



PROPOSED ACTION
MEMORANDUM

Protecting Consumers from Short-Term Limited Duration Insurance

Departments of Health and Human Services, Labor, and Treasury
December 2020

I. Summary

The Trump administration dramatically expanded access to short-term limited duration health insurance (STLDI), a product that discriminates against people with preexisting conditions, does not qualify as minimum essential coverage (MEC), and does not have to comply with the Affordable Care Act's (ACA's) market reforms or other federal consumer protections. Several studies have shown increased enrollment in and deceptive marketing of STLDI, a development that poses risks to enrollees and the stability of the individual health insurance market. Because STLDI is only available to those in better health, the sale of these products results in adverse selection and leads to higher premiums for consumers who do not qualify for ACA subsidies.

To address this harm, the Departments of Health and Human Services, the Treasury, and Labor (the Departments) could adopt a new rule, via notice and comment rulemaking, to help ensure that STLDI is not offered as an alternative to ACA coverage. The new rule should limit the duration of STLDI to no more than three months, prohibit renewals and stacking of STLDI policies, and strengthen notice requirements.

II. Justification

STLDI includes significant coverage gaps that leave enrollees who become sick with catastrophic medical bills and limited ability to access comprehensive ACA coverage until the next open enrollment period. The media has reported many stories of consumers who enrolled in STLDI only to learn that their health costs are not covered, and their coverage is inadequate.¹ High unpaid medical bills when someone with STLDI actually needs health care often lead to financial instability for enrollees and uncompensated care for hospitals and other providers.

Despite these gaps, enrollment has increased following a 2018 rule that expanded access to STLDI.² Enrollment is driven in significant part by aggressive and highly misleading marketing.³

STLDI affects more than its own enrollees. Given its benefit gaps and insurers' ability to underwrite, STLDI premiums are unsurprisingly lower than ACA premiums and thus attract healthier enrollees.⁴ As a result,

¹ See, e.g., Michelle Andrews, "Think Your Health Care Costs Are Covered? Beware the 'Junk' Insurance Plan," *NPR* (Dec. 3, 2020); Stephanie Armour, "Shorter-Term Health Plans Force Many to Pay for Lifesaving Treatments, Report Finds," *Wall Street Journal* (Jun. 25, 2020); Ben Conarck, "A Miami Man Who Flew to China Worried He Might Have Coronavirus. He May Owe Thousands," *Miami Herald* (Feb. 24, 2020); Jenny Deam, "A Doctor's Scribbled Note Leads to Patient Losing Health Insurance," *Houston Chronicle* (Nov. 27, 2019); Donna Rosato, "Short-Term Health Insurance Isn't As Cheap As You Think," *Consumer Reports* (Oct. 2, 2018); Zeke Faux et al., "Health Insurance That Doesn't Cover the Bills Has Flooded the Market Under Trump," *Bloomberg* (Sep. 17, 2019); Reed Abelson, "Without Obamacare Mandate, 'You Open the Floodgates' for Skimpy Health Plans," *New York Times* (Nov. 30, 2017); Erik Larson & Zachary Tracer, "The Health Plans Trump Backs Have a Long History of Disputes," *Bloomberg* (Oct. 16, 2017). More patient stories could be collected from congressional testimony, news reports, and partners.

² U.S. 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* at 6 (June 2020), <https://degette.house.gov/sites/degette.house.gov/files/STLDI%20Report%2006%2025%2020%20FINAL.pdf> [hereinafter *Shortchanged*]; National Association of Insurance Commissioners, 2019 Accident and Health Policy Experience Report (2020), https://www.naic.org/prod_serv/AHP-LR-20.pdf (finding that more than 188,000 people were covered by STLDI nationwide in 2019, up from 86,600 people in 2018).

³ See, e.g., *Shortchanged* at 29-41; Christen Linke Young & Kathleen Hannick, Misleading Marketing of Short-Term Health Plans Amid COVID-19, Brookings Institution (Mar. 24, 2020), <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/03/24/misleading-marketing-of-short-term-health-plans-amid-covid-19/>;

Sabrina Corlette et al., The Marketing of Short-Term Health Plans, Robert Wood Johnson Foundation (Jan. 31, 2019), <https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html>.

