Individual Health Insurance Markets Improving in States that Fully Permit Short-Term Plans

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OVERVIEW

Given freedom to purchase health coverage, some people will choose plans that contain fewer benefits or that charge lower premiums for people with lower expected medical claims. Many political leaders, however, believe the government should allow plans to be sold only if they cover a prescribed set of benefits and charge people of similar ages the same premium regardless of their health status. The conflict between the freedom that some Americans desire to purchase less-regulated health coverage and the preferences of some government leaders to restrict that freedom has caused deep division at the federal and state government levels for more than a decade. However, evidence is emerging to suggest that a free market can coexist with a more regulated and subsidized market.

Because of the Affordable Care Act (ACA), people are guaranteed the opportunity to buy health insurance that covers 10 essential benefits, provides pre-existing conditions protections, and charges healthy and sick people of the same age the same premium if they buy coverage during designated enrollment periods. However, many people—particularly those who earn a middle income or above—have been priced out of the market because of how significantly the ACA has increased premiums and deductibles. Lower-income people can qualify for large subsidies to purchase ACA coverage and largely have been held harmless by premium changes.

One alternative to ACA-compliant individual market coverage is short-term, limited-duration insurance. These plans permit millions of people the opportunity to purchase coverage that is more affordable and flexible, and a 2018 rule by the Departments of Health and Human Services (HHS), Labor, and the Treasury increased the amount of time short-term coverage could last to up to 364 days, with renewals permitted for up to three years. An estimated 3 million people enrolled in this coverage at some point in 2019.[1]

[1] Brian Blase and Doug Badger, "The Value of Short-Term Health Plans: Rebutting the Energy and Commerce Democratic Staff Report," *Health Affairs*, August 17, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200813.226193/full/.

Critics of short-term plans, and of the 2018 rule, argue that the plans would lead to greater adverse selection in the individual market as some relatively healthy people drop more expensive individual market plans and replace them with more affordable short-term plans. They have warned that the 2018 rule would lead to fewer individual market enrollees, fewer insurers offering individual market plans, and higher premiums for individual market plans. For example, Timothy Westmoreland, M. Gregg Bloche, and Lawrence Gostin wrote in the *Journal of American Medical Association*, "By drawing healthier people away from ACA-qualifying plans, short-term plans make ACA-qualifying coverage less affordable."[2]

Some policy experts have proposed significant federal restrictions on short-term plans that would effectively take away these plans from millions of people who have them and deny that option to tens of millions more people who could benefit from them in the future.[3] Moreover, these restrictions would be inconsistent with one of President Biden's promises during the presidential campaign: "If you have private insurance, you can keep it."[4]

Fortunately, since some states have permitted short-term plans to the full extent that federal law allows while others have placed restrictions on these plans, policymakers and regulators can determine whether the predictions about harm to the individual market from allowing short-term plans have come to fruition. Perhaps surprisingly, it turns out that states that fully permit short-term plans have had a much more favorable experience in their individual markets since the 2018 rule took effect. States that permit short-term plans have lost fewer enrollees in the individual market, have had far more insurers offer coverage in the market, and have had larger premium reductions since the 2018 rule took effect. The only states where individual market premiums have increased since 2018 are the five states that effectively prohibit short-term plans.

Contrary to projections, the evidence shows that the 2018 rule expanding short-term options not only expanded consumer choice of coverage and reduced the number of uninsured but also had no adverse impact on the individual market.

The 2018 short-term plan rule may have, in fact, helped improve the individual market. This could have occurred because short-term plans forced insurers selling ACA-compliant products to offer more attractive products because of the added competition and because people with short-term plans who got sick or injured had short-term plans pay their expenses instead of moving to the individual market to get coverage to pay their expenses.

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[2] Lawrence Gostin, Timothy Westmoreland, and Gregg Bloche, "Executive Action to Expand Health Services in the Biden Administration," *Journal of the American Medical Association*, Vol. 325, No. 3 (2021), pp. 217–218, https://jamanetwork.com/journals/jama/fullarticle/2775292.

[3] Paige Winfield Cunningham, "The Health 202: Joe Biden Could Undo Trump's Changes to the Obamacare Marketplaces," *Washington Post*, July 14, 2020, https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2020/07/14/the-health-202-joe-biden-could-undo-trump-s-changes-to-the-obamacare-marketplaces/5f0c624488e0fa7b44f7302f/.

[4] Jon Greenberg, "'If You Like Your Plan, You Can Keep It.' Biden's Invokes Obama's Troubled Claim," *Kaiser Health News*, July 30, 2019, https://khn.org/news/if-you-like-your-plan-you-can-keep-it-bidens-invokes-obamas-troubled-claim/.

