



June 24, 2026

This product is a part of a five-part series on the Great Healthcare Plan

ISSUE BRIEF | Healthy America

IT'S YOUR MONEY: MAKING YOUR HEALTH DOLLAR WORK FOR YOU, THE PATIENT

ONE SIZE FITS NOBODY (PT III)

Hannah Anderson

“I want to end this flagrant scam and put extra money straight into the healthcare savings account in your name, and you go out and buy your own healthcare, and you’ll make a great deal, you’ll get better healthcare for less money—that way you can choose the care that is right for your family.”

-President Donald J. Trump

Give People Control through Healthcare Options

Personalized health care is diametrically opposed to one-size-fits-all. Healthy people need options, and healthy markets need competition. Healthcare is no exception. The only way to truly lower costs, while improving patient health, is through competition between a variety of health plans, providers, and health systems. Without marketplace competition, health plans and providers do not have an incentive to improve quality or lower prices.

Giving people their health dollars is catalyzed by giving people greater options to purchase care. Broadly, the only way to make Americans healthy again is to promote individualized options for prevention, treatment, and accountability; yet regulations constrain patients from participating in these individualized options. Restricting Americans from purchasing the type of healthcare that works best for them condemns them to another century of poor health outcomes. It is essential that policymakers provide patients with more options than just one type of insurance to purchase healthcare.



Current regulations restrict or disincentivize health plans from trying new ways of providing care for patients. Policymakers should modernize requirements of health plans to ensure that outdated, prescriptive regulatory requirements for care delivery do not interfere with providing new benefits to patients. Patients are unable to realize the benefits of innovative care models—such as direct primary care—unless these models follow the thousands of federal rules, regulations, and instructions for health insurance in that market. Giving patients control by letting them choose the type of healthcare that works for them—even if it is not traditional insurance—will connect their healthy choices with greater health outcomes.

Making the Health Exchanges Actually Work for Patients

Giving subsidies directly to patients is step one. Step two is to expand the variety of healthcare that patients can use to best prevent chronic disease and treat their health conditions.

Patients-last policymakers have been more concerned with dogmatic compliance with the ACA over what is actually working for patients; instead, the Trump Administration should bring more options to market, like the health-contingent wellness pilot plans from the first Trump Administration as “MAHA” wellness plans ([Center for Consumer Information & Insurance Oversight, 2019](#)). As part of MAHA wellness plans, patients could get health wearables, enhanced diagnostics, access to DPC, or direct purchase of GLP-1s on TrumpRx. States could offer preventative wellness plans for those seeking to protect wellness or chronic disease plans for certain conditions. Rather than simply offer reinsurance to health insurers for costly health conditions, MAHA wellness plans could cut the red tape that keeps patients from receiving the kind of specialized, personalized healthcare they need. This would build on recent reforms to allow multi-year catastrophic plans in the individual exchanges ([Centers for Medicare and Medicaid Services, 2026](#)).

Policymakers should increase flexibilities for states seeking to establish new models of care when applying for waivers under Section 1332 of the ACA, thereby allowing states to follow the spirit of the law while being able to break out of the prescriptive requirements of care delivery to patients. Regulators could go further and allow ACA subsidies to be used on higher quality or lower cost health plans approved in other states or territories ([Cannon, 2025](#); [Nelson, 2024](#)).

Patients-first regulators have also found success in using their convening authority and could consider meeting with insurance companies to promote ACA plan designs that allow for more flexibility and patient choice in where the dollars go within the plan. For instance, if a plan wanted to offer a benefit as an allotment into an HRA, CMS could consider using enforcement discretion to allow them to offer that benefit.

In addition, patients-first regulators could increase the “shoppability” of the ACA exchanges; rather than requiring one plan to fulfill the coverage requirements in the



statute, regulators could make the coverage more modular. For instance, consistent with the statute, regulators could allow patients (enrollees) to build their own coverage—selecting three or four different plans to build their comprehensive coverage. Enrollees would log in to their ACA exchange site, and as they shop for coverage, could select different options for hospital coverage, outpatient coverage, primary care coverage, and prescription drug coverage. To fulfill statutory requirements, enrollees would have to select a plan from each category, but this would allow them greater choice and optionality compared with the limitations of the standard option. These types of plans could fulfill essential health benefit requirements while also allowing more personalization towards an individual patient’s needs. Patients-first regulators have already taken steps to allow more flexibility and choice for patients, like the addition of non-network Qualified Health Plans (QHPs) to empower enrollees to get the type of plan that works best to take back their own health ([Centers for Medicare & Medicaid Services, 2026](#)).