⁴ Larry Levitt et al., Why Do Short-Term Health Insurance Plans Have Lower Premiums Than Plans That Comply with the ACA? Kaiser Family Foundation (Oct. 31, 2018),

STLTI segments healthier consumers into a separate risk pool, leading to premium increases for people with preexisting conditions.⁵ These premium increases may be especially felt by middle-income Americans who live in rural areas and do not qualify for ACA subsidies.⁶

In light of the rising uninsured rate and the COVID-19 pandemic, there is an urgent need to ensure that consumers are enrolled in insurance products that will cover the care they need without leaving catastrophic medical bills. The Departments also have an interest in protecting consumers from misleading marketing practices. This is always true but is heightened during the pandemic when access to affordable care and coverage has never been more important.

III. Current State

STLTI stems from the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In defining “individual health insurance coverage,” Congress included an exception for STLTI, which was designed for individuals who were transitioning between health plans.⁷ This is the only reference to STLTI in federal statute, and the term is left undefined. Beginning with an interim final rule in 1997, the Departments defined STLTI as having a duration of up to twelve months.⁸ This definition was maintained in rulemaking in 2004 and remained in place until 2016.⁹

Because Congress incorporated HIPAA’s definition of “individual health insurance coverage” when enacting the ACA, STLTI plans are exempt from the ACA’s individual market reforms. STLTI plans also do not qualify as MEC under the ACA, which means these plans do not satisfy the individual mandate, and the loss of STLTI does not qualify as a loss of MEC for purposes of eligibility for a special enrollment period.

The Obama administration revised the regulatory definition of STLTI in 2016, reducing the duration of STLTI to no more than three months and prohibiting coverage renewals (the “2016 rule”).¹⁰ The 2016 rule also required a prominent notice that STLTI does not qualify as MEC.¹¹ The 2016 rule applied to policy years beginning on or after January 1, 2017, but allowed already approved STLTI products to remain in effect through December 31, 2017.¹²

The 2016 rule was short-lived. The Trump administration reversed the rule, opting instead to expand access to STLTI. In response to an Executive Order,¹³ the Departments promulgated a rule that extended the duration of STLTI to up to twelve months and allowed these products to be renewed for up to thirty-six months at the insurer’s option (the 2018 rule).¹⁴ The 2018 rule also imposed more specific notice requirements for STLTI application materials.¹⁵

<https://www.kff.org/health-reform/issue-brief/why-do-short-term-health-insurance-plans-have-lower-premiums-than-plans-that-comply-with-the-aca/>

⁵ See generally Sarah Lueck, Commentary: Growing Evidence Shows Need for Stronger Rules for Short-Term Health Plans, Center on Budget and Policy Priorities (Oct. 23, 2020), <https://www.cbpp.org/research/health/commentary-growing-evidence-shows-need-for-stronger-rules-for-short-term-health> (summarizing data on STLTI).

⁶ See Rachel Fehr et al., How Affordable are 2019 ACA Premiums for Middle-Income People? Kaiser Family Foundation (Mar. 5, 2019), <https://www.kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people/>.

⁷ See 42 U.S.C. 300gg-91(b)(5) (“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.”).

⁸ 62 Fed. Reg. 16894-976 (Apr. 8, 1997).

⁹ See 69 Fed. Reg. 78719-99 (Dec. 30, 2004).

¹⁰ See 81 Fed. Reg. 75316, 75317-19 (Oct. 31, 2016).

¹¹ *Id.*

¹² *Id.* at 75318-19.

¹³ Executive Order 13813, 82 Fed. Reg. 48385-87 (Oct. 12, 2017).

¹⁴ See 83 Fed. Reg. 38212-43 (Aug. 3, 2018).

¹⁵ *Id.* at 38222-25.