Background

Short-term health plans, which are exempt from most federal insurance regulation, had been available for nearly two decades before the ACA's major changes took effect in 2014. Under a 1997 rule issued pursuant to the Health Insurance Portability and Accountability Act, the Departments of HHS, Labor, and the Treasury defined *short-term plans* 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 that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract."[5] This definition of *short-term coverage* applied for two decades until April 1, 2017.

As premiums for individual market coverage escalated rapidly after 2013, short-term plans became an attractive source of coverage for individuals and families, particularly those who earned too much to qualify for premium tax credits for ACA plans. The Obama Administration was concerned about the growth in the short-term market and issued a rule in the fall of 2016—that took effect on April 1, 2017—to reduce the contract period to 90 days and prevent insurers from renewing individuals' enrollment in the same plan. The concern was, in part, that "because these policies can be medically underwritten based on health status, healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for Affordable Care Act-compliant coverage."[6] If adverse selection occurred, it would raise premiums in the individual market.

Even with the 2016 rule restricting short-term plans, premiums in the individual market continued to escalate rapidly through 2018. As the need for flexible coverage increased with the emerging gig economy and premiums for ACA-compliant coverage continued to rise for those ineligible for subsidies, regulators reversed course.

In 2018, the Departments of HHS, Labor, and the Treasury issued a rule that largely restored the long-standing federal regulatory approach to short-term

[5] "Interim Rules for Health Insurance Portability for Group Health Plans," *Federal Register*, Vol. 62, No. 67 (April 8, 1997), pp. 16894-16976, https://www.govinfo.gov/content/pkg/FR-1997-04-08/pdf/97-8275.pdf.

[6] "Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance," *Federal Register*, Vol. 81, No. 210 (October 31, 2016), pp. 75316–75327, https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance.

plans.[7] In addition to defining *short-term* as "up to 364 days," the final rule permitted plan renewals for up to three years (essentially defining *limited-duration* as up to three years). In addition, the new guidance strengthened the notice requirements, clearly specifying that these plans did not comply with the requirements of the ACA and that purchasers should closely review the coverage. The rule expanding short-term coverage took effect on October 1, 2018.

Benefits of the 2018 Rule

In addition to increasing choices of coverage, principally lower-priced coverage, the 2018 rule reduced application costs, meaning that people did not have to apply for a new plan every three months if they wished to maintain coverage. It also meant that people did not have their plan's deductibles reset every three months. And perhaps most importantly, the 2018 rule helped people who got sick during their three-month plan and would otherwise not be able to secure additional coverage because of the limited open enrollment period on the exchanges for individual market plans. Short-term plans also tend to pay providers higher rates than individual market plans so more hospitals and doctors accept short-term coverage relative to individual market coverage. In 2019, the White House Council of Economic Advisers released an estimate that the short-term plan rule benefited Americans by $8 billion annually, on net.[8]

There are at least two reasons for why an expansion of short-term plans might help the individual market. First, more attractive short-term plans could spur insurers selling individual market plans to become more efficient since, for some people, short-term plans might be a substitute for individual market coverage. Second, less adverse selection will occur in the individual market if people who develop medical conditions while enrolled in short-term plans have their expenses covered by the short-term plans instead of switching to ACA-compliant plans during open enrollment or special enrollment periods.

While federal regulation of short-term plans is restricted to defining the terms *short-term* and *limited-duration*, states have full power to regulate these plans. States can place benefit requirements on these plans, prohibit or limit underwriting, institute pricing restrictions, restrict the contract period, or even

[7] "Short-Term, Limited-Duration Insurance," *Federal Register*, Vol. 83, No. 150 (August 3, 2018), pp. 38212–38243, https://www.federalregister.gov/documents/2018/08/03/2018-16568/short-term-limited-duration-insurance.,

[8] Council of Economic Advisers, *Deregulating Health Insurance Markets: Value to Market Participants*, February 2019, https://trumpwhitehouse.archives.gov/wp-content/uploads/2019/02/Deregulating-Health-Insurance-Markets-FINAL.pdf.

prohibit short-term coverage altogether. Some states have enacted new restrictions over the past few years, while others have eliminated existing restrictions. The variation in state approaches to short-term plans allows policymakers to assess the effect of restricting short-term plan flexibility on individual market enrollment, premium changes, and coverage options.

Data and Methodology

The Kaiser Family Foundation (KFF) releases annual reports at the conclusion of each open enrollment period, showing the number of people by state who selected coverage through an exchange.[9] KFF also releases annual reports containing premium information[10] and insurer participation in the exchanges by state.[11] In addition to KFF data, Mark Farrah Associates (MFA), which analyzes health insurance market trends, also reports off-exchange individual market enrollment by state.[12] MFA's data matches Kaiser's enrollment data for on-exchange individual market enrollment and represents enrollment at the end of the first quarter of each calendar year.

