The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending

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In Brief

On February 20, 2018, the Departments of Treasury, Labor, and Health and Human Services released a proposed regulation that would increase the maximum length of short-term, limited-duration insurance policies to one year. These plans, sold to individuals and families, are not federally required to comply with the Affordable Care Act regulations that prohibit annual and lifetime benefit limits, require coverage of all essential health benefits, and otherwise prohibit insurers from setting premiums or choosing whether to sell coverage to particular people based on applicants' health status and health history. As such, these plans do not meet minimum essential coverage standards under the law; thus, the Congressional Budget Office does not consider them private insurance. If implemented, the rule would permit these plans to compete against the ACA-compliant plans.

Importantly, this change would be implemented on top of an array of other significant policy changes made since the beginning of 2017. We analyze the implications of the 2017 policy changes relative to the ACA as originally designed and implemented (prior law), in addition to the potential consequences of the proposed expansion of short-term limited-duration policies. In estimating the effects of these changes on insurance coverage, premiums, and federal spending, we take into account the variations in state circumstances and state-specific laws on short-term plans.

Key findings include the following:

- The elimination of the individual-mandate penalties and the other policy changes, such as the withdrawal of cost-sharing reduction payments and the diminution of federal investments in advertising and enrollment assistance during 2017 that affected the 2018 open enrollment period, will lead to an additional 6.4 million people uninsured in 2019 compared with prior law (12.5 percent of the nonelderly population uninsured compared with 10.2 percent).
- The introduction of expanded short-term, limited-duration policies, consistent with proposed regulations, would increase the number of people without minimum essential coverage by 2.5 million in 2019. Of the 36.9 million people without minimum essential coverage, 32.6 million would have no coverage at all (completely uninsured), and 4.2 million would enroll in expanded short-term limited-duration plans.
- The combined effect of eliminating the individual-mandate penalties and expanding short-term limited-duration policies would increase 2019 ACA-compliant nongroup insurance premiums 18.2 percent on average in the 43 states that do not prohibit or limit short-term plans.
- Federal government spending in 2019 will be an estimated 9.3 percent higher than under prior law, owing to the combined effect of expanding short-term limited-duration policies, eliminating the individual-mandate penalties, and other recent policy changes. This increase in federal spending is lower than the overall increase in premiums because of cost reductions caused by decreases in enrollment.

Introduction

The October 2017 executive order calls for the Departments of Treasury, Labor, and Health and Human Services to consider new regulations that would increase the maximum length of short-term limited-duration coverage. Such policies are not regulated by the Affordable Care Act's (ACA's) reform of the private nongroup insurance market; as such, they are exempt from guaranteed issue, guaranteed renewal, modified community rating, essential health benefit requirements, prohibitions on preexisting condition exclusions, annual and lifetime limit prohibitions, and other protections. In addition, these policies are not part of the ACA's risk-adjustment system that spreads the costs associated with large claims across all nongroup insurers in a state. Recently, enrollment in these policies has been limited by two factors. First, someone buying a short-term policy without other coverage would not satisfy the ACA's individual responsibility requirement (the individual mandate) and would be subject to a financial penalty. Second, regulations promulgated by the Departments of Labor, Treasury, and Health and Human Services in 2016 prohibited short-term policies sold in April 2016 or later from coverage exceeding three months. The regulations also required the companies selling short-term policies to clearly warn potential purchasers that the policies do not satisfy the individual mandate.

The expansion of short-term, limited-duration policies would be implemented on top of other significant changes to the ACA's private nongroup insurance markets since early 2017. These include

cessation of federal reimbursement for cost-sharing reductions, shortened open enrollment periods in most states, substantially reduced federal funding for outreach and enrollment assistance, and the elimination of the individual=mandate penalty beginning in 2019. If, consistent with the proposed rule released on February 20, 2019,[1] new regulations allow short-term policies to be sold for coverage lasting as long as a year, these policies could compete as medically underwritten, largely unregulated alternatives to the products sold in the ACA's private nongroup insurance markets (both inside and outside Marketplaces). In this way, they could pull healthier people out of the ACA-compliant nongroup insurance market, leaving an enrollee population with higher average health care needs in the regulated insurance pool. The elimination of the individual-mandate penalties must be accounted for when assessing the potential impact of the expansion of short-term limited-duration policies, as these two changes intrinsically interact. The state-specific implications of this policy change vary and should also be taken into account, since some states have their own laws and regulations limiting sales of short-term policies, and other states may be interested in developing some in response to the federal change in policy.

We analyze the national and state-specific effects of ending the individual mandate and loosening limits on short-term, limited-duration policies on insurance coverage, premiums in the ACA-compliant nongroup insurance market, and federal spending in 2019. Our analysis relies on the Urban Institute's Health Insurance Policy Microsimulation Model (HIPSM), which is used extensively to estimate the cost and coverage implications of the ACA, reforms to the ACA, and repeal and replace proposals. We provide 2019 estimates of the coverage and costs under three scenarios:

1. the trend preceding the 2017 policy changes introduced by the current administration (prior-law ACA);
2. the collective policy changes introduced by the current administration in 2017 that have affected Marketplace and nongroup insurance enrollment in 2018 (as evidenced by enrollment data and premium changes), as well as the elimination of penalties for the ACA's individual mandate (current-law ACA); and
3. current-law ACA plus the expansion of short-term limited-duration, or STLD, policies (current law plus expansion of STLD).

Methodological Approach

The Health Insurance Policy Simulation Model is a detailed microsimulation model of the health care system designed to estimate the cost and coverage effects of proposed health care policy options. HIPSM is based on two years of the American Community Survey, which provides a representative sample of families that is large enough for us to produce estimates for individual states. The population is aged to future years using projections from the Urban Institute's Mapping America's Futures program. HIPSM is designed to incorporate timely, real-world data when they are available. As described below, we regularly update the model to reflect published Medicaid and Marketplace

enrollment and costs in each state. The enrollment experience in each state under current law affects how the model simulates policy alternatives.

HIPSM is unique among microsimulation models of health coverage and costs because individual and family decisions combine the two most common types of microsimulation decisionmaking: elasticity and expected utility. Decisionmaking follows an expected-utility framework that captures factors such as individual health risk, but we add a latent preference term for each observation that represents factors involved in their observed choices that the expected-utility approach alone could not capture. These terms are set so the model leads to each person in the data making the choice they reported in the survey, and the distribution of latent preference terms is set so the model replicates premium elasticity targets from the literature. This approach makes it easier to simulate novel policies consistently while calibrating the model to a wide range of real-world data, such as Medicaid and Marketplace enrollment.

