Short-Term Limited Duration Insurance
Proposed Rule
[CMS-9924-P, Reg-133491-17; RIN 1210-AB86]

SUMMARY

On February 21, 2018, the Departments of Treasury, Labor and Health and Human Services ("the Departments") published in the *Federal Register* (83 *FR* 7437-7447) a proposed rule amending the definition of short-term, limited duration insurance for purposes of its exclusion from the definition of individual health insurance coverage. If this proposed rule is finalized, short-term, limited duration coverage will be able to be offered for a period of time that is less than 12 months after the original effective date of the contract. This would be a change from the current rule which limits the duration of such coverage to less than 3 months with no renewals.[1] Short-term, limited duration coverage is not subject to the individual insurance market requirements that apply under the Patient Protection and Affordable Care Act (PPACA, hereafter referred to as the Affordable Care Act (ACA)). The Departments intend for the policy change to provide more affordable consumer choice for health coverage. **There is a 60-day comment period, which ends April 23, 2018.** The proposed rule would apply 60 days after publication of the final rule in the *Federal Register.*

I. Background

President's Executive Order

The proposed rule is in response to President Trump's October 12, 2017 Executive Order (EO) 13813, "Promoting Healthcare Choice and Competition Across the United States." The Executive Order charged the Secretaries of Treasury, Labor, and Health and Human Services (HHS) to consider proposing regulations or revising guidance, consistent with law, to expand the availability of short-term, limited-duration insurance. "To the extent permitted by law and supported by sound policy, the Secretaries should consider allowing such insurance to cover longer periods and be renewed by the consumer."

2017 Tax Law

As the preamble notes, the President signed into law the Tax Cut and Jobs Act (Pub. L. 115-97) on December 22, 2017. The new law includes a provision under which the ACA's individual shared responsibility provision (also referred to as the individual mandate), which imposes a tax penalty on individuals who fail to have minimum essential coverage,[2] will no longer be effective for months beginning after December 31, 2018. This is relevant to short-term, limitation duration insurance because individuals who elect to enroll in such insurance after December 31, 2018 will not be subject to a tax penalty on the basis that they do not have minimum essential coverage.

[1] 45 CFR 144.103
[2] Many individuals who do not have minimum essential coverage do not pay the tax penalty because they are determined to meet one of a number of exemptions.

Short-Term, Limited-Duration Insurance

As described in the rule's preamble, short-term, limited-duration (STLD) insurance is a type of health insurance designed to fill temporary gaps in coverage that may occur when an individual is transitioning from one plan or coverage to another plan or coverage. It is not considered under the Public Health Service (PHS) Act to be an "excepted benefit" (such as vision and dental coverage, long-term care insurance, Medicare supplement coverage, and health flex plans), which is a type of benefit that is explicitly exempt from the PHS Act's individual-market requirements (including those established by the ACA) because it is not "health insurance coverage." However, section 2791(b)(5) of the PHS Act provides "[t]he term 'individual health insurance coverage' means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance."

The Departments note that the PHS Act does not define STLD insurance. Under regulations implementing the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and that continued to apply through 2016, however, STLD insurance was defined as "health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract."

The ACA's market reforms largely apply to "a group health plan" or "a health insurance issuer offering group or individual health insurance coverage." Since STLD coverage is excluded from the definition of individual health insurance coverage, it is not subject to the ACA's requirements.[3]

To address the issue of STLD insurance as a type of primary coverage as well as concerns about the potential for a growing STLD insurance market to adversely impact the ACA-compliant individual market, the Departments proposed in June 2016[4] a change to definition of STLD insurance. Under its proposed rule, finalized without change in October of that year,[5] the definition of STLD insurance was revised so that such coverage could not provide coverage for longer than 3 months (including any renewal period(s)).[6] In addition, the Departments added a

[3] The Obama Administration's regulations for minimum essential coverage (MEC) specified that STLD insurance did not qualify as MEC. Thus, as noted above, individuals who enroll in short-term policies as their primary coverage could have to pay the individual mandate penalty. Internal Revenue Service, Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage, 78 *FR*, 53646-53664, August 30, 2013, www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21157.pdf. In addition, regulations implementing the ACA's changes to HIPAA's guaranteed availability and renewability requirements included a definition of "individual health insurance coverage" that excluded short-term coverage and cross-referenced the previous HIPAA definition. HHS, Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Final Rule, 79 *FR* 30240, May 27, 2014, www.gpo.gov/fdsys/pkg/FR-2014-05-27/pdf/2014-11657.pdf.