The 2018 rule was challenged by a coalition of safety net health insurers and patient advocates who argued that the revised rule is contrary to HIPAA and the ACA, and that the rulemaking violated the Administrative Procedure Act (APA). A district court upheld the rule as a reasonable interpretation of HIPAA and the ACA, and held that the changes from the 2016 rule were not arbitrary and capricious.¹⁶ On appeal, a divided panel of the Court of Appeals for the D.C. Circuit (D.C. Circuit) affirmed that ruling, concluding that the phrase “short-term limited duration insurance” is ambiguous and deferring to the Departments’ interpretation as a reasonable exercise of policymaking authority.¹⁷ In doing so, the D.C. Circuit opined that a future administration could change this interpretation.¹⁸ The challengers have sought *en banc* review and that petition is pending.

IV. Proposed Action

To protect consumers and promote individual market stability, the Departments should revise the definition of STLDI in 26 C.F.R. § 54.9801-2, 29 C.F.R. § 2590.701-2, and 45 C.F.R. § 144.103 to limit the duration of STLDI to three months, prohibit renewals and stacking, and strengthen notice requirements. A new rule should define STLDI as health insurance coverage provided pursuant to a contract with an issuer that:

- has an expiration date specified in the contract (taking into account any extensions or the sale of multiple or consecutive policies to the same enrollee) that is less than three months after the original effective date of the contract; and
- displays a prominent notice about the limitations of STLDI in the contract, any application materials, and any marketing materials provided in connection with enrollment—whether physical or online—in at least 14-point type.

Both the 2016 and 2018 rules were promulgated quickly using traditional notice-and-comment rulemaking with sixty-day comment periods.¹⁹ The Departments should do the same here using a sixty-day comment period and align the rule’s effective date with the 2022 open enrollment period. This would ensure that those who lose access to STLDI under the new rule would have an opportunity to enroll in comprehensive ACA coverage, and would provide a justification for a swift court ruling if the rule is challenged in court. STLDI products sold before the rule’s effective date could remain in effect until the end of the contract term, but the Departments should prohibit any further renewal of those policies. Ideally and as outlined in a separate memorandum, the White House would also revoke the Executive Order that directed the Departments to adopt the 2018 rule.

To further minimize litigation risk, the Departments could consider a temporary nonenforcement stance towards STLDI products that were approved for sale by state regulators ahead of the rule’s effective date (even if not already issued to consumers). The Departments adopted a similar stance in the 2016 rule: that rule went into effect for policy years beginning on or after January 1, 2017, but enforcement was delayed for STLDI approved and sold before April 1, 2017, so long as coverage ended on or before December 31, 2017.²⁰ Since those policies may expire throughout the calendar year, the Department of Health and Human Services

¹⁶ *Ass’n for Cmty. Affiliated Plans v. United States Dep’t of Treasury*, 392 F. Supp. 3d 22, 29 (D.D.C. 2019).

¹⁷ *Ass’n for Cmty. Affiliated Plans v. United States Dep’t of Treasury*, 966 F.3d 782, 794 (D.C. Cir. 2020).

¹⁸ *Id.*

¹⁹ The proposed 2016 rule was published in the Federal Register on June 10, 2016 and finalized on October 31, 2016. The proposed 2018 rule was published in the Federal Register on February 21, 2018 and finalized on August 3, 2018.

²⁰ 81 Fed. Reg. at 75318-19.

could authorize a sixty-day exceptional circumstances special enrollment period for those who lose STLDI coverage during the nonenforcement period.

Authority to Revise the Definition of STLDI

The Departments can assert that the revised interpretation is necessary to correct the 2018 rule's inherent defect of allowing consumers to rely on STLDI as a primary source of coverage. The ACA, by adopting a single risk pool requirement and other comprehensive reforms, never contemplated the possibility that STLDI would be marketed as a primary source of coverage and precluded the Departments' interpretation in the 2018 rule. The revised interpretation is thus needed to correct the 2018 rule which, as the dissent in the D.C. Circuit put it, "flies in the face" of the ACA "by expanding a narrow statutory exemption beyond recognition" to create an alternative market exempt from the ACA's reforms.²¹ In other words, the Departments can adopt the dissent's argument that the present rule violates the ACA.