Prior- and Current-Law ACA Scenarios

Our prior-law and current-law ACA simulations for 2019 are based on real-world snapshots of Marketplace enrollment in each state under two different policy regimes: (1) that of the Obama administration, culminating in the 2017 open enrollment period (OEP), and (2) that of the Trump administration for the 2018 OEP. The current-law simulation also eliminates the ACA's individual-mandate penalties; the prior-law scenario includes them. The collective effect of the policy changes implemented by the Trump administration are captured by benchmarking the current-law simulation to 2018 Marketplace enrollment, the most recent Medicaid enrollment data, and nongroup market premium changes between 2017 and 2018. To simulate the effect of the individual mandate, we compute eligibility for the most common mandate exemptions (income below the tax filing threshold, lack of affordability of available premiums, undocumented status) and tax penalties for people without exemptions if they were to become uninsured. Other exemptions, such as those for individual hardship circumstances and religious conscience objections, cannot be modeled. However, our estimates of the number of families paying the tax penalty are similar to published IRS estimates, so the missing exemptions do not appear to affect our results substantially.

Based on the coverage gains resulting from the 2006 Massachusetts health reform law, we assume that the mandate would have an impact larger than the dollar amount of the penalties would suggest. Recent research using ACA-era data has confirmed that this assumption is appropriate (Salzman 2017). To estimate the size of the nonfinancial effect of the mandate and the size of the nongroup market outside the Marketplaces, we use the total reported nongroup enrollment in the 2017 National Health Interview Survey (which is generally considered the most reliable national measure of enrollment in major health coverage types) combined with reported Marketplace enrollment. Specifically, we simulate health insurance coverage based on financial factors (premiums, expected out-of-pocket costs, a measure of risk aversion, individual-mandate penalties) and other factors known to affect individual and family coverage, and we compare the resulting levels of coverage to benchmarks based on Marketplace enrollment and the National Health Interview Survey. The difference between coverage

levels based on financial factors and the benchmarks is attributed to the nonfinancial effect of the individual mandate, and the model's simulated coverage is calibrated to hit those benchmarks in the 2017 prior-law scenario.

As of February 2018, no data are available on nongroup enrollment outside the Marketplaces in 2018, so this was simulated by HIPSM. The increases in nongroup premiums from 2017 to 2018 are estimated to reduce enrollment among people not eligible for tax credits in 2018, an effect that increases further in 2019 once the individual-mandate penalties are eliminated.

Short-Term Limited-Duration Policy Expansion

For our third simulation, we start with the current-law ACA framework described above, based on evidence from 2018 coverage decisions and premiums plus the elimination of individual-mandate penalties, and we assume that access to STLD plans is expanded. However, a change in federal regulations to expand STLDs would not preempt state laws regarding such plans. Based on preliminary analysis of state regulations by Georgetown University's Center on Health Insurance Reforms (Lucia et al., forthcoming), we categorize states into three groups: those that have regulations that would effectively prohibit the expansion of STLD policies, those that would significantly reduce the expansion of STLD policies but would not eliminate them, and those where the new regulations would effectively allow STLD policies to compete with ACA-compliant policies without further state action.[2]

Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington have laws that would prevent an expansion of STLDs. Results for these six states are the same as in the current-law scenario. Michigan and Nevada have laws that would limit STLD policy expansion. In these two states, we reduce the incentives to choose STLDs by roughly half. The remaining states either have no regulations that would substantially limit STLD policy expansion or have regulations that would allow sales, renewals, or extensions of STLD policies for 12 months or more. Our second and third categories are primarily based on duration limits of contract length and renewals. Many states have limits, but our categorization is based on the ability of a person to enroll in and extend or renew a STLD plan for up to 12 months.[3]

Within HIPSM, in states whose laws would not prevent STLD plan expansion, people would now have a choice between ACA-compliant nongroup coverage and STLD plans. We assume that full-year STLD coverage would differ from ACA-compliant coverage because such coverage would have a lower actuarial value (approximately 50 percent) and, in general, health status, gender rating, and broad age rating variations would be allowed when setting premiums. STLD plans do not cover all ACA essential health benefits, but we did not model benefit exclusions given the complexity involved. These differences ensure that those who prefer STLD to ACA-compliant plans will tend to have lower expected health care needs, since high premiums for those with greater needs as well as higher cost-sharing requirements associated with STLD plans would dissuade enrollment by those with serious health conditions. As more people enroll in STLD plans who would otherwise have chosen ACA-compliant coverage, premiums for ACA-compliant policies will rise. These price increases lead to more people choosing STLD policies, and HIPSM captures this adverse selection behavior until coverage and premium changes stabilize in successive iterations.

Short-term limited-duration plans would not meet the standards of minimum essential coverage. The Congressional Budget Office's definition of private insurance would not include these plans.[4] Consequently, we group STLD purchasers with the completely uninsured (those with no coverage whatsoever) as people without minimum essential coverage.

Results

National Distribution of Health Insurance Coverage

Table 1 shows the estimated 2019 national distribution of insurance coverage under prior law, current law, and current law plus the expansion to the availability of STLD policies. We estimate that the percentage of nonelderly people uninsured will be 2.3 percentage points higher in 2019 (12.5 percent uninsured versus 10.2 percent uninsured) as a consequence of the combined 2017 policy changes as well as elimination of the individual-mandate penalties. (Consumer confusion about whether the ACA is still in place[5] may also contribute to lower enrollment.) This is equivalent to an additional 6.4 million uninsured people, with 3.7 million of that increase resulting from reduced nongroup coverage purchased without tax credits, 1.8 million people fewer enrolling in nongroup coverage with tax credits, and roughly 500,000 and 400,000 fewer people with employer-sponsored insurance coverage and Medicaid/CHIP, respectively. The reduction in Medicaid/CHIP coverage is largely attributable to reductions in coverage for children whose parents would, under prior law, learn of their children's eligibility for public insurance when applying for Marketplace coverage. Because fewer people would apply for nongroup coverage, fewer would find out their children are eligible. The reduction in employer-sponsored insurance is largely attributable to the elimination of the individual-mandate penalties.

