health insurance. The PHSA already contained a definition of "State" that incorporated US territories; the PPACA contained a different definition of "State" that excluded the territories.[36] Were the PHSA definition to apply, federal law would impose Obamacare's regulations on US territories. Representatives from the territories complained that applying the PHSA definition would destroy their health insurance markets. In 2014, the Obama administration responded with guidance clarifying that the definition of "State" in Title I of the PPACA would

Figure 2

Exchange plan enrollments, 2014–2026

Millions of individuals



Sources: KFF, "Marketplace Enrollment," 2025. Note: The data show Exchange enrollments during each of the enrollment periods from 2014 through 2025.

govern the implementation of the new regulations that PPACA Title I added to the PHSA.[37]

That simple clarification relieved "health insurance issuers in the territories"—as well as consumers—of the burden of Obamacare's costliest health insurance regulations: guaranteed availability (PHSA section 2702), community rating (PHSA section 2701), single-risk pool (PPACA section 1312(c)), rate review (PHSA section 2794), medical loss ratio (PHSA section 2718), and essential health benefits (PHSA section 2707).[38] Obama's health insurance relief remains in effect to this day.

Congress can make Obama's health insurance relief universal and permanent by enacting the legislative language in Appendix A. That language goes no further than making Obama's health insurance relief universal and permanent. It extends that relief to individuals and employers in all 50 states by allowing them to purchase Obamacare-exempt health insurance across state and territorial lines.

Making Obama's health insurance relief universal and permanent would provide consumers with greater protection. As with President Trump's approach (see below), it would allow insurers to sell long-term health insurance that protects enrollees from the largest coverage gap in the United States: the loss of coverage that occurs when consumers change jobs, divorce, lose a spouse, or "age off" their parents' health insurance plans.[39] Consumers could purchase health insurance at lower premiums than Obamacare and free from regulations that ration care to the sick. Consumers and employers could enforce their insurance contracts in their home states with help from their home-state regulators.

Consumers would notice little change aside from more choices, lower premiums, and better coverage. Many of the largest health insurers in the country already operate in US territories and have provider networks in the states. Consumers and employers could purchase coverage from the same insurer they do now with lower premiums and broader provider networks.

Making Trump's Health Insurance Relief Permanent

President Trump's health insurance relief is a proven strategy for providing relief to consumers currently suffering under excessive premiums and health care rationing, all without disrupting other health insurance arrangements.

Congress can make Trump's health insurance relief permanent by inserting the legislative language in Appendix B into the PHSA. That language would codify the consumer-protection-maximizing interpretation of existing federal law that President Trump promulgated in 2018 and that federal courts validated in 2019 and 2020 as reasonable and consistent with federal law. It would add nothing to federal law beyond Trump's 2018 rule.

CONCLUSION

Consumers who are buckling under Obamacare's rising premiums and inadequate coverage deserve relief. Congress can expand access to quality, affordable health insurance coverage by making Obama's and Trump's regulatory relief universal and permanent. This would restore consumers' freedom to choose their own health plans. A real-world test shows no evidence that Trump's reforms created instability in Obamacare's Exchanges. Obamacare would remain for those who want it, and Congress would be free to adjust it.

APPENDIX A

The following legislative language would codify and make available to all individuals and employers in the 50 states the same relief from Obamacare's health insurance regulations that President Obama issued to individuals and employers in US territories.

Section 1

Insert after the period at the end of 42 U.S.C. § 18024(d): "This definition shall apply for purposes of PHSA §§ 2701, 2702, 2707, 2718, 2794, as well as PPACA § 1312(c)."[40]

Section 2

Insert in 42 U.S.C. Chapter 157 the following new section:

"§ 18123. Universal access to health insurance relief.

"(a) Notwithstanding any provision of federal, State, or territorial law, no State or territory shall prohibit any resident from purchasing, or impose any levy on, any lawful health insurance product available in any other State or territory.

"(b) In cases where the purchaser and issuer of a lawful health insurance product are not in the same State or territory, the State or territory where the purchaser resides may enforce the licensing State's or territory's health insurance requirements as part of the insurance contract."

APPENDIX B

The following legislative language would codify each element of President Trump's interpretation of "short-term," "limited duration," and "insurance" as those terms appear in 42 U.S.C. § 300gg–91(b)(5)—an interpretation that expanded consumer protections in those plans and that multiple federal courts upheld as reasonable and consistent with existing law.