Alternatively, the Departments can cite their authority to revise the interpretation of STLDI, as asserted in the preamble to the 2018 rule²² and affirmed by the D.C. Circuit.²³ In the 2018 rule, the Departments justified the interpretation by arguing that (i) meaning must be given to STLDI to determine the scope and enforcement of the rules regarding individual health insurance coverage, (ii) the absence of a statutory definition gives the authority to define STLDI "and set standards that distinguish it from individual health insurance coverage," and (iii) the Departments have rulemaking authority to issue regulations as may be necessary or appropriate to implement the Public Health Service Act.²⁴ The D.C. Circuit agreed, opining that a future administration could change this interpretation: "[I]f a new Administration comes to power with a different vision of how the ACA's competing policy goals should be balanced, it can revisit the Departments' choice."²⁵

Beyond returning to the standards set in the 2016 rule, the Departments should newly prohibit the "stacking" of STLDI policies by barring insurers from selling consecutive or multiple STLDI policies to the same enrollee. In particular, the rule could clarify that the three-month duration limit cannot be extended by issuing the same policy for successive back-to-back terms or by issuing a different STLDI policy to the same policyholder more than once in a given year. Insurers thus could not issue an STLDI policy to a consumer if it would result in a person being covered by an STLDI policy with that insurer for more than three months in a twelve-month period.

Legal and Policy Justifications for Revising the Definition of STLDI

The revised interpretation to the definition of STLDI should be upheld so long as it is "rational, based on consideration of the relevant factors and within the scope of the authority delegated to the agency by the statute."²⁶ The Departments must explicitly acknowledge the change in position, offer a reasoned explanation that addresses why they are changing their position, address why those arguments are no longer persuasive,

²¹ 966 F.3d at 794, 789 (Rogers, J. dissenting) (relying on *King v. Burwell* and noting that "[i]t is difficult to imagine a starker conflict between a statutory scheme and a rule that purports to administer it").

²² 83 Fed. Reg. at 38215 ("The Departments have clear statutory authority under the PHS Act to interpret undefined provisions of the PHS Act, ERISA, and the Code.").

²³ 966 F.3d at 789 ("Congress granted the Departments wide latitude to define STLDI, and while the Departments retain the flexibility to narrow their definition in the future, nothing in the text forecloses their current interpretation.").

²⁴ 83 Fed. Reg. at 38215.

²⁵ 966 F.3d at 794.

²⁶ See *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 42 (1983) (internal quotations and citations omitted). Agencies cannot, however, rely on factors that Congress did not intend for it to consider, fail to consider an important aspect of the problem, offer an explanation that runs counter to the evidence, or adopt a position that is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. *Id.* at 43.

consider alternatives (including maintaining the current interpretation), address reliance interests based on the 2018 rule, and explain why the statute supports their interpretation.²⁷

First, the aggressive and misleading marketing tactics used to sell STLDI and consumer confusion has created an even more urgent need to delineate between STLDI and comprehensive individual health insurance coverage than there was in 2016. The proposed rule—with a three-month duration limit, a ban on renewals and stacking, and strengthened notice requirements—would better ensure that STLDI is more clearly differentiated from major medical coverage.

There is significant evidence that STLDI insurers and brokers misrepresent coverage to consumers, urge consumers to purchase plans over the phone without written information, or fail to disclose major coverage limitations.²⁸ Some STLDI insurers and brokers deliberately design and sell STLDI plans to mimic ACA-compliant plans, or target consumers searching for comprehensive coverage, promising coverage for specific medical conditions without disclosing exclusions.²⁹ And broker-mediated enrollment in STLDI increased by about 60% in December 2018 and then 120% in January 2019, suggesting that STLDI insurers and brokers are “benefiting from, and possibly capitalizing on the marketing and advertising around the ACA’s open enrollment season.”³⁰ Other investigations have revealed deceptive online advertising campaigns to lure consumers to purchase STLDI.³¹

While increased federal and state oversight is needed to fully address these concerns, limiting the duration of STLDI to no more than three months with no renewals or stacking would strike a clear contrast with twelve-month individual health insurance coverage. Such a limit would help ensure that consumers are less easily duped into enrolling in STLDI—which can currently be sold for up to twelve months and renewed for up to thirty-six months—when they intended to enroll in comprehensive coverage. The expanded notice requirement (which would appear on more than paper marketing materials that a consumer rarely sees) would also help inform applicants of the limitations of STLDI relative to major medical coverage. Additional analyses focused on misleading and aggressive marketing tactics by STLDI insurers and brokers would help bolster this justification.

