Congressional Budget Office

How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans

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Notes

This analysis was conducted in August 2018 using projections of federal revenues and spending for fiscal years 2019 through 2028. Estimates of health insurance coverage reflect average monthly enrollment during a calendar year and include spouses and dependents covered under family policies. Those estimates are for the noninstitutionalized civilian population under age 65.

Numbers in the text, tables, and figure may not sum to totals because of rounding.

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How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans

Summary

During the summer of 2018, the Administration issued final rules governing coverage offered through association health plans (AHPs) and short-term, limited-duration insurance. (AHPs are legal arrangements that allow associations or unrelated employers to jointly offer fringe benefits to members or employees.) The rules were designed to increase enrollment in such plans, which may be sold in the small-group and nongroup insurance markets. AHPs and short-term plans are exempt from many of the regulations that govern other insurance offerings in those markets.

This report describes how the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) analyzed the new rules and determined how those rules would affect the agencies' projections of the number of people who obtain health insurance and the costs of federal subsidies for that coverage. It also provides details about the projected effects.

CBO and JCT's current findings are similar to those from an analysis of the two rules as they were proposed. Those findings were published in a report on federal subsidies for insurance coverage that CBO released with its spring 2018 baseline.[1]

The agencies' two main findings from the current analysis are as follows:

- Each year over the next decade, roughly 5 million more people are projected to be enrolled in AHPs or short-term plans as a result of the two rules. Almost 80 percent are people who would otherwise have purchased coverage in the small-group or nongroup markets. The remaining 20 percent (roughly 1 million people) are projected to be newly insured as a result of the rules.

- Once the two rules take full effect, premiums for coverage in the fully regulated small-group and nongroup markets are projected to be roughly 3 percent higher than they would have been without the rules. In 2028, for example, such an increase would raise average annual premiums by roughly $350 to $400 for single coverage and by $900 to $950 for family coverage. Premiums for fully regulated coverage are projected to rise because people who continue to purchase coverage in the fully regulated markets are expected to have higher average health care costs than those who purchase AHPs or short-term plans. Because federal subsidies defray some of the higher costs, CBO and JCT do not expect that premium increase to spur a noticeable decline in insurance coverage.

What Are the New Rules?

In June 2018, the Administration published a final rule that modified the definition of "employer" under title I of the Employee Retirement Income Security Act, or ERISA. In August, it published a final rule to amend the definition of "short-term, limited-duration insurance."[2]

1. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), pp. 10–11, www.cbo.gov/publication/53826.

2. See Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28912 (June 21, 2018), https://go.usa.gov/xPf4M; and Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38212 (August 3, 2018), https://go.usa.gov/xEcKs.

Association Health Plans

The first rule makes it easier for business associations and other entities to offer health insurance through AHPs. Although such coverage existed before that rule was issued, the rule established a new, less restrictive pathway for groups to form associations that offer plans, and it broadened the definition of "small employer" to include self-employed people.[3]

The rule also specifies that AHPs formed under the new pathway would be regulated as though they offered large-group coverage—rather than nongroup or small-group coverage—regardless of the size of member businesses. (Large-group coverage is generally for businesses with more than 50 employees; small-group coverage is for businesses with 50 employees or fewer. Nongroup coverage is purchased directly by an individual from an insurer or through a health insurance marketplace rather than through an employer.) Although large-group coverage is subject to federal and state regulations, it is exempt from some requirements that are specific to the nongroup and small-group markets, notably the following:

- Insurance plans must cover what are termed essential health benefits—that is, 10 categories of health care services that federal law defines as essential; and
- Within a given geographic region, premiums must be community rated—they may vary only within a predefined range and only on the basis of age and tobacco use.

All other factors being equal, coverage of essential health benefits increases the financial protection associated with health insurance by increasing the scope of coverage but also the cost of premiums. Community rating makes it easier for people who are older or less healthy to afford health insurance, but it tends to lead to higher premiums for people who are younger and healthier.

Short-Term, Limited-Duration Insurance

The new rule for short-term plans extends their maximum duration from three months to 364 days and allows people to renew their policies for up to three years. Federal law exempts short-term plans from compliance with most regulations that govern nongroup coverage, including those that require coverage of essential health benefits and community rating but also guaranteed issue—the requirement that insurers offer policies to all applicants regardless of health status. Guaranteed issue makes it easier for people with preexisting conditions to gain access to health insurance, but it leads to higher premiums for other people.

Similarities Between AHPs and Short-Term Plans Offered Under the New Rules

Because coverage sold under either of the two new rules need not comply with all of the requirements governing the nongroup and small-group markets, CBO and JCT expect that, on average, premiums for coverage under both types of plans will cost less than premiums for coverage in the fully regulated nongroup and small-group markets. That is particularly the case for the new types of coverage that will be available for younger and healthier people.

Differences Between AHPs and Short-Term Plans Offered Under the New Rules

Although the two new types of coverage share some features, there are important distinctions concerning the types of plans that insurers may offer and the characteristics of people who might purchase those plans.

Availability and Pricing. For AHPs, premiums may reflect the expected health care spending of each association, but insurers cannot refuse coverage to association members. For short-term plans, insurers may charge premiums that reflect the expected health care spending for individual applicants and may refuse to cover people with high expected health care spending or preexisting conditions.