Section 1

At the end of 42 U.S.C. § 300gg–91(b)(5), delete the period and insert: "or long-term health insurance.

"(A) The term "short-term" means health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is no more than 12 months after the original effective date of the contract.

"(B) The term "limited duration" means health coverage provided pursuant to a contract with an issuer that, taking into account renewals or extensions, has a duration of no longer than 36 months in total.

"(C) The term "long-term health insurance" means health coverage provided pursuant to a contract with an issuer that also contains a renewal guarantee.

"(D) The term "renewal guarantee" means an insurance product (including a rider) that permits a policyholder to elect to purchase, for periods of time following expiration of the initial contract, another policy or policies at some future date, at a premium that would not reflect any additional underwriting."[41]

NOTES

1. Barack Obama, "Remarks by the President in State of the Union Address," The White House, Office of the Press Secretary, January 27, 2010; Jake Tapper, "Rising Health Costs Undermine Obama Pledge to Curb Trend," ABC News, September 25, 2012; and "Health Care that Works for Americans," The White House, 2015.

2. Lisa Myers and Hannah Rappleye, "Obama Administration Knew Millions Could Not Keep Their Health Insurance," NBC News, October 29, 2013; and Ashley Killough, "Obama Apologizes for Insurance Cancellations Due to Obamacare," CNN, November 7, 2013.

3. Tom Kertscher, "Have Obamacare Premiums Increased Three Times the Rate of Inflation?," Wisconsin Watch, October 28, 2025; and Cynthia Cox, "ACA Insurers Are Raising Premiums by an Estimated 26%, but Most Enrollees Could See Sharper Increases in What They Pay," KFF, October 28, 2025. See also Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "Individual Market Premium Changes: 2013–2017," ASPE Data Point, May 22, 2017. (Individual-market premiums increased at an average annual rate of 20 percent from 2013 to 2017.)

4. President Obama's "jaw-dropping" comment referred to an average premium increase of 25 percent, which affected "almost a million" people. See Jared Allen, "Obama Slams Anthem Rate Increase in Pushing Healthcare Bill," *The Hill*, February 20, 2010. (Obamacare's 26 percent average premium increase for 2026 will apply to 24 million Obamacare enrollees plus 25 million uninsured individuals.) See "Marketplace Enrollment, 2014–2025," KFF, 2025; and Jennifer Tolbert et al., "Key Facts About the Uninsured Population," KFF, December 18, 2024.

5. Michael Geruso, "Screening in Exchanges: Some Facts and Findings from Geruso, Layton, Prinz (2016)," (lecture, Penn LDI HIX Conference, University of Pennsylvania, September 2017); and Michael Geruso at al., "Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges," *American Economic Journal: Economic Policy* 11, no. 2 (May 2019): 64–107.

6. Broad hospital networks went from 80 percent of individual-market plan offerings in 2013 to 59 percent in 2014. See Noam Bauman et al., "Hospital Networks: Updated National View of Configurations on the Exchanges," McKinsey and Company, June 1, 2014. ("Of the 82 rating areas that do not have a broad network on the 2014 exchange, 35 did not have any broad networks in the 2013 individual market either.") See also Leemore S. Dafny et al., "Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network," *Health Affairs* 36, no. 9 (September 2017): 1606–14. ("The share of full networks decreased from 37 percent to 27 percent" from 2014 to 2015.) Senators Ron Johnson and Mike Lee, "Letter on McKinsey and Company Study," US Senate, July 19, 2017.

7. Michael Geruso at el., "Screening in Contract Design: Evidence from the ACA Health Insurance Exchanges," *American Economic Journal: Economic Policy* 11, no. 2 (May 2019): 64–107.

8. "HHS Poverty Guidelines for 2025," Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, 2025.

9. Jared Ortaliza et al., "Inflation Reduction Act Health Insurance Subsidies: What Is Their Impact and What Would Happen If They Expire?," KFF, July 26, 2024.

10. Brian Blase, *Expanded ACA Subsidies: Exacerbating Health Inflation and Income Inequality* (Galen Institute, June 2021).

11. Jared Ortaliza et al., "Inflation Reduction Act Health Insurance Subsidies: What Is Their Impact and What Would Happen If They Expire?," KFF, July 26, 2024.

12. Phillip L. Swagel, "Letter to Chairman Arrington and Chairman Smith Concerning Premium Tax Credits," Congressional Budget Office, June 24, 2024.