Second, the proposed restrictions are more consistent with the text and goals of the ACA as well as the purpose of STLDI to fill short-term gaps in coverage when a consumer is between major medical policies. Consistent with the need to prevent aggressive marketing and draw a clear distinction with major medical coverage, the revised rule is needed to ensure that the sale of STLDI remains consistent with its statutory purpose of serving as a short-term gap filler policy and not as a parallel market to ACA coverage. As the D.C. Circuit dissent argued, the three-month rule is compelled by the ACA; at a minimum, it is a permissible interpretation of the ACA.

Critics might argue that a limit of three months (rather than, say, six months) is arbitrary if the rule is simply designed to show a contrast between STLDI and individual health insurance coverage. But the Departments would have discretion in determining the appropriate duration of STLDI. The Departments could also bolster the justification for the three-month limit by pointing to the same justification from the 2016 rule. There, the Departments aligned the duration of STLDI with the short coverage gap exemption to the individual mandate.³² Even though the individual mandate penalty was set to \$0, the ACA’s short coverage gap

²⁷ *Dep’t of Commerce v. New York*, 588 U.S. ___, 139 S.Ct. 2551, 2575-76 (2019); *F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (1999) (*Fox*). The agency’s burden is not to convince a reviewing court that the new policy is better than the old policy, but that the new policy is permissible under the relevant statute, there are good reasons for it, and the agency believes it to be better. *Fox* at 515.

²⁸ See *Shortchanged* at 29-41; Corlette et al., *supra* note 3.

²⁹ *Shortchanged* at 29-41.

³⁰ *Id.* at 93.

³¹ Jeremy B. Merrill & Marshall Allen, “‘Trumpcare’ Does Not Exist. Nevertheless Facebook and Google Cash In on Misleading Ads for ‘Garbage’ Health Insurance,” *ProPublica* (Oct. 20, 2020); Office of Senator Bob Casey, *Health Care Sabotage Online: A Warning to Consumers* (Oct. 2019), <https://www.casey.senate.gov/download/casey-report-on-health-care-sabotage-online>.

³² See 81 Fed. Reg. at 75318; see also I.R.C. § 5000A(e)(4); 26 C.F.R. § 1.5000A-3(f).

exemption remains in statute, and it would be permissible for the Departments to analogize the limit on STLDI to that exemption.

Third, the Department can cite justifications that are similar to those from the 2016 rulemaking while relying on an even stronger evidence base. In the preamble to the 2016 rule, the Departments asserted that (i) there is less need for STLDI as a source of transitional coverage, because ACA coverage is available on a guaranteed basis through special enrollment periods, (ii) STLDI does not provide meaningful health coverage due to significant benefit limitations, and (iii) STLDI is being targeted to healthier individuals, which is adversely impacting the ACA risk pool.³³

As noted above, the ACA has eliminated the need for STLDI as originally intended—as a source of transitional coverage—since gap-filler coverage is not needed in a reformed market. Critics will argue that the increase in STLDI enrollment contradicts this point by showing an increased demand for short-term coverage, but the Departments can respond that higher STLDI enrollment is more likely attributed to (i) the 2018 rule which enabled STLDI to be sold as an alternative to ACA coverage, and (ii) aggressive, often fraudulent, marketing of STLDI products. Additional data to confirm these assumptions would be helpful to countering this criticism.