This is entirely different from how patients-last regulators in previous administrations thought. For Calendar Year 2024, CMS limited health insurance issuers from offering more than four non-standardized plan options per product network type, actuarial value, or metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage in any service area ([Centers for Medicare & Medicaid Services, 2023](#)). Patients-first policymakers should ensure that patients have a variety of choices to choose from, without artificial constraints on how many plans the market offers.

Patients-first policymakers should also consider using the ACA’s Basic Health Program (BHP), which has been abused by patients-last states to provide healthcare to illegal immigrants ([Giovannelli & Schwab, 2024](#)). Policymakers could reform it to provide low-cost catastrophic care to patients who cannot afford the ACA and are ineligible for Medicaid. The BHP could allow the purchase of low-cost health options for the working poor, including alternative health arrangements, and have these programs supported by federal and state health programs.

Ultimately, policymakers should delink these dollars from the requirement that they can only be used to purchase a qualified health plan within the individual marketplace. Patients-last policymakers wrote in this requirement, in addition to the requirement for insurance plans that are double-regulated (by both state insurance commissioners and federal insurance commissioners), expensive, and inaccessible for real patients. By delinking these dollars from the requirement to buy a certain qualified health plan, they can instead follow the patient to whatever plan is approved by their state insurance commissioner ([Jindal & Overton, 2024](#)).

Getting Better Options at Work

For the 160 million Americans in employer-sponsored health coverage, the options are better but still need work ([Keisler-Starkey & Bunch, 2024](#)). The fastest way to improve health, lower costs, and increase quality is to tailor the offerings more closely to patient needs—



whether that means giving the employer more options to provide to their employees or giving more options to the employees directly. Patient-last policymakers often forget that healthcare is an *employee welfare benefit plan*, like a retirement plan, and good, employer-sponsored benefits are a recruitment and retention tool. Employers are naturally incentivized to provide good health benefits to their employees, but they are no longer incentivized to provide anything other than a standard option and a low-cost option for their employees. In fact, in a recent employer survey, 96% of respondents saw health and well-being benefits as essential to the effort to attract and retain talent ([National Alliance of Healthcare Purchaser Coalitions, 2025](#)).

First and foremost, employers should no longer be restricted by patients-last bureaucracy that ties their hands from offering true preventative care. While binding the hands of employers to truly tailor and customize care offerings to patients, the ACA gave authority to the bureaucracy to regulate preventative care benefits offered outside of the comprehensive care benefit. For 15 years, wellness and preventative care benefits offered by employers have languished, as they have been restricted from the same tax incentives as costly insurance provisions ([RSM, 2024](#)). Patients-first regulators at the Department of Treasury (Treasury) and the Department of Health and Human Services (HHS) should immediately expand and revise these wellness benefits—allowing a full suite of “MAHA” tools for employers to offer to their employees.

Building upon these preventative tools, policymakers should contemplate reforms to allow employers to provide a suite of options that culminate in a comprehensive plan offering, without being penalized. For example, the Employee Benefits Security Administration (EBSA) could promulgate guidance that clarifies that a group health plan offered by a plan sponsor (*e.g.*, an employer) could fulfill its statutory obligation to provide preventive care services by directly contracting with primary care practices to provide them on-site to their employees. This would exceed the spirit of the law, which is to ensure that Americans receive critical preventative care services, while increasing uptake of those services and decreasing costs.



DIRECT CONTRACTING

Direct contracting, or, business to business (B2B) purchasing is commonplace throughout private industry but is not used in private health negotiations. There are no regulations which forbid direct contracting within ERISA, but a lack of transparency in health costs along with anti-competitive practices by TPAs prevent plan sponsors from pursuing rate negotiations between a group health plan and a local health provider.

Direct contracting services patient, employer, and provider alike; health systems have to negotiate and arbitrate health costs with large, national payers which lead to delays in payment and use of revenue cycle management to plan payment cycles. Employers who directly contract with local health systems benefit local doctors and rural system. And patients get the benefit of lower costs by cutting out middlemen fees.

