

**DEPARTMENT OF THE TREASURY****Internal Revenue Service****26 CFR Part 54**

[TD 9837]

RIN 1545–BO41

**DEPARTMENT OF LABOR****Employee Benefits Security Administration****29 CFR Part 2590**

RIN 1210–AB86

**DEPARTMENT OF HEALTH AND HUMAN SERVICES****45 CFR Parts 144, 146, and 148**

[CMS–9924–F]

RIN 0938–AT48

**Short-Term, Limited-Duration Insurance**

**AGENCY:** Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

**ACTION:** Final rule.

**SUMMARY:** This final rule amends the definition of short-term, limited-duration insurance for purposes of its exclusion from the definition of individual health insurance coverage. This action is being taken to lengthen the maximum duration of short-term, limited-duration insurance, which will provide more affordable consumer choices for health coverage.

**DATES:**

*Effective date:* These final regulations are effective on October 2, 2018.

*Applicability date:* Insurance policies sold on or after October 2, 2018 must meet the definition of short-term, limited-duration insurance contained in this final rule in order to be considered such insurance.

**FOR FURTHER INFORMATION CONTACT:**

Amber Rivers or Matthew Litton, Department of Labor, (202) 693–8335; Dara Alderman, Internal Revenue Service, Department of the Treasury, (202) 317–5500; David Mlawsky, Centers for Medicare & Medicaid Services, Department of Health and Human Services, (410) 786–1565.

*Customer Service Information:* Individuals interested in obtaining information from the Department of

Labor concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline, at 1–866–444–EBSA (3272) or visit the Department of Labor’s website (<http://www.dol.gov/ebsa>). In addition, information from the Department of Health and Human Services (HHS) on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website ([www.cms.gov/ccio](http://www.cms.gov/ccio)) and information on health reform can be found at [www.HealthCare.gov](http://www.HealthCare.gov).

**SUPPLEMENTARY INFORMATION:****I. Background**

This rule finalizes amendments to the definition of “short-term, limited-duration insurance” for purposes of its exclusion from the definition of “individual health insurance coverage” in 26 CFR part 54, 29 CFR part 2590, and 45 CFR part 144.

**A. General Statutory Background and Enactment of PPACA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA)<sup>1</sup> added title XXVII to the Public Health Service Act (PHS Act), part 7 to the Employee Retirement Income Security Act of 1974 (ERISA), and Chapter 100 to the Internal Revenue Code (the Code), providing portability and nondiscrimination rules with respect to health coverage. These provisions of the PHS Act, ERISA, and the Code were later augmented by other laws, including the Mental Health Parity Act of 1996,<sup>2</sup> the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,<sup>3</sup> the Newborns’ and Mothers’ Health Protection Act,<sup>4</sup> the Women’s Health and Cancer Rights Act,<sup>5</sup> the Genetic Information Nondiscrimination Act of 2008,<sup>6</sup> the Children’s Health Insurance Program Reauthorization Act of 2009,<sup>7</sup> Michelle’s Law,<sup>8</sup> and the Patient Protection and Affordable Care Act, as amended by the Health Care and

Education Reconciliation Act of 2010 (PPACA).<sup>9</sup>

PPACA reorganizes, amends, and adds to the provisions of Part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. PPACA added section 715 of ERISA and section 9815 of the Code to incorporate provisions of Part A of title XXVII of the PHS Act (generally, sections 2701 through 2728 of the PHS Act) into ERISA and the Code.

**B. President’s Executive Order**

On October 12, 2017, President Trump issued Executive Order 13813 entitled “Promoting Healthcare Choice and Competition Across the United States.”<sup>10</sup> This Executive Order states in relevant part: “Within 60 days of the date of this order, the Secretaries of the Treasury, Labor, and Health and Human Services shall 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.”

**C. 2017 Tax Legislation**

Section 5000A of the Code, added by PPACA, provides that all non-exempt applicable individuals must maintain minimum essential coverage (MEC) or pay the individual shared responsibility payment.<sup>11</sup> On December 22, 2017, the President signed tax reform legislation into law.<sup>12</sup> This legislation includes a provision under which the individual shared responsibility payment under section 5000A of the Code is reduced to

<sup>9</sup> The Patient Protection and Affordable Care Act, Public Law 111–148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, Public Law 111–152, was enacted on March 30, 2010. These statutes are collectively referred to as PPACA.

<sup>10</sup> 82 FR 48385.

<sup>11</sup> The eligibility standards for exemptions can be found at 45 CFR 155.605. Section 5000A of the Code and Treasury regulations at 26 CFR 1.5000A–3 provide exemptions from the requirement to maintain MEC for the following individuals: (1) Members of recognized religious sects; (2) members of health care sharing ministries; (3) exempt noncitizens; (4) incarcerated individuals; (5) individuals with no affordable coverage; (6) individuals with household income below the income tax filing threshold; (7) members of federally recognized Indian tribes; (8) individuals who qualify for a hardship exemption certification; and (9) individuals with a short coverage gap of a continuous period of less than 3 months in which the individual is not covered under MEC.

<sup>12</sup> Public Law 115–97, 131 Stat. 2054.

<sup>1</sup> Public Law 104–191, 110 Stat. 1936 (August 21, 1996).

<sup>2</sup> Public Law 104–204, 110 Stat. 2944 (September 26, 1996).

<sup>3</sup> Public Law 110–343, 122 Stat. 3881 (October 3, 2008).

<sup>4</sup> Public Law 104–204, 110 Stat. 2935 (September 26, 1996).

<sup>5</sup> Public Law 105–277, 112 Stat. 2681–436 (October 21, 1998).

<sup>6</sup> Public Law 110–233, 122 Stat. 881 (May 21, 2008).

<sup>7</sup> Public Law 111–3, 123 Stat. 64 (February 4, 2009).

<sup>8</sup> Public Law 110–381, 122 Stat. 4081 (October 9, 2008).

\$0, effective for months beginning after December 31, 2018.

#### *D. Short-Term, Limited-Duration Insurance*

Short-term, limited-duration insurance is a type of health insurance coverage that was primarily 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. 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.”<sup>13</sup> However, the PHS Act does not define short-term, limited-duration insurance. In 1997, the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (together, the Departments), issued regulations implementing the portability and renewability requirements of HIPAA, which included definitions of individual health insurance coverage as well as short-term, limited-duration insurance.<sup>14</sup> Those regulations defined short-term, limited-duration insurance 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.”<sup>15</sup>

Short-term, limited-duration insurance is generally exempt from the Federal market requirements applicable to health insurance sold in the individual market because it is not considered individual health insurance coverage. For example, short-term, limited-duration insurance is not subject to the requirement to provide essential health benefits and it is not subject to the prohibitions on preexisting condition exclusions or lifetime and annual dollar limits. It is also not subject to requirements regarding guaranteed availability and guaranteed renewability.

To address the issue of short-term, limited-duration insurance being sold as a type of primary coverage, as well as concerns regarding possible adverse selection impacts on the risk pools for PPACA-compliant plans, the Departments published a proposed rule on June 10, 2016 in the **Federal Register** entitled “Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance.”<sup>16</sup> The June 2016 proposed rule proposed changing the definition of short-term, limited-duration insurance that had been in place for nearly 20 years by revising the definition to specify that short-term, limited-duration insurance could not provide coverage for 3 months or longer taking into account any extensions that may be elected by the policyholder with or without the issuer’s consent.<sup>17</sup>

The June 2016 proposed rule also proposed to require 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 at least 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.<sup>18</sup>

After reviewing public comments and feedback received from stakeholders, on

October 31, 2016, the Departments finalized the June 2016 proposed rule without change in a final rule published in the **Federal Register** entitled “Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance.”<sup>19</sup>

On June 12, 2017, HHS published a request for information in the **Federal Register** entitled “Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients,”<sup>20</sup> 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. Several commenters stated that changes to the October 2016 final rule may provide an opportunity to achieve these goals. Consistent with many comments submitted on the June 2016 proposed rule, commenters stated that shortening the permitted length of short-term, limited-duration insurance policies had deprived individuals of affordable coverage options. One commenter explained that due to the increased costs of PPACA-compliant major medical coverage, many financially-stressed individuals may be faced with a choice between short-term, limited-duration insurance coverage and going without any coverage at all. One commenter highlighted the need for short-term, limited-duration insurance coverage among individuals who are between jobs. Another commenter explained that states have the primary responsibility to regulate short-term, limited-duration insurance and opined that the October 2016 final rule was overreaching on the part of the federal government.

In addition to considering these comments, the Departments also considered that, while individuals who qualify for premium tax credits (PTCs) under section 36B of the Code are largely insulated from premium increases for individual health insurance coverage (that is, the government, and thus federal taxpayers, largely bear the cost of the increases), individuals who are not eligible for PTCs are particularly harmed by increased premiums in the individual market due to a lack of other, more affordable alternative coverage options. Based on CMS data on Exchange-effectuated enrollment and payment,

<sup>13</sup> Sections 733(b)(4) of ERISA and 2791(b)(4) of the PHS Act provide that group health insurance coverage means “in connection with a group health plan, health insurance coverage offered in connection with such plan.” Sections 733(a)(1) of ERISA and 2791(a)(1) of the PHS Act provide that a group health plan is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents (as defined under the terms of the plan) directly, or through insurance, reimbursement, or otherwise. There is no corresponding provision excluding short-term, limited-duration insurance from the definition of group health insurance coverage. Thus, any health insurance that is sold in the group market and purports to be short-term, limited-duration insurance must comply with applicable group health insurance requirements established under Part A of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code.

<sup>14</sup> The definition of individual health insurance coverage (and its exclusion of short-term, limited-duration insurance) has some limited relevance with respect to certain provisions that apply to group health plans and group health insurance issuers over which the Departments of Labor and the Treasury have jurisdiction. For example, an individual who loses coverage due to moving out of an HMO service area in the individual market triggers a special enrollment right into a group health plan. See 26 CFR 54.9801–6(a)(3)(i)(B), 29 CFR 2590.701–6(a)(3)(i)(B), and 45 CFR 146.117(a)(3)(i)(B). Also, a group health plan that wraps around individual health insurance coverage is an excepted benefit if certain conditions are satisfied. See 26 CFR 54.9831–1(c)(3)(vii), 29 CFR 2590.732(c)(3)(vii), and 45 CFR 146.145(b)(3)(vii).

<sup>15</sup> 62 FR 16894 at 16928, 16942, 16958 (April 8, 1997); see also 69 FR 78720 (December 30, 2004).

<sup>16</sup> 81 FR 38019.

<sup>17</sup> 81 FR 38019, 38032.

<sup>18</sup> Id. at 38032.

<sup>19</sup> 81 FR 75316 (October 31, 2016).

<sup>20</sup> 82 FR 26885.

average monthly enrollment for individuals without PTCs declined by 1.3 million, or 20 percent, between 2016 and 2017.<sup>21</sup> Some of this decline is likely a response to increased premiums.<sup>22</sup> Further, in 2018, about 26 percent of enrollees (living in 52 percent of counties) have access to just one issuer in the Exchange.<sup>23</sup> Such monopoly markets, which are more predominant in rural counties, do not provide meaningful choice for consumers and cause premiums to be higher than they would be in a competitive market. Additionally, although the October 2016 final rule was intended to boost enrollment in individual health insurance coverage by reducing the maximum duration of coverage in short-term, limited-duration plans, it did not succeed in that regard. Rather, average monthly enrollment in individual market plans decreased by 10 percent between 2016 and 2017, while premiums increased by 21 percent.<sup>24</sup> Therefore, the Departments determined that the expansion of additional coverage options such as short-term, limited-duration insurance is necessary, as premiums have escalated and

<sup>21</sup> Centers for Medicare and Medicaid Services, "Trends in Subsidized and Unsubsidized Individual

Health Insurance Market Enrollment", July 2, 2018. Available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-2.pdf>.

<sup>22</sup> Note, however, that the reduction in the number of unsubsidized enrollees is due to several different effects. As implied in the main text, some of the reduction is attributable to unsubsidized enrollees dropping coverage due to premium increases. Unsubsidized enrollees might also have left the Exchange because the labor market has improved, which might have resulted in increased availability of employer-sponsored coverage. In addition, because Exchange enrollees pay a fixed share of income for premiums with PTC covering the remainder, when premiums rise some unsubsidized enrollees become subsidized, even if enrollment does not change at all. Between February 2017 and February 2018, effectuated enrollment fell by about 209,000 among the unsubsidized but rose by 522,000 for the subsidized, suggesting some movement from unsubsidized to subsidized status without a change in enrollment. See "2017 Effectuated Enrollment Snapshot", June 12, 2017, available at <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf> and "Early 2018 Effectuated Enrollment Snapshot", June 2, 2018, available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-1.pdf>.