[4] Departments of Treasury, HHS and Labor, "Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance," 81 *FR* 38020-38048, June 10, 2016, www.gpo.gov/fdsys/pkg/FR-2016-06-10/pdf/2016-13583.pdf.

[5] The rule was finalized on October 31, 2016, 81 *FR* 75316, www.gpo.gov/fdsys/pkg/FR-2016-10-31/pdf/2016-26162.pdf

[6] Specifically, the proposed and final rules provided that the three-month limit applied to any extensions "that may be elected with or without the issuer's consent." This language was intended to prevent insurers from indefinitely

requirement that the following notice be prominently displayed in the contract and in any application materials provided in connection with enrollment in short-term, limited-duration insurance, in 14 point type: THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

On June 12, 2017, HHS published a Request for Information (RFI) in the *Federal Register*[7] which solicited public comments about potential changes to existing regulations and guidance "that could promote consumer choice, enhance affordability of coverage for individual consumers, and affirm the traditional regulatory authority of the States in regulating the business of health insurance, among other goals." The Departments observe that in response to this RFI, several commenters stated that changes to the October 2016 final rule related to STLD insurance might provide an opportunity to achieve these goals by allowing such insurance to cover longer periods of time. They argued that STLD policies would then be better able to offer an alternative, lower-cost source of coverage than is available from ACA compliant plans, especially for those who do not qualify for the ACA's premium subsidies. Another theme in some stakeholder comments was that the October 2016 final rule represented an overreach on the part of the federal government since the primary regulator of STLD insurance is the states.

It is now the Departments' view that making STLD insurance available for longer periods than 3 months would help meet a growing need for lower cost alternatives to ACA plans. To support this view, the Departments' cite recent data on individual market plan selections. For the first quarters of 2016 and 2017, the number of off-Exchange and unsubsidized enrollees with individual market coverage fell by nearly 2 million, representing an almost 25 percent decrease. In 2018, about 26 percent of enrollees (living in 52 percent of counties) have access to just one insurer in the Exchange, thus suggesting in the view of the Department the need for additional coverage options.

II. Overview of the Proposed Regulations

Under the proposed rule, the definition of STLD insurance would be modified so that such insurance may offer a maximum coverage period of less than 12 months after the original effective date of the contract. This would be, in the Departments' words, "consistent with the original definition in the 1997 HIPAA rule (that is, the proposed rule would expand the potential maximum coverage period by 9 months). This proposed definition states that "the expiration date specified in the contract takes into account any extensions that may be elected by the policyholder without the issuer's consent."[8]

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extending or renewing short-term coverage at the end of the three-month coverage period. 81 *FR* 38032, June 10, 2016, www.gpo.gov/fdsys/pkg/FR-2016-06-10/pdf/2016-13583.pdf.

[7] Department of Health and Human Services, Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients, 82 FR 26885, June 12, 2017, www.gpo.gov/fdsys/pkg/FR-2017-06-12/pdf/2017-12130.pdf

[8] Coverage renewed "without the issuer's consent" is generally understood to mean a guaranteed renewable policy which enables the policyholder to continue coverage even if the insurer does not want to renew it. Coverage renewed "with the issuer's consent" generally means renewal or enrollment where both the insurer and policyholder

In addition, the proposed rule would revise the required notice that must appear in the STLD's policy's contract and any application materials for enrollment in STLD insurance. Because the Departments are concerned that such policies may provide coverage lasting almost 12 months, it may be more difficult for some individuals to distinguish them from ACA-compliant coverage which is typically offered on a 12-month basis. Thus, one of two versions (see the discussion of the applicability date below) of the following notice would be required to be prominently displayed (in at least 14 point type) in the contract and in any application materials provided in connection with enrollment:

> THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOESN'T COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. ALSO, THIS COVERAGE IS NOT "MINIMUM ESSENTIAL COVERAGE". IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE FOR ANY MONTH IN 2018, YOU MAY HAVE TO MAKE A PAYMENT WHEN YOU FILE YOUR TAX RETURN UNLESS YOU QUALIFY FOR AN EXEMPTION FROM THE REQUIREMENT THAT YOU HAVE HEALTH COVERAGE FOR THAT MONTH.