We estimate that once the rules limiting STLD policies are loosened, ACA-compliant nongroup coverage would decrease by another 2.1 million people. About 70 percent of that decrease (1.5 million people) comes from fewer people buying ACA-compliant coverage without a tax credit, and about 30 percent of the decrease (about 600,000 people) comes from fewer people buying nongroup insurance with a tax credit. Employer coverage would fall by an additional 230,000 people and Medicaid/CHIP by an additional 150,000 people. Approximately 36.9 million people would be without minimum essential coverage, an increase of 9.0 million people over prior law and 2.5 million people over current law. Of that number, 32.6 million people would be uninsured (no coverage at all) and 4.2 million people would be enrolled in the expanded STLD policies. About 1.7 million of the people buying STLD policies would have been uninsured (in the traditional sense) under current law, and 2.5 million STLD policy holders would otherwise have had insurance of some type.

TABLE 1

Distribution of Health Insurance Coverage among the Nonelderly under Prior-Law, Current-Law, and Current Law with Expanded Short-Term Limited-Duration (STLD) Policies, 2019

Thousands of people

	Prior Law		Current Law				Current Law with Expanded STLD Policies					
					Difference from Prior Law				Difference from Prior Law		Difference from Current Law	
	Number	Percent	Number	Percent	Number	Pct.-pt.	Number	Percent	Number	Pct.-pt.	Number	Pct.-pt.
Insured	**246,415**	**89.8%**	**239,988**	**87.5%**	**-6,427**	**-2.3%**	**237,465**	**86.6%**	**-8,950**	**-3.3%**	**-2,523**	**-0.9%**
Employer	149,115	54.4%	148,580	54.2%	-535	-0.2%	148,346	54.1%	-769	-0.3%	-234	-0.1%
Nongroup (with tax credits)	9,748	3.6%	7,990	2.9%	-1,758	-0.6%	7,373	2.7%	-2,375	-0.9%	-617	-0.2%
Nongroup (without tax credits)	9,700	3.5%	6,002	2.2%	-3,698	-1.3%	4,484	1.6%	-5,217	-1.9%	-1,519	-0.6%
Medicaid/CHIP	69,278	25.3%	68,842	25.1%	-436	-0.2%	68,688	25.0%	-590	-0.2%	-154	-0.1%
Other (including Medicare)	8,574	3.1%	8,574	3.1%	0	0.0%	8,574	3.1%	0	0.0%	0	0.0%
Without minimum essential coverage	**27,901**	**10.2%**	**34,328**	**12.5%**	**6,427**	**2.3%**	**36,851**	**13.4%**	**8,950**	**3.3%**	**2,523**	**0.9%**
Uninsured	27,901	10.2%	34,328	12.5%	6,427	2.3%	32,646	11.9%	4,745	1.7%	-1,682	-0.6%
Expanded STLD plans	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	4,205	1.5%	4,205	1.5%	4,205	1.5%
Total	**274,316**	**100.0%**	**274,316**	**100.0%**	**0**	**0.0%**	**274,316**	**100.0%**	**0**	**100.0%**	**0**	**0.0%**

Source: Urban Institute analysis based on HIPSM 2018. Reform simulated in 2019.

Notes: The results take into account that Massachusetts has a state-enforced individual mandate and that states have differing levels of laws governing short-term limited-duration policies. "Prior law" refers to what would have been the case had the trends in place before January 2017 persisted. "Current law" includes policy changes made since January 2017, including the elimination of individual-mandate penalties. n.a. = not applicable; pct.-pt. = percentage-point.

State-by-State Findings

ACA-Compliant Nongroup Insurance Coverage. Table 2 shows the effect of current-law changes and expanded STLD policies on ACA-compliant nongroup coverage (Marketplace and non-Marketplace combined) in each state. Findings are shown for the three state categories described earlier: those that would experience the full impact of expanded STLD, those where state laws and regulations would effectively prohibit the expansion, and those with a moderated effect.

As noted earlier, nongroup insurance coverage is estimated to decrease by 5.5 million people, or 28.1 percent, under current law compared to prior law in 2019. This estimated decrease includes all the policy changes made beginning in 2017, including the elimination of the individual mandate. The smallest effect of these policy changes is seen in Massachusetts, which has its own individual mandate that will remain in place even after the federal penalties are eliminated. Massachusetts also saw smaller 2018 premium increases than many other states. The effect in New York is also much smaller than others, as recent large gains in insurance coverage there are attributable to the implementation of the Essential Plan, a basic health program for people with incomes between 138 and 200 percent of the federal poverty level; those gains resulted from affordability improvements and would not be reversed when the individual-mandate penalties are eliminated.

We estimate that ACA-compliant markets in Alaska, Arizona, Iowa, Louisiana, Mississippi, Oklahoma, West Virginia, and Wyoming will lose more than 40 percent of their enrollment because of policy changes made beginning in 2017. The magnitude of the effects varies across states because of premium levels, differences in characteristics of those in the private nongroup insurance market, and different state Marketplace policies. For example, states with more aggressive outreach and enrollment strategies or with active community organizations involved in outreach and enrollment, and which kept longer open enrollment periods than the federal government, have been shown to have more continuing robust participation (e.g., New York, Vermont, and Connecticut). States with smaller nongroup markets, where exits resulting from the end of the individual-mandate penalties are likely to have larger effects on premiums, are expected to lose larger shares of their markets. The simplest changes to understand are those that correspond with large reported premium differences between 2017 and 2018 and states with high premium levels. Among the states listed above that would lose the most nongroup insurance enrollment, Iowa, Mississippi, and Wyoming had exceptionally large 2018 premium increases; those increases have the strongest effect on those not eligible for tax credits. In contrast, Arizona, Louisiana, and West Virginia had disproportionately large declines in 2018 Marketplace nongroup enrollment among people who are eligible for tax credits.

The effects of the expansion of STLD policies on nongroup coverage also vary widely across states. The six states prohibiting their expansion would experience no change relative to current law. However, on average, the states experiencing the full effect of expanded STLD policies would lose an additional 18.6 percent of their nongroup policies, or 2.1 million nongroup insurance enrollees. Compared with prior law, these states' ACA nongroup markets would decrease by 7.0 million people, or 43.3 percent of the people that would have been covered in these markets under prior law. The expansion of STLD

policies alone would reduce the Washington, DC, nongroup market 30.5 percent and the Arkansas nongroup market 25.0 percent, absent city- or state-specific legal changes to prevent such a reduction. We estimate expanded STLD policies would reduce nongroup coverage by only 10.8 percent in Michigan and 13.2 percent in Nevada because of some moderating state laws in each.