Similar to the concerns raised in the preamble to the 2016 rule, STLDI still fails to provide meaningful health coverage. Recent analyses show that STLDI products exclude entire categories of benefits (such as prescription drugs or maternity care);³⁴ deny coverage or benefits to those with preexisting conditions;³⁵ discriminate against women;³⁶ engage in medical underwriting;³⁷ require much higher cost-sharing than ACA products;³⁸ and lead to significant out-of-pocket costs for those who become ill.³⁹ Some STLDI does not cover even routine preventive care or injuries,⁴⁰ and many do not cover treatment for COVID-19.⁴¹ As a result, those who purchase these plans risk, often unknowingly, catastrophic medical bills. These and other gaps were documented in an extensive investigation of STLDI by the U.S. House of Representatives' Energy and Commerce Committee.⁴²

These benefit gaps remain despite predictions by the Congressional Budget Office (CBO) that STLDI would evolve to offer more comprehensive benefits following the 2018 rule⁴³ and limited studies by proponents of STLDI.⁴⁴ One review of more than 400 policies plans concluded that twelve-month STLDI denied coverage

³³ 81 Fed. Reg. at 75317-18.

³⁴ Karen Pollitz et al., Understanding Short-Term Limited Duration Health Insurance, Kaiser Family Foundation (April 23, 2018), <https://www.kff.org/report-section/understanding-short-term-limited-duration-health-insurance-issue-brief/>.

³⁵ See American Cancer Society Cancer Action Network, Inadequate Coverage: An ACS CAN Examination of Short-Term Health Plans (May 13, 2019),

<https://www.fightcancer.org/sites/default/files/ACS%20CAN%20Short%20Term%20Paper%20FINAL.pdf>; Sarah Lueck, Key Flaws of Short-Term Health Plans Pose Risks to Consumers, Center for Budget and Policy Priorities (Sep. 20, 2018), <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-poses-risks-to-consumers>.

³⁶ See, e.g., JoAnn Volk et al., Trump Administration Promotes Coverage That Fails to Adequately Cover Women's Key Health Care Needs, The Commonwealth Fund (Oct. 9, 2020),

<https://www.commonwealthfund.org/blog/2020/trump-administration-promotes-coverage-that-fails-to-cover-womens-key-health-care-needs>.

³⁷ Karen Pollitz et al., *supra* note 34; American Cancer Society Cancer Action Network, *supra* note 35.

³⁸ Dania Palanker et al., New Executive Order: Expanding Access to Short-Term Health Plans is Bad for Consumers and the Individual Market, The Commonwealth Fund (Oct. 11, 2017),

<https://www.commonwealthfund.org/blog/2017/new-executive-order-expanding-access-short-term-health-plans-bad-consumers-and-individual>.

³⁹ Dane Hansen & Gabriela Diguez, The Impact of Short-Term Limited Duration Policy Expansion on Patients and the ACA Individual Market, Milliman (Feb. 2020), <https://www.wlls.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf>.

⁴⁰ *Shortchanged* at 61; Cheryl Fish-Parcham, Seven Reasons the Trump Administration's Short-Term Health Plans Are Harmful to Families, Families USA (Aug. 1, 2018), <https://familiesusa.org/resources/seven-reasons-the-trump-administrations-short-term-health-plans-are-harmful-to-families/> (finding STLDI exclusions for sports injuries and tonsillectomies); Jackson Williams, "Short-term Health Insurance Coverage is Almost Worthless," *Philadelphia Inquirer* (July 30, 2018) (noting that some STLDI policies limit hospitalization coverage to \$1,000 per day, even though the average U.S. cost of hospitalization is more than \$5,000 per day).

⁴¹ See Emily Curran et al., In the Age of COVID-19, Short-Term Plans Fall Short for Consumers, The Commonwealth Fund (May 12, 2020), <https://www.commonwealthfund.org/blog/2020/age-covid-19-short-term-plans-fall-short-consumers>.

⁴² See generally *Shortchanged*.

⁴³ See Congressional Budget Office, How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans (Jan. 2019), <https://www.cbo.gov/publication/54915>.