Even further, regulators for the tri-departments (HHS, DOL, Treasury) could publish an FAQ document that allows chronic disease excepted benefit plans; plan sponsors could contract outside of their health insurance benefit to offer an a la carte plan specifically for chronic conditions, like diabetes, covering full wrap-around coverage for the services that diabetics often need. Patients could enroll in this plan as an excepted benefit without waiting for open enrollment, which would increase access to care while reducing costs for the plan and patient alike. When regulators in the first Trump Administration made similar changes for telehealth, more patients were able to see counselors and social workers at lower costs for both patient and employers ([Employee Benefits Security Administration, 2020](#)).

Rather than depending on the complexity of a third party to build networks, certain self-funded group health plans should lean more heavily on direct contracting, or, using their third-party administrator (TPA) as a claims adjudicator and not as a rate negotiator. Businesses are sophisticated when it comes to business-to-business (B2B) negotiations and purchasing, but many neglect this ability when it comes to designing the healthcare benefit for their employees.

There are no formal regulatory prohibitions on direct contracting within group health plans; in fact, as the plan sponsor, the employer who manages the self-funded group health plan is the fiduciary who is legally accountable for managing the beneficiaries' dollars appropriately.¹ However,

¹ There are, however, state-level regulatory burdens for state-regulated insurance plans to allow direct contracting. For more, read Ge Bai and David Hyman's 2024 piece entitled, "Will Cash Price Transparency Benefit Patients?"



regulatory compliance, a lack of transparency, and anti-competitive behavior by TPAs discourage group health plans from using this authority.

For instance, a group health plan in a large metropolitan area could offer a traditional provider network as part of its health benefit. However, they could also directly partner with a major health system in the area to provide discounted rates to their employees. Neither party must pay excessive administrative fees or lose value on costs leaking to other middlemen. Both parties benefit from prompt payment, without waiting in a 30, 60, or 90-day cycle, or using a revenue cycle management company solely to recoup their costs ([American Medical Association, 2019](#); [Fish, 2022](#)).

Other successful models of direct contracting, like DPC, promote a different payment model for primary care services by paying the provider practice directly rather than using insurance coverage to provide access to primary care practices ([Hamilton Health Hub, 2026](#); [Texas Direct Medical Care, 2019](#)). One employer, an industrial employer in Houston, deployed a micro-site/direct primary care unit at their business. The direct primary care unit resulted in a \$71/member/month savings for this 320-employee business, saving patients and the company roughly a quarter of a million dollars. Today, some employers can access this model when designing health benefits for their employees, but patients cannot unless they are willing to pay extra outside of the spending already done by their health plan. The Working Family Tax Cut (WFTC) cut through the regulatory red tape and allowed DPC to be purchased by the patient with their own health dollars—a big first step towards giving patients more options and control with their health dollars. However, recent guidance from Treasury on how to implement this provision needs to be corrected; instead of regulating DPC as part of the underlying health insurance, and therefore connected to allowances in pre-deductible spending, DPC should be allowed to be purchased pre-deductible.

This is not restricted to large employers—this could be a tool for small employers as well. A recent survey found that all sizes of employers are using direct contracting to manage health costs, with 20% of “small” employers and 44% of “jumbo” employers surveyed saying that they are taking steps like direct contracting to manage costs.² Why? One respondent put it succinctly, “[on the fiduciary confidence of the TPA]...I am not convinced the health insurer/TPA is doing it well, but they are doing it” ([National Alliance of Healthcare Purchaser Coalitions, 2025](#)).

In parallel, another employer group piloted a tool for large employers, demonstrating that direct contracting (with accurate data) could save employers a significant sum of money—ranging from 10% to 60%, depending on the market. In fact, one employer that participated in

² The survey considered “small” employers as those under 1,000 FTEs, and “jumbo” employers to be greater than 50,000 FTEs.



the demonstration project “...was able to quantify that their direct contract was a higher value than any of the UnitedHealthcare contracts that they had signed” ([Daly, 2025](#)). In sum, employers and health systems could gain:

- ★ **Lower healthcare costs** through direct negotiation with health systems, rather than using their middleman to negotiate those costs on their behalf. Health systems can better plan revenue cycles and reduce their billing lags.
- ★ **Better healthcare**, since care needs are tailored to the employer group and health system providing them, rather than working through complex quality and value targets
- ★ **Community-tailored care**, which allows patients to prioritize care from local providers, rather than catalyzing consolidation.