13. Brian Blase, "Obamacare Fraud, by the Numbers," Paragon Health Institute, October 1, 2025.

14. Niklas Kleinworth et al., "Ghostbusting ACA Fraud: Millions Who Don't Use Their Health Insurance Expose Abuse in the Program," Paragon Health Institute, October 1, 2025; and Zeke Faux and Zachary R. Mider, "Chasing Big Money with the Health-Care Hustlers of South Florida," *Bloomberg Businessweek*, June 5, 2025.

15. Mark Howell, "Almost Entire Obamacare Premium Increases Paid for by Taxpayers," Paragon Health Institute, 2025.

16. Phillip L. Swagel, "Letter to Chairman Arrington and Chairman Smith Concerning Premium Tax Credits," Congressional Budget Office, June 24, 2024.

17. Phillip L. Swagel, "Letter to Chairman Arrington and Chairman Smith Concerning Premium Tax Credits," Congressional Budget Office, June 24, 2024.

18. Jackson Hammond, "Obamacare: Overbudget and Underdelivering," Paragon Health Institute, October 28, 2024; and Congressional Budget Office, "The Budget and Economic Outlook: 2025 to 2035," January 2025.

19. Barack Obama, "Remarks by the President in State of the Union AddressRemarks by the President in State of the Union Address," The White House, Office of the Press Secretary, January 27, 2010.

20. National Association of Insurance Commissioners, "Implementation of the Affordable Care Act in the US Territories," October 7, 2013.

21. Sarah Kliff, "Think Your State Has Obamacare Problems? They're Nothing Compared to Guam.," *Washington Post*, December 19, 2013; and Jason Millman, "The Administration Just Took Obamacare Away from the Territories," *Washington Post*, July 17, 2014.

22. Marilyn Tavenner, "Letter to Commissioner Gregory R. Francis," Department of Health and Human Services, July 16, 2014.

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

24. Short-Term, Limited Duration Insurance, 83 Fed. Reg. 38222 (August 3, 2018).

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. Michelle Long et al., "Examining Short-Term Limited-Duration Health Plans on the Eve of ACA Marketplace Open Enrollment," KFF, October 15, 2025.

27. 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.

28. Juan Pablo Atal et al., "German Long-Term Health Insurance: Theory Meets Evidence," *Journal of Political Economy* 133, no. 6 (June 2025), p. 37.

29. Juan Pablo Atal et al., "Long-Term Health Insurance: Theory Meets Evidence," National Bureau of Economic Research Working Paper 26870, December 2021, p. 46.

30. Association for Community Affiliated Plans v. Treasury, Civil Case No. 18-2133 (D.C. Cir. 2019); and Association for Community Affiliated Plans v. Treasury, No. 19-5212 (D.C. Cir. 2020).

31. Association for Community Affiliated Plans v. Treasury, No. 19-5212 (D.C. Cir. 2020).

32. Michael F. Cannon, "Biden Short-Term Health Plans Rule Creates Gaps in Coverage," Cato Institute Policy Analysis no. 970, March 14, 2024.

33. Centers for Medicare and Medicaid Services, "Statement of US Departments of Labor, Health and Human Services,

and the Treasury Regarding Short-Term, Limited-Duration Insurance," August 7, 2025.

34. Short-Term, Limited Duration Insurance, 83 Fed. Reg. 38234 (August 3, 2018).

35. "Percent Change in Average Marketplace Premiums by Metal Tier," KFF, 2025.

36. Patient Protection and Affordable Care Act, Pub. L. No. 111–148, 124 Stat. 119 (2010) § 1304(d); and 42 U.S.C. § 18024(d).

37. Marilyn Tavenner, "Letter to Commissioner Gregory R. Francis," Department of Health and Human Services, July 16, 2014.

38. Marilyn Tavenner, "Letter to Commissioner Gregory R. Francis," Department of Health and Human Services, July 16, 2014.

39. Michael F. Cannon, "Health Insurance Companies Are Actually the Good Guys," *US News and World Report*, September 9, 2025.

40. 42 U.S.C. § 18024(d).

41. 42 U.S.C. § 300gg–91(b)(5).

The views expressed in this paper are those of the author(s) and should not be attributed to the Cato Institute, its directors, its Partners, or any other person or organization. Nothing in this paper should be construed as an attempt to aid or hinder the passage of any bill before Congress. Copyright © 2025 Cato Institute. This work by the Cato Institute is licensed under a Creative Commons Attribution-NonCommercial-ShareAlike 4.0 International License.