TABLE 2

ACA-Compliant Nongroup Coverage by State under Prior Law, Current Law, and Expansion of Short-Term Limited-Duration (STLD) Policies, 2019

Thousands of people

	Prior Law	Current Law			Current Law Plus Expanded STLD Policies				
	Number with compliant nongroup insurance	Number with compliant nongroup insurance	Change from Prior Law		Number with compliant nongroup insurance	Change from Prior Law		Change from Current Law	
State			Number	Percent		Number	Percent	Number	Percent
Full-impact states	**16,091**	**11,209**	**-4,882**	**-30.3%**	**9,127**	**-6,963**	**-43.3%**	**-2,081**	**-18.6%**
Alabama	266	176	-90	-33.7%	145	-121	-45.4%	-31	-17.6%
Alaska	32	15	-17	-53.4%	12	-21	-64.0%	-3	-22.8%
Arizona	318	180	-138	-43.4%	128	-190	-59.7%	-52	-28.8%
Arkansas	120	75	-44	-37.1%	57	-63	-52.8%	-19	-25.0%
California	2,514	1,843	-671	-26.7%	1,456	-1,058	-42.1%	-387	-21.0%
Colorado	283	191	-92	-32.4%	142	-141	-49.8%	-49	-25.7%
Connecticut	178	143	-34	-19.4%	112	-66	-36.9%	-31	-21.8%
Delaware	42	27	-15	-36.3%	21	-21	-49.5%	-6	-20.7%
District of Columbia	25	17	-9	-35.0%	11	-14	-54.8%	-5	-30.5%
Florida	2,166	1,729	-437	-20.2%	1,461	-705	-32.6%	-268	-15.5%
Georgia	697	458	-240	-34.4%	388	-309	-44.3%	-69	-15.1%
Hawaii	50	37	-13	-26.2%	30	-20	-40.0%	-7	-18.7%
Idaho	154	113	-41	-26.9%	91	-63	-40.7%	-21	-18.8%
Illinois	662	497	-165	-25.0%	403	-259	-39.1%	-94	-18.9%
Indiana	306	194	-112	-36.5%	155	-151	-49.2%	-39	-20.0%
Iowa	135	79	-56	-41.6%	63	-71	-52.9%	-15	-19.4%
Kansas	176	126	-50	-28.2%	101	-75	-42.8%	-26	-20.4%
Kentucky	132	106	-26	-19.7%	84	-48	-36.3%	-22	-20.6%
Louisiana	243	139	-103	-42.6%	109	-133	-54.9%	-30	-21.6%
Maine	94	68	-25	-27.2%	61	-32	-34.4%	-7	-9.9%
Maryland	276	221	-56	-20.1%	181	-96	-34.7%	-40	-18.3%
Minnesota	282	170	-112	-39.8%	132	-150	-53.3%	-38	-22.5%
Mississippi	129	75	-53	-41.6%	59	-69	-53.8%	-16	-21.0%
Missouri	365	253	-113	-30.9%	209	-157	-42.9%	-44	-17.4%
Montana	76	51	-25	-33.3%	41	-35	-46.0%	-10	-19.1%
Nebraska	151	105	-46	-30.3%	89	-61	-40.8%	-16	-15.0%
New Hampshire	69	48	-22	-31.2%	40	-30	-42.8%	-8	-16.9%
New Mexico	77	51	-26	-34.4%	40	-37	-48.6%	-11	-21.6%

State	Prior Law	Current Law			Current Law Plus Expanded STLD Policies				
	Number with compliant nongroup insurance	Number with compliant nongroup insurance	Change from Prior Law		Number with compliant nongroup insurance	Change from Prior Law		Change from Current Law	
			Number	Percent		Number	Percent	Number	Percent
North Carolina	758	496	-263	-34.6%	418	-340	-44.8%	-77	-15.6%
North Dakota	51	40	-11	-22.0%	30	-21	-40.8%	-10	-24.1%
Ohio	445	305	-141	-31.6%	242	-203	-45.6%	-62	-20.5%
Oklahoma	227	135	-93	-40.7%	113	-114	-50.4%	-22	-16.3%
Pennsylvania	688	480	-209	-30.3%	392	-296	-43.0%	-87	-18.2%
Rhode Island	51	42	-9	-17.5%	34	-17	-33.1%	-8	-18.9%
South Carolina	307	198	-109	-35.6%	165	-142	-46.1%	-32	-16.4%
South Dakota	66	42	-24	-36.3%	32	-34	-51.0%	-10	-23.0%
Tennessee	373	244	-128	-34.5%	198	-175	-47.0%	-47	-19.2%
Texas	1,737	1,095	-642	-37.0%	884	-854	-49.1%	-211	-19.3%
Utah	291	221	-70	-24.0%	178	-113	-38.9%	-43	-19.7%
Virginia	615	418	-197	-32.1%	355	-260	-42.2%	-62	-14.9%
West Virginia	50	26	-24	-47.9%	22	-28	-55.9%	-4	-15.4%
Wisconsin	368	258	-110	-29.8%	220	-147	-40.1%	-38	-14.6%
Wyoming	45	24	-21	-47.0%	20	-25	-54.9%	-4	-15.0%
States prohibiting STLD plans	**2,656**	**2,303**	**-353**	**-13.3%**	**2,303**	**-353**	**-13.3%**	**0**	**0.0%**
Massachusetts	380	367	-13	-3.3%	367	-13	-3.3%	0	0.0%
New Jersey	456	350	-106	-23.2%	350	-106	-23.2%	0	0.0%
New York	1,240	1,168	-72	-5.8%	1,168	-72	-5.8%	0	0.0%
Oregon	216	158	-58	-26.8%	158	-58	-26.8%	0	0.0%
Vermont	38	34	-5	-12.4%	34	-5	-12.4%	0	0.0%
Washington	326	226	-100	-30.6%	226	-100	-30.6%	0	0.0%
States with moderate STLD impact	**701**	**480**	**-221**	**-31.5%**	**426**	**-275**	**-39.2%**	**-54**	**-11.3%**
Michigan	551	383	-168	-30.5%	342	-209	-38.0%	-41	-10.8%
Nevada	150	97	-53	-35.2%	85	-66	-43.8%	-13	-13.2%
Total	**19,448**	**13,992**	**-5,456**	**-28.1%**	**11,857**	**-7,592**	**-39.0%**	**-2,136**	**-15.3%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: The results take into account that Massachusetts has a state-enforced individual mandate and that states have differing laws governing STLD policies. "Prior law" refers to what would have been the case had the trends in place before January 2017 persisted. "Current law" includes policy changes made since January 2017, including the elimination of individual-mandate penalties. The District of Columbia is considered a state in this analysis.