Scope of Benefits. Although neither type of plan must cover all essential health benefits, AHPs tend to cover most of them. Short-term plans, however, are more likely to exclude many of those benefits and often exclude coverage for preexisting conditions. On the basis of

3. The rule retained the original pathway for groups to form associations and offer AHPs but created a new pathway that has less stringent requirements for the "commonality of interest" test for associations. In particular, groups of employers are considered to meet that requirement if they share an industry (real estate, law, or hospitality, for example) or are based in the same geographic area. Under the original pathway, employer groups must have both attributes in common. AHPs formed under the new pathway will operate under a different set of regulations. For example, unlike AHPs formed under the original pathway, they will not be able to vary premiums on the basis of health status for each member of the association. For more information, see Fritz Busch and Jason Karcher, *Association Health Plans After the Final Rule* (Milliman, August 2018), http://tinyurl.com/y7nmfoyv.

interviews with insurers and other stakeholders, CBO and JCT expect that most of the new short-term plans will provide coverage that is more similar to AHP coverage than it is to coverage in short-term plans that predate the new rule but that, overall, AHPs will continue to provide broader coverage than short-term plans.

Eligibility. To be eligible to purchase AHP coverage, one must either work for a small employer that offers AHP coverage or be self-employed and a member of an association that sponsors an AHP. No similar requirements apply to purchasers of short-term plans.

How Does CBO's Baseline Reflect Administrative Actions?

CBO's baseline budget and economic projections are constructed to reflect an assumption that current laws governing taxes and spending would generally remain in place during the current fiscal year and for the ensuing 10 years. The baseline projections are not intended to predict budgetary outcomes; rather, they reflect the agency's best assessment about how the economy and the federal budget would evolve under existing laws. The baseline serves as a neutral benchmark against which Members of Congress can measure the budgetary effects of proposed legislation.

Each year, CBO provides the Congress with updated baseline projections of federal revenues, spending, and the resulting deficits. It adjusts those projections throughout the year to account for enacted legislation and for other changes in law, including new regulations that are issued between formal baseline updates.

Those projections include the costs of federal subsidies for health insurance, which reflect CBO's estimates of the number of people with various types of coverage. The agency uses that coverage baseline to estimate the effects of proposed legislation on people's sources of health insurance and on the number of people who would be without insurance.

The new rules for AHPs and short-term plans had been proposed but were not yet final in May 2018, when CBO last reported on federal subsidies for insurance coverage.[4] In keeping with CBO's practices for estimating the effects of proposed rules, those projections incorporated an assumption reflecting a 50 percent chance that the final rules would be the same as those proposed and a 50 percent chance that no rules like those proposed would be issued. A final rule, once issued, becomes CBO's basis for estimating the effects of legislation. After the two rules were made final, CBO incorporated 100 percent of the estimated effects of each into its baseline projections.

The final rules were similar to the proposed rules. The most significant difference that affected CBO and JCT's estimate was that both rules were implemented earlier than the agencies had assumed for their spring estimates. The earlier implementation dates would—in isolation—have increased CBO and JCT's estimates of enrollment in AHPs and short-term plans. However, several states enacted laws that prohibited the sale of short-term plans or required short-term plans to comply with all regulations that govern the nongroup health insurance market. Those laws are expected to reduce enrollment in short-term plans. As a result, CBO and JCT estimate that enrollment in AHPs and short-term plans under the final rules will be similar to the estimated enrollment described in CBO's May 2018 report on federal subsidies for health insurance coverage.

How Did CBO and JCT Approach the Analysis?

To estimate the effects of the new rules for AHPs and short-term plans, CBO and JCT analyzed the incremental increase in coverage in both types of plans that will result from the rules (rather than assessing total enrollment in those plans, which were available before the final regulations were issued). The agencies followed several steps in completing their analysis, beginning with a comparison of estimated premiums for the new plans with those for the lowest-cost insurance otherwise available to individuals and small employers.

Then, CBO and JCT adjusted that comparison to reflect any differences in the portion of medical expenses paid by the insurer (often called a plan's actuarial value) and the scope of services covered.[5] Although a premium for a new plan might be as much as 90 percent below the

4. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028* (May 2018), pp. 10–11, www.cbo.gov/publication/53826.

5. CBO and JCT estimated actuarial values on the basis of data from existing AHPs and short-term plans and after accounting for information gathered in interviews with insurers and other stakeholders about how the AHPs and short-term plans offered as a result of the rules would compare with existing products.

premium of the lowest-priced plan currently available to someone with low expected health care spending, a new plan need not offer comparable benefits. (For many people, the premium amount for a new plan could be higher than their existing premium. Moreover, insurers can deny coverage in the new plans to an applicant or association with particularly high expected health care costs.)

The estimated average differences in premiums also reflect the expected health care spending for purchasers of AHPs and short-term plans. CBO and JCT used CBO's health insurance simulation model to estimate potential purchasers' expected health care costs under the new types of AHPs and short-term plans and to project those costs relative to costs for other people with small-group and nongroup coverage.[6] On the basis of that analysis and other research, CBO and JCT projected that roughly 40 percent of people either would prefer fully regulated coverage to that offered by AHPs or short-term plans or would have health conditions that might prompt insurers to deny them coverage under a new plan. The remaining 60 percent of people would be candidates for coverage offered under the new rules.

Potential purchasers are people who have no preexisting condition that would cause an insurer to deny them coverage entirely, those without a preexisting condition that requires continuing treatment that might not be covered under the new types of plans, and those who do not expect to use essential health benefits that are covered under fully regulated health plans but not under the new types of AHPs and short-term plans.

After identifying potential purchasers, CBO and JCT estimated a measure known as elasticity: the percentage change in the number of people who would choose different health coverage in response to a 1 percent change in a premium. In this case, elasticity is used to arrive at an estimate of how readily someone would respond to the availability of lower-priced insurance. In general, CBO and JCT expect that lower premiums are more likely to attract people and employers who already purchase coverage than they are to convince a person or employer to purchase coverage for the first time. That is, the estimated elasticity is higher among people and employers currently in the insurance market. That expectation reflects both a thorough review of the literature and interviews with insurers and other stakeholders about what types of people and employers would be most likely to take up the new types of coverage offered under the two rules. (Specific elasticities, the research involved, and the basis for other key inputs to the estimate are discussed below in "What Key Technical Inputs Did CBO and JCT Use?")