<sup>23</sup> Kaiser Family Foundation, "Insurer Participation on ACA Marketplaces, 2014–2018," November 10, 2017. Available at <http://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/>.

<sup>24</sup> Centers for Medicare and Medicaid Services, "Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment", July 2, 2018. Available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-2.pdf>.

affordable choices in the individual market have dwindled.

Accordingly, in light of Executive Order 13813 directing the Departments to consider proposing regulations or revising guidance to expand the availability of short-term, limited-duration insurance, as well as in response to continued feedback from stakeholders expressing concerns about the October 2016 final rule, the Departments published a proposed rule on February 21, 2018 entitled "Short-Term, Limited-Duration Insurance" under which the Departments proposed to amend the definition of short-term, limited-duration insurance to provide (as did the regulations implementing HIPAA) that such insurance may have a maximum coverage period of less than 12 months after the original effective date of the contract, taking into account any extensions that may be elected by the policyholder without the issuer's consent.<sup>25</sup>

In addition, the Departments proposed to revise the content of the notice that must appear in the contract and any application materials provided in connection with enrollment in short-term, limited-duration insurance, to be prominently displayed (in at least 14 point type), and to read as follows:

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.

Under the proposed rule, the final two sentences of the notice would only be required for policies sold on or after the applicability date of the final rule, if finalized, that have a coverage start date before January 1, 2019, because the individual shared responsibility payment is reduced to \$0 for months beginning after December 2018.

The Departments proposed that the rule would be effective 60 days after publication of the final rule in the **Federal Register**, and with respect to

the applicability date, the Departments proposed that policies sold on or after the 60th day following publication of the final rule would have to meet the definition of short-term, limited-duration insurance in the final rule in order to be considered short-term, limited-duration insurance. Further, the Departments proposed that group health plans and group health insurance issuers, to the extent they must distinguish between short-term, limited-duration insurance and individual health insurance coverage, must apply the definition of short-term, limited-duration insurance in the final rule as of the 60th day following publication of the final rule.

#### Request for Comments

The Departments requested comments on all aspects of the proposed rule, including whether the length of short-term, limited-duration insurance should be some other duration. Also, the Departments requested comments on any regulations or other guidance or policy that limits issuers' flexibility in designing short-term, limited-duration insurance or poses barriers to entry into the short-term, limited-duration insurance market. In addition, the Departments specifically sought comments on both the conditions under which issuers should be able to allow short-term, limited-duration insurance to continue for 12 months or longer with the issuer's consent and the revised notice.

The Departments requested comments on the economic impact analysis provided in the proposed rule, and welcomed other estimates of the increase in enrollment in short-term, limited-duration insurance under the proposal, and on the health status and age of individuals who would purchase these policies.

The comment period on the proposed rule ended on April 23, 2018. The Departments received approximately 12,000 comments. After careful consideration of these comments, the Departments are issuing these final rules.

## II. Overview of the Final Regulations

After considering the public comments, the Departments are finalizing the proposed rule with some modifications. Under this final rule, short-term, limited-duration insurance means health coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account

<sup>25</sup> 83 FR 7437 (February 21, 2018).

renewals or extensions, has a duration of no longer than 36 months in total.

This final rule also retains the requirement that issuers of short-term, limited-duration insurance display one of two versions of a notice prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14-point type. However, the language of the notice in the final rule is revised to read as follows:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. 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.

As under the proposed rule, the last two sentences of the notice are only required for policies sold on or after the applicability date of this final rule that have a coverage start date before January 1, 2019. As explained in more detail later in this preamble, in response to comments, the notice in the final rule contains additional specificity, including a list of health benefits that might not be covered. However, the Departments do not have evidence that short-term, limited-duration insurance policies have not historically or are unlikely to cover hospitalization and emergency services. Further, this final rule provides that the notice may contain any additional information as required by applicable state law and that the notice typeface should be in sentence case, rather than all capital letters.

Based on comments submitted, the Departments have also revised the estimates of the impact of short-term, limited-duration coverage on the individual health insurance market and the uninsured as explained further below. In addition, a severability clause has been added to this final rule. Finally, as was proposed in the proposed rule, this final rule is effective and applicable 60 days after publication in the **Federal Register**.

#### Comments on Authority

Several commenters questioned the Departments’ legal authority with regard to various aspects of the proposed rule. One commenter stated that because the PHS Act exempts short-term, limited-duration insurance from the definition of “health insurance coverage,” there is no delegation of Congressional authority giving HHS the power to define short-term, limited-duration insurance. Several commenters questioned whether the Departments have legal authority to define short-term, limited-duration insurance as having a maximum contract term of less than 12 months. One commenter stated that allowing such coverage to last nearly as long as individual health insurance coverage would be arbitrary, capricious, and not in accordance with law. Another commenter stated that the Departments failed to provide any reasonable justification for the change and expressed concern that short-term, limited-duration insurance will harm consumers and the individual market, will increase premiums for individual market plans, and will increase PTC expenditures. The commenter noted that despite acknowledging these potential outcomes of the proposed rule, the Departments stated that they are proposing this action to provide more affordable consumer choice for health coverage. The commenter stated that this does not suffice to explain the decision for a rule change that is inconsistent with the Departments’ earlier position, cannot carry the force of law, and is not entitled to deference and therefore is arbitrary and capricious, and cannot stand. One commenter stated that none of the three preambles supporting the less-than-12-month duration (the 1997 rules, the 2004 rules and the proposed rule that this rule finalizes) provide a “reasoned explanation” for this choice as the maximum length of coverage. Another commenter stated that 3 months is a reasonable, ordinary-English meaning of the word “short,” that the Departments’ adoption of it in 2016 was well-reasoned, and that neither the facts nor the statute have changed, only a policy agenda inimical to PPACA is new.

Another commenter stated that the definition in the proposed rule is inconsistent with the statutory text of PHS Act section 2791(b)(5) because the proposed maximum duration for short-term, limited-duration insurance coverage is not sufficiently shorter than individual health insurance coverage to be consistent with any reasonable reading of the statutory phrase “short-term.” This commenter also asserted

that the proposed definition is inconsistent with PPACA, because an issuer meeting the proposed definition could avoid all PPACA insurance reforms, which would deprive consumers of PPACA’s protections and damage individual market risk pools. Taking all this into consideration, the commenter asserted that the proposed definition is thus arbitrary and capricious.

The Departments disagree with these commenters that questioned our legal authority.

The Departments have clear statutory authority under the PHS Act to interpret undefined provisions of the PHS Act, ERISA, and the Code.<sup>26</sup> In order to determine the scope of individual health insurance coverage, which is essential to allow enforcement of the rules that apply to individual health insurance coverage, the Departments must give meaning to the term short-term, limited-duration insurance.<sup>27</sup> Relatedly, Congress provided the Secretaries of HHS, Labor and the Treasury with explicit authority to promulgate regulations as may be necessary or appropriate to carry out the provisions of the PHS Act.<sup>28</sup> Due to the absence of a statutory definition for the term short-term, limited-duration insurance, and the fact that the only reference to such coverage is as an exclusion from individual health insurance coverage, this includes the authority to issue regulations on short-term, limited-duration insurance to define it and set standards that distinguish it from individual health insurance coverage.

The Departments also disagree that the definition in the proposed rule and as revised in this final rule is inconsistent with PPACA. Both the proposed rule and the final rule establish federal standards for short-term, limited-duration insurance in a manner that clearly distinguishes such insurance from the individual health insurance coverage that is subject to PPACA’s individual market requirements. Further, there are no explicit statutory standards governing

<sup>26</sup> See section 715 of ERISA and section 9815 of the Code, which incorporate provisions of Part A of title XXVII of the PHS Act (generally, sections 2701 through 2728 of the PHS Act) into ERISA and the Code. See also, section 104 of HIPAA. See also, sections 505 and 734 of ERISA, sections 2761 and 2792 of the PHS Act, section 1321(a)(1) and (c) of PPACA and section 7805 of the Code.

<sup>27</sup> As discussed in footnote 14, the definition of short-term, limited-duration insurance also has some relevance with respect to certain provisions that apply to group health plans and group health insurance issuers over which the Departments of Labor and the Treasury have jurisdiction.

<sup>28</sup> See section 2792 of the PHS Act.

the degree to which short-term, limited-duration insurance must vary from individual health insurance coverage, leaving it to the Departments to use their interpretive authority to distinguish between the two terms. Indeed, when the federal regulations for short-term, limited-duration insurance were first implemented in 1997, short-term, limited-duration insurance was considered to be health insurance coverage with a period of coverage that was less than 12 months, as under the proposed rule. That standard was in place for nearly two decades without objection. As demonstrated by the definition of short-term, limited-duration insurance in this final rule, short-term, limited-duration insurance and individual health insurance coverage are distinguished by the differences in their initial contract terms, the maximum duration of a policy itself, and the types of notice requirements applicable to each type of coverage. The two types of insurance are further distinguished with respect to whether the coverage is considered MEC. In the Departments' view, these differences are significant and sufficient to distinguish short-term, limited-duration insurance from individual health insurance coverage, and the definition of short-term, limited-duration insurance in this final rule is consistent with PPACA, is well reasoned, is clearly within the Departments' authority, and is therefore not arbitrary and capricious. Rather than deprive consumers of PPACA protections, this final rule expands access to additional, more affordable coverage options for individuals, including those who might otherwise be uninsured, as well as to those who do not qualify for PTCs or who otherwise find individual health insurance coverage unattractive. Consumers who want comprehensive, individual health insurance coverage as defined by PPACA will continue to be able to purchase such coverage on a guaranteed availability and guaranteed renewability basis in the individual market. As to the comment regarding whether the rule is justified, see the discussion in the Regulatory Impact Analysis in this final rule for updated estimates of the impact of enrollment in short-term, limited-duration insurance on consumers and the individual market.

As stated above, some commenters challenged the legal authority of the Departments to set a less-than-12 month maximum contract term, including extensions that may be elected by the policyholder without the issuer's consent. In this final rule, the

Departments instead set a less-than-12-month maximum on the length of the initial contract term. The Departments would have had the authority to do the former (had we chosen to do so), and also have the authority to do the latter. As explained above, the Departments have authority to establish regulatory standards for short-term, limited-duration insurance, including setting a limit on the length of the initial contract term. The Departments have explained in the proposed rule and elsewhere in this final rule that this regulatory action is necessary and appropriate to remove federal barriers that inhibit consumer access to additional, more affordable coverage options and support state efforts to develop innovative solutions in response to market-specific needs.

This final rule recognizes the role that short-term, limited-duration insurance can fulfill, while at the same time distinguishing it from individual health insurance coverage by interpreting "short-term" to mean an initial contract term of less than 12 months and implementing the "limited-duration" requirement by precluding renewals or extensions that extend a policy beyond a total of 36 months. See below for a discussion of the rationale for the interpretation of the "limited-duration" requirement to mean no longer than 36 months. States remain free to adopt a definition with a shorter maximum initial contract term or shorter maximum duration (including renewals and extensions) for a policy to meet their specific market needs, including the adoption of strategies to mitigate adverse selection in the individual market.

One commenter stated that unlike health insurance products sold in the non-group market, short-term, limited-duration insurance is exempt from federal regulation and is subject only to state regulation and that the extent of CMS's statutory authority is to define what short-term, limited-duration insurance is. The commenter stated that the Departments have no legal authority to impose regulatory burdens or limitations on short-term, limited-duration insurance, such as the notice requirement.