In January 2020, the Commonwealth Fund released an analysis of state approaches to short-term plans, producing the map that appears below.[13] States shown in gray permit short-term plans to the full extent of federal law. States shown in dark blue prohibit underwritten short-term plans, which essentially means that short-term plans are prohibited in those states. States shown in teal limit the total length of time a consumer may be enrolled in underwritten short-term plans to less than 364 days, meaning they prohibit the issuance

[9] KFF, "Marketplace Enrollment, 2014-2020," https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/.

[10] Daniel McDermott et al., "2021 Premium Changes on ACA Exchanges and the Impact of COVID-19 on Rates," KFF, October 19, 2020, https://www.kff.org/private-insurance/issue-brief/2021-premium-changes-on-aca-exchanges-and-the-impact-of-covid-19-on-rates/.

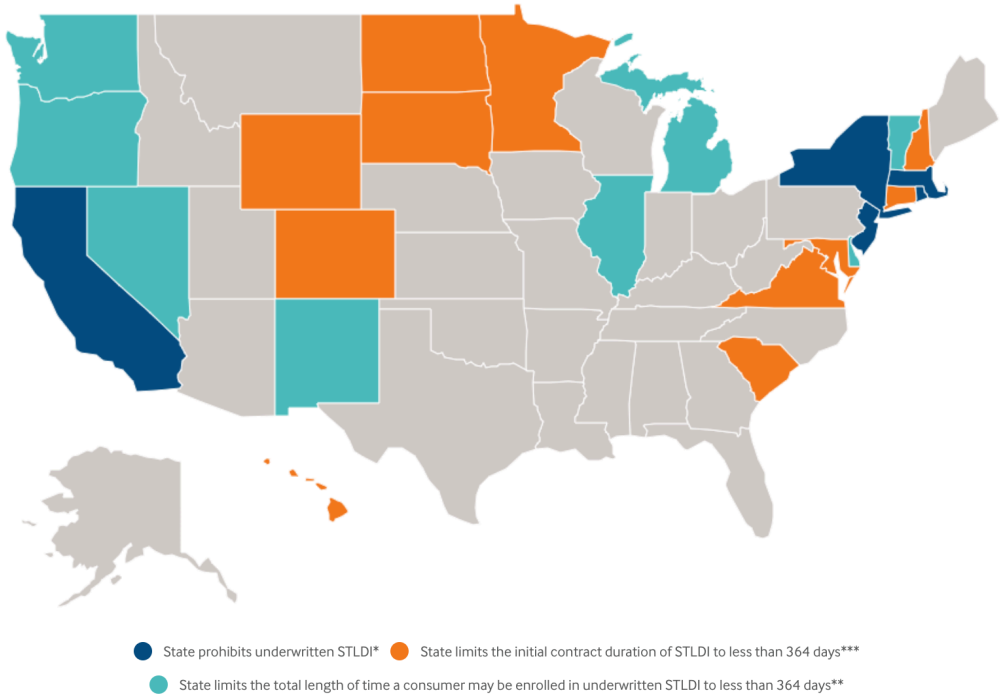
[11] Daniel McDermott and Cynthia Cox, "Insurer Participation on the ACA Marketplaces, 2014-2021," KFF, November 23, 2020, https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/.

[12] For this assessment, MFA applied the assumption that the difference between total individual enrollment reported by carriers and on-exchange, Marketplace enrollment reported in the Centers for Medicare and Medicaid Services' Open Enrollment Period public use files, is a reasonable representation of off-exchange membership. See MFA, "A Brief Analysis of the Individual Health Insurance Market," August 6, 2018, http://www.markfarrah.com/mfa-briefs/a-brief-analysis-of-the-individual-health-insurance-market/.

[13] Commonwealth Fund, "State Regulation of Short-Term, Limited-Duration Insurance," January 15, 2020, https://www.commonwealthfund.org/chart/2020/state-regulation-short-term-limited-duration-insurance.

FIGURE 1

State Regulation of Short-Term, Limited-Duration Insurance (STLDI)



SOURCE: Commonwealth Fund, "State Regulation of Short-Term, Limited-Duration Insurance," January 15, 2020, https://www.commonwealthfund.org/chart/2020/state-regulation-short-term-limited-duration-insurance.

of multiple short-term policies consecutively. Washington state, for example, prohibits the issuance of a short-term plan during the annual open enrollment period for individual market coverage. Delaware, as another example, prohibits insurers from issuing the same short-term policy to an enrollee for back-to-back terms. States shown in orange limit the initial contract duration of underwritten short-term plans to less than 364 days if a short-term plan lasting longer than a specified duration would become subject to one or more of the following: guarantee issue, guaranteed renewability, or required coverage of essential health benefits.