The applicability date for this proposed rule, if finalized, would be 60 days after the publication of the final rule. Policies sold on or after that date would have to meet the requirements of the final rule in order to constitute STLD short-term, limited-duration insurance. Because the individual shared responsibility payment under the ACA is reduced to $0 for months beginning after December 2018, the Departments propose that the final two sentences of the above notice be required to appear only with respect to policies sold on or after the applicability date of the rule, if finalized, that have a coverage start date before January 1, 2019. **Comments are requested on this revised notice, and whether its language or some other language would best ensure that it is understandable and sufficiently apprises individuals of the nature of the coverage.**

Under current regulations, the definition of STLD insurance limiting it to 3 months duration (as finalized in October 2016) applies for policy years beginning on or after January 1, 2017. Because state regulators may have approved STLD products for sale in 2017 that met the definition in effect prior to January 1, 2017, HHS noted that it would not take enforcement action against an issuer with respect to its sale of a short-term product before April 1, 2017. The Departments now state that the definition in the October 2016 final rule, and the non-enforcement policy as applied to policies sold before April 1, 2017 and that end on or before December 31, 2017, will continue to apply unless and until this rule is finalized.

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want to continue coverage. (Health Insurance Association of America, *Individual Health Insurance*, Part A, 1994.) It seems likely that the Departments intend for the proposed change in regulations to allow individuals to reapply for short-term coverage, if not renew their policy, at the end of the 12-month period. Presumably, most issuers of this type of coverage would subject an application for renewal to medical underwriting, potentially leading to premium changes.

Effective Date and Applicability Date

This proposed rule, if finalized, would be effective 60 days after publication of the final rule and would apply with respect to short term policies sold on or after the 60th day following publication of the final rule. Details are provided with respect to the applicability date and the conforming changes to the rules at 26 CFR 54.9833-1; 29 CFR 2590.736, 45 CFR 146.125; and 45 CFR 148.102.

Request for Comments

The Departments seek comments on all aspects of this proposed rule, including whether the length of STLD insurance should be some other duration. In addition, comments are requested on:

- Any regulations or other guidance or policy that limits issuers' flexibility in designing STLD insurance or poses barriers to entry into the STLD insurance market;
- The conditions under which issuers should be able to allow STLD insurance to continue for 12 months or longer with the issuer's consent;
- Whether any processes for expedited or streamlined reapplication for STLD insurance that would simplify the reapplication process and minimize the burden on consumers may be appropriate and whether federal standards are appropriate for such processes;
- Whether any clarifications are needed regarding the application of the definition of STLD insurance in the proposed rule to such practices. (The example is provided that an expedited process could involve setting minimum federal standards for what must be considered as part of the streamlined reapplication process while allowing insurers to consider additional factors in accordance with contract terms); and
- Information on any state approaches that they are considering to minimize the burden or the reapplication process for issues and consumers.

The Departments note that because STLD insurance can be priced so that the premium paid by an individual reflects that individual's associated insurance risks (that is, "priced in an actuarially fair manner") subject to state law, individuals who are likely to purchase this type of insurance are also likely to be relatively young or healthy. Because STLD insurance policies do not have to comply with the ACA's insurance market standards, they could adversely affect the individual market single risk pools that are required under the ACA. (See also "Economic Impact and Paperwork Burden" below.) The Departments estimate that in 2019, after the elimination of the individual shared responsibility payment, between 100,000 and 200,000 individuals previously enrolled in Exchange coverage would instead purchase STLD policies, resulting in an increase in the average monthly individual market premiums and average monthly premium tax credits to increase. Specifically, total annual advance payments of the premium tax credit (APTC) would increase in the range of $96 million to $168 million. **The Departments seek comments on these estimates, and welcome other estimates of the increase in enrollment in STLD insurance under this proposal, and the health status and age of individuals who would purchase these policies.**

Comments are also requested on the proposed effective dates and applicability dates and whether the fixed applicability date, which would first impose the new definition of STLD insurance on group health plans and group health insurance issuers on a date that may occur in the middle of a plan year, would cause any special challenges for such plans and issuers.