The Departments agree with the commenter that short-term, limited-duration insurance is exempt from the PHS Act's individual market rules and is generally subject to state regulation. However, the Departments also have limited authority under the PHS Act to establish federal regulatory standards for short-term, limited-duration insurance, including standards related to the maximum length of the initial contract term, the maximum duration

(including renewals and extensions) for a policy, and a consumer notice. This final rule establishes such federal standards for short-term, limited-duration insurance in a way that is necessary and appropriate to distinguish this coverage from individual health insurance coverage. As stated above, Congress provided the HHS, Labor, and Treasury Secretaries with explicit authority to promulgate regulations as may be necessary or appropriate to carry out the provisions of the PHS Act.<sup>29</sup> The Departments believe that the federal regulatory definition of short-term, limited-duration insurance as set forth in this final rule, including the notice requirement, is necessary and appropriate to carry out the provisions of the PHS Act. As explained above, the Departments must give meaning to the undefined statutory term short-term, limited-duration insurance and the meaning must distinguish it from individual health insurance coverage. This is because the PHS Act imposes certain requirements on individual health insurance coverage, and does not impose those same requirements on short-term, limited-duration insurance. Further, the Departments believe it is necessary and appropriate for consumers considering the purchase of short-term, limited-duration insurance, and those actually purchasing such insurance, to be aware that such coverage is not subject to the federal individual market rules under the PHS Act. Therefore, one component of the federal standards for short-term, limited-duration insurance in this final rule is inclusion of the notice specified in this final rule, to inform applicants and enrollees that short-term, limited-duration insurance is not individual health insurance coverage and therefore is not required to meet the federal market requirements that apply to individual health insurance coverage. Defining short-term, limited-duration insurance in such a way that requires a short, standard description of how the coverage might vary from individual health insurance coverage allows for a clear determination by regulators that the policy is intended to be short-term, limited-duration insurance, facilitates compliance by issuers, and promotes ease of understanding by consumers. We further clarify that to the extent a health insurance policy sold to an individual in the non-group market includes the notice, and satisfies the other federal standards for short-term, limited-duration insurance in this final rule, it constitutes short-term, limited-duration insurance and is not subject to

<sup>29</sup> See section 2792 of the PHS Act.

the federal individual market rules under the PHS Act. As described elsewhere in this final rule, states can adopt a definition with a shorter maximum initial contract term and/or a shorter maximum duration of a policy, and can require issuers to provide additional information as part of the consumer notice.

The proposed rule did not address whether any aspect (or standard) in the definition of short-term, limited-duration insurance should be considered independent of other provisions, and thus severable, if such part of the definition were to be determined invalid. Although there were no comments that directly addressed severability, from the comments received on the proposed rule, the Departments recognize there is a possibility that some stakeholders may challenge the 36-month maximum duration standard in court. The Departments expect to prevail in any such challenge, as this final rule and each of the federal standards for short-term, limited-duration insurance finalized herein are legally sound. If a court should conclude that the 36-month maximum duration standard for short-term, limited-duration insurance in this final rule is invalid, the Departments wish to emphasize our intent that the remaining standards of the final rule will take effect and be given the maximum effect as permitted by law. Thus, we have added a severability clause as a new paragraph (4) to the final rule, which addresses two situations—one where the 36-month provision is invalidated “as applied,” and the other where it is invalidated “facially.” The severability provision reads as follows: “If a court holds the 36-month maximum duration provision set forth in paragraph (1) of this definition or its applicability to any person or circumstances invalid, the remaining provisions and their applicability to other people or circumstances shall continue in effect.”

#### General Comments on the Proposed Rule

Many commenters generally agreed that short-term, limited-duration insurance plays an important role in providing temporary health coverage to individuals who would otherwise go uninsured. Most commenters also stated that such plans are not meant to take the place of comprehensive health insurance coverage, and allowing them to be marketed as a viable alternative to comprehensive coverage would subject uninformed consumers to potentially severe financial risks, and would siphon off healthier individuals from the

market for individual health insurance coverage, thereby raising premiums for such coverage. Commenters who supported the proposed rule stated that it would allow purchasers of short-term, limited-duration insurance to obtain the coverage they want (excluding services they do not want) at a more affordable price for a longer period of time. These commenters explained that currently, enrollees have to reapply for short-term, limited-duration insurance every 3 months, have their deductibles reset every 3 months, and might lose coverage for conditions that develop during the initial 3 months. They also noted that many individuals may be unable to obtain more comprehensive coverage at the end of the 3-month coverage period because they may not qualify for a special enrollment period for individual health insurance coverage and might have a long time to wait for the next individual market open enrollment period.

The Departments agree that short-term, limited-duration insurance plays an important role in providing temporary valuable health coverage to individuals who would otherwise go uninsured. Short-term, limited-duration insurance can also provide a more affordable, and potentially desirable, coverage option for some consumers, such as those who cannot afford unsubsidized coverage in the individual market. This final rule balances the important role that short-term, limited-duration insurance plays in the market, while at the same time distinguishing it from individual health insurance coverage and requiring issuers of short-term, limited-duration insurance to inform consumers of how coverage under the policy might differ from coverage under individual health insurance coverage. The rule does this by setting the maximum length of the initial contract term to less than 12 months, establishing the total maximum duration for a policy (including coverage during the initial contract term and renewals or extensions under the same insurance contract) of no longer than 36 months, and providing for a notice to inform consumers of how coverage under the policy might differ from coverage under individual health insurance coverage. Thus, under this final rule, issuers may offer coverage under a short-term, limited-duration insurance policy for up to a total of 36 months, without any medical underwriting or experience rating beyond that completed upon the initial sale of the policy (as long as the applicable notice is provided to

consumers and the initial contract term is less than 12 months).

The Departments acknowledge that making short-term, limited-duration insurance more available, and for longer initial contract terms and periods of duration than is currently permitted, could have an impact on the risk pools for individual health insurance coverage, and could therefore raise premiums for individual health insurance coverage (see the discussion in the Regulatory Impact Analysis section). However, as discussed more fully below, we believe the critical need for coverage options that are more affordable than individual health insurance coverage, combined with the general need for more coverage options and choice, substantially outweigh the estimated impact on individual health insurance premiums.

#### Initial Contract Term for Short-Term, Limited-Duration Insurance

The proposed rule would have set a maximum length of short-term, limited-duration coverage, including any extensions that may be elected by the policyholder without the issuer's consent, of less than 12 months. Given that the proposed rule did not include a proposal to permit renewal periods in addition to or longer than the less-than-12-month period, we are addressing all comments related to the “less-than-12-month” aspect of the proposed rule as comments on the initial contract term. The Departments discuss and respond to comments related to renewals and extensions beyond the initial contract term, including comments on the permissible maximum duration for a policy (including renewals and extensions of the same insurance contract), later in this preamble. With respect to the maximum length of the initial contract term for short-term, limited-duration insurance, most comments suggested not extending the maximum duration beyond the current less-than-3-month maximum. Others suggested periods such as less than 6 or 8 months. Most commenters who supported extending the maximum initial contract term suggested it should be 364 days. A few commenters suggested more than 1 year. Other commenters stated that any short-term, limited-duration policy should end by December 31 of the calendar year in which the policy period commences, while others stated that the maximum duration should be 1 year or until December 31 of the calendar year in which the policy period commences, whichever occurs later. Other commenters stated that the maximum

length of the coverage should be left to the states.

As explained in the proposed rule, we proposed to return to the less-than-12-month standard in order to expand more affordable coverage options to consumers who desire and need them, to help individuals avoid paying for benefits provided in individual health insurance coverage that they believe are not worth the cost, to reduce the number of uninsured individuals, and to make available more coverage options with broader access to providers than certain individual health insurance coverage has. The Departments disagree with the commenters who supported a shorter maximum initial contract term. To the extent the initial contract term would be limited to a shorter duration, for example, 3 months, this would mean that every 3 months, absent renewability of the policy, an individual purchasing short-term, limited-duration insurance would be subject to re-underwriting if they did not have a renewal guarantee, and would possibly have his or her premium greatly increased as a result. The issuer could also decline to issue a new policy to the consumer based on preexisting medical conditions. Also, to the extent that the policy has a deductible, the individual would not get credit for money spent toward the deductible during the previous 3 months. In addition, to the extent that the policy excluded preexisting conditions for a specified period of time or imposed a waiting period on specific benefits, the individual might not get credit for the amount of the time he or she had the previous coverage, and thus the waiting period on preexisting conditions or on specific benefits would start over, leaving the consumer without coverage for the condition(s) or benefit(s) until the new waiting period expires. Although these circumstances would be somewhat mitigated if the maximum initial contract term was somewhat longer than less than 3 months, for example, less than 9 months, the Departments believe that mitigating these circumstances even further, by establishing a federal maximum initial contract term of less than 12 months, is preferable. The Departments find all of these to be compelling reasons in favor of permitting a maximum initial contract term of less than 12 months, rather than a shorter maximum initial contract term.

With respect to the comment that any short-term, limited-duration policy should end by December 31 of the calendar year in which the policy period commences, this could result in many such policies having an initial contract term of far less than 12 months,

which for the reasons stated above, the Departments believe is not desirable. With respect to the comment that the maximum duration should be 1 year or until December 31 of the calendar year in which the policy period commences, the Departments do not believe that a policy with an initial contract term of 1 full year would satisfy the “short-term” component of short-term, limited-duration insurance, as it would have the same initial contract term as individual health insurance coverage.

The Departments agree that states remain free to adopt a definition with a shorter maximum initial contract term. The maximum initial contract term of less than 12 months established in this final rule provides a uniform federal standard for the initial contract term for short-term, limited-duration insurance. As explained in the proposed rule and elsewhere in this final rule, this standard was selected in order to promote access to health coverage choices in addition to individual health insurance coverage, which, as stated above, may or may not be the most appropriate or affordable policies for some individuals. Therefore, this rule sets a federal standard for the maximum initial contract term for short-term, limited-duration insurance. This federal standard defines the “short-term” component of short-term, limited-duration insurance as less than 12 months. The federal maximum duration for a policy (including renewals and extensions of the same insurance contract), discussed further below, implements the “limited-duration” component of short-term, limited-duration insurance.

Many commenters that opposed the extension of the maximum initial contract term for short-term, limited-duration insurance generally expressed concerns about the lack of protections for consumers who purchase short-term, limited-duration insurance. Some of these commenters stated that such insurance is not a viable option for people with serious or chronic medical conditions because of potential policy exclusions. Commenters also stated that short-term, limited-duration policies discriminate against those with serious illnesses and other preexisting conditions including mental health and substance abuse disorders, older consumers, women, transgender patients, persons with gender-identity-related health concerns, and victims of rape and domestic violence.

The commenters did not provide persuasive evidence for concluding that short-term, limited-duration policies discriminate against individuals. The Departments acknowledge that short-

term, limited-duration insurance may not be suitable coverage for all individuals in all circumstances and that in some instances it may not provide coverage that is as comprehensive as individual health insurance coverage. However, short-term, limited-duration insurance can be a viable health insurance option for many people in many circumstances. Also, no individual is required to enroll in short-term, limited-duration insurance; rather, it is simply an additional, and likely more affordable, option that may be available to them. Individual health insurance coverage is unaffordable for many consumers, particularly those who do not qualify for PTCs. Of uninsured consumers visiting the *HealthCare.gov* website in the past year, 63 percent of those who did not purchase a plan cited high premiums as the primary reason not to purchase.<sup>30</sup> Furthermore, the availability of short-term, limited-duration insurance provides an additional choice for many consumers that exists side-by-side with individual market coverage, with the end result that individuals are provided with more choices and have the opportunity to purchase the type of coverage that is most desirable and suitable for the individual and/or her family. Additionally, many individuals who have health conditions for which they desire coverage that might be more comprehensive than what is available through short-term, limited-duration insurance, can access individual health insurance coverage on a guaranteed available and guaranteed renewable basis and, if enrollment is pursued through an Exchange and the individual is otherwise eligible, may qualify for the PTC to offset the cost of such coverage and, in some cases, cost-sharing reductions. PTCs and cost-sharing reductions generally are not available to purchasers of short-term, limited-duration insurance. However, states may be able to provide subsidies to purchasers of short-term, limited-duration insurance with funds provided under waivers authorized by section 1332 of PPACA<sup>31</sup> should they choose to do so and should the waiver satisfy all applicable requirements.

Also, states have flexibility to establish a different, shorter maximum initial contract term consistent with state law. In addition, these final rules require the prominent display of a notice in the contract and any application materials provided in connection with enrollment in short-term, limited-duration insurance to alert

<sup>30</sup> CMS Exchanges Trend Report, July 2, 2018.

<sup>31</sup> 42 U.S.C. 18052.



consumers about how coverage under the policy might vary from coverage under individual health insurance coverage. See the discussion below for an explanation of the changes the Departments are making to the required notice in this final rule in response to commenters' concerns about consumers' potential misunderstanding of some of those variations. These changes include a clarification that states have the flexibility to require additional consumer disclosures.

Many commenters who opposed the extension of the maximum initial contract term for short-term, limited-duration insurance expressed concern about what they viewed as a history of aggressive and deceptive marketing practices by individuals who market short-term, limited-duration insurance. One commenter stated that over the past 2 years, state regulators have seen an increase in complaints about such insurance, with consumers saying they were unaware their plan did not provide comprehensive coverage or that they could be refused a new policy at the end of the contract term. Many commenters provided examples of specific issues states were dealing with, such as issues with claims handling. In a 10-state survey conducted by the Commonwealth Fund<sup>32</sup> cited to by some commenters, state regulators noted an increase in complaints about brokers using deceptive practices to enroll people in short-term, limited-duration insurance over the phone. Some commenters also mentioned the low levels of health literacy, particularly among younger adults, and how this could exacerbate deceptive marketing practices by short-term, limited-duration insurance issuers and brokers. Several commenters stated that they did not want state laws prohibiting the sale of short-term, limited-duration insurance preempted.