Gloom and Doom Predictions

The variation in state regulatory approaches to short-term plans allows for a test of the critics' hypotheses that they inflict damage on the ACA-compliant individual market. For example, Margaret Murray and Heather Foster, who represent a coalition of insurers that sell individual market plans and which has unsuccessfully sued to undo the 2018 rule, recently wrote that short-term plans will have a "destabilizing effect … on the entire health insurance market, leading to higher premiums for millions of Americans. Because STLDI [Short-Term Limited Duration Insurance] is much cheaper than ACA-compliant coverage for healthy individuals, it is likely that healthy people will abandon ACA-compliant plans for STLDI, seriously undermining the ACA risk pool."[14]

In 2018, several organizations—including government entities such as the Congressional Budget Office and the Office of the Actuary at the Centers for Medicare and Medicaid Services, policy organizations such as the Urban Institute and the Commonwealth Fund, and actuarial firms such as the Wakely Group—projected the impact of the rule expanding short-term plans. All the organizations acknowledged that their estimates were subject to significant uncertainty.

Adding significant uncertainty to the organizations' projections was that the tax penalty associated with the ACA's individual mandate was zeroed out beginning on January 1, 2019—only three months after the rule expanding short-term plans took effect. This major tax change made it difficult to interpret the marginal impact of just the short-term rule expansion since many studies blended the impact of eliminating the penalty with the short-term plan expansion. In their *Health Affairs* blog post, for example, Murray and Foster misinterpreted the results of some of these studies by attributing the combined projected effect of the penalty elimination and the short-term coverage expansion to just the 2018 rule. Moreover, many of the initial projections of the effect of short-term plans did not properly account for state regulatory behavior. For example, the Urban Institute estimated more than 600,000 people would purchase short-term plans in California and the number of uninsured would plunge by 200,000, but California has essentially prohibited short-term plans.[15]

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[14] Margaret Murray, "Even in 14-Point Text, 'Buyer Beware' Is No Organizing Principle for Insurance Reform," *Health Affairs*, November 3, 2020, https://www.healthaffairs.org/do/10.1377/hblog20201029.468878/full/.

[15] Linda J. Blumberg, Matthew Buettgens, and Robin Wang, "Updated: The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending," Urban Institute, March 14, 2018, https://www.urban.org/research/publication/updated-potential-impact-short-term-limited-duration-policies-insurance-coverage-premiums-and-federal-spending.

Ultimately, the consensus of the various projections made in 2018 was that about 2 million to 3 million people would enroll in short-term plans, the number of uninsured would decrease by about a million people, and between 1 million and 1.5 million people would replace other coverage—largely individual market plans with a short-term plan.

The consensus was that the people who eschewed individual market plans for short-term coverage would be healthier than the average person enrolled in individual market coverage, causing individual market premiums to slightly increase. On average, individual market premiums were projected to increase about 2–3 percent. Most people who purchase coverage in the individual market would not be negatively affected by the premium increase, as the structure of the ACA's premium tax credits holds people eligible for subsidies harmless from increases in premiums. The effect on the federal deficit was likely to be very small, with some projections showing a slight increase and others a slight decrease.

As is often the case with projections of new policies, the expansion of short-term plans appears to be working differently than expected. Rather than having an adverse effect on the individual market, the expansion of short-term plans has either not affected the individual market or has benefitted it. Relative to states that have restricted short-term plans, states that fully permit short-term plans have had a smaller loss of individual market enrollment—particularly exchange enrollment—have had far more insurers entering the exchanges to offer coverage, and have had a greater reduction in exchange plan premiums.

Individual Market Enrollment Declined Less

The number of individuals enrolled in individual market coverage nationwide declined by about 800,000 people, or 5.1 percent, between the first quarter of 2018 and the first quarter of 2020. The percentage decline in enrollment was about 50 percent larger in the 25 states, including the District of Columbia, that restrict short-term plans compared to the 26 states that fully permit short-term coverage.

Table 1 shows enrollment for the overall individual market, as well as broken down into exchange enrollment and estimated off-exchange enrollment, at the end of the first quarters of 2018 and 2020 as well as the percentage decline from 2018 to 2020. The off-exchange enrollment includes short-term plan enrollment, although short-term plan enrollment is generally significantly

TABLE 1

Individual Market Enrollment, 2018–2020

State Grouping	2018	2020	% Change
Fully permit STP	8.90m	8.53m	-4.1%
Exchange	*6.85m*	*6.73m*	*-1.8%*
Off-exchange	*2.10m*	*1.76m*	*-15.9%*
Restrict STP	6.86m	6.42m	-6.4%
Exchange	*4.90m*	*4.68m*	*-4.4%*
Off-exchange	*2.01m*	*1.67m*	*-16.7%*

NOTE: The exchange enrollment figures are the numbers reported by the Centers for Medicare and Medicaid Services as the number of sign-ups at the end of open enrollment. The total enrollment figures represent the total individual enrollment reported by carriers to state insurance regulators, as compiled by Mark Farrah Associates (MFA). The off-exchange row is the individual market enrollment minus exchange enrollment. For three states—Maine, Missouri, and Virginia—MFA reported negative off-exchange enrollment in 2018, and these states were excluded from the 2018-2020 data for off-exchange enrollment. They were included for on-exchange enrollment and total individual market enrollment. For this reason, the total individual market enrollment is not the sum of the exchange and off-exchange enrollment numbers. There were 26 states that fully permitted short-term plans and 25 states, including the District of Columbia, that restrict short-term plans.