Patients-first regulators and policymakers could accelerate the shift to direct contracting by clarifying that a direct contract between a group health plan and a provider practice is not an insurance plan and should not be regulated as such. In addition, while such tools to support direct contracting for large employers exist, the Small Business Administration (SBA) could partner with HHS to develop tools for small employers to better negotiate and navigate direct contracting. Under Section 1701 of the Public Health Service Act (PHSA), HHS is uniquely granted authority to develop tools for the health promotion of employers in small businesses ([Public Health Service Act, 1988](#)). Direct contracting, rather than middleman contracting, is built for making Americans healthy again because it directly connects the employees’ dollar with the doctor’s office.

Direct contracting, rather than middleman contracting, is built for making Americans healthy again because it directly connects the employee’s dollar with the doctor’s office.

Getting Better Options for Small Businesses

The most highly regulated health insurance plans in the private market are plans offered by small businesses: these plans must comply with the ACA’s costly mandates, along with the mandates applied to them by their state insurance commissioner.

To comply with federal health insurance regulations but avoid other red tape, the first Trump Administration expanded Association Health Plans (AHPs) so that patients, including those employed by sole proprietors, could purchase these types of health plans ([Internal](#)



[Revenue Service et al., 2019](#)). However, patients-first attorneys general sued to block patients from purchasing this type of care, insisting that small businesses continue to offer expensive, highly regulated health insurance plans or nothing.

As many patients-first state regulators have put the needs of insurance companies over the needs of patients, they have stymied other innovative health plan designs for small businesses. Small businesses that set out to negotiate health costs on their own (self-funding, rather than being fully insured) often use level-funding or stop-loss insurance in combination with their group health plan. Many states have put restrictions on the use of these tools, and the Biden Administration requested information on changing eligibility for level-funded arrangements ([U.S. Department of Health and Human Services, U.S. Department of Labor, & U.S. Department of the Treasury, 2023](#)). Policymakers should ensure that small businesses can continue to stabilize health costs for their employees through the use of these tools.

Policymakers should also consider reforms that would allow for the increased purchase of a la carte plan options through cafeteria plan offerings. These plans give employees a set dollar amount to choose from a variety of pretax benefits, including retirement savings, health insurance, adoption assistance, and disability insurance. Cafeteria plans could be further expanded by allowing for a la carte health insurance options, such as the purchase of DPC or other health subscriptions separate from long-term care insurance or hospital insurance. However, patient-first regulators need to align tax regulations with cafeteria plan offerings, as previous regulators have restricted the cafeteria plan offering for patients ([RSM, 2024](#)).

Getting Better Options for Everyone

One-size-fits-all is a prescription to keep patients unhealthy. Patients should have as many options as they need to fit their health needs, and differentiation drives competition among insurers and providers that will help the healthcare system improve the health of Americans while also lowering their costs (Herzlinger, 2004).

To that extent, policymakers should continue supporting other ways of paying for healthcare: HSAs, Farm Bureau plans, short-term medical plans, fixed indemnity plans, or other health arrangements, which have positive impacts on both quality and cost of care. Patients like the flexibility and choices that these options provide. These offerings have also been shown to reduce premiums, not just for those opting to use an alternative health arrangement, but for everyone ([Blase, 2021](#); [Dicken, 2023](#)).

For instance, patients-first policymakers could look to expand HSAs by creating new gig worker accounts for those who are ineligible for traditional health coverage as independent contractors, and by requiring a minimum value to be deposited in the HSA versus



requiring a minimum deductible. HSAs are one of the most versatile tools that patients have to pay for healthcare, and instead, they are stuck with antiquated rules on what they can be used for. Patients are the only ones with a limit on the tax-preferred dollars they can use for healthcare—employers, providers, and others in the system do not have these restrictions. Patients should be given parity in their use of tax-preferred dollars so that they can have the freedom to pay for what they know will make them healthy. Should policymakers be concerned about these accounts being used inappropriately, they could consider the expansion of the 401(h) account exclusively for investments, leaving in place the investment contribution limit, but uncap the contribution for HSAs. In essence, HSAs become a health spending account, and the 401(h) becomes the health savings account.