III. Economic Impact and Paperwork Burden

Department of Labor and Department of Health and Human Services

After summarizing background on the requirements leading to a determination of regulatory actions requiring impact analyses, the two Departments state that this proposed rule meets the definition of "significant rule" (i.e., likely to have economic impacts of at least $100 million or more in at least 1 year) and thus they have provided an assessment of the potential costs, benefits, and transfers associated with it.

In the section, "Need for Regulatory Action," the Departments note that "While individuals who qualify for premium tax credits are largely insulated from significant premium increases, individuals who are not eligible for subsidies are harmed by increased premiums in the individual market due to a lack of other, more affordable alternative coverage options." They say that the proposed rule would increase the coverage options for individuals unable or unwilling to purchase ACA-compliant plans.

Summary of Impacts

Table 1 reproduced from 83 *FR* 7442 depicts an accounting statement summarizing the Departments' assessment of the benefits, costs, and transfers associated with this regulatory action.

TABLE 1—ACCOUNTING TABLE

Benefits:

Qualitative:
- Increased access to affordable health insurance for consumers unable or unwilling to purchase PPACA-compliant plans, potentially resulting in improved health outcomes for them.
- Increased choice at lower cost and increased protection (for consumers who are currently uninsured) from catastrophic health care expenses for consumers purchasing short-term, limited-duration insurance.
- Potentially broader access to health care providers compared to PPACA-compliant plans for some consumers.

Costs:

Qualitative:
- Reduced access to some services and providers for some consumers who switch from PPACA-compliant plans.
- Increased out-of-pocket costs for some consumers, possibly leading to financial hardship.
- Worsening of States' individual market single risk pools and potential reduced choice for some other individuals remaining in those risk pools.

Transfers	Low estimate (million)	High estimate (million)	Year dollar	Discount rate (percent)	Period covered
Annualized Monetized ($/year)	$96	$168	2017	7	2019
	96	168	2017	3	2019

Quantitative:
- Transfer from the Federal government to enrollees in individual market plans in the form of increased APTC payments.

Qualitative:
- Transfer from enrollees in individual market plans who experience increase in premiums to individuals who switch to lower premium short-term, limited-duration insurance.
- Tax liability for consumers who replace PPACA-compliant plans and will thus no longer maintain minimum essential coverage in 2018.

Data are provided on the relative size of the STLD insurance market to that for comprehensive individual market coverage (160,600 covered lives in 2016 prior to the Obama Administration's October 2016 final rule vs. about 13.6 million at the end of 2016). The STLD policies typically provided coverage for less than 3 months. The Departments say that it is unclear how the October 2016 final rule affected the sales of STLD insurance policies but that sales were increasing prior to that rule's publication. They conclude that given prior trend and the recent increases in premiums in the individual market, this proposed rule, if finalized, "would encourage more consumers to purchase short-term, limited-duration insurance for longer durations, including individuals who were previously uninsured and some who are currently enrolled in individual market plans, especially in 2019 and beyond, when the individual shared responsibility payment included in section 5000A of the Code is reduced to $0, as provided under Pub. L. 115-97."

Benefits

The Departments state that the average monthly premium for STLD coverage for the last quarter of 2016 was about $124 compared to $393 for an unsubsidized ACA-compliant plan. They posit that consumers would purchase STLD policies for periods longer than 3 months if they needed more than 3 months to find new employment or because ACA-compliant plans are unaffordable. Compared with being uninsured, they say that STLD coverage would help improve health outcomes and protect individuals from catastrophic health care expenses. They also assert that STLD policies could provide broader access to health care providers compared to ACA-compliant plans with narrow networks.

Comments are requested on how many consumers may purchase STLD insurance instead of going uninsured or purchasing ACA-compliant plans and the benefits of the former. They also ask for any impacts on the ACA-individual market single risk pools.

The benefits of higher enrollment, increased revenues and profits for issuers of these products are noted which would be possible especially because the issuers could price on the basis of actuarial risk.