This final rule establishes federal standards for short-term, limited-duration insurance only with respect to the maximum length of the initial contract term, the maximum duration of a policy (including renewals and extensions under the same insurance contract), and a consumer notice. States are free to regulate such coverage in every other respect. This contrasts with the federal regulation of individual health insurance coverage under the PHS Act, which touches many aspects

of individual health insurance coverage, and therefore limits the degree to and areas in which states may regulate such coverage. This is yet another way in which the federal regulation of short-term, limited-duration insurance in this rule is different from individual health insurance coverage. In fact, several commenters (both in favor of, and opposed to, the proposed rule) said that states should retain the authority to regulate short-term, limited-duration insurance, and that such authority should not be preempted by the PHS Act. Several commenters requested the Departments to coordinate with the states on the regulation of short-term, limited-duration insurance. The Departments have considered those comments, and we acknowledge and respect states' authority to regulate the business of insurance. The Departments generally agree that states retain the authority to regulate short-term, limited-duration insurance and further note that this final rule does not change or otherwise modify the existing PHS Act preemption standard.<sup>33</sup> As such, states may shorten the length of the maximum initial contract term, the 36-month total maximum duration (including renewals or extensions) discussed further below, or both, although they may not lengthen them. Relatedly, as discussed later in this preamble, in this final rule, the Departments added language to the notice to alert consumers to how the coverage they are purchasing might vary from individual health insurance coverage and also added a clarification to the regulation text that states may also impose additional requirements with respect to the language in the consumer notice. States remain free to regulate short-term, limited-duration insurance. We also clarify that this final rule does not preempt any state laws prohibiting the sale of short-term, limited-duration insurance.

#### Renewability of Short-Term, Limited-Duration Insurance Coverage

The proposed rule provided that in determining whether an insurance contract had a duration of less than 12 months, extensions that may be elected by the policyholder without the issuer's consent were taken into account. The Departments solicited comments on the conditions under which issuers should be able to allow short-term, limited-duration insurance to continue 12 months or longer with the issuer's consent. The Departments also solicited comments on whether any processes for

expedited or streamlined reapplication for short-term, limited-duration insurance that would simplify the reapplication process and minimize the burden on consumers may be appropriate; whether federal standards are appropriate for such processes; and whether any clarifications are needed regarding the application of the proposed definition of short-term, limited-duration insurance to such practices. For example, the proposed rule preamble noted that an expedited process could involve setting minimum federal standards for what must be considered as part of the streamlined reapplication process while allowing issuers to consider additional factors in accordance with contract terms. The Departments were also interested in information on any state approaches (including any approaches that states are considering adopting) to minimize the burden of the reapplication process for issuers and consumers.

Several commenters questioned the Departments' authority to permit the duration of short-term, limited-duration insurance to extend to 12 months or longer through renewal or extension of such policies. One commenter stated that "limited-duration" means these policies cannot be made guaranteed renewable. Several commenters stated that establishing a guaranteed renewability requirement for short-term, limited-duration insurance would be contrary to the plain language of the statute since short-term, limited-duration insurance is excluded from the statutory definition of individual health insurance coverage. One commenter stated that short-term, limited-duration insurance issuers should be permitted to sell a policy with a duration of less than 12 months, with a separate guaranteed renewability rider, allowing the customer to buy a new policy without underwriting. The commenter stated that the Departments have no statutory authority to prohibit or otherwise regulate such arrangements, and that the Departments have no authority to require guaranteed renewability, or prohibit it. One commenter suggested that issuers be allowed to sell multiple consecutive policies at the initial point of sale and be allowed to sell renewal options with and without preexisting conditions exclusions. One commenter stated that the term "short-term, limited-duration insurance" provides authority to define the length of time within which such insurance contracts must expire, but does not provide authority to limit how many contracts consumers enter into, or to regulate renewal guarantees. The commenter

<sup>32</sup> Dania Palanker, Kevin Lucia, Sabrina Corlette, Maanasa Kona, "Proposed Federal Changes to 'Short-Term Health Coverage Leave Regulation to States'", Commonwealth Fund, February 20, 2018. Available at <https://www.commonwealthfund.org/blog/2018/proposed-federal-changes-short-term-health-coverage-leave-regulation-state>.

<sup>33</sup> See section 2724 (formerly section 2723) of the PHS Act and 45 CFR 146.143 and 148.210. See also 62 FR 16894 at 16904 and 69 FR 78719 at 78739.



asserted that renewal guarantees are not “health insurance coverage,” explaining that such guarantees protect against premiums increasing, but do not provide benefits consisting of items and services paid for as medical care and therefore, the Departments cannot regulate these contracts. Since renewal guarantees are not “health insurance coverage,” the commenter asserted, it is reasonable to interpret the statute as not counting renewal guarantees against the time limit the Departments set for the contract for medical benefits. Another commenter stated that, should the final rule allow renewals, then changing the interpretation of this from the current rule, without support, would violate federal law.

Other commenters commented on the renewal of short-term, limited-duration insurance coverage from a policy perspective. Most such commenters who supported the proposed rule stated that short-term, limited-duration insurance should be permitted to be renewable, while those who opposed the proposed rule and some who agreed with lengthening the maximum period were opposed to permitting such policies to be renewable. One commenter stated that a federal mandate for automatic renewability would limit the rights of states and the ability of state regulators to determine the design, length, and sales practices of short-term, limited-duration insurance plans in a manner that best protects their consumers and markets. A few commenters addressed the extent to which, and the circumstances under which, individuals should be permitted to reapply for coverage under an expedited application process. Some of these commenters opposed such an expedited process, while others favored permitting it. One commenter suggested that short-term, limited-duration insurance issuers could design a less-than-12-month plan with an option to re-write at point of sale. This product would have a different set of underwriting questions at point of sale for the option. Upon expiration of the initial contract term, the issuer could elect to waive preexisting conditions and underwriting for the new less-than-12-month period. One commenter stated that federal standards should regulate short-term, limited-duration insurance policies, including standards for reapplication, while one commenter asserted that states should maintain authority to regulate the application and reapplication process. Another commenter that supported the proposed rule suggested further expanding the proposed federal standards to permit

guaranteed renewals for short-term, limited-duration insurance.

Although some commenters questioned whether the Departments have authority to impose a guaranteed renewability requirement on short-term, limited-duration insurance, this final rule does not impose such a requirement. Rather, it permits, but does not require, issuers to renew or extend a short-term, limited-duration policy up to a maximum total duration of 36 months and still have such coverage considered short-term, limited-duration insurance. This rule does so by establishing a maximum duration of a short-term, limited-duration insurance policy (inclusive of the initial contract term and renewals or extensions under the same insurance contract) of no longer than 36 months.

Under this final rule, the total number of consecutive days of coverage under a single (that is, the same) insurance contract is the relevant metric to calculate the duration of the coverage to determine if it satisfies the 36-month maximum duration standard. In contrast, the total number of consecutive days of coverage under two or more (that is, separate) insurance contracts, even if one picks up where the last ended, is irrelevant to the 36-month maximum duration standard. The number of days of coverage in separate contracts is considered separately and the relevant question is whether each individual contract satisfies the 36-month maximum duration standard. Nothing in this final rule precludes the purchase of separate insurance contracts that run consecutively, so long as each individual contract is separate and can last no longer than 36 months.

With respect to the comment that, should the final rule allow renewals, then changing the interpretation of this from the current rule, without support, would violate federal law, the Departments note that the current rule (the October 2016 final rule) also allows renewals.<sup>34</sup> Accordingly, with regard to permitting renewals, there is no change of interpretation. The only difference between the two rules with respect to renewals is that the current rule allows renewals to the extent the total duration of coverage, including the initial contract term and any extensions or

renewals, is less than 3 months, whereas this final rule allows renewals to the extent the maximum duration of a policy, including the initial contract term and renewals or extensions, is up to 36 months.

The Departments have determined that the 36-month limit on coverage, including the initial contract term, plus renewals or extensions (without limiting consecutive periods of *separate* coverage, as explained above) satisfies the “limited-duration” component of the statutory term “short-term, limited-duration insurance” (while the less-than-12-months limit on the initial contract term, discussed above, satisfies the “short-term” component of the term). The Departments note that Congress did not change the existing reference to short-term, limited-duration insurance as an exclusion from the PHS Act definition of “individual health insurance coverage” or otherwise address short-term, limited-duration insurance in PPACA, which indicates Congress was not concerned with short-term, limited-duration insurance existing side-by-side, at least under the standard in place prior to the October 2016 rule, with individual health insurance coverage. The Departments believe that a maximum duration of 36 months for short-term, limited-duration insurance is consistent with these two insurance markets existing side-by-side, while still giving meaning and effect to the “limited-duration” component of short-term, limited-duration insurance.

Likewise, the Departments’ interpretation is consistent with the canon of statutory construction that disfavors rendering one or more statutory words or phrases redundant. Here, Congress used two terms: “short-term” and “limited-duration.” The Departments have concluded that these two terms are best interpreted to refer to periods of time of differing length; if they both referred to a time period of the same length (for example, if the Departments interpreted both words to refer to a time period of less than twelve months), then one of the terms would be rendered redundant, or nearly so. The Departments likewise conclude that the term “limited-duration” refers to a longer time period than “short-term,” because, while an insurance policy’s duration is (absent cancellation) never shorter than its term, a policy’s term can be shorter than its duration (if the policy is renewed or extended). Thus, the Departments conclude that the term “limited-duration” refers to a period of time that is longer than the time period contemplated by the term “short-term,” and contemplates renewal of a short-term policy for a time period potentially

<sup>34</sup> The 1997 HIPAA rule similarly addressed extensions for short-term, limited-duration insurance (that is, short-term, limited-duration 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 elected by the policyholder without the issuer’s consent) that is less than 12 months after the original effective date of the contract). 62 FR 16894 (April 8, 1997).

longer than the maximum term length for which a short-term policy can be acquired (under this final rule, less than 12 months).

In determining the appropriate limits on the permissible range of renewals or extensions in giving meaning to the term “limited-duration,” the Departments were informed by the stakeholder comments and other circumstances under which Congress authorized temporary limited coverage options. In particular, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires certain group health plans to extend group health coverage to certain individuals otherwise losing that coverage.<sup>35</sup> COBRA requires certain group health plan sponsors to provide a temporary continuation coverage option for a minimum of 18, 29, or 36 months, depending on the nature of the qualifying event that triggers the temporary coverage period. Under COBRA, the maximum period that COBRA coverage could extend is for a period of 36 months (where the qualifying event is employee enrollment in Medicare, divorce or legal separation, death of an employee, or loss of dependent child status (that is, “aging out” under the plan)). In certain circumstances, individuals experiencing a qualifying event such as job loss, which triggers an initial 18-month COBRA continuation coverage period, may experience a second qualifying event, making them eligible for a total maximum duration of 36 months of COBRA continuation coverage.

Similar to COBRA, short-term, limited-duration insurance also serves as temporary coverage for individuals transitioning between other types of coverage, and accordingly the Departments believe that it is reasonable to look to COBRA in giving meaning to “limited-duration,” as both types of coverage serve an analogous purpose—that is, to provide temporary health coverage for individuals who are not currently eligible for or enrolled in comprehensive medical coverage, and are transitioning between types of coverage. Unlike COBRA, where Congress explicitly authorized a sliding scale of maximum duration periods, the Departments decline to adopt a sliding scale approach to the maximum duration period for short-term, limited-duration coverage. We adopt the approach outlined in this final rule for simplicity in the absence of explicit, staggered statutory maximums and because no party is required to renew or

extend coverage for the maximum duration with respect to a short-term, limited-duration insurance policy; instead whether to provide coverage for the maximum period is left to the states and/or contracting parties. Accordingly, in establishing federal standards for short-term, limited-duration insurance, the Departments interpret the term “limited-duration” in a manner consistent with the temporary continuation coverage maximums available through COBRA and the somewhat similar statutory temporary continuation of coverage provisions under the Federal Employees Health Benefits Program,<sup>36</sup> which permit continuation of coverage for up to a maximum duration of 36 months.