CBO and JCT estimated the effects of the two rules jointly because each provides an alternative way for people to purchase coverage that does not comply with the regulations governing other insurance sold in the nongroup and small-group markets. For many self-employed people, AHPs and short-term plans can be seen as substitutes for one another: If one type of plan is not available, people can instead purchase the other.[7] CBO and JCT expect that if there had been no rule increasing the availability of short-term plans, more people would enroll in an AHP offered by their employer. In developing the estimates, CBO interviewed national and regional insurers, policy and legal experts, people who work for industry associations, and state insurance regulators.

Association Health Plans

CBO and JCT began by estimating premiums for the new AHPs and comparing those estimates with estimates of premiums for coverage currently sold in the small-group market.[8] On the basis of their analysis of existing

6. For more information about CBO's current health insurance simulation model, see Congressional Budget Office, "The Health Insurance Simulation Model Used in Preparing CBO's 2018 Baseline" (presentation, February 2018), www.cbo.gov/publication/53592. CBO will use an updated version of that model to develop the agency's spring 2019 projections and subsequent cost estimates. For more information, see Jessica Banthin and Alex Minicozzi, "Updating CBO's Health Insurance Simulation Model (HISIM)" (presentation at the Bipartisan Policy Center, Washington D.C., June 19, 2018), www.cbo.gov/publication/54063.

7. Because people who do not work for small employers and are not self-employed can purchase short-term plans but not AHPs, their choice of coverage is affected only by the rule on short-term plans.

8. Although some self-employed people may purchase coverage through AHPs as a result of the rule, others may purchase short-term plans. CBO and JCT expect that such people will compare the AHP and short-term plan premiums with premiums for fully regulated nongroup coverage. CBO and JCT therefore modeled the decisions of self-employed people as a choice to move from fully regulated nongroup coverage into either AHP or short-term plan coverage.

premiums and as a result of interviews with insurers and other stakeholders, CBO and JCT estimate that premiums for AHPs sold under the new rules will be, on average, roughly 30 percent lower than premiums for fully regulated small-group coverage.

That difference reflects two considerations: First, AHPs need not cover all essential health benefits, and second, AHPs are permitted to set premiums on the basis of each association's expected or actual health care spending rather than at the community level. CBO and JCT estimate that the majority of the difference in premiums will stem from lower expected health care spending for AHP enrollees and not from differences in the scope of coverage. Indeed, CBO and JCT expect that the coverage provided by the newly offered AHPs will be similar to that under AHPs sold before the new rule, many of which need not cover all of the essential health benefits but still offer coverage that is similar to comprehensive employment-based coverage. According to insurers and other stakeholders, although AHPs may exclude some benefits that are required in the nongroup and small-group markets, they sometimes offer wider provider networks or lower deductibles than are available through other types of nongroup and small-group coverage. CBO and JCT expect that, on balance, the scope of benefits offered by AHPs will be somewhat narrower than the scope of benefits offered by other plans in the small-group market.

The primary factor driving lower premiums for AHPs is the ability to price premiums on the basis of each association's expected health care spending and thereby attract employers with relatively low-risk employees and avoid those with higher-risk employees. In the existing nongroup and small-group markets, insurers must use community rating to set premiums that reflect average costs across all enrollees within the markets. By offering coverage outside of those markets, AHPs can selectively cover people with lower expected health care costs and thus offer lower premiums.

Because expected health care costs for people who purchase the newly created AHPs are likely be lower than those of the average small-group enrollee, CBO and JCT anticipate that the departure of such people from the regulated small-group market will result in an increase of roughly 3 percent for premiums among the plans offered by the remaining employers. However, because premiums for AHPs will be lower than premiums small employers are currently paying, premiums for the small-group market as a whole are projected to decline as a result of the rule.

Short-Term Plans

To estimate enrollment in newly offered short-term plans, CBO and JCT compared expected premiums with the lowest premiums available in the fully regulated nongroup market. That analytical choice reflects an assumption that people who are expected to purchase a short-term plan would compare the premium for that plan with the lowest-cost alternative otherwise available (including any premium tax credits).[9] For most people who have nongroup coverage or are uninsured, the lowest-cost premium for available coverage generally corresponds to that for a bronze health plan (for which the insurer pays, on average, 60 percent of covered expenses).[10]

The difference in premiums between short-term plans and plans sold in the fully regulated nongroup market occurs because short-term plans are not required to cover all essential health benefits, insurers can price premiums on the basis of an individual's expected health care spending, and short-term plans are permitted to exclude coverage of preexisting conditions or to refuse to provide or renew a plan for someone who uses costly health care services. That ability to exclude people with higher expected health care costs is a significant contributor to the lower premiums charged by short-term plans. Because people who purchase the newly created short-term plans will have lower average health care costs than other nongroup enrollees, CBO and JCT estimate that their departure from the regulated nongroup market will raise premiums for the rest of that market by roughly 3 percent.

The difference between premiums for short-term plans and for the lowest-cost option available through the marketplaces depends on the applicant's characteristics, including age, health status, and income. Net premiums

9. Under current law, tax credits are available to defray the cost of premiums for people whose income is generally between 100 percent and 400 percent of the federal poverty guidelines (the federal poverty level) who have no other affordable source of health insurance.

10. In most marketplaces, people can choose a plan on the basis of its actuarial value. On average, bronze, silver, and gold plans pay about 60 percent, 70 percent, and 80 percent, respectively, of covered expenses.