SOURCE: MFA, "A Brief Analysis of the Individual Health Insurance Market," August 6, 2018, http://www.markfarrah.com/mfa-briefs/a-brief-analysis-of-the-individual-health-insurance-market/ and MFA, "Individual Health Insurance Enrollment Trends and Market Insights," July 30, 2020, http://www.markfarrah.com/mfa-briefs/individual-health-insurance-enrollment-trends-and-market-insights/.

underreported.[16] The appendix contains tables that break down the 25 states that restrict short-term plans by the three categories of restrictions, per the Commonwealth Fund's analysis.

The bottom line is that there was larger attrition in individual market enrollment, particularly in the exchanges, in states that restrict short-term plans than in states that fully permit short-term plans. The decline in individual market

[16] Enrollment data for short-term plan coverage has generally been unreliable and underestimated. A large part of the reason appears to be that people purchase short-term coverage through associations, and these associations often do not report enrollment information to the state insurance commissioner's office. "It is important to note that Mark Farrah Associates (MFA) applied enrollment figures for select carriers not required to report health enrollment on a quarterly basis and made other adjustments based on market analysis. Furthermore, individual enrollment includes short term plan enrollees and may include Medicaid programs, such as CHIP, as some states include subsidized lines in the individual segment. These factors may have resulted in moderate understatement or overstatement of enrollment." See Mark Farrah Associates (MFA), "Current Trends in Individual Segment Enrollment," August 20, 2019, https://www.markfarrah.com/mfa-briefs/current-trends-in-individual-segment-enrollment/.

TABLE 2

Individual Enrollment Excluding Medicaid Expansion States

State Grouping	2018	2020	% Change
Fully permit STP	8.46m	8.13m	-3.9%
Exchange	*6.49m*	*6.39m*	*-1.5%*
Off-exchange	*2.02m*	*1.70m*	*-15.7%*
Restrict STP	6.50m	6.08m	-6.5%
Exchange	*4.50m*	*4.41m*	*-1.9%*
Off-exchange	*2.01m*	*1.67m*	*-16.7%*

NOTE: See note below Table 1.

enrollment was about 2.3 percentage points greater in states that restricted short-term plans.

It is not surprising that the drop in off-exchange enrollment has been greater than the drop in exchange enrollment in both categories of states. Although individual market premiums have generally been flat or declined from 2018 to 2020, off-exchange enrollment includes people enrolled in grandfathered and grandmothered plans, and over time people transition off this coverage, and new people are not able to enroll.[17]

Excluding states that adopted the ACA's Medicaid expansion during this period does not have an appreciable effect on the results. Four states expanded Medicaid between January 1, 2019, and January 1, 2020—Idaho, Maine, Utah, and Virginia. According to the design of the ACA, individuals with incomes between 100 and 138 percent of the poverty level would lose eligibility for premium tax credits to purchase coverage through the exchange by gaining Medicaid eligibility. The table below replicates Table 1 after excluding these four states and shows that the main results become slightly more pronounced as the decline in individual market enrollment was about 2.6 percentage points greater in states that restricted short-term plans.

[17] Grandfathered plans are health plans that were in effect when the ACA was passed on March 23, 2010, and are exempt from certain provisions of the law. Grandmothered plans are policies purchased between the 2010 passage of the ACA and 2014 and are neither ACA-compliant nor grandfathered plans but remain on the market in accordance with an HHS policy first announced in the fall of 2013 that permits renewals of such plans.

More Insurers Entering Exchanges

Some commenters expressed concern that the 2018 short-term plan rule would cause fewer insurers to offer individual market plans. According to the final rule:

> These commenters expressed deep fears that as a result of this rule, they would lose coverage because issuers would stop offering individual market plans or because those plans would become too expensive.

Commenters suggested that the resulting market segmentation and adverse selection would increase premiums for individual market plans and may decrease the number of plans available as issuers exit the individual market, potentially leading to "bare counties."[18]

Not only did this not happen, but far *more* insurers have started offering exchange plans in states that fully permit short-term plans since the 2018 rule took effect.