Individuals may choose to purchase short-term, limited-duration insurance for a variety of different reasons, which may align with various COBRA qualifying events or not. Further, whereas COBRA describes the *minimum* period that certain group health plan sponsors *must* offer COBRA continuation coverage, these regulations describe the *maximum* coverage period during which insurers *may* renew a short-term, limited-duration insurance policy. However, the Departments conclude that the 36-month maximum coverage period is a reasonable and appropriate benchmark for interpreting the term “limited-duration.” By allowing COBRA coverage to last up to 36 months in some circumstances, Congress recognized that 36 months qualifies as a temporary period of transition, during which coverage of limited duration may be useful. The Departments have strong policy considerations, as described elsewhere herein, for adopting an interpretation of the term “limited-duration” that provides a flexible period of insurance for individuals transitioning between other types of coverage, and COBRA’s 36-month maximum provides precedent for a 36-month coverage period that is designed to be of limited duration. Therefore, in looking to COBRA as a guidepost for determining the maximum duration of short-term, limited-duration insurance (that is, the length of coverage under the initial contract term, plus renewals or extensions), the Departments believe the 36-month COBRA period, rather than the 18-month COBRA period, is more appropriate.

The Departments also believe permitting renewal or extension of a short-term, limited-duration insurance policy, but only to the extent the maximum duration of coverage under a

policy is no longer than 36 months, serves to further distinguish such short-term, limited-duration insurance from individual health insurance coverage, which must be guaranteed renewable indefinitely, except under certain limited circumstances.<sup>37</sup> As noted earlier in this rule, states have flexibility to establish a different, shorter maximum duration for a short-term, limited-duration policy (including renewals or extensions) consistent with state law.

While the Departments did not specifically propose the 36-month maximum duration period for short-term, limited-duration insurance coverage in the proposed rule, comments were solicited on all aspects of the proposed rule, including whether the length of short-term, limited-duration insurance should be a different duration than less than 12 months, and the circumstances, if any, under which issuers should be allowed to continue (that is, renew) such coverage for 12 months or longer.<sup>38</sup> Comments were also solicited on a potential reapplication process for short-term, limited-duration insurance, including whether there should be federal standards for such a process. In response, the Departments received a wide range of comments indicating that short-term, limited-duration insurance coverage should be required to be guaranteed renewable, should be permitted to be renewed or extended for a designated period of time, and also that it should not be allowed to be renewed or extended beyond the initial contract term. We also received a number of suggestions regarding the adoption of federal standards governing any reapplication processes. After consideration of all the comments related to the issue of renewability or extensions, and for the reasons stated above, this final rule permits a short-term, limited-duration insurance policy to be renewed or extended so that the total duration of coverage under the policy may be up to 36 months.

Renewal guarantees generally permit a policyholder, when purchasing his or her initial insurance contract, to pay an additional amount, in exchange for a guarantee that the policyholder can elect to purchase, for periods of time following expiration of the initial contract, another policy or policies at some future date, at a specific premium that would not reflect any additional underwriting. In 2009, shortly before enactment of PPACA, one of the

<sup>35</sup> 26 U.S.C. 4980B(f), 29 U.S.C. 1161–1168, 42 U.S.C. 300bb–1—300bb–8.

<sup>36</sup> 5 U.S.C. 8905(a).

<sup>37</sup> Section 2703 of the PHS Act; *see also* 42 U.S.C. 300gg–42.

<sup>38</sup> *See, for example,* 83 FR 7440.

nation's largest health insurance issuers received regulatory approval from 25 states to offer renewal guarantees as a standalone product, for an annual premium equal to 20 percent of the cost of a guaranteed renewable health insurance policy.<sup>39</sup> With respect to the comments on renewal guarantees, to the extent a contract for health insurance coverage is extended or renewed, whether due to a renewal guarantee or otherwise, the period of health insurance coverage that is covered by the renewal or extension of the policy is counted toward the 36 month maximum duration, as to not do so would ignore the meaning of the statutory phrase "limited-duration." However, to the extent a contract does not provide health insurance coverage<sup>40</sup> and instead consists of a separate transaction or other instrument under which the individual can, in advance, lock in a premium rate in the future or the ability to purchase a new, separate short-term, limited-duration insurance policy at a specified premium rate at a future date without re-underwriting, such subsequent periods of coverage under the new, separate short-term, limited-duration insurance policies would not count toward the 36-month maximum. Through these mechanisms, it may be possible for a consumer to maintain coverage under short-term, limited-duration insurance policies for extended periods of time to protect themselves against financial vulnerabilities, such as developing a costly medical condition. The ability to purchase such instruments, which are essentially options to buy new policies in the future, is at present permitted under federal law, and this rule does nothing to forbid or permit such transactions. Furthermore, the Departments note that anyone, not just policyholders of short-term, limited-duration insurance, can purchase such instruments under current federal law (which this rule does not alter).

Similarly, the Departments also have not, and do not in this final rule, prohibit issuers from offering a new short-term, limited-duration insurance policy to consumers who have previously purchased this type of coverage, or otherwise prevent consumers from stringing together coverage under separate policies offered by the same or different issuers, for total coverage periods that would exceed 36

months.<sup>41</sup> The Departments are also significantly limited in their ability to take an enforcement action under the PHS Act market rules with respect to such transactions involving products or instruments that are not health insurance coverage.<sup>42</sup> As commenters mentioned, we also recognize that the mechanisms and means by which coverage may be extended or renewed may vary from state to state. Further, states can shorten the maximum duration for a short-term, limited-duration insurance policy, but cannot extend the maximum duration beyond the 36-month federal standard.

Therefore, as stated above, under this final rule, the total number of consecutive days of coverage under the *same* insurance contract is considered when calculating the duration of a policy for purposes of determining if the insurance satisfies the 36-month maximum duration federal standard. In contrast, the total number of consecutive days of coverage under *separate* insurance contracts is *not* considered when calculating the duration of coverage for such purpose. Rather, in such cases, the number of days of coverage under *each* contract of insurance is considered separately, to determine if the duration of the coverage under each contract satisfies the 36-month maximum duration standard, and coverage under each new contract commences a new period of coverage. The Departments generally defer to state law to determine the circumstances under which consecutive periods of coverage are under the same, or under separate, insurance contracts.

In addition to having authority to allow renewals or extensions for a maximum duration of up to 36 months, the Departments also determined there are sound policy reasons to provide the ability for renewals and extensions as set forth in the final rule. Many of these reasons are discussed above with respect to the less-than-12-month initial contract term maximum finalized in this rule. As many commenters pointed out, to the extent that the maximum duration of short-term, limited-duration insurance is limited to a relatively short period of time, for example, less than 3 months, or even less than 12 months, without permitting renewals or extensions, this would mean that every 3 months or every 12 months, an individual purchasing short-term, limited-duration insurance would be subject to re-underwriting, and would

possibly have his or her premium greatly increased as a result. Also, to the extent the policy excluded preexisting conditions for a specified period of time or imposed a waiting period on specific benefits, the individual might not get credit for the amount of time he or she had the previous coverage. The issuer could also decline to issue a new policy to the consumer based on preexisting medical conditions. The Departments find all of these to be compelling reasons in favor of permitting renewals and extensions as set forth in the final rule, such that the maximum duration of coverage under a single short-term, limited-duration insurance policy may be 36 months (including renewal or other extension periods), as opposed to less than 12 months. While the Departments anticipate that some issuers will choose to provide renewals without the restrictions described above (such as providing renewals without premium increases and without resetting preexisting condition exclusion waiting periods), we note that short-term, limited-duration insurance issuers are not required to do so under this final rule and may determine the terms of the renewal in the short-term, limited-duration insurance contract, subject to the definition of short-term, limited-duration insurance in this final regulation and any permissible state law variations. Further, in consideration of Congress' intent to exempt from the definition of individual health insurance coverage (and therefore, to exempt from the HIPAA and PPACA individual market requirements) short-term, limited-duration insurance, the Departments are not imposing a guaranteed renewability requirement on short-term, limited-duration insurance.

The Departments appreciate the comments and suggestions regarding simplified or expedited application and reapplication processes. The Departments decline to adopt or otherwise establish federal standards regarding such procedures at this time. Rather, the Departments defer to the states to define and regulate such practices.

#### Notice

In the proposed rule, the Departments proposed to revise the notice that must appear in the contract and any application materials provided in connection with enrollment in short-term, limited-duration insurance. The Departments noted concerns that short-term, limited-duration insurance policies that provide coverage lasting almost 12 months may be more difficult for some individuals to distinguish from coverage available in the individual

<sup>39</sup> Reed Abelson, "United Health to Insure the Right to Insurance," *New York Times*, December 2, 2008, <https://www.nytimes.com/2008/12/03/business/03insure.html>.

<sup>40</sup> See section 2792(b)(1) of the PHS Act.

<sup>41</sup> 81 FR 75318.

<sup>42</sup> However, the Departments may have the authority to regulate health insurance coverage issued pursuant to such an instrument.

market, which is typically offered on a 12-month basis. Accordingly, under the proposed rule, one of two versions of the following notice was proposed to 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.

Given that the individual shared responsibility payment is reduced to \$0 for months beginning after December 2018, the Departments proposed that the final two sentences of the notice must appear only with respect to policies sold on or after the proposed applicability date of the rule, if finalized, that have a coverage start date before January 1, 2019.

The Departments solicited comments 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.

Many commenters generally supported the approach in the proposed rule that a short-term, limited-duration insurance policy must include such a notice. One commenter stated that the notice should not be part of the definition of short-term, limited-duration insurance, but should be a separate requirement that applies once a policy satisfies the short-term, limited-duration insurance definition. One commenter stated that requiring short-term, limited-duration insurance issuers to use one of two different notices (depending on the year) is burdensome to issuers and state regulators with respect to filing policies, and suggested developing one notice that could be used for all years. A few other commenters also more generally supported the use of just one type of notice. One commenter stated that issuers should be permitted to modify

the notice to provide additional disclosures about their short-term, limited-duration insurance product, subject to state approval, while another commenter said that states should be permitted to prescribe their own notice language, with the federal language as a default for those states that fail to do so.

The Departments believe it is important and appropriate for issuers of short-term, limited-duration insurance to disclose the key potential characteristics of such insurance to applicants and policyholders. Consumers need as complete and accurate information as possible in order to make informed coverage purchasing decisions—whether it be for comprehensive, major medical coverage in the individual market or for short-term, limited-duration insurance, which can consist of a wide variety of coverage options. Therefore, the final rule retains the notice requirement, with some changes to content and style, as discussed below.

The Departments decline to adopt the suggestion that the notice should not be part of the definition of short-term, limited-duration insurance, but instead should be a separate requirement, once a policy satisfies the definition of short-term, limited-duration insurance. The Departments do not believe there is a compelling reason to so change the regulatory structure. The Departments also decline to adopt the suggestion that one disclosure notice be used, regardless of the year in which the policy is issued. As previously stated, the amount of the individual shared responsibility payment will be \$0 for months beginning January 2019. For short-term, limited-duration policies covering any months before January 2019, the Departments believe it is critical that the disclosure notice inform applicants and policyholders that they could be liable for the individual shared responsibility payment, given the potential financial consequences for not maintaining MEC during that time. However, for policies not covering any such month, not only would such language be irrelevant, but the Departments believe it could be confusing. The Departments further note that the language in the two notices is verbatim with the exception of the final two sentences (which must not appear in notices provided with short-term, limited-duration insurance policies with a coverage start date on or after January 1, 2019). Therefore, the Departments believe any burden associated with the two notices applying to different periods are outweighed by the benefits of mitigating the potential for consumer confusion that could result from

maintaining the last two sentences in the notice, when provided for policies with an effective date on or after January 1, 2019.

With respect to additional flexibility to add language to the notices, the Departments have clarified as part of the final regulations that states may require additional language to be included in the notices, as discussed elsewhere in this rule. In addition, there is no prohibition on issuers including additional language in their notices, as long as the additional language accurately describes the coverage.

Many commenters suggested specific changes to the content of the notices. Some commenters suggested expanding the notice to include details such as which benefits are not covered by the plan, whether preexisting conditions are covered, which PPACA protections will not be applicable, and more clearly state that loss of short-term, limited-duration insurance will not trigger a special enrollment period in the individual market. Several commenters stated that the notice should not only distinguish short-term, limited-duration insurance from available individual market plans, but should also distinguish the former from excepted benefits coverage. Some commenters suggested making the notice available in several languages. One commenter stated that the notice should illustrate how certain conditions would be covered. Several commenters stated that the notice should not be in capital letters. A few commenters stated that the notice should inform consumers that if they choose to purchase short-term, limited-duration insurance following expiration of the policy, they will be underwritten again, while another commenter stated that the notice should state that, even if the consumer passes re-underwriting, he may not be covered for medical conditions that the previous policy covered. A few commenters stated that the notice should indicate that purchasers of short-term, limited-duration insurance cannot qualify for PTCs (although some purchasers of qualified health plans sold on the Exchange can). One commenter stated that the notice should say that the policy "does not comply," as well as "is not required to comply," with PPACA requirements. One commenter stated that the notice should have a CAUTION heading, be in bullet form, be written in dark-color type, be literacy-tested to a 6th grade reading level, and have the MEC language listed first. One commenter stated that the notice should appear on the first page of the policy, rather than be displayed "prominently." One commenter stated that the

statement that short-term, limited-duration insurance may not comply with PPACA and may require additional payment with your taxes should be removed. One commenter noted that in addition to PPACA, short-term, limited-duration insurance is also exempt from other specific federal laws and that should be included in the notice as well. One other commenter recommended that the notice include a link to the applicable state-based Exchange website or *HealthCare.gov*.