(premiums paid after accounting for federal subsidies for health insurance) for the lowest-cost plan available in the marketplaces vary significantly depending on the size of the premium tax credit purchasers are eligible to receive. For example, some people can obtain bronze plans while paying a negligible net premium even though their total or gross premium might be significantly higher. CBO and JCT estimate that premiums for plans newly offered as a result of the short-term rule also will vary significantly because insurers will set premiums on the basis of a person's health status and in some cases will deny coverage to an applicant. As a result, premiums for short-term plans will be less than premiums for the lowest-cost marketplace plan for some people and higher for others.

On the basis of interviews with insurers and other stakeholders, CBO and JCT expect that a range of new short-term insurance products will be sold as a result of the new rule. For this estimate, CBO and JCT modeled two categories: traditional short-term plans (TSPs) and insured short-term plans (ISPs).

TSPs would be similar to the short-term plans that were available before August 2018 but would provide coverage for up to 364 days rather than for three months. The terms of such plans vary widely, but most offer limited benefits and cover only a fixed amount for large expenses, such as inpatient hospital care. TSPs do not cover high-cost, low-probability events and therefore do not meet CBO's definition of private health insurance.[11] Estimating the actuarial value of such products is challenging because the scope of coverage is so varied and because coverage generally completely excludes services for any preexisting condition. CBO and JCT estimate that uninsured people with low expected health care costs who are ineligible for premium tax credits may be able to enroll in a TSP with premiums that are as much as 90 percent below those of the lowest-cost bronze plan available through a nongroup marketplace. However, many people who are eligible for premium tax credits or who are older or have higher expected health care spending would probably pay more for a TSP than for the lowest-cost bronze plan.

CBO and JCT project that ISPs, unlike TSPs, will offer financial protection against high-cost, low-probability events. ISPs thus meet CBO's definition of insurance. CBO and JCT expect that ISPs will resemble a typical nongroup insurance plan offered before 2014, when many federal regulations—for example, those governing essential health benefits and guaranteed issue—took effect. Although ISPs may exclude some benefits that other nongroup plans must cover, they may have lower deductibles or wider provider networks than plans in the fully regulated nongroup market. Premiums for ISPs will vary with individuals' health characteristics but may be as much as 60 percent lower than premiums for the lowest-cost bronze plan for people with low expected health care costs who are ineligible for premium tax credits.

How Are the New Rules Expected to Change Coverage?

CBO and JCT estimated the number of people who would newly enroll either in an AHP or in a short-term plan as a result of the two final rules. The estimates account for increased enrollment resulting from the two rules but not for total enrollment in AHPs or short-term plans. The agencies' analysis was confined to the effects of the rules and did not account for other recent administrative actions that could change the types of health insurance available to individuals or to employers.[12]

CBO and JCT anticipate that roughly 5 million more people will be enrolled in an AHP or a short-term plan each year over the next decade as a result of the new rules (see Table 1). Of that group, roughly 3 million would otherwise have been insured in the small-group market, 1 million would have had insurance through the nongroup market, and 1 million would have been uninsured. Almost three-quarters of the 5 million people who change coverage will purchase an AHP, CBO and JCT estimate, and the rest will purchase a short-term plan.

11. CBO broadly defines private health insurance coverage as a comprehensive major medical policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals. See Congressional Budget Office, *How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65* (May 2018), www.cbo.gov/publication/53822.

12. In particular, CBO and JCT did not consider the effects of the proposed rule on health reimbursement arrangements because their analysis was conducted in August 2018 before the notice of proposed rulemaking was published. See Health Reimbursement Arrangements and Other Account-Based Group Health Plans, 83 Fed. Reg. 54420 (October 29, 2018), https://go.usa.gov/xP6tC. Similarly, the agencies did not account for the October 2018 guidance issued to states on waivers under section 1332 of the Affordable Care Act; see State Relief and Empowerment Waivers, 83 Fed. Reg. 53575 (October 24, 2018), https://go.usa.gov/xPz5Z.

Table 1.

Projected Average Annual Enrollment With and Without the New Rules for AHPs and Short-Term Plans, 2019 to 2028

		With the New Rules		
	Without the New Rules[a] (Millions of people)	Coverage Status Changes[b] (Millions of people)	(Percent)	Coverage Status Stays the Same (Millions of people)
Uninsured	35.2	1.1	3	34.1
Insured in the Small-Group Market	23.2	3.1	13	20.1
Insured in the Nongroup Market With a Premium Tax Credit	6.9	0.2	3	6.7
Insured in the Nongroup Market Without a Premium Tax Credit	5.2	0.7	12	4.6
Total	**70.5**	**5.1**	**7**	**65.5**

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

AHP = association health plan.

a. The four categories are the groups that CBO and JCT identified as potentially affected by the new rules for AHPs and short-term plans. The numbers of people are CBO and JCT's coverage projections before accounting for any likely effects of the new rules.

b. CBO and JCT expect that some short-term plans will not cover high-cost, low-probability events and therefore will not meet CBO's definition of private health insurance. For more information, see Congressional Budget Office, *How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65* (May 2018), www.cbo.gov/publication/53822.

Those movements represent a small share of the total number of people in each category. Specifically, CBO and JCT expect that of the people who would otherwise be uninsured altogether or who would be insured and receiving a premium tax credit for nongroup coverage, fewer than 5 percent will change their coverage status. The agencies anticipate that among people who would otherwise be insured in the nongroup market without a premium tax credit or who would otherwise be insured in the small-group market, fewer than 15 percent will switch to a new type of coverage. Those findings are consistent with estimates provided by other organizations (see below, "How Do CBO and JCT's Estimates Compare With Other Analyses?").