In the 26 states that fully permit short-term plans, the number of insurers offering ACA exchange coverage increased on average per state from 3.2 to 5.1 from 2018 to 2021, an increase of 61.0 percent. The corresponding increase in the 25 states that restrict short-term plans is 25.3 percent, from 4.0 to 5.0. This data overwhelmingly indicates that plan actuaries and experts do not believe the availability of short-term plan deters the business prospects of offering or expanding individual market coverage and that permitting short-term plans either has no bearing on insurers' decision to offer individual market coverage or has caused greater insurer participation in the individual market. There were other policy changes that no doubt influenced insurers' participation decisions during this period—such as the elimination of the individual mandate penalty, reducing the open enrollment period from three months to six weeks, and tightening the special enrollment period to reduce abuse—but these changes were made across the country, generally irrespective of state decisions.[19]

[18] "Short-Term, Limited-Duration Insurance," *Federal Register*, Vol. 83, No. 150 (August 3, 2018), pp. 38212–38243.

[19] These changes did not affect all states equally. Many state-based exchanges have set their own open enrollment periods, and a few states reinstituted a tax penalty on people who failed to purchase ACA-compliant coverage.

TABLE 3

Number of Insurers Offering ACA Exchange Coverage

State Grouping	2018	2021	% Change
Fully permit STP	82	132	+61.0%
Restrict STP	99	124	+25.3%

SOURCE: Daniel McDermott and Cynthia Cox, "Insurer Participation on the ACA Marketplaces, 2014-2021," Kaiser Family Foundation, November 23, 2020, https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/.

Exchange Premiums Dropped Much More

Perhaps because of a greater increase in the number of insurers offering coverage in the individual market, individual market premiums have declined more significantly in states that fully permit short-term plans.

The tables below show the average premiums for those plans across the state categories, weighting states by the number of people who selected exchange coverage during open enrollment. The tables show the change from 2018 to 2020 along with the percentage change as well as the 2021 premiums and the percentage change between 2018 and 2021.[20]

Overall, individual market premiums have declined since 2018, but the decline has been much more significant in states that fully permit short-term plans. Whether looking at the change from 2018 to 2020 or from 2018 to 2021, states that fully permit short-term plans had percentage declines in individual market premiums at least twice as large as the percentage decline in states that restrict short-term plans for lowest-cost bronze plans, lowest-cost silver plans, benchmark plans, and lowest-cost gold plans. In fact, as shown in the tables in the appendix, the only states where individual market premiums have

[20] The 2021 premiums are weighted using the 2020 enrollment data because the 2021 open enrollment data is not yet available. The weights do not adjust for plan selection across states. In other words, the same weight is applied—using total enrollment at the end of the first quarter—across all metal tiers.

TABLE 4

Lowest-Cost Bronze Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
Fully permit STP	$356	$339	-4.7%	$336	-5.7%
Restrict STP	$319	$319	0.0%	$317	-0.6%

SOURCE: Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018-2021," https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/.

TABLE 5

Lowest-Cost Silver Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
Fully permit STP	$479	$459	-4.2%	$452	-5.6%
Restrict STP	$424	$416	-1.7%	$412	-2.7%

SOURCE: Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018-2021," https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/.

TABLE 6

Benchmark Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
Fully permit STP	$507	$479	-5.6%	$468	-7.9%
Restrict STP	$443	$437	-1.3%	$428	-3.2%

SOURCE: Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018-2021," https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/.

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TABLE 7

Lowest-Cost Gold Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
Fully permit STP	$551	$519	-5.8%	$493	-10.6%
Restrict STP	$490	$473	-3.5%	$466	-5.0%

SOURCE: Kaiser Family Foundation, "Average Marketplace Premiums by Metal Tier, 2018-2021," https://www.kff.org/health-reform/state-indicator/average-marketplace-premiums-by-metal-tier/.

increased since 2018 are the five states (California, Massachusetts, New Jersey, New York, and Rhode Island) that effectively prohibit short-term plans.

Nearly 60 percent of exchange enrollees select silver plans, so the premium changes for silver plans are most relevant for consumers. Between 2018 and 2020, the premiums for the lowest-cost silver plan declined by 4.2 percent in states that fully permit short-term plans and by 1.7 percent in states that restrict short-term plans. Between 2018 and 2021, the respective declines were 5.6 percent and 2.7 percent. The difference is even more profound when looking at the benchmark plans. Between 2018 and 2021, the premiums for the second lowest-cost silver plan declined by 5.6 percent in states that fully permit short-term plans and by 1.3 percent in states that restrict short-term plans. Between 2018 and 2021, the respective declines were 7.9 percent and 3.2 percent.