The Departments agree with some of the commenters who suggested providing additional specificity in the notice. Therefore, the notice in the final rule has been revised to add language to make consumers aware of potential exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). The notice in the final rule also contains new language informing consumers that the policy might have lifetime and/or annual dollar limits on health benefits. The Departments did not incorporate the other additional language suggested by other commenters. The Departments believe the language added in this final rule provides important new information to consumers, without lengthening the notice to such an extent that would make it cumbersome to read, or cause consumers to not read it at all. The Departments are also cognizant of the burdens and costs on issuers that would be associated with a longer notice. However, states may require additional language in the notice, consistent with their authority to regulate short-term, limited-duration insurance. The Departments also agree with the commenters who suggested that the notice not be in all capital letters, as the Departments believe the notice will be more readable in sentence case.<sup>43</sup> Therefore, the notice in the final rule is in sentence case.

Given the varying demographics of different states, the Departments disagree with the comment that this final rule should require the notice to be available in several languages. Although the Departments believe it is important for the disclosure notice to be useful and informative to individuals who are most literate in a language other than English, the Departments decline in this rule to require that the notice be

provided in additional languages. States as primary regulators of short-term, limited-duration insurance can impose additional requirements as may be necessary to meet local needs. The Departments disagree with the comment that the notice have a CAUTION heading, should be in bullet form, should be written in dark-color type, be literacy-tested to a 6th grade reading level, and should have the MEC language listed first. The Departments believe the form of this notice should be in straight text, which is the same form of most documents that individuals are accustomed to reading. The Departments also believe that a CAUTION heading might inappropriately bias the reader against short-term, limited-duration insurance; the Departments instead believe the notice should assist the consumer in making an informed choice about the type of coverage that is most appropriate for him or her. The Departments disagree with the comment that the MEC language should appear first in the notice. Although that language is important, the Departments believe most consumers would find the language that appears before the MEC language in the final notice to be more significant when deciding whether short-term, limited-duration insurance is the most appropriate type of coverage for their personal needs.

In addition, the Departments believe the language in the notice in the proposed rule stating that “This coverage is not required to comply with federal requirements for health insurance” could be interpreted too broadly, as meaning that the issuer of such coverage is not required to comply with certain other federal requirements not related to health insurance market rules that apply generally to issuers as well as other entities. Therefore, the Departments revise that clause in the notice in this final rule to read: “This coverage is not required to comply with certain federal market requirements for health insurance.” In this final rule, the disclosure now reads as follows, with the first, second and third sentences differing from the proposal:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. 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.

Importantly, the Departments note that we do not have evidence that erm, limited-duration insurance has not historically covered or is unlikely to cover hospitalization and emergency services. These benefits are included in the notice, however, due to an abundance of caution. Several commenters stated that, in order to meet the definition of short-term, limited-duration insurance, the issuer should be required to provide information through other means in addition to the notice. One commenter stated that, in addition to the notice, to satisfy the definition of short-term, limited-duration insurance, issuers should be required to include a plain-language explanation of the general limits of such insurance in the application, and that the application should have a signature line indicating that the consumer received and understood it. Several commenters stated that the notice should require the purchaser to initial several discrete statements about the limitations of the policy at the time of application. Several commenters stated that the Summary of Benefits and Coverage (SBC) requirement, as set forth in section 2715 of the PHS Act, should apply to short-term, limited-duration insurance. One commenter stated that the term “short-term, limited-duration insurance” should display prominently in the footer on every page of the contract, and in any application, sales, and marketing materials, and the outline of coverage should include a “warning” that this is temporary coverage that provides limited benefits. Several commenters stated that the statement in the notice should also appear in marketing materials. One commenter stated that the notice should be read out loud to any prospective purchaser, particularly those with limited English proficiency. One commenter stated that, in addition to providing the notice, short-term, limited-duration issuers should be required to name their policies in such a way as to distinguish them from individual health insurance coverage, maybe by inserting the word “Limited” as part of the name of the policy. Several commenters stated that the notice should be accompanied by a list of network providers.

<sup>43</sup> See also, for example, Bryan A. Garner, *What’s Wrong With Initial-Caps Point Headings*, <https://bit.ly/2uNHtNL> (over use of capital letters may mean that “readers will probably skip over what you’re trying to make sink in.”)

The Departments believe that the requirements relating to both the content and delivery of the notice as set forth in this final rule strike the appropriate balance to help each consumer make an informed choice about the type of coverage that is most appropriate for him or her, while not being overly burdensome to issuers of short-term, limited-duration insurance or inappropriately biasing the reader against short-term, limited-duration insurance. The Departments therefore decline to adopt these suggestions by commenters. However, as previously noted, states may specify additional methods and forms of disclosure, as well as mandate additional disclosure requirements that issuers of short-term, limited-duration insurance must comply with, consistent with their authority to regulate such coverage. Because short-term, limited-duration insurance is not individual health insurance coverage under the PHS Act, it is not subject to the SBC requirements established under section 2715 of the PHS Act.

Finally, the Departments note that to the extent an issuer of short-term, limited-duration insurance provides a contract or application materials in connection with extension or renewal of a short-term, limited-duration policy, the notice must be displayed prominently in any such materials, just as it must be displayed prominently in the contract and in any materials provided in connection with enrollment in such coverage.

#### Short-Term, Limited-Duration Insurance as Student Health Insurance Coverage

Some commenters asked whether short-term, limited-duration insurance may be sold as “student health insurance coverage” within the meaning of HHS regulations. It may not.

“Student health insurance coverage” is defined in HHS regulations at 45 CFR 147.145(a), which provides that “student health insurance coverage” is a type of individual health insurance coverage. Thus, “student health insurance coverage” under the definition of “student health insurance coverage” must satisfy the PHS Act requirements for individual health insurance coverage, except for those specified in 45 CFR 147.145(b). Accordingly, short-term, limited-duration insurance cannot be “student health insurance coverage” because it is by definition not individual health insurance coverage. However, to the extent permitted by state law, an issuer may sell short-term, limited-duration insurance to individual students in institutions of higher education (or to individual students in boarding or other

pre-higher-education institutions). Some higher education institutions may require their students to either purchase “student health insurance coverage,” or a type of coverage other than short-term, limited-duration insurance.

#### Short-Term, Limited-Duration Insurance and Minimum Essential Coverage

A few commenters asked whether, under the final rule, short-term, limited-duration insurance would be considered MEC. One commenter suggested that the Departments provide a special enrollment period to purchase individual health insurance coverage for individuals who lose short-term, limited-duration insurance coverage outside of the individual market open enrollment period, similar to how individuals who lose MEC are currently provided a special enrollment period.

Short-term, limited-duration insurance is not individual health insurance coverage, nor is it MEC. This rule does not recognize short-term, limited-duration insurance as MEC. The Departments further note that the reduction of the individual shared responsibility payment to \$0 beginning with coverage months after December 31, 2018, mitigates the need to designate short-term, limited-duration insurance as MEC, given that individuals who do not have MEC during any such coverage months, including individuals who have short-term, limited-duration coverage, will not be subject to the individual shared responsibility payment. Additionally, this rule does not create a special enrollment period to enroll in individual health insurance coverage for individuals whose short-term, limited-duration insurance has ended. The disclosure notice puts purchasers of short-term, limited-duration insurance on notice that no such special enrollment period is available. The Departments acknowledge that the loss of eligibility for short-term, limited-duration insurance creates a special enrollment opportunity to enroll in a group health plan (as opposed to individual health insurance coverage), either insured or self-insured.<sup>44</sup>

#### Other Federal and State Requirements

Several commenters were in favor of imposing various additional federal requirements on short-term, limited-duration insurance that were not included in the proposed rule. These included requiring additional training for agents and brokers who sell such insurance, minimum federal standards

such as a minimum range of benefits to be offered equally in rural and urban areas, basing premiums on statewide markets, coverage of preexisting conditions and preventive services and network adequacy standards, federal regulation and oversight of short-term, limited-duration insurance policies sold through group trusts and associations, and requirements for websites marketing both short-term, limited-duration insurance and individual health insurance coverage.

For purposes of establishing federal standards for short-term, limited-duration insurance, the Departments believe that setting the initial contract term to less than 12 months, a maximum duration for a policy (including renewals or extension under the same insurance contract) of 36 months, and a notice requirement, as set forth in this final rule, are the only necessary federal standards for short-term, limited-duration insurance. In recognition of the states’ important, traditional role in regulating short-term, limited-duration insurance, the Departments decline to adopt any additional federal standards such as those suggested by the commenters. As discussed elsewhere in this final rule, states generally remain free to adopt these suggested standards, or other standards, as they see fit.

In response to the Departments’ solicitation of comments on any regulations or other guidance or policy that limits issuers’ flexibility in designing short-term, limited-duration insurance or poses barriers to entry into the short-term, limited-duration insurance market, a few commenters mentioned section 1557 of PPACA as such a limitation. One commenter observed that the lack of standardized regulation of short-term, limited-duration insurance across state lines causes barriers to entry, and suggested the Departments encourage state insurance departments to participate in an interstate compact to create standard regulations that result in one policy form filing and approval that is effective in many states.

Section 1557 of PPACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. This provision is administered by the HHS Office for Civil Rights, and it is beyond the scope of this rule to address the impact of section 1557 of PPACA on short-term, limited-duration insurance. With respect to the comment that state insurance departments should participate in an interstate compact to create standard regulations that result in

<sup>44</sup> See 26 CFR 54.9801–6, 29 CFR 2590.701–6, 45 CFR 146.117.

one policy form filing and approval that is effective in many states, the Departments did not propose and are not adopting such federal standards and generally defer to state insurance departments on that issue.

#### Effective Date and Applicability Date

The Departments proposed that this rule, if finalized, would be effective 60 days after publication of the final rule in the **Federal Register**. With respect to the applicability date, the Departments proposed that insurance policies sold on or after the 60th day following publication of the final rule, if finalized, would have to meet the definition of short-term, limited-duration insurance in the final rule in order to be considered such insurance. The Departments also proposed that group health plans and group health insurance issuers, to the extent they must distinguish between short-term, limited-duration insurance and individual health insurance coverage, must apply the definition of short-term, limited-duration insurance in the final rule as of the 60th day following publication of the final rule. The current regulations specify the applicability date for the definition of short-term, limited-duration insurance at 26 CFR 54.9833–1, 29 CFR 2590.736, 45 CFR 146.125, and 45 CFR 148.102. Therefore, the Departments proposed conforming amendments to those rules as part of this rulemaking.

The Departments also proposed a technical update in 26 CFR 54.9833–1, 29 CFR 2590.736, and 45 CFR 146.125 to delete the reference to the applicability date for amendments to 26 CFR 54.9831–1(c)(5)(i)(C), 29 CFR 2590.732(c)(5)(i)(C), and 45 CFR 146.145(c)(5)(i)(C) (regarding supplemental coverage excepted benefits).<sup>45</sup> Given that the applicability date for the amendments to those sections has passed, the Departments explained that it is no longer necessary to mention the “future” applicability date.<sup>46</sup> HHS similarly proposed to amend 45 CFR 148.102 to remove the reference to the applicability date for amendments to 45 CFR 148.220(b)(7) (regarding supplemental coverage excepted benefits).<sup>47</sup>

<sup>45</sup> As explained in the proposed rule, the reference in current regulations at 45 CFR 146.125 to the applicability date of 45 CFR 146.145(c)(5)(i)(C) was a drafting error. It was intended to be a reference to 45 CFR 146.145(b)(5)(i)(C).

<sup>46</sup> The applicability date for these amendments (policy years and plan years beginning on or after January 1, 2017) remains unchanged.

<sup>47</sup> The applicability date for these amendments (policy years beginning on or after January 1, 2017) remains unchanged.