Those without Minimum Essential Coverage. Table 3 shows the number of uninsured (those with no coverage at all) in each state under prior law, current law, and current law with expansions of STLD policies. In the third scenario, we also show the number of people with short-term, limited-duration policies—a group, as explained earlier, that does not meet the current Congressional Budget Office definition of private health insurance because the coverage does not meet minimum essential coverage standards. We estimate that the number of people uninsured under current law in 2019 will increase by 23 percent on average compared with prior law. The percentage increases in the uninsured will be above 10 percent in all but six states, with the largest effects in states that had the biggest decreases in 2018 Marketplace enrollment and the largest 2018 nongroup premium increases.

Once STLD plans are expanded, 8.3 million fewer people would have insurance compared with prior law, and 2.5 million fewer people would have insurance compared with current law in the 43 states that do not prohibit or limit STLD plan expansion. The STLD expansion alone would decrease the number of those completely uninsured by 5.4 percent in these states (1.7 million people) compared with current law, although these new purchasers would have significantly narrower coverage than that offered in the ACA-compliant nongroup insurance market. Enrollment in the short-term limited-duration plans would total 4.1 million people in those states. The isolated effect of the STLD expansion compared with current law in the states fully affected ranges from a 4.4 percent increase in those without minimum essential coverage in Texas (a state with a high current-law uninsurance rate) to a 23.4 percent effect in North Dakota (a state with a particularly extreme mixture of young adults and older, higher-risk adults). States with the largest effects will tend to be those with high unsubsidized ACA-compliant premiums and those with low Marketplace participation. Health status and socioeconomic characteristic differences also affect the ability of state residents to enroll in STLD plans and their preferences for doing so.

States with the largest absolute numbers of enrollees in STLD plans have the largest populations, including 620,000 people in California, 421,000 people in Texas, and 394,000 people in Florida. These totals include people who would otherwise be uninsured, an even larger number of people opting for these policies instead of enrolling in ACA compliant nongroup insurance, and a considerably small number of people enrolling in the plans instead of employer-sponsored insurance.

TABLE 3

People without Minimum Essential Coverage by State, under Prior Law, Current Law, and Current Law Plus Expanded Short-Term Limited-Duration (STLD) Policies, 2019

Thousands of people

	Prior Law	Current Law			Current Law Plus Expanded STLD Policies						
			Change from Prior Law					Change from Prior Law		Change from Current Law	
State	Uninsured	Uninsured	Number	Percent	STLD policies	Uninsured	Total without MEC	Number	Percent	Number	Percent
Full-impact states	**24,415**	**30,238**	**5,823**	**23.9%**	**4,127**	**28,581**	**32,707**	**8,293**	**34.0%**	**2,470**	**8.2%**
Alabama	510	715	206	40.4%	90	677	767	258	50.6%	52	7.3%
Alaska	97	94	-3	-3.3%	30	77	107	10	9.8%	13	13.6%
Arizona	717	841	124	17.3%	167	772	939	222	31.0%	98	11.6%
Arkansas	160	285	125	78.1%	36	271	307	147	91.6%	22	7.6%
California	2,972	4,626	1,654	55.7%	620	4,439	5,059	2,087	70.2%	433	9.4%
Colorado	390	484	94	24.1%	108	433	540	150	38.4%	56	11.6%
Connecticut	159	193	34	21.1%	52	176	228	69	43.5%	36	18.5%
Delaware	61	70	9	15.5%	9	67	76	15	25.4%	6	8.6%
District of Columbia	26	34	8	32.3%	5	34	38	13	49.3%	4	12.9%
Florida	2,220	2,532	312	14.1%	394	2,435	2,829	609	27.4%	297	11.7%
Georgia	1,619	1,778	159	9.9%	172	1,689	1,861	242	15.0%	83	4.7%
Hawaii	93	104	11	12.0%	12	99	111	19	20.0%	7	7.2%
Idaho	177	213	36	20.1%	39	199	238	60	34.1%	25	11.7%
Illinois	961	1,193	233	24.2%	157	1,131	1,288	327	34.1%	94	7.9%
Indiana	482	663	181	37.5%	74	628	702	220	45.6%	39	5.9%
Iowa	151	206	54	35.8%	41	182	223	71	47.2%	17	8.4%
Kansas	313	363	50	16.0%	50	343	393	80	25.5%	30	8.2%
Kentucky	200	222	22	11.0%	38	208	246	46	23.2%	24	10.9%
Louisiana	325	434	109	33.6%	64	403	467	143	43.9%	33	7.7%
Maine	77	120	42	55.0%	22	106	128	51	66.0%	9	7.1%
Maryland	355	407	52	14.7%	63	384	447	92	26.0%	40	9.8%
Minnesota	325	411	85	26.3%	97	365	463	137	42.2%	52	12.6%
Mississippi	383	448	65	17.0%	47	425	472	89	23.2%	24	5.4%
Missouri	556	723	167	30.0%	96	683	779	223	40.2%	57	7.8%
Montana	74	87	13	17.8%	21	79	100	26	35.0%	13	14.6%
Nebraska	159	197	38	23.7%	43	172	216	57	35.5%	19	9.5%
New Hampshire	58	80	21	36.9%	18	70	87	29	49.9%	8	9.5%
New Mexico	169	200	31	18.4%	20	192	211	42	25.0%	11	5.5%