Excluding 1332 Waiver States Bolsters Performance

Another major policy change that affected certain states' individual markets during this period was the approval of 1332 waivers for states to institute reinsurance programs. Section 1332 of the ACA permits states to petition HHS to waive certain provisions of the ACA so long as the state waiver proposal meets several requirements. In 2018 and 2019, nine states received approval for 1332 waivers. Using these waivers, states put up some funds for reinsurance programs, where insurers received government support to cover much of the costs of people who incurred significant claims during a year. These states received

federal funds back, generally around 60 percent of the amount that they put up, as the program lowered premiums and premium tax credits as a result.[21] Three states that fully permit short-term plans—Maine, Montana, and Wisconsin—and six states that restrict short-term plans—Colorado, Delaware, Maryland, New Jersey, North Dakota, and Rhode Island—received a 1332 waiver in 2018 and 2019 to establish a reinsurance program.

Since these waivers significantly affect the individual market, I performed the same analysis as above after excluding the nine states that received 1332 reinsurance waivers in 2018 and 2019 (Table 8). The first row consists of states that fully permit short-term plans and did not receive 1332 waivers in 2018 or 2019, the second row consists of states that restricted short-term plans and did not receive 1332 waivers in 2018 or 2019, and the final row consists of the states that did receive 1332 waivers in 2018 or 2019. The premium tables show only the lowest-cost silver and the benchmark plans, although the appendix shows the other tables.

It turns out that excluding these nine states bolsters the finding that states that fully permit short-term plans had better experience in their individual markets—in terms of enrollment, number of insurers offering exchange coverage, and premiums—than states that restricted short-term plans. The tables below show the information. The decline in enrollment in states that fully permit short terms plans was only about half as much, more than twice as many insurers entered those state exchanges, and the percentage premium declines were four times greater than in states that restricted short-term plans, excluding the 1332 waiver states.

Of note, the 1332 waivers seemed to be quite successful in lowering premiums. Since the premium reductions are more meaningful for off-exchange purchasers because they do not receive tax credits, the decline in off-exchange enrollment was about 60 percent less in the nine states that received 1332 waivers in 2018 or 2019.

[21] Section 1332 waivers must be deficit neutral for the federal government. If 1332 waivers generate savings for the federal government, states can receive pass through funds. Reinsurance programs result in lower premiums. The premium tax credit is a function of the second lowest-cost silver plan in a region, so when premiums decline, so does the amount of premium tax credits. The less aggregate projected spending on premium tax credits can be returned to states as savings to the federal government from the waiver. As a general rule, states receive about 60 cents of each dollar they provided in reinsurance funds returned to them as pass-through savings.

TABLE 8

Individual Market Enrollment, 2018–2020

State Grouping	2018	2020	% Change
Fully permit STP	8.51m	8.20m	-3.7%
Exchange	*6.50m*	*6.43m*	*-1.2%*
Off-exchange	*2.06m*	*1.73m*	*-15.9%*
Restrict STP	5.87m	5.47m	-6.9%
Exchange	*4.23m*	*4.03m*	*-4.7%*
Off-exchange	*1.69m*	*1.39m*	*-19.0%*
1332 waiver states	1.37m	1.29m	-5.9%
Exchange	*1.02m*	*0.95m*	*-6.4%*
Off-exchange	*0.35m*	*0.33m*	*-5.5%*

NOTE: See note below Table 1.

TABLE 9

Number of Insurers Offering ACA Exchange Coverage

State Grouping	2018	2021	% Change
Fully permit STP	66	113	+71.2%
Restrict STP	82	104	+26.8%
1332 waiver states in 2018 or 2019	33	39	+18.2%

TABLE 10

Lowest-Cost Bronze Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
Fully permit STP	$354	$339	-4.5%	$336	-5.3%
Restrict STP	$316	$324	+2.6%	$323	+2.3%
1332 waivers in 2018 or 2019	$353	$309	-12.7%	$299	-15.4%

TABLE 11

Lowest-Cost Silver Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
Fully permit STP	$476	$458	-3.8%	$453	-4.9%
Restrict STP	$424	$423	-0.2%	$419	-1.1%
1332 waivers in 2018 or 2019	$461	$408	-11.5%	$393	-14.8%

TABLE 12

Benchmark Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
Fully permit STP	$504	$478	-5.1%	$468	-7.2%
Restrict STP	$442	$445	+0.6%	$436	-1.5%
1332 waivers in 2018 or 2019	$486	$421	-13.4%	$405	-16.6%

TABLE 13

Lowest-Cost Gold Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
Fully permit STP	$549	$520	-5.4%	$493	-10.1%
Restrict STP	$479	$471	-1.8%	$464	-3.3%
1332 waivers in 2018 or 2019	$570	$496	-13.1%	$480	-15.8%

Conclusion: Restricting Short-Term Plans Is a Bad Idea

In the regulatory impact analysis of the 2018 short-term plan rule, the Departments of HHS, Labor, and the Treasury wrote:

> The Departments believe the need for coverage options that are more affordable than individual health insurance coverage is critical, combined with the general need for more coverage options and choice. Therefore, the Departments believe that the benefits associated with this rule outweigh the costs.[22]

The projected costs, not to mention the significant concerns raised by the critics, have not come true. States that fully permit short-term plans did not have reduced individual market enrollment, less choice of individual market coverage, or higher individual market premiums, as predicted by a number of analysts. On the contrary, actual experience shows that states that fully permit short-term plans have experienced improvements in their individual markets compared to states that restrict short-term plans on every dimension—enrollment, choice of plans, and premiums.