Some commenters supported the proposed effective and applicability date, suggesting that the rule should be effective and applicable as soon as possible, while others stated that the rule should be applicable as of January 1, 2019. Others stated that it should be applicable January 1, 2020, to allow issuers time to plan and prepare new plan designs and regulatory filings and to allow states the chance to enact any legislation or promulgate regulations they felt necessary. One commenter asserted that if the rule were to become effective in 2018, it would disrupt the markets for 2018 and 2019 without providing a fair opportunity for health insurance issuers of individual market plans to adjust their rates to account for the potential impact on the individual market risk pool. This commenter also stated that a delayed effective date would allow states time to educate the public. Some states and the National Association of Insurance Commissioners (NAIC) expressed concerns about the timing of this rule, noting that some states may want to modify existing laws and regulations and asked the Departments to give such states time to review their rules and seek statutory or regulatory changes. These states asked for flexibility in overseeing short-term, limited-duration insurance plans according to market-specific needs, including the ability to postpone or otherwise delay the effective date to review existing state requirements to facilitate a smooth transition and educate the public about this coverage option. Another commenter asked for an effective date that would allow issuers to begin selling short-term, limited-duration insurance, as defined in this final rule, in 2019, stressing the collapse of its individual market. One commenter stated that, given that individual health insurance issuers have set their 2018 rates assuming that short-term, limited-duration insurance is limited to less than 3 months, a change in the rule at this point would violate serious reliance interests.

The Departments understand that an applicability date of 60 days following publication of this final rule might cause challenges for some states and issuers as they move to adopt, enforce, and comply with the final rule. However, as stated elsewhere in this final rule, the Departments believe there is a critical need to expand access to health coverage choices in addition to individual health insurance coverage, which, as stated above, may not be the most appropriate or affordable policies for many individuals. The Departments believe that a uniform federal standard

of less than 12 months for the initial contract term, with renewals or extensions permitted for a maximum duration of up to 36 months under a policy, and with the notice set forth in the final rule, is the appropriate federal standard for the reasons stated earlier, and must be applicable as soon as possible. Therefore, this final rule provides that the new definition of short-term, limited-duration insurance applies to insurance policies sold on or after October 2, 2018. This effective and applicability date, which is 60 days after the date this final rule was published in the **Federal Register**, is the effective and applicability date that was proposed in the proposed rule. The Departments realize that some states may wish to retain the less-than-3-month duration standard that was set forth in the October 2016 final rule, or some other standard that is narrower than the federal definition but for whom it might be difficult to enact legislation, or promulgate a regulation before the final rule goes into effect. Thus, the Departments reiterate that included in states’ ability and authority to define and regulate short-term, limited-duration insurance, is the ability and authority to define and regulate such coverage in such a way as to impose a shorter (but not longer) maximum initial contract term and a shorter (but not longer) maximum duration for a policy than those included in this final rule. In addition, issuers of short-term, limited-duration insurance must comply with the notice requirement in this final rule, with respect to policies sold on or after October 2, 2018, with states having flexibility to require additional disclosures.

Group health plans, to the extent they must distinguish between short-term, limited-duration insurance and individual health insurance coverage for purposes of the federal requirements under the PHS Act, may apply the definition of short-term, limited-duration insurance contained in the final rule, as of October 2, 2018. The Departments believe this approach might substantially reduce burden for group health plan sponsors, particularly sponsors of large group health plans that operate in multiple states, as the Departments believe it could be burdensome for sponsors of such plans to have to familiarize themselves with the definition of short-term, limited-duration insurance that applies in each state in which the group health plan operates. However, to the extent an insurance contract is subject to state law that requires short-term, limited-duration insurance to have a maximum



initial contract term and/or total duration of coverage that is shorter than the maximum periods under the definition of short-term, limited insurance in this final rule, and that requires the notice specified in that definition, a plan or a health insurance issuer may, or, if permitted or required by applicable state insurance law, must, as applicable, determine whether a given insurance contract is individual health insurance coverage or is short-term, limited-duration insurance by applying that state law to the coverage.

The Departments received no comments on the proposed conforming amendments and technical updates with respect to the applicability date, and are finalizing them in this final rule.

### III. Economic Impact and Paperwork Burden

#### A. Summary

This rule amends the definition of short-term, limited-duration insurance coverage so that the coverage has a maximum initial contract term of less than 12 months and a maximum duration (including the initial contract term and renewals and extensions of the same insurance contract) of no longer than 36 months. The final rule also requires a notice be included in the contract and any application materials provided in connection with enrollment in such coverage.

The Departments have examined the effects of this rule as required by Executive Order 13563 (76 FR 3821, January 18, 2011, Improving Regulation and Regulatory Review), Executive Order 12866 (58 FR 51735, September 30, 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (September 19, 1980, Pub. L. 96-354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104-4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2)) and Executive Order 13771 (January 30, 2017, Reducing

Regulation and Controlling Regulatory Costs).

#### B. Executive Orders 12866 and 13563

Executive Order 12866 (58 FR 51735) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 (76 FR 3821, January 21, 2011) is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) Having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or state, local or tribal governments or communities (also referred to as “economically significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis must be prepared for major rules with economically significant effects (for example, \$100 million or more in any 1 year), and a “significant” regulatory action is subject to review by the Office of Management and Budget (OMB). The Departments anticipate that this regulatory action is likely to have economic impacts of \$100 million or more in at least 1 year, and therefore meets the definition of a “significant

rule” under Executive Order 12866. Therefore, the Departments have provided an assessment of the potential costs, benefits, and transfers associated with this final rule. In accordance with the provisions of Executive Order 12866, this final rule was reviewed by OMB.

#### 1. Need for Regulatory Action

This rule contains amendments to the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage under the PHS Act. This regulatory action is taken in light of Executive Order 13813 directing the Departments to consider proposing regulations or revising guidance to expand the availability of short-term, limited-duration insurance, as well as continued feedback from stakeholders expressing concerns about the October 2016 final rule. While individuals who qualify for PTCs are largely insulated from significant premium increases, individuals who are not eligible for subsidies are harmed by increased premiums in the individual market and the lack of other, more affordable, alternative coverage options. This final rule aims to increase insurance options for individuals unable or unwilling to purchase available individual market plans and provide more flexibility to states to pursue innovative solutions to meet their market-specific needs.

#### 2. Summary of Impacts

In accordance with OMB Circular A-4, Table 1 depicts an accounting statement summarizing the Departments’ assessment of the benefits, costs, and transfers associated with this regulatory action. The Departments believe the need for coverage options that are more affordable than individual health insurance coverage is critical, combined with the general need for more coverage options and choice. Therefore, the Departments believe that the benefits associated with this rule outweigh the costs.

TABLE 1—ACCOUNTING TABLE

#### Benefits:

#### Qualitative:

- Increased access to affordable health insurance for consumers unable or unwilling to purchase available individual market plans, potentially decreasing the number of uninsured individuals and resulting in improved health outcomes for these individuals.
- Increased choice at lower cost and increased financial protection (for consumers who are currently uninsured or face extremely high premiums and deductibles for PPACA coverage) from catastrophic health care expenses for consumers purchasing short-term, limited-duration insurance.
- Potentially broader access to health care providers compared to available individual market plans for some consumers.
- Increased profits for issuers and brokers of short-term, limited-duration insurance.
- Economic efficiency gains from people buying unsubsidized coverage and minimizing overinsurance.

TABLE 1—ACCOUNTING TABLE—Continued

## Costs:

## Qualitative:

- Reduced access to some services and providers for some consumers who switch from available individual market plans and possibly reduced choice for individuals remaining in the individual market risk pools.
- Potential increase in out-of-pocket costs for some consumers, possibly leading to financial hardship.

## Transfers:

## Qualitative:

- Transfer from taxpayers (via the Federal government) to enrollees in individual market plans in the form of increased PTC payments.
- Potentially higher premiums for some consumers remaining in the individual market as healthier than average individuals choose short-term, limited-duration insurance to a greater degree.
- Tax liability for consumers who replace available individual market plans and will thus no longer maintain minimum essential coverage in 2018.
- Potential increase in uncompensated care by hospitals.

Short-term, limited-duration insurance represents a small fraction of the health insurance market. Based on data from the NAIC, in 2016, before the October 2016 final rule became effective, total premiums earned for policies designated short-term, limited-duration by carriers were approximately \$146 million for approximately 1,279,500 member months and with approximately 160,600 covered lives at the end of the year. During the same period, total premiums for individual market (comprehensive major medical) coverage were approximately \$63.25 billion for approximately 175,689,900 member months with approximately 13.6 million covered lives at the end of the year.<sup>48</sup> One commenter stated, however, that the actual enrollment in short-term, limited-duration insurance was close to 500,000 covered lives in December 2016, once association based sales were taken into account. Another commenter cited a report<sup>49</sup> stating that enrollment in such coverage may be closer to one million. Based on data from the NAIC, in 2017, total premiums earned for policies designated short-term, limited-duration by carriers were approximately \$151 million for approximately 1,053,082 member months and with approximately 122,483 covered lives at the end of the year.<sup>50</sup> While sales of short-term, limited-duration insurance declined after the October 2016 final rule was finalized, the sales of such coverage were

increasing prior to the issuance of that rule. In part because under the October 2016 rule short-term, limited-duration plans may be offered only for periods of less than three months, fixed administrative costs for issuers, including underwriting, are likely to be high relative to premiums. In addition, the transactions costs of obtaining plans are high for consumers, relative to benefits claimed. Allowing plans to be sold for a longer period of time is expected to reduce these costs, making short-term, limited-duration plans more attractive for issuers and consumers. Given this and the trend we observed prior to issuance of the October 2016 rule, the Departments expect more issuers to offer a greater variety of short-term, limited-duration plans, and more consumers to purchase such plans, as a result of this rule.<sup>51</sup>

## a. Benefits

This rule will benefit individuals who have been harmed by the increasing premiums, deductibles and cost-sharing associated with individual market plans and by limited choices. This rule empowers consumers to purchase the benefits they want and reduce overinsurance. Short-term, limited-duration insurance is likely to represent more efficient amounts of coverage since it lacks distortionary price controls and regulation that can greatly separate price from value and lead some people to overinsure and others to underinsure.

Lengthening the term of short-term, limited-duration plans will help reduce the fraction of the population that is uninsured by giving the uninsured a greater variety of plan choices. Similarly

this rule also offers additional choice to persons who would otherwise be limited to the products offered on their local Exchange. By reducing the per-month transactions and administrative costs on such plans, this rule confers an economic benefit to its members because the insurance market passes on some or all of the cost savings as premium savings. This rule also helps the economic burden of PPACA to be shared more equitably by shifting some of the premium costs to general revenue from individual-market customers who are induced to purchase short-term, limited-duration plans rather than Exchange plans.

Consumers who purchase short-term, limited-duration insurance for longer periods than currently permitted will benefit from increased insurance options at lower premiums, as the average monthly premium for an individual in the fourth quarter of 2016 for a short-term, limited-duration policy was approximately \$124 compared to \$393 for an unsubsidized individual market plan—a premium savings of 70 percent.<sup>52</sup> This disparity may be wider given that unsubsidized premiums significantly increased from 2016 to 2018. A recent study concluded that the least expensive short-term, limited-duration insurance policy often costs 20 percent or less of the premium for the lowest-cost individual market bronze plan in the area.<sup>53</sup> While there is a significant difference in the premiums for short-term, limited-duration

<sup>48</sup> National Association of Insurance Commissioners, “2016 Accident and Health Policy Experience Report”, July 2017. Available at [http://www.naic.org/prod\\_serv/AHP-LR-17.pdf](http://www.naic.org/prod_serv/AHP-LR-17.pdf).

<sup>49</sup> Reed Abelson, “Without Obamacare Mandate, ‘You Open the Floodgates’ for Skimpy Health Plans”, the New York Times, November 30, 2017. Available at <https://www.nytimes.com/2017/11/30/health/health-insurance-obamacare-mandate.html>.

<sup>50</sup> National Association of Insurance Commissioners, “2017 Accident and Health Policy Report”, July 2018. Available at [https://naic.org/prod\\_serv/AHP-LR-18.pdf](https://naic.org/prod_serv/AHP-LR-18.pdf).

<sup>51</sup> Other analysts also expect issuers to offer a greater variety of short-term limited-duration plans as a result of this rule. See Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028,” May 23, 2018. Available at <http://cbo.gov/publication/53826>.

<sup>52</sup> Michelle Andrews, “Sales Of Short-Term Insurance Plans Could Surge If Health Law Is Relaxed”, NPR, January 31, 2017. Available at <http://www.npr.org/sections/health-shots/2017/01/31/512518502/sales-of-short-term-insurance-plans-could-surge-if-health-law-is-relaxed>.