⁴⁴ See, e.g., Chris Pope, Renewable Term Health Insurance: Better Coverage Than Obamacare (May 2019),

based on health status, excluded coverage for preexisting conditions, excluded major benefit categories, such as prescription drugs, and imposed low dollar limits on care.⁴⁵ These persistent gaps, researchers concluded, show that the CBO's forecast has not come to fruition: the STLDI market "continues to place enrollees at huge risk."⁴⁶

There is also evidence to suggest that the proliferation of STLDI under the 2018 rule adversely impacts the ACA risk pool by increasing premiums for ACA coverage.⁴⁷ This is consistent with the Departments' own estimates⁴⁸ and a separate analysis by the independent chief actuary of the Centers for Medicare and Medicaid Services that estimated that average Exchange premiums would be 3% higher in 2019 and 6% higher beginning in 2022 due to the rule.⁴⁹ Higher premiums were expected⁵⁰ and among the reasons why the vast majority of health care stakeholders who commented criticized or opposed the 2018 rule.⁵¹

This evidence notwithstanding, some of these studies are dated and focused solely on the impacts of the proposed (rather than final) rule. It has also proved challenging to assess the isolated impact of the 2018 rule on premiums and enrollment. Additional empirical data would be helpful to show evidence of the new rule's effect on state insurance markets, premiums, and uncompensated care. One possibility is comparing rates in states that permit STLDI with those in states that prohibit it.

Fourth, while states continue to have the authority to ban or restrict the sale of STLDI, federal restrictions are especially important, because STLDI is sold predominantly through out-of-state associations that many states do not regulate.⁵² Of the estimated three million people enrolled in STLDI in 2019, most—2.2 million—were enrolled through an association, an increase from 1.7 million in 2018.⁵³ Association sales are likely increasing because insurers can use associations to circumvent state restrictions. Federal action is thus necessary to protect consumers fully and help maintain a level playing field of minimum standards across all states.

<https://media4.manhattan-institute.org/sites/default/files/R-0519-CP.pdf>

⁴⁵ Dania Palanker et al., *Limitations of Short-Term Health Plans Persist Despite Predictions That They'd Evolve*, The Commonwealth Fund (Jul. 22, 2020),

<https://www.commonwealthfund.org/blog/2020/limitations-short-term-health-plans-persist-despite-predictions-theyd-evolve>.

⁴⁶ *Id.* In light of this study, the *Shortchanged* investigation, and other analyses, the CBO was asked to reevaluate its projections regarding STLDI. It declined to do so and continues to expect that most people who enroll in STLDI will enroll in plans that satisfy its definition of health insurance coverage. Congressional Budget Office, *CBO's Estimates of Enrollment in Short-Term, Limited-Duration Insurance* (Sep. 25, 2020), <https://www.cbo.gov/publication/56622>.

⁴⁷ See Hansen & Diguez, *supra* note 39 (finding that the 2018 rule increased unsubsidized ACA individual market premiums by about 4 percent in 2020 among states that allowed full expansion of STLDI policies and estimating that 6 percent of members in the ACA-compliant individual market will migrate to non-MEC including STLDI because of the 2018 rule and elimination of the individual mandate penalty); Rabah Kamal et al., *How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums*, Kaiser Family Foundation (Oct. 2018), <https://www.kff.org/health-reform/issue-brief/how-repeal-of-the-individual-mandate-and-expansion-of-loosely-regulated-plans-are-affecting-2019-premiums/>.

⁴⁸ See 83 Fed. Reg. at 38234. In the preamble to the rule, the Departments noted that those who purchase STLDI were "likely to be relatively young or relatively healthy" and that the rule "may weaken states' individual market single risk pools." The preamble went on to state that individual market insurers "could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market," and that this rule "may further reduce choices for individuals remaining in those individual market single risk pools." Although the Departments estimated that the rule would increase premiums by 1% in 2019 and by 5% by 2028, other independent analyses suggest that the Departments underestimated the impact of the rule on ACA premiums.

⁴⁹ Chief Actuary Paul Spitalnic, *Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule*, Office of the Actuary (Apr. 6, 2018), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf>. Higher premiums would result in higher premium tax credits and thus higher federal outlays, with federal spending expected to increase by about \$1.2 billion in 2019 and about \$38.7 billion over the next 10 years.