Movement From the Small-Group Market

The largest estimated change occurs for people who would otherwise be insured in the small-group market and who will move into a new AHP (see Figure 1). CBO and JCT estimate that, on average, roughly 3 million people who would have had small-group coverage in the regulated market will instead have AHP coverage under that rule (see Table 2). That group is the largest of those projected to change their coverage status, primarily because the small-group market is roughly twice the size of the nongroup market. Furthermore, enrollment in AHPs is expected to be higher among employers that already offer coverage than it is among employers that do not.

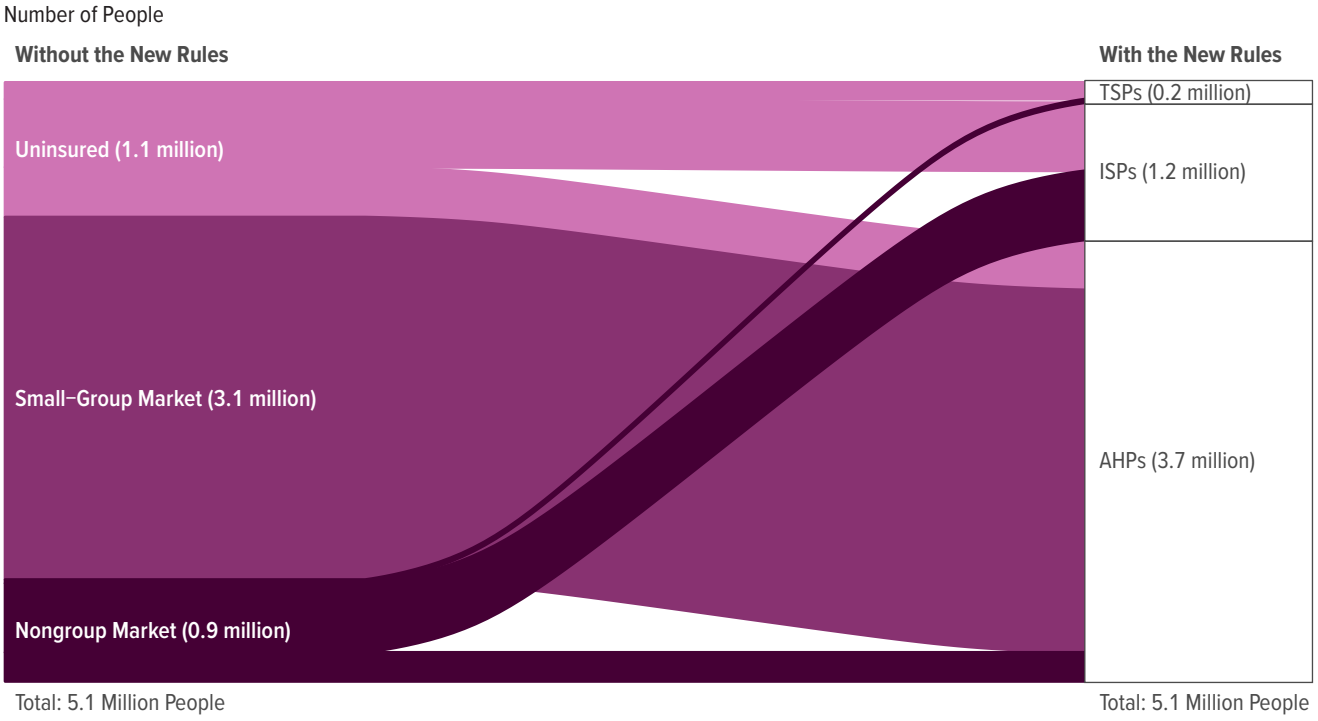
Movement From the Nongroup Market

The estimated movement among people with nongroup coverage is smaller in part because subsidies are available for nongroup coverage as long as that coverage is purchased through the marketplaces. People whose income is generally between 100 percent and 400 percent of the federal poverty guidelines (also called the federal poverty level, or FPL) are eligible for tax credits that reduce the price of the premium on the basis of income if they purchase nongroup coverage through a marketplace. Such individuals represented almost 60 percent of all people with nongroup coverage in 2018, CBO and JCT estimate. Those credits provide the most extensive subsidies to lower-income recipients and to recipients who are older and have higher premiums; they decrease as income rises and as premiums decrease.

Because of the credits, CBO and JCT estimate, net premiums for TSPs and ISPs generally will be higher than those for bronze plans for people whose income is below 300 percent of the FPL. CBO and JCT therefore expect that people with income below 300 percent of the FPL will be unlikely to purchase short-term plans.

Figure 1.

Estimated Average Annual Enrollment of People Who Are Projected to Change Their Insurance Coverage Because of the New Rules for AHPs and Short-Term Plans, 2019 to 2028



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The estimated 5.1 million people whose coverage will be affected by the new rules represent less than 10 percent of people who otherwise would be uninsured or would be insured through the small-group or nongroup market.

TSPs do not cover high-cost, low-probability events and therefore do not meet CBO's definition of private health insurance. For more information, see Congressional Budget Office, *How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65* (May 2018), www.cbo.gov/publication/53822.

AHP = association health plan; ISP = insured short-term plan; TSP = traditional short-term plan.

Even for people whose income is between 300 percent and 400 percent of the FPL, CBO and JCT expect, bronze plans generally would be less costly than any short-term plan. Although most people who receive premium tax credits will pay less for a bronze health plan than for a short-term plan, CBO and JCT estimate that some young people with very low expected health care spending might pay less for a short-term plan and, therefore, switch coverage. The agencies estimate that in an average year, fewer than 50,000 people who would otherwise have purchased nongroup coverage with a tax credit will instead enroll in a short-term plan.