In addition, patients-first policymakers can protect states that want to allow some alternative forms of coverage. Patient-last policymakers have previously restricted innovative state designs by requiring specific legislative language to be passed by state legislatures before approving new insurance designs. Even if a state has existing authorities to introduce a new insurance design, the ACA requires the new insurance design to meet the threshold of “creditable coverage.” If a state does not meet the threshold of creditable coverage, states can either not offer the plan altogether or pass a new law exempting the health plan from health insurance restrictions. Instead of this red tape, policymakers can clarify the definition of “creditable coverage” in the ACA to ensure that states are not required to jump through additional hoops in order to provide innovative models of care, like Farm Bureau plans.

Policymakers should also consider reforms that make these offerings more permanently available, such as permanent changes to short-term, limited duration plans. CMS has recently exercised enforcement discretion to expand these plans, yet private companies that want to offer these health products risk patients-last administrations rescinding or restricting their availability through regulatory actions ([U.S. Department of Labor, U.S. Department of Health and Human Services, & U.S. Department of the Treasury, 2025](#)).



Policy Recommendations

- ★ Congress could amend the ACA to allow premium subsidies to be applied towards any health plan approved by the state insurance commissioner—restoring states’ rights to the health insurance market.
- ★ Congress should expand HSA usage by uncapping contributions to HSAs, shifting investment contribution limits to other investment accounts, like 401(h) accounts, and allow all Americans access to HSA accounts.
- ★ Create MAHA Wellness Plans by promulgating regulations through the Tri-Departments to reinstate health-contingent wellness plans as well as revise guidance on the definition of “wellness” to allow employers to provide additional services.
- ★ CMS could exercise enforcement discretion to allow more flexible benefit structures within the individual market.
- ★ EBSA could allow plan sponsors to fulfill their statutory obligation under the law to provide preventative care through direct contracting (e.g., direct primary care) rather than only through health insurance.
- ★ CMS could expand recent multi-year catastrophic health plans to include multi-year chronic disease plans and other flexible benefit designs to support chronic disease patients.
- ★ Treasury can amend current guidance around DPC to ensure that plan sponsors can contribute towards their employees’ DPC (through their HSA) without needing to meet deductible limits.
- ★ Congress should consider reforms to allow for the increased purchase of a la carte plan options through cafeteria plan offerings.
- ★ Congress can clarify the statutory definition of “creditable coverage” so that more states can offer innovative care models, such as Farm Bureau plans.

AUTHOR BIOGRAPHY

Hannah I. Anderson is the Senior Director of Policy, Healthy America Policy, at the America First Policy Institute.



Works Cited

- American Medical Association. (2019, November). *Custom Networks and Contract Terms*. <https://www.ama-assn.org/system/files/2019-11/direct-to-employer-case-studies.pdf>
- Blase, B. (2021). *Individual Health Insurance Markets Improving in States that Fully Permit Short-Term Plans*. Galen Institute. <https://galen.org/assets/Individual-Health-Insurance-Markets-Improving-in-States-that-Fully-Permit-Short-Term-Plans.pdf>
- Cannon, M. (2025, October 13). *The Only Defensible Obamacare Deal*. Cato Institute. <https://www.cato.org/blog/only-defensible-obamacare-deal>
- Center for Consumer Information & Insurance Oversight. (2019, September 30). *Insurance Standards Bulletin Series -- INFORMATION*. Center for Medicare and Medicaid Services.: <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Wellness-Program-Demonstration-Project-Bulletin.pdf>
- Centers for Medicare & Medicaid Services. (2023). *Patient Protection and Affordable Care Act; HHS notice of benefit and payment parameters for 2024 final rule*. U.S. Department of Health and Human Services. <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-and-payment-parameters-2024-final-rule>
- Centers for Medicare & Medicaid Services. (2026). *HHS notice of benefit and payment parameters for 2027 final rule*. U.S. Department of Health and Human Services. <https://www.cms.gov/newsroom/fact-sheets/hhs-notice-benefit-payment-parameters-2027-final-rule>
- Daly, R. (2025, November 11). *Employers turn to direct contracting as hospital costs continue to rise*. Healthcare Financial Management Association. <https://www.hfma.org/fast-finance/healthcare-data-tool-employers/>
- Dicken, J. (2023). *Private Health Coverage: Information on Farm Bureau Health Plans, Health Care Sharing Ministries, and Fixed Indemnity Plans*. U.S. Government Accountability Office. <https://www.gao.gov/products/gao-23-106034>
- Employee Benefits Security Administration. (2020, April 11). *FAQs About Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42*. Department of Labor. <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42>
- Fish, M. A. (2022, April 6). *Direct-to-Employer Contracting Has Arrived*. FTI Consulting. <https://www.fticonsulting.com/insights/articles/direct-employer-contracting-arrived>
- Giovannelli, J., & Schwab, R. (2024, February 8). *States Expand Access to Affordable Private Coverage for Immigrant Populations*. The Commonwealth Fund. <https://www.commonwealthfund.org/blog/2024/states-expand-access-affordable-private-coverage-immigrant-populations>
- Hamilton Health Hub. (2026, June). *The Advantages of Employer Clinics: How Hamilton Health Hub Brings Care Directly to Employer Workplaces*.