⁵⁰ See Katie Keith, "The Short-Term, Limited-Duration Coverage Final Rule: The Background, The Content, And What Could Come Next," Health Affairs Blog (Aug. 1, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180801.169759/full/> (summarizing analyses by the Urban Institute, Wakely, Oliver Wyman, and the Congressional Budget Office that each found the impact of the proposed rule on premiums and enrollment to be greater than federal estimates in large part because the Departments' prior analysis modeled only the effects on enrollment on on-Exchange coverage).

⁵¹ Noam N. Levey, "Trump's New Insurance Rules are Panned by Nearly Every Healthcare Group that Submitted Formal Comments," *Los Angeles Times* (May 30, 2018).

⁵² See Emily Curran et al., *Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections*, The Commonwealth Fund (Jan. 31, 2019),

<https://www.commonwealthfund.org/blog/2019/short-term-health-plans-sold-through-out-state-associations-threaten-consumer-protections>.

⁵³ *Shortchanged* at 25.

Fifth, the Departments should prohibit the “stacking” of STLDI policies by barring insurers from selling consecutive or multiple STLDI policies to the same enrollee if it would result in a person being covered by an STLDI policy with that insurer for more than three months in a twelve-month period. Commenters had urged the Departments to ban stacking in the 2016 rule.⁵⁴ But the Departments declined to do so, concluding that such a restriction was not needed at that time, because the individual mandate would sufficiently discourage the purchase of multiple, successive STLDI policies.⁵⁵ The Departments also raised concerns that this restriction would be difficult for state regulators to enforce, since a consumer’s prior coverage would have to be tracked.

Circumstances have clearly changed, and the Departments would be justified in adopting this new restriction. The individual mandate penalty has been set to \$0 so it no longer serves as an incentive to prevent prolonged enrollment in STLDI. STLDI products have led to consumer confusion and are being aggressively marketed. And states have adopted similar stacking restrictions. Of the twenty-five states with some restrictions on STLDI, ten states limit the total length of time that a consumer can be enrolled in STLDI coverage.⁵⁶

To alleviate enforcement concerns, the Departments could prohibit insurers from selling stacked or consecutive policies only to enrollees that had purchased an STLDI policy *with that insurer* in the past twelve months. Under this proposed policy, insurers could sell STLDI policies to consumers who were previously enrolled in STLDI with *another* insurer. This increases the possibility that consumers could extend enrollment in STLDI beyond three months by enrolling with different insurers, but it alleviates the need to track prior coverage, thereby reducing burdens on insurers and regulators.

Finally, the Departments should directly respond to the justifications cited in the preamble to the 2018 rule. There, the Departments argued that expanded access to STLDI would reduce the number of uninsured individuals, provide an alternative to ACA coverage, and promote choice and affordability.⁵⁷ Despite these assertions, the uninsured rate continues to rise even as STLDI enrollment has increased. And most new STLDI enrollees were estimated to come not from the ranks of the uninsured but from ACA-compliant plans.⁵⁸ Nationwide, insurer competition in the Exchanges continues to increase. And the Departments should, in the new preamble, take the view that the expansion of STLDI hinders consumer choice and affordability, because STLDI results in adverse selection against the ACA’s single risk pool.

⁵⁴ 81 Fed. Reg. at 75318 (urging the Departments to “prohibit issuers from offering [STLDI] to consumers who have previously purchased this type of coverage to prevent consumers from stringing together coverage under policies offered by the same or different issuers”).

⁵⁵ *Id.*

⁵⁶ The Commonwealth Fund, What is Your State Doing to Affect Access to Adequate Health Insurance? (Nov. 6, 2020), <https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/what-your-state-doing-affect-access-adequate-health>; *see also* Dania Palanker et al., States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans (May 2, 2019), <https://www.commonwealthfund.org/publications/issue-briefs/2019/may/states-step-up-protect-markets-consumers-short-term-plans>. Not all states limit enrollment to 3 months in a 12-month period; some allow a longer duration of enrollment (such as 6 months in a 12-month period, or 3 months in a 5-month period).

⁵⁷ 83 Fed. Reg. at 38228-31.

⁵⁸ *Id.* at 38236.