	Prior Law	Current Law			Current Law Plus Expanded STLD Policies						
			Change from Prior Law					Change from Prior Law		Change from Current Law	
State	Uninsured	Uninsured	Number	Percent	STLD policies	Uninsured	Total without MEC	Number	Percent	Number	Percent
North Carolina	1,144	1,430	287	25.1%	221	1,325	1,546	402	35.1%	115	8.1%
North Dakota	43	46	3	7.3%	15	41	57	14	32.4%	11	23.4%
Ohio	576	713	137	23.7%	116	661	776	200	34.7%	63	8.9%
Oklahoma	561	668	107	19.1%	70	633	703	142	25.3%	35	5.2%
Pennsylvania	542	702	160	29.6%	165	644	810	268	49.5%	108	15.4%
Rhode Island	47	51	4	7.9%	11	48	60	12	26.2%	9	17.0%
South Carolina	549	660	111	20.1%	76	627	704	154	28.1%	44	6.6%
South Dakota	85	109	24	27.9%	23	98	121	36	42.0%	12	11.0%
Tennessee	653	769	115	17.7%	120	713	833	180	27.5%	64	8.4%
Texas	4,731	5,304	573	12.1%	421	5,117	5,538	807	17.1%	234	4.4%
Utah	298	373	75	25.3%	67	352	419	121	40.6%	46	12.3%
Virginia	912	1,069	157	17.2%	137	1,003	1,141	229	25.1%	72	6.7%
West Virginia	74	101	27	36.5%	21	91	112	38	51.6%	11	11.1%
Wisconsin	348	441	93	26.8%	58	420	478	130	37.5%	37	8.5%
Wyoming	61	78	17	27.5%	19	67	86	24	39.6%	7	9.5%
States prohibiting STLD plans	**2,643**	**3,040**	**397**	**15.0%**	**0**	**3,040**	**3,040**	**397**	**15.0%**	**0**	**0.0%**
Massachusetts	96	103	7	7.5%	0	103	103	7	7.5%	0	0.0%
New Jersey	589	681	92	15.6%	0	681	681	92	15.6%	0	0.0%
New York	1,222	1,315	94	7.7%	0	1,315	1,315	94	7.7%	0	0.0%
Oregon	241	293	52	21.8%	0	293	293	52	21.8%	0	0.0%
Vermont	24	43	19	78.8%	0	43	43	19	78.8%	0	0.0%
Washington	473	605	133	28.1%	0	605	605	133	28.1%	0	0.0%
States with moderate STLD impact	**843**	**1,050**	**207**	**24.6%**	**78**	**1,025**	**1,103**	**261**	**30.9%**	**54**	**5.1%**
Michigan	497	662	165	33.2%	54	646	700	203	40.9%	38	5.8%
Nevada	346	388	42	12.1%	25	379	403	57	16.5%	15	4.0%
Total	**27,901**	**34,328**	**6,427**	**23.0%**	**4,205**	**32,646**	**36,851**	**8,950**	**32.1%**	**2,523**	**7.4%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: The results take into account that Massachusetts has a state-enforced individual mandate and that states have differing levels of laws governing STLD policies. "Prior law" refers to what would have been the case had the trends in place before January 2017 persisted. "Current law" includes policy changes made since January 2017, including the elimination of individual-mandate penalties. Minimum essential coverage (or MEC) refers to any insurance plan that satisfies the ACA's requirement to have health insurance coverage. STLD plans do not meet that standard and are thus not considered private insurance coverage by the Congressional Budget Office. The District of Columbia is considered a state in this analysis.

Effect of Expanded STLD Plans on Premiums in the ACA-Compliant Nongroup Insurance Market. We estimate that average premiums in the ACA-compliant nongroup insurance market would increase approximately 18 percent in the states that do not prohibit or limit expanded STLD plans (table 4). This premium increase includes the expansion of the STLD plans and the elimination of the individual-mandate penalties. The premium effect varies modestly across states, with the clear majority falling in the 17 to 21 percent range. States like Alaska and Minnesota that have reinsurance mechanisms in place in the ACA-compliant market, would experience still significant (but smaller premium) increases. The same is true for Michigan and Nevada (12.2 and 15.2 percent increases, respectively), where state law would significantly limit enrollment in STLD plans. Massachusetts is the only state with its own individual mandate and effective prohibitions on expansions of STLD policies and thus no measurable premium effect. The premium effects in the other five states prohibiting STLD plan expansion are attributable to the elimination of the individual-mandate penalties alone.

TABLE 4

Percent Change in ACA-Compliant Premiums because of Expanded Short-Term Limited-Duration (STLD) Policies and Loss of Individual Mandate, 2019

State	Change	State	Change
Full-impact states	**18.2%**	**Full-impact states (cont'd)**	
Alabama	21.6%	New Mexico	9.1%
Alaska	8.5%	North Carolina	17.8%
Arizona	20.6%	North Dakota	20.8%
Arkansas	18.8%	Ohio	16.8%
California	17.8%	Oklahoma	18.7%
Colorado	18.3%	Pennsylvania	19.2%
Connecticut	16.5%	Rhode Island	20.7%
Delaware	19.9%	South Carolina	17.2%
District of Columbia	13.6%	South Dakota	21.7%
Florida	16.9%	Tennessee	18.1%
Georgia	19.5%	Texas	20.2%
Hawaii	17.5%	Utah	18.5%
Idaho	17.5%	Virginia	19.1%
Illinois	19.4%	West Virginia	20.0%
Indiana	19.6%	Wisconsin	20.0%
Iowa	15.8%	Wyoming	18.6%
Kansas	19.2%	**States prohibiting STLD plans**	**8.3%**
Kentucky	18.7%	Massachusetts	0.0%
Louisiana	14.0%	New Jersey	10.9%
Maine	15.9%	New York	8.8%
Maryland	18.4%	Oregon	9.1%
Minnesota	11.1%	Vermont	12.2%
Mississippi	17.2%	Washington	13.6%
Missouri	18.3%	**States with moderate STLD impact**	**12.8%**
Montana	19.8%	Michigan	12.2%
Nebraska	20.4%	Nevada	15.2%
New Hampshire	19.6%		
		Total	**16.4%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.
Notes: The results take into account that Massachusetts has a state-enforced individual mandate and that states have differing laws governing STLD policies. The District of Columbia is considered a state in this analysis.