Effects are anticipated to be larger among people whose income is too high to receive subsidies: CBO and JCT estimate that roughly 600,000 people who would otherwise have purchased nongroup coverage without a premium tax credit (about 10 percent of that population) will enroll in a short-term plan. The agencies also estimate that 95 percent of people moving from fully regulated nongroup coverage into short-term plans will purchase ISPs and that the remaining 5 percent will purchase TSPs. (Because TSPs are not expected to cover high-cost, low-probability events and therefore do not meet CBO's definition of private health insurance, people moving from the nongroup market into TSPs would be considered uninsured.)

Several factors led CBO and JCT to anticipate that most new enrollment in short-term plans will be in ISPs rather than TSPs. First, interviews with insurers and other stakeholders suggested that most people would prefer more comprehensive insurance coverage to TSPs, and many insurers indicated a preference for offering more substantial coverage. In addition, enrollment data for the nongroup market as a whole that predate 2014

(when many of the regulations governing nongroup insurance coverage took effect) suggest that the number of people who purchased coverage resembling ISPs was far greater than the number purchasing coverage that resembled TSPs.

New Short-Term Coverage Among Previously Uninsured People

CBO and JCT also expect a small number of currently uninsured people to purchase short-term plans. That group includes younger and healthier people who are not eligible for premium tax credits. They are likely to see short-term plans with premiums that are significantly lower than the lowest-cost option available through the fully regulated nongroup market. CBO and JCT estimate that roughly 600,000 people will gain insurance coverage by purchasing ISPs as a result of the short-term-plan rule. Only about 100,000 people will purchase TSPs and thus, in CBO and JCT's projections of health insurance coverage, will remain uninsured.

New Offers of Coverage by Employers

CBO and JCT expect that a small number of employers who otherwise would not have offered coverage will start offering AHP coverage to their employees. The agencies estimate that, on average, 400,000 people will have new AHP coverage who otherwise would be uninsured over the 2019–2028 period. (A smaller number who would have been insured in the nongroup market would be expected to receive an employment-based offer of AHP coverage.) Although most people will probably accept the newly offered employment-based coverage, CBO and JCT estimate that roughly 5 percent will decline (see the section on key technical inputs).

Eligibility for the premium tax credits for nongroup coverage purchased through the marketplaces is conditional on not having an affordable offer of insurance through an employer. As a result of those new affordable offers of AHP coverage (which would meet CBO's definition of insurance), CBO and JCT estimate that a very small number of people will receive but decline an affordable AHP offer, which will cause them to lose eligibility for the premium tax credits and to become uninsured.

What Are the Greatest Sources of Uncertainty in the Estimates?

CBO and JCT's estimates of the effects of the AHP and short-term-plan rules aim to represent the middle of an extremely broad range of possible outcomes. The projections are inherently uncertain in large part because of legal and administrative questions. There is considerable uncertainty regarding the Administration's implementation and enforcement of the new rules—for example, the AHP rule includes language suggesting that the Administration might preempt state laws that limit the new rule's effects. To the extent that the Administration challenges state laws, such actions might affect the availability of various types of insurance coverage. Furthermore, both rules are facing court challenges.[13]

Some questions about how insurers, states, employers, individuals, and other affected parties will respond to the new rules cannot be answered definitively. Considerable change has occurred in the nongroup and small-group markets in recent years; the market fluctuations caused by mergers and by the entry and exit of insurers, for

Table 2.

Estimated Average Annual Enrollment of People Who Are Projected to Change Their Insurance Coverage Because of the New Rules for AHPs and Short-Term Plans, 2019 to 2028

Millions of People

Coverage Status	Without the New Rules	Coverage Status With the New Rules		
		AHP	TSP	ISP
Uninsured	1.1	0.4	0.1	0.6
Insured in the Small-Group Market	3.1	3.1	*	*
Insured in the Nongroup Market	0.9	0.2	*	0.6
Total	**5.1**	**3.7**	**0.2**	**1.2**

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

The estimated 5.1 million people whose coverage will be affected by the new rules represent less than 10 percent of people who otherwise would be uninsured or would be insured through the small-group or nongroup market.

TSPs do not cover high-cost, low-probability events and therefore do not meet CBO's definition of private health insurance. For more information, see Congressional Budget Office, *How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65* (May 2018), www.cbo.gov/publication/53822.

AHP = association health plan; ISP = insured short-term plan; TSP = traditional short-term plan; * = between zero and 49,000 people.

13. See *New York v. Department of Labor*, No. 18-1747 (D.D.C. filed July 26, 2018); and *Association for Community Affiliated Plans v. Department of the Treasury*, No. 18-2133 (D.D.C. filed September 24, 2018).

Table 3.

Estimates of Annual Enrollment in AHPs and Short-Term Plans Resulting From the New Rules for AHPs and Short-Term Plans

Millions of Enrollees

Published Source	Year	Enrollment
AHPs		
Avalere Health, 2018	2022	2.4 to 4.3
CBO and JCT	**2022**	**4.6**
Short-Term Plans		
Rao, Nowak, and Eibner, 2018	Not specified	Negligible to 5[a]
Wakely Consulting Group, 2018	After 4 years	1.1 to 1.9[b]
Federal Register, 2018	2028	1.4
CBO and JCT	**2028**	**1.6**
Center for Health and Economy, 2018	2028	3.2
Blumberg, Buettgens, and Wang, 2018a, b	2019	4.3[a]

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

AHP = association health plan.

a. Includes the effects of repealing the requirement for individuals to have insurance.

b. Includes only the number of people leaving the nongroup market.

example, make forecasting people's responses more tenuous than might be possible under more stable conditions.

Although CBO and JCT interviewed a wide range of stakeholders about how people might respond to the two rules, the new types of AHPs and short-term plans that insurers will actually offer—and the premiums that they charge—may differ considerably from those that CBO and JCT have modeled. Different plan offerings or pricing would affect enrollment in the new plans, the characteristics of the enrollees those plans attract, and the resulting effects on the fully regulated small-group and nongroup markets.