Cost and Transfers

The Departments note the ways in which STLD policies would fail to include the consumer protections required for ACA-compliant plans. Among these are the preexisting condition exclusion prohibition, coverage of essential health benefits without annual or lifetime dollar limits, preventive care, maternity and prescription drug coverage, rating restrictions, and guaranteed renewability. The result would be an increase in out-of-pocket expenditures related to such excluded services although the Departments assert that these are "benefits that in many cases consumers do not believe are worth their cost (which could be one reason why many consumers, even those receiving subsidies for PPACA-compliant plans, may switch to short-term, limited-duration policies…." **The Departments seek comments on the value of such excluded services to individuals who switch coverage.** They also note the potential for enrollees in STLD policies to develop chronic conditions that could result in financial hardship

until they are able to enroll in ACA-compliant plans. Lacking minimum essential coverage in 2018 could also trigger a tax penalty.

The Departments again reiterate the potential for the growth in STLD policies to take a toll in the form of reduced enrollment in and adverse risk selection for states' individual market single risk pools. This may lead some individual market issuers to exit, reducing choices for those consumers remaining in those individual market single risk pools. **The Departments seek comments on these and any other potential costs.**

The Departments note the potential federal costs of a worsening risk pool for those eligible to receive the ACA's advance payment tax credits (premium subsidies) that could result from the proposed rule combined with the effect of the repeal of the penalty, beginning for 2019, for not having minimum essential coverage. The Departments conclude that approximately 100,000 to 200,000 additional individuals would shift from the individual market to STLD insurance in 2019 and that most would be young or healthy and only about 10 percent of them would have been eligible for APTC if they maintained their Exchange coverage. The reduced number of subsidized enrollees would tend to reduce total payments for subsidies but increasing premiums would offset some of those reductions, producing a net increase in federal outlays for the premium subsidies of $96 million to $168 million annually. The Departments note the uncertainty of these estimates because changes in premiums and enrollment depend on a variety of economic factors and the uncertain behavioral responses to them on the part of consumers and issuers. (See 83 *FR* 7443-7445 for a discussion of the assumptions used in producing this estimate and table 2 at 83 *FR* 7443-4 for a breakout of the range of estimated effects on individual market exchanges in 2019).

Regulatory Alternatives

The only alternative identified would be to set the maximum duration for STLD insurance to a six-month or nine-month period. But the Departments say that this would not adequately increase choices for individuals unable or unwilling to purchase ACA-compliant plans.

Paperwork Reduction Act – HHS

Because the exact text for the notice requirement is included in the proposal and the language would not need to be customized, the Departments have concluded that the associated burden is not subject to the Paperwork Reduction Act.

Regulatory Flexibility Act

The Departments explain their reasoning in certifying that this proposed rule would not have a significant impact on a substantial number of small entities (see 83 *FR* 7444).

Special Analysis - Treasury

The proposed rule has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Unfunded Mandates Reform Act

The Departments find that the proposed rule does not include any federal mandate that may result in expenditures by state, local or tribal governments, or the private sector that may impose any annual burden that exceeds the $148 million threshold triggering an impact assessment.

Federalism – Labor and HHS

The Departments of Labor and HHS conclude that the proposed rule has no federalism implications to the extent that current state law requirements for STLD insurance are the same as or more restrictive than the federal standard proposed in this proposed rule. They advise that *states may continue to apply such state law requirements.*

Congressional Review Act

The Departments state that the proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 and will be transmitted to the Congress and to the Comptroller General for review in accordance with such provisions.

Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. This proposed rule, if finalized as proposed, is expected to be an Executive Order 13771 deregulatory action.

IV. Statutory Authority

The following statutory authorities are identified for each of the 3 Departments for the proposed rule:

> Treasury regulations: Sections 7805 and 9833 of the Internal Revenue Code
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> Labor: 29 U.S.C. 1135 and 1191c; and Secretary of Labor's Order 1-2011, 77 FR 1088 (Jan. 9, 2012)
>
> HHS: Sections 2701 through 2763, 2791, 2792 and 2794 of the PHS Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, 300gg-92 and 300gg-94), as amended.