Federal Health Care Spending. Table 5 provides estimates of federal health care spending (acute care spending for the nonelderly through Medicaid and CHIP plus Marketplace premium tax credits) in each state under prior law, current law, and current law plus the expanded STLD plans in 2019. The largest effect on federal spending is attributable to the policy changes made since early 2017, particularly the elimination of the individual-mandate penalties. The federal spending effect of the expanded STLD policies alone is negligible, a decrease of roughly 0.2 percent, or $686 million, in 2019. This stability in federal spending is the consequence of the offsetting effects of reducing the number of people receiving ACA premium tax credits by about 600,000 while increasing private nongroup premiums approximately 16 percent on average nationally. With the expanded STLD policies in place, however, federal spending is estimated to be 9.3 percent or $33.3 billion higher than under prior law. This higher spending takes

into account lower enrollment in subsidized Marketplace coverage and Medicaid along with higher Marketplace premiums stemming from a worsened nongroup insurance risk pool caused the individual-mandate penalties being eliminated and other 2017 policy changes. The higher average-cost insurance pool leads to significantly higher premium tax credits per enrollee.

Variation across states in the federal spending effects of expanded STLD policies alone is driven by interactions between reductions in Marketplace subsidized enrollment and premium increases. For example, Virginia has more modest losses of nongroup coverage than many other states; as such, the increase in average premium tax credits received by Virginia residents due to higher premiums significantly outweighs the federal savings from reduced enrollment. In Arkansas, however, the federal savings from larger reductions in Marketplace enrollment create small net reductions in federal spending even in the face of premium increases.

TABLE 5

Federal Costs by State under Prior Law, Current Law, and Current Law Plus Expanded Short-Term Limited-Duration (STLD) Policies, 2019

Millions of dollars

State	Prior Law	Current Law			Current Law Plus Expanded STLD Policies				
	Total federal spending	Total federal spending	Difference from Prior Law		Total federal spending	Difference from Prior Law		Difference from Current Law	
			Amount	Percent		Amount	Percent	Amount	Percent
Full-impact states	**289,499**	**317,356**	**27,857**	**9.6%**	**316,646**	**27,147**	**10.9%**	**-710**	**-0.2%**
Alabama	4,581	5,009	428	9.3%	4,986	405	8.8%	-24	-0.5%
Alaska	1,045	1,183	138	13.2%	1,165	120	11.5%	-17	-1.5%
Arizona	10,145	10,458	313	3.1%	10,396	251	2.5%	-62	-0.6%
Arkansas	5,185	5,152	-33	-0.6%	5,128	-57	-1.1%	-24	-0.5%
California	46,027	49,521	3,494	7.6%	49,299	3,272	7.1%	-222	-0.4%
Colorado	5,449	5,839	390	7.2%	5,834	384	7.1%	-6	-0.1%
Connecticut	4,402	4,871	469	10.7%	4,871	470	10.7%	1	0.0%
Delaware	1,222	1,388	166	13.6%	1,368	145	11.9%	-20	-1.5%
District of Columbia	1,360	1,417	56	4.1%	1,417	57	4.2%	1	0.0%
Florida	20,359	23,380	3,020	14.8%	23,321	2,961	14.5%	-59	-0.3%
Georgia	9,063	10,697	1,634	18.0%	10,662	1,599	17.6%	-35	-0.3%
Hawaii	992	1,089	97	9.8%	1,097	105	10.6%	8	0.7%
Idaho	1,791	1,981	190	10.6%	1,982	191	10.6%	1	0.0%
Illinois	8,864	9,834	970	10.9%	9,821	957	10.8%	-13	-0.1%
Indiana	8,433	8,538	104	1.2%	8,521	87	1.0%	-17	-0.2%
Iowa	2,997	3,608	611	20.4%	3,598	601	20.1%	-10	-0.3%
Kansas	1,857	1,985	128	6.9%	2,005	148	8.0%	20	1.0%
Kentucky	8,088	8,831	744	9.2%	8,830	742	9.2%	-2	0.0%
Louisiana	6,620	7,036	416	6.3%	7,017	397	6.0%	-19	-0.3%
Maine	1,710	1,939	229	13.4%	1,937	227	13.2%	-2	-0.1%
Maryland	6,112	6,878	765	12.5%	6,868	755	12.4%	-10	-0.1%
Minnesota	6,146	6,838	692	11.3%	6,804	658	10.7%	-34	-0.5%
Mississippi	4,237	4,411	173	4.1%	4,404	166	3.9%	-7	-0.2%
Missouri	7,559	8,182	623	8.2%	8,227	669	8.8%	45	0.6%
Montana	1,868	2,243	375	20.1%	2,215	347	18.5%	-28	-1.3%
Nebraska	1,303	1,864	562	43.1%	1,853	551	42.3%	-11	-0.6%
New Hampshire	908	1,062	153	16.9%	1,063	154	17.0%	1	0.1%
New Mexico	5,060	5,168	108	2.1%	5,173	113	2.2%	5	0.1%
North Carolina	14,045	15,155	1,110	7.9%	15,148	1,103	7.9%	-7	0.0%

State	Prior Law	Current Law			Current Law Plus Expanded STLD Policies				
	Total federal spending	Total federal spending	Difference from Prior Law		Total federal spending	Difference from Prior Law		Difference from Current Law	
			Amount	Percent		Amount	Percent	Amount	Percent
North Dakota	514	558	45	8.7%	561	47	9.2%	3	0.5%
Ohio	14,021	14,697	676	4.8%	14,716	695	5.0%	19	0.1%
Oklahoma	4,046	4,724	678	16.8%	4,658	612	15.1%	-66	-1.4%
Pennsylvania	14,848	16,507	1,659	11.2%	16,414	1,566	10.5%	-93	-0.6%
Rhode Island	1,100	1,234	133	12.1%	1,232	132	12.0%	-2	-0.2%
South Carolina	4,812	5,185	373	7.7%	5,208	396	8.2%	23	0.4%
South Dakota	683	784	101	14.8%	785	102	14.9%	1	0.2%
Tennessee	8,390	9,541	1,151	13.7%	9,585	1,194	14.2%	43	0.5%
Texas	27,340	29,219	1,878	6.9%	29,234	1,893	6.9%	15	0.1%
Utah	2,819	3,618	799	28.4%	3,588	769	27.3%	-30	-0.8%
Virginia	5,448	6,852	1,404	25.8%	6,854	1,406	25.8%	2	0.0%
West Virginia	2,850	2,959	109	3.8%	2,907	57	2.0%	-52	-1.8%
Wisconsin	4,729	5,355	626	13.2%	5,329	600	12.7%	-26	-0.5%
Wyoming	467	567	100	21.5%	567	100	21.5%	0	0.0%
States prohibiting STLD plans	**52,461**	**57,310**	**4,849**	**9.2%**	**57,310**	**4,849**	**10.0%**	**0**	**0.0%**
Massachusetts	6,971	6,530	-441	-6.3%	6,530	-441	-6.3%	0	0.0%
New Jersey	6,719	6,995	276	4.1%	6,995	276	4.1%	0	0.0%
New York	23,970	28,110	4,140	17.3%	28,110	4,140	17.3%	0	0.0%
Oregon	5,693	6,217	525	9.2%	6,217	525	9.2%	0	0.0%
Vermont	1,207	1,261	55	4.5%	1,261	55	4.5%	0	0.0%
Washington	7,902	8,197	294	3.7%	8,197	294	3.7%	0	0.0%
States with moderate STLD impact	**16,175**	**17,440**	**1,265**	**7.8%**	**17,464**	**1,289**	**8.6%**	**24**	**0.1%**
Michigan	13,109	14,180	1,071	8.2%	14,206	1,096	8.4%	25	0.2%
Nevada	3,066	3,260	194	6.3%	3,258	193	6.3%	-2	-0.1%
Total	**358,135**	**392,106**	**33,971**	**9.5%**	**391,420**	**33,285**	**9.3%**	**-686**	**-0.2%**