States also will react in ways that could affect the types of plans offered and their enrollments. Some states have taken regulatory actions to block the rules from taking effect. When the rule on short-term plans was first proposed, three states—Massachusetts, New Jersey, and New York—already had rules banning such short-term plans, and other states had policies that limited the initial or total contract duration of short-term plans. Between publication of the proposed and the final rules, more states acted to prohibit or limit the sale of short-term coverage. CBO and JCT's current estimates reflect state governments' policies in place as of September 2018 (see the section on key technical inputs).

At the time that CBO and JCT conducted the analysis, other states were considering actions that might strengthen the effect of the proposed rules. For example, New Hampshire was evaluating how to amend state law to better conform to federal law and to ease the burden on insurers and associations offering new AHPs. Because some states were considering legislation that would enhance the effects of the final rules and other states were considering legislation that would dampen such effects, for this analysis, CBO and JCT did not attempt to project state actions into the future.

Finally, states could create other mechanisms for people to purchase coverage that is exempt from the regulations on small-group and nongroup markets. Iowa, for example, has enacted legislation authorizing the sale of "health benefit plans" through its Farm Bureau. Because the state does not define those plans as insurance, they need not comply with the federal or state regulations for nongroup and small-group coverage. CBO and JCT expect that the availability of such state-specific products will reduce enrollment in AHPs and short-term plans but will nevertheless increase enrollment outside of the fully regulated markets.

How Do CBO and JCT's Estimates Compare With Other Analyses?

CBO and JCT's assessment of the effects of the rules concerning AHPs and short-term plans is in line with other published analyses, although comparing results is difficult because the policy scenarios evaluated are different. (Those sources are listed in this report's selected bibliography.)[14] In particular, CBO and JCT found only one study, Covered California (2018), that analyzed the effects of both rules jointly. As a further complication, several studies of the rule for short-term plans presented combined findings for the effects of that rule and for repealing the requirement for individuals to have insurance.

Table 3 and Table 4 compare CBO and JCT's estimates of the effects of the rules after full implementation with

14. For another analysis of the various estimates of short-term plans, see Pope (2018) in the selected bibliography.

the estimates of other organizations. CBO and JCT's estimates, shown in those tables, are larger than the enrollment numbers presented earlier in this report because those earlier numbers are 10-year averages, which encompass several years during which the effects of the rules will be phased in. CBO and JCT expect that the markets will respond to the rules over several years and that the effects of both rules will be fully evident by 2022.

CBO and JCT's estimates of enrollment in the new types of plans are similar to those of other organizations. For example, CBO and JCT estimate that, in 2022, roughly 4.6 million people will newly enroll in AHPs and that, in 2028, roughly 1.6 million people will newly enroll in short-term plans as the result of the rules (see Table 3). Although CBO and JCT's estimate of enrollment in AHPs in 2022 is slightly above the range of the other comparable estimate, the agencies' estimate of enrollment in short-term plans is within the broad range of estimates by other organizations.

The agencies' estimates of premium increases in the nongroup market also are similar to those of other organizations, which range up to 9 percent (see Table 4). As of December 2018, CBO and JCT had found no analyses of the effects of the rules on premiums in the fully regulated small-group market.

Table 4.

Estimates of Premium Increases in the Fully Regulated Nongroup Market Resulting From the New Rules for AHPs and Short-Term Plans

Percentage Increase

Published Source	Year	Premium Increase
AHPs and Short-Term Plans		
Covered California, 2018	2021	1.3 to 5.4
CBO and JCT	**2028**[a]	**3**
AHPs		
Corlette, Hammerquist, and Nakahata, 2018	Not specified	1.4 to 4.4
Avalere Health, 2018	2022	3.5
Short-Term Plans		
Rao, Nowak, and Eibner, 2018	Not specified	Negligible to 3.6[b]
Wakely Consulting Group, 2018	After 4 years	2.2 to 6.6
Federal Register, 2018	2028	5
Center for Health and Economy, 2018	2028	1 to 9

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

AHP = association health plan.

a. CBO and JCT estimate that in 2021, premiums for nongroup coverage sold in the fully regulated markets would be 2 percent higher as a result of the two rules. However, the effects of both rules will not be fully evident until 2022.

b. Includes the effects of repealing the requirement for individuals to have insurance.

What Key Technical Inputs Did CBO and JCT Use?

CBO and JCT developed several key technical inputs for the model that serves as this report's foundation. The agencies relied on research from various sources—listed in the selected bibliography—in developing and applying those inputs to estimate various populations' responses to new health insurance options (see Table 5).

Elasticities for Small Employers and for Individuals in the Nongroup Market

In economic research, price elasticity is a summary measure of the extent to which purchasing decisions are influenced by changes in price. CBO and JCT considered two inputs: purchase elasticity and cross-price elasticity.[15] Purchase elasticity measures changes in employers' and individuals' decisions to purchase coverage (either on behalf of employees or as individuals) in response to changes in premiums. Cross-price elasticity measures how readily people will switch between sources of insurance coverage in response to changes in premiums.

Research suggests that cross-price elasticities are much larger than purchase elasticities: That is, people respond to price changes by switching between plans more readily once they have decided that insurance coverage is something they want. (Although employers and individuals alike tend to view their current insurance as the default, the literature and interviews with insurers and stakeholders suggest that even with that tendency to renew coverage, cross-price elasticities are larger. This may be particularly true in the nongroup and small-group markets, which have been changing rapidly in recent years.)

15. In the economic literature, elasticities are often referred to as being on the extensive margin (whether to purchase or not) or the intensive margin (the amount to purchase). This report refers to the extensive margin as purchase elasticity.

Table 5.