https://assets.ctfassets.net/13v9j0ltz3yi/vzun4FkkQDMLoISvsRpPx/a7289a068fec3d582c55dfff71553b74/Hamilton_Health_Hub_Employer_Clinic_Case_Study.pdf

Herzlinger, R. E. (Ed.). (2004). *Consumer Driven Health Care*. Jossey-Bass.

Internal Revenue Service, Employee Benefits Security Administration, & Department of Health and Human Services. (2019). *Health reimbursement arrangements and other account-based group health plans* (Final rule). *Federal Register*, 84(119), 28888–28944.

<https://www.federalregister.gov/documents/2019/06/20/2019-12571/health-reimbursement-arrangements-and-other-account-based-group-health-plans>

Jindal, B., & Overton, H. (2024, January 25). *To Make Health Care Affordable, Give Patients Choices*. Newsweek. <https://www.newsweek.com/make-health-care-affordable-give-patients-choices-opinion-1862900>

Keisler-Starkey, K., & Bunch, L. N. (2024). *Health insurance coverage in the United States: 2023* (Current Population Reports, P60-284). U.S. Census Bureau.

<https://www.census.gov/library/publications/2024/demo/p60-284.html>

National Alliance of Healthcare Purchaser Coalitions. (2025). *Pulse of the Purchaser 2025 Survey Results*. <https://www.nationalalliancehealth.org/resources/pulse-of-the-purchaser-2025-survey-results/>

Nelson, P. (2024, July). *Section 133 Health Care Choice Compacts*. The American Experiment.

<https://files.americanexperiment.org/wp-content/uploads/2024/07/Health-Care-Choice-Compacts.pdf>

Public Health Service Act, 42 U.S.C. § 300u (1988).

<https://www.govinfo.gov/content/pkg/COMPS-8788/pdf/COMPS-8788.pdf>

RSM. (2023, September 13). *Executive Summary: IRS says that certain wellness plans are subject to employment taxes*. <https://rsmus.com/insights/tax-alerts/2023/wellness-plan-schemes-.html>

Texas Direct Medical Care. (2019, November). *Case Study: Direct Primary Care*.

<https://www.txmedicalcare.com/wp-content/uploads/2019/11/DPC-Employer-Case-Study.pdf>

U.S. Department of Health and Human Services, U.S. Department of Labor, & U.S. Department of the Treasury. (2023, July 12). *Short-term, limited-duration insurance; independent, noncoordinated excepted benefits coverage; level-funded plan arrangements; and tax treatment of certain accident and health insurance* (88 Fed. Reg. 44596).

<https://www.federalregister.gov/d/2023-14238>

U.S. Department of Labor, U.S. Department of Health and Human Services, & U.S. Department of the Treasury. (2025, August 7). *Statement of U.S. Departments of Labor, Health and Human Services, and the Treasury regarding short-term, limited-duration insurance* (CMS publication). Centers for Medicare & Medicaid Services.

<https://www.cms.gov/files/document/statement-regarding-short-term-limited-duration-insurance.pdf>