Source: Urban Institute analysis using HIPSM 2018. Reform simulated in 2019.

Notes: The results take into account that Massachusetts has a state-enforced individual mandate and that states have differing laws governing STLD policies. "Prior law" refers to what would have been the case had the trends in place before January 2017 persisted. "Current law" includes policy changes made since January 2017, including the elimination of individual-mandate penalties. The District of Columbia is considered a state in this analysis.

Discussion

The expansion of short-term limited-duration policies implied in the current administration's proposed rule has significant implications, particularly for insurance coverage and premiums in the remaining ACA-compliant insurance market. We estimate that ACA-compliant private nongroup coverage would fall by 2.1 million people in 2019 from the expansion of STLD policies alone, exacerbating the nongroup market decline of 5.5 million people already anticipated in 2019 because of the elimination of the individual-mandate penalties and other policy changes made since early 2017. The effects will vary across the states given differences in state laws and regulations as well as differences in health care costs and population characteristics. In the 43 states most affected, premiums in the ACA-compliant nongroup insurance market would increase 18 percent on average owing both to the expansion of the short-term plans and elimination of the individual-mandate penalties. This premium effect would be 20 percent or higher in nine states. Those affected by these large premium increases would be disproportionately middle-income people with health problems because they prefer health insurance that covers essential health benefits, are unlikely to have access to medically underwritten short-term limited-duration policies, and are not financially protected by the ACA's premium tax credits. For people who have ACA-compliant coverage and are eligible for premium tax credits, these higher premiums translate into higher premium tax credits per enrollee paid by the federal government. In total, 9.0 million fewer people would have insurance (minimum essential coverage) compared with prior law.

Several issues cannot be captured through a microsimulation analysis. First, as the ACA-compliant nongroup insurance markets decrease and as healthier enrollees exit for short-term plans, insurers will by necessity reexamine the profitability of remaining in the compliant markets. This may well lead to more insurer exits from the compliant markets in the next years, reducing choice for the people remaining and ultimately making the markets difficult to maintain. Second, STLD policies are generally not subject to the ACA's medical loss ratio requirements,[6] and therefore the companies that sell them can pay higher commissions to their brokers than they can for ACA-compliant plans. As a result, brokers are likely to market these plans very aggressively, and consumers may purchase them without understanding how they differ from compliant plans. If this is the case, more people may be pulled out of the compliant market than we have estimated here, increasing the effects of the policy change. Third, some people buying the narrower STLD polices will incur serious health problems once enrolled, and find that their plans do not meet their medical needs. This could lead to increases in unmet medical need and uncompensated care. Finally, states can impose regulations that would limit the types of short-term plans that could be sold, and they can effectively prohibit them. While only a small number of states have done so thus far, more could make such legal and/or regulatory changes and thereby significantly reduce or even eliminate the effects estimated here.

Notes

[1] "A Proposed Rule by the Internal Revenue Service, the Employee Benefits Security Administration, and the Health and Human Services Department," 83 Fed. Reg. 7437 (Feb. 21, 2018).

[2] Our three categories differ from the five categories that the Center on Health Insurance Reforms developed. We use the detailed information in their analysis to assess the practical outcome of state regulatory approaches.

[3] For example, Minnesota limits the duration of these policies to 185-day contracts, but they can be renewed for as many as 365 days of coverage in a 555-day period (Dania Palanker, Kevin Lucia, Sabrina Corlette, and Maanasa Kona, "Proposed Federal Changes to Short-Term Health Coverage Leave Regulation to States," *To the Point* (blog), The Commonwealth Fund, February 20, 2018, http://www.commonwealthfund.org/publications/blog/2018/feb/short-term-health-plan-proposed-changes.

[4] Jared Maeda and Susan Yeh Beyer, "How Does CBO Define and Estimate Health Insurance Coverage for People under Age 65?" Congressional Budget Office blog, December 20, 2016, https://www.cbo.gov/publication/52352.

[5] Harriet Sinclair, "Trump Claims Obamacare is 'Dead' and 'You Shouldn't Even Mention It'," *Newsweek*, October 16, 2017, http://www.newsweek.com/trump-claims-obamacare-dead-686219.

[6] The one exception seems to be Rhode Island.

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Errata

This brief was updated February 26, 2018. The title and notes for table 4 were altered to remove references to current law that had been inadvertently copied from tables 1–3.

About the Authors

Linda J. Blumberg is an Institute fellow in the Health Policy Center at the Urban Institute. She is an expert on private health insurance (employer and nongroup), health care financing, and health system reform. Her recent work includes extensive research related to the ACA; in particular, providing technical assistance to states, tracking policy decisionmaking and implementation at the state and federal levels, interpreting and analyzing the implications of particular policies, and estimating the implications of repeal and replace proposals. She codirects a large, multiyear project using qualitative and quantitative methods to monitor and evaluate ACA implementation in states and nationally. Examples of her research include several analyses of competition in nongroup Marketplaces, an array of studies on the implications of the *King v. Burwell* Supreme Court case, analysis of the remaining uninsured, and codirecting 22 state case

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