CBO and JCT's Use of Technical Inputs to Estimate the Effects of the Rules on AHPs and Short-Term Plans

AHPs		Insured Short-Term Plans	
The number of people in uninsured families who work for small employers that do not offer any health insurance without the rule change	**8.9 million**[a]	The number of people with family marketplace coverage and income above 400 percent of the FPL without the rule change	**1.0 million**[a]
The percentage of small employers that do not offer any health insurance coverage and are potential purchasers of AHPs	× **60 percent**	The percentage of families with family marketplace coverage and income above 400 percent of the FPL who are potential purchasers	× **60 percent**
The average change in the small-employer premium	× **-30 percent**	The average change in the family premium	× **-55%**
The elasticity of small employers that do not currently offer coverage with respect to premiums	× **-0.38**	The elasticity of current nongroup market enrollees with respect to premiums	× **-1.18**
The share of people who accept their employer's offer of coverage	× **80 percent**	The share of people who live in states that allow ISPs under federal regulations	× **60 percent**
The projected number of people who are uninsured and gain family coverage through a small employer that begins to offer an AHP	**500,000**[a]	The projected number of people with income above 400 percent of the FPL who switch from family marketplace coverage to family ISPs	**200,000**[a]

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

AHP = association health plan; FPL = federal poverty level; ISP = insured short-term plan.

a. Rounded to the nearest hundred-thousand people.

For health insurance, elasticities are expressed as negative numbers because people are less inclined to purchase coverage when premiums rise.

In the models for AHPs and short-term plans, CBO and JCT used elasticities to anticipate people's choices about nongroup coverage and employers' choices for small-group coverage. The agencies estimated those elasticities through a review of the literature cited in the selected bibliography. In the small-group market, the elasticity for small employers that did not currently offer coverage is estimated at –0.38, and for small employers that did offer coverage, it is estimated at –0.76. In the nongroup market, CBO and JCT estimated, the purchase elasticity for coverage among people who are currently uninsured is –0.59, and the cross-price elasticity for people currently insured in the nongroup market is –1.18. (An elasticity of –0.59 implies that if premiums increase by 10 percent, the number of people with coverage will decrease by 5.9 percent.)

Take-Up Rates for People With Offers of Coverage From a Small Employer

After identifying small employers that would offer AHP coverage under the new rule, CBO and JCT examined take-up rates—the percentage of eligible people who actually enroll. For most populations, CBO and JCT used the take-up rates that they estimate as part of their health insurance projections. Those rates tend to be around 75 percent or 80 percent: That is, between 75 percent and 80 percent of the people who are offered coverage through a small employer accept that offer.

In some instances, CBO and JCT adjusted the rate to reflect certain populations' characteristics. A lower rate was used for people who, in the projections, would have an offer of employment-based insurance coverage in the absence of the two final rules but would choose not to take up that offer. A higher rate was used for people who expressed a strong preference for insurance (such as those who, in the absence of the new rules, would purchase nongroup coverage without a tax credit). Finally, CBO and JCT expect that most people who are projected to have insurance through a small employer would

retain that coverage, regardless of whether the employer switched to an AHP or continued to offer fully regulated coverage.

Effects of State Policies to Prevent Implementation of the Rules

AHPs and short-term plans are subject to federal and state regulation that in some cases could prevent the two new final rules from taking full effect. In their modeling, CBO and JCT reduced estimated enrollment in short-term plans by almost 40 percent to account for the possible mitigating effects of state laws, which can take a variety of forms but may include any of the following:

- Prohibitions on the sale of short-term plans;
- Requirements that short-term plans comply with guaranteed issue, community rating, and coverage of essential health benefits (regulations that govern the nongroup market); and
- Limiting enrollment in short-term plans to periods of as little as three or six months.

At the time that CBO and JCT conducted the analysis, the states of California, Hawaii, Illinois, Maryland, Massachusetts, New Jersey, New York, Oregon, Vermont, and Washington had laws in place that could be expected to nullify the effects of the new rule for short-term plans. Other states had laws that would reduce but not eliminate the effects, and none had enacted legislation that would augment the effects of the new rule. The selected bibliography lists the sources CBO and JCT consulted. The agencies will account for future changes to state laws during regular updates to their baseline projections of health insurance coverage.

CBO did not make a similar adjustment for the AHP rule because the extent to which states' policies will preclude the expansion of AHPs is not clear, nor is it clear whether the Administration will seek to preempt state laws that attempt to limit the possibility of expansion.

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About This Document

This document, which is part of the Congressional Budget Office's continuing effort to make its work transparent, explains how CBO and the staff of the Joint Committee on Taxation estimated the coverage changes associated with new rules that were aimed at increasing health insurance coverage either through association health plans or through short-term, limited-duration insurance. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

Alice Burns and Kevin McNellis wrote the report with contributions from Kate Fritzsche, Philippa Haven, and Keren Hendel and with guidance from Chad Chirico, Leo Lex, and Sarah Masi. Alissa Ardito, Elizabeth Bass, Susan Yeh Beyer, and Sebastien Gay commented, as did the staff of the Joint Committee on Taxation.

Comments also were provided by Katherine Baicker of the University of Chicago Harris School of Public Policy, Michael Cohen of the Wakely Consulting Group, Sabrina Corlette and Kevin Lucia of the Center on Health Insurance Reforms at the Georgetown University Health Policy Institute, and Preethi Rao of RAND Corporation. The assistance of external reviewers implies no responsibility for the final product, which rests solely with CBO.

Jeffrey Kling and Robert Sunshine reviewed the report, Kate Kelly edited it, Kim Kowalewski created the figure, and Casey Labrack prepared the report for publication. An electronic version is available on CBO's website (www.cbo.gov/publication/54915).

CBO seeks feedback to make its work as useful as possible. Please send comments to communications@cbo.gov.

Keith Hall
Director
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