According to some news reports, the Biden Administration may take action to again restrict short-term coverage, perhaps similar to the 2016 rule.[23] This would violate President Biden's promise during the campaign that people would be able to maintain their private insurance.[24] Moreover, the experience to date should caution them against limiting short-term coverage. If the Biden Administration restricts short-term coverage, it would likely increase the total number of uninsured by upward of 1 million people, decrease choice and the number of lower-premium products available to consumers, and reduce competition in state health insurance markets. Based on the favorable individual market experience of states that fully permit short-term plans, restrictions could also harm the individual market and people who enroll for coverage there.

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[22] "Short-Term, Limited-Duration Insurance."

[23] Sheryl Gay Stolberg and Abby Goodnough, "Biden Moves to Expand Health Coverage in Pandemic Economy," *The New York Times*, January 28, 2021, https://www.nytimes.com/2021/01/28/us/politics/biden-health-insurance.html.

[24] Greenberg, "'If You Like Your Plan, You Can Keep It.'"

Appendix: Additional Data Tables

The following three tables show the trends for individual market enrollment, as well as for exchange enrollment and off-exchange enrollment, in the states that restrict short-term plans, broken down by the Commonwealth Fund's categorization from January 2020.

TABLE B-1

Individual Market Enrollment, 2018–2020

State Grouping	2018	2020	% Change
No underwritten STP	3.47m	3.36m	-3.0%
Initial STP must be less than 364 days	1.72m	1.61m	-6.7%
Consumer cannot be enrolled in underwritten STP for more than 364 days	1.67m	1.45m	-13.0%

TABLE B-2

Exchange Enrollment, 2018–2020

State Grouping	2018	2020	% Change
No underwritten STP	2.35m	2.41m	+2.7%
Initial STP must be less than 364 days	1.31m	1.17m	-10.8%
Consumer cannot be enrolled in underwritten STP for more than 364 days	1.24m	1.10m	-11.2%

TABLE B-3

Off-Exchange Enrollment, 2018–2020

State Grouping	2018	2020	% Change
No underwritten STP	1.12m	0.95m	-15.0%
Initial STP must be less than 364 days	0.46m	0.37m	-19.3%
Consumer cannot be enrolled in underwritten STP for more than 364 days	0.43m	0.35m	-18.3%

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The following table show the trends in insurers offering of exchange plans in the states that restrict short-term plans, broken down by the Commonwealth Fund's categorization from January 2020.

TABLE B-4

Number of Insurers Offering ACA Exchange Coverage

State Grouping	2018	2021	% Change
No underwritten STP	35	36	+2.9%
Initial STP must be less than 364 days	32	43	+34.4%
Consumer cannot be enrolled in underwritten STP for more than 364 days	32	45	+40.6%

The following four tables show the trends in exchange plan premiums in the states that restrict short-term plans, broken down by the Commonwealth Fund's categorization from January 2020.

TABLE B-5

Lowest-Cost Bronze Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
No underwritten STP	$299	$317	+6.0%	$327	+9.4%
Initial STP must be less than 364 days	$371	$330	-10.9%	$312	-15.8%
Consumer cannot be enrolled in underwritten STP for more than 364 days	$303	$313	+3.1%	$301	-0.7%

TABLE B-6

Lowest-Cost Silver Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
No underwritten STP	$401	$406	+1.2%	$413	+3.0%
Initial STP must be less than 364 days	$489	$452	-7.6%	$428	-12.6%
Consumer cannot be enrolled in underwritten STP for more than 364 days	$397	$402	+1.1%	$394	-0.8%

TABLE B-7

Benchmark Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
No underwritten STP	$422	$434	+2.8%	$434	+2.9%
Initial STP must be less than 364 days	$506	$465	-8.1%	$441	-12.8%
Consumer cannot be enrolled in underwritten STP for more than 364 days	$416	$414	-0.4%	$403	-3.0%

TABLE B-8

Lowest-Cost Gold Plan Premiums

State Grouping	2018	2020	% Change (2018–2020)	2021	% Change (2018–2021)
No underwritten STP	$463	$485	+4.9%	$491	+6.1%
Initial STP must be less than 364 days	$576	$468	-18.8%	$439	-23.8%
Consumer cannot be enrolled in underwritten STP for more than 364 days	$451	$451	0.0%	$437	-3.0%

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