<sup>53</sup> Karen Pollitz, Michelle Long, Ashley Semanskee, and Rabah Kamal, “Understanding Short-Term Limited Duration Health Insurance”, Kaiser Family Foundation, April 23, 2018. Available at <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

insurance and unsubsidized individual market plans, individuals qualifying for PTCs may not find the difference in premiums as appealing, as the difference in their out-of-pocket premium costs is likely relatively small. A recent study estimated that in 2016 the consumer portion of the premium, after the tax credit, for a 40 year old non-smoker making \$30,000 per year ranged from \$163 to \$206 per month in most of the country.<sup>54</sup> However, the premium cost for a 40 year old non-smoker making \$30,000, before accounting for any tax credit, ranged from \$183 to \$719 per month depending on location.<sup>55</sup> This rule will provide an affordable alternative to individuals who do not qualify for PTCs and have been harmed by rising premiums in the individual market. This final rule will also benefit individuals who need coverage for longer periods, such as those who need more than 3 months to find new employment, or who find available individual market plans to be unaffordable. Individuals who purchase short-term, limited-duration insurance as opposed to being uninsured will potentially experience improved health outcomes and have greater financial protection from catastrophic health care expenses. Individuals purchasing short-term, limited-duration policies may obtain broader access to health care providers compared to what they would obtain through individual market plans that have narrow provider networks.<sup>56</sup>

Issuers of short-term, limited-duration insurance will benefit from higher enrollment. They are likely to experience an increase in premium revenues and profits because such policies can be priced in an actuarially fair manner (by which the Departments mean the policies are priced so that the premium paid by an individual reflects the risks associated with insuring the particular individual or individuals covered by that policy) and issuers have experience pricing in this manner. In addition, the fixed costs of issuing plans

will be reduced relative to premiums as issuers will not need to reissue plans every 3 months in order to cover consumers for a year or more.

In response to the Departments' request for comments on the benefits of having short-term, limited-duration insurance, many commenters stated that short-term, limited-duration insurance has served a critical role in providing temporary limited health coverage to individuals who would otherwise go uninsured. Some commenters also stated that the proposed changes would allow potential purchasers of short-term, limited-duration insurance, especially those who find individual market plans to be unaffordable, to obtain the coverage they want (and exclude services they do not want) at a more affordable price for a longer period of time. Other benefits commenters stated would flow from extending the maximum duration for short-term, limited-duration insurance include the facts that deductibles will not be reset every 3 months and that health conditions that develop during this coverage period will continue to be covered for a longer period of time. Commenters also stated that increasing the length of coverage would expand access to affordable coverage options for those who otherwise would lose coverage and could not pass underwriting and would not qualify for a special enrollment period because they would not be forced to go without coverage until the next open enrollment period. One commenter cited Bureau of Labor Statistics data that the average length of unemployment in the United States (U.S.) is 24.1 weeks, or about 5.5 months, as of March 2018; further stating that in 20.3 percent of cases the period of unemployment lasts 27 weeks or more, which means that 6 months is often not long enough to secure gainful employment.<sup>57</sup> Therefore, limiting the duration of short-term, limited-duration insurance policies to 3 months, or even 6 months, harms those Americans who find themselves unemployed for the average length of time or longer.

The Departments agree with the commenters that increasing the maximum duration of a short-term, limited-duration insurance policy will benefit consumers who have been most harmed by PPACA (for example, those who cannot afford or do not want individual health insurance coverage) or who want to purchase such coverage for

longer than 3 months; it also will provide states with additional flexibility to pursue innovative approaches to expand access to coverage options in addition to individual health insurance coverage. The final rule increases the maximum duration of the initial contract term, under the federal definition, to less than 12 months and permits such policies to be renewed or extended such that the maximum duration of a policy, including the initial contract term specified in the contract and renewals and extensions, is no longer than 36 months.

One commenter asserted that short-term, limited-duration insurance plans typically provide coverage for all major benefits such as: Doctor and specialist visits, preventive/wellness care, emergency care, x-rays, lab tests, transplants, intensive care, and hospitalization. In addition, the commenter noted, short-term, limited-duration insurance policies can include benefits for mental health disorders, substance abuse, physical therapy, speech therapy, home health care, ambulance, and other covered medical expenses. The commenter also claimed that these policies generally provide coverage for prescription drugs that are administered by a doctor in a setting covered by the policy and there is typically outpatient prescription coverage for drugs that require a written prescription and are necessary to treat a condition covered by the policy.

One commenter stated that a key feature of typical short-term, limited-duration insurance is that the plan benefits are paid for covered expenses incurred from any provider in the U.S. and there is no referral required if a member would like to see a specialist. According to the commenter, members have the added benefit of receiving discounted network rates if they choose to use an in-network provider.

The Departments agree that short-term, limited-duration insurance could be a desirable and affordable option for many consumers. The Departments are therefore finalizing a definition in this final rule to remove federal barriers that inhibit consumer access to additional, more affordable coverage options while, at the same time, distinguishing it from individual market health insurance coverage. States remain free to regulate these products as set forth elsewhere in this final rule.

Some commenters stated that the potential risks of high copayments and severely limited health coverage associated with short-term, limited-duration insurance significantly outweigh the cost savings from enrollment in such plans. A commenter

<sup>54</sup> Cynthia Cox, Selena Gonzales, Rabah Kamal, Gary Claxton and Larry Levitt, "Analysis of 2016 Premium Changes in the Affordable Care Act's Health Insurance Marketplaces", Kaiser Family Foundation, October 26, 2015. Available at <https://www.kff.org/health-reform/fact-sheet/analysis-of-2016-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/>.

<sup>55</sup> Id.

<sup>56</sup> Anna Wilde Mathews, "Sales of Short-Term Health Policies Surge: Some consumers opt for limited coverage, saying it is cheaper than conventional plans", Wall Street Journal, April 10, 2016. Available at <https://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539>. The ability of short-term, limited-duration plans to provide broad provider networks has been touted by some in the insurance community.

<sup>57</sup> The Departments note that the average duration of unemployment as reported by the Bureau of Labor Statistics is an arithmetic mean based on observed incomplete spells of unemployment. The actual average duration of completed spells of unemployment could be longer or shorter.

stated that the analysis in the proposed rule does not sufficiently explain how the benefits of expanding short-term, limited-duration insurance could possibly outweigh the disruption and consumer harm caused by the proposed changes.

Some commenters stated that some of the benefits are mischaracterized; for example, people with short-term, limited-duration insurance don't have broader access to health care providers, when many benefits and health conditions are entirely excluded from short-term, limited-duration plans. Commenters suggested that other purported benefits of the proposed rule (such as lower premiums for some healthier people) would be erased by its harmful impacts (higher premiums in the individual market as a whole).

One commenter stated that potential increases in access to health care and choice are "illusory". The commenter provided an example where an issuer of short-term, limited-duration insurance claims not to restrict enrollees to a network, but in reality pays claims up to a fixed percentage of Medicare reimbursement rates, leaving enrollees responsible for any amounts above that threshold. The commenter explained that this essentially is equivalent to being enrolled in a PPO plan with an empty network that leaves enrollees faced with high out-of-pocket expenses after receiving care.

With regard to the claim that short-term, limited-duration insurance can offer broader network coverage, a commenter expressed concerns that the Departments relied on promotional material provided by an issuer. Another commenter stated that the coverage may have a very limited network of providers and may not provide any coverage for out-of-network providers, while others stated that the exclusion of services effectively limits the actual networks by excluding providers, and this could particularly affect rural areas.

One commenter stated that while premiums for short-term, limited-duration insurance policies will likely be lower relative to individual market plans, using premiums as the sole measure of a benefit to consumers provides an incomplete analysis. This commenter noted that short-term, limited-duration insurance policies fail to provide comprehensive coverage and thus expose consumers who have a serious medical condition, such as cancer, to significant out-of-pocket costs. The commenter also suggested that the analysis fails to take into account that due to underwriting, premiums for short-term, limited-duration insurance policies can expose

even relatively healthy older individuals to significant premiums, and could also result in individuals with preexisting conditions being denied coverage or charged significantly higher premiums due to their health conditions.

A few commenters stated that short-term, limited-duration insurance plans should also not be compared with being uninsured, rather they should be compared to individual market plans. Many commenters stated that the Departments should look at the benefits to all consumers and not just young and healthy individuals.

This rule will benefit individuals who have been harmed by the increasing premiums, deductibles and cost sharing associated with individual market plans and limited choices—both in terms of coverage options and in terms of narrowing provider networks. The Departments' judgment is that individuals are in the best position to evaluate the tradeoffs between the benefits and costs of various coverage alternatives. This rule empowers consumers to make decisions on the benefits they want and reduce the potential for overinsurance and underinsurance while expanding access to more affordable coverage options. As acknowledged previously, short-term, limited-duration insurance may not be the most suitable coverage for everyone. Individuals who desire comprehensive coverage subject to PPACA rules will continue to have the option of purchasing individual market health insurance coverage on a guaranteed available and guaranteed renewal basis. Also, individuals who receive PTCs generally will not experience an increase in out-of-pocket costs for premiums if they continue to purchase Exchange coverage. However, this final rule provides another choice in addition to individual health insurance coverage for consumers to consider, based on their own personal circumstances and needs. In many cases, short-term, limited-duration insurance will provide a more desirable option for individuals, especially those who would otherwise be uninsured, those not eligible for PTCs, those who have lost their employment and are unable to afford individual market coverage, and those with objections to purchasing coverage of certain services or products that are mandated to be covered by PPACA. In that regard, the Departments believe it is appropriate to compare having short-term, limited-duration insurance to both being uninsured as well as having individual health insurance coverage. Uninsured individuals who purchase short-term, limited-duration insurance

will experience an increase in financial protection and may gain greater access to certain health care providers.

Moreover, individual market plan networks may also be quite restrictive, and short-term, limited-duration plan networks may very well cover a broader array of providers. For most individuals who switch to short-term, limited-duration insurance from individual market plans, lower premiums will provide the biggest benefit. Short-term, limited-duration insurance may also provide consumers with benefits that are more tailored to their individual or familial needs or circumstances.

Commenters have valid concerns about the potential for misleading information about provider networks, which can also be a concern with individual market plans,<sup>58</sup> and we generally defer to the states to address such concerns as part of their regulation and oversight of health insurance.

Many commenters stated that issuers and brokers will receive higher profits and commissions for these plans, as issuers have made moves to reduce broker commissions for individual market plans. One commenter mentioned that according to available data from the NAIC, in 2015 the industry-wide average MLR for "Short-Term Medical" was 69.76 percent, with smaller companies falling below 50 percent MLR for the vast majority of the total market share. The commenter stated that health insurance products with an MLR at or below 50 percent raise a red flag because when a majority of the company's revenue is not spent on medical services, consumer health becomes a secondary part of its business.

The Departments acknowledge that issuers and brokers of short-term, limited-duration insurance will benefit from the changes finalized in this rule to varying degrees depending on state regulations of short-term, limited-duration insurance. Short-term, limited-duration insurance is not subject to the federal MLR standards under section 2718 of the PHS Act and this final rule does not establish a federal MLR threshold for short-term, limited-duration insurance. There is also a large variation in the reported MLR for short-term, limited-duration insurance. Average MLR for short-term, limited-duration coverage was approximately 67 percent in 2016.<sup>59</sup> For the top 10 issuers

<sup>58</sup> Chad Terhune, "Top insurers overstated doctor networks, California regulators charge", Los Angeles Times, November 18, 2014. Available at <http://www.latimes.com/business/la-fi-obamacare-network-probe-20141119-story.html>.

<sup>59</sup> National Association of Insurance Commissioners, "2016 Accident and Health Policy

that accounted for almost 94 percent of the national short-term, limited-duration insurance market their MLRs ranged from 47.46 percent to 219.61 percent in 2016.<sup>60</sup> MLR may be of limited utility in evaluating the efficiency of insurance coverage and may result in higher medical costs and premiums, less innovation in plan design, less consumer choice, and increased market concentration.<sup>61</sup> As previously mentioned, the majority of short-term, limited-duration insurance policies were sold as transitional coverage in 2016, and the duration of such policies typically was less than 3 months. Increased administrative costs due to underwriting and the short duration may also explain the lower-end reported MLRs for short-term, limited-duration insurance policies in 2016. As the short-term, limited-duration insurance market grows, the Departments anticipate that in the long term more issuers will sell such coverage, increasing competition and limiting excessive profits.

#### b. Costs and Transfers

Short-term, limited-duration insurance policies are unlikely to include all the requirements applicable to individual market plans, such as 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. Therefore, consumers who switch to such policies from individual market plans will experience loss of third-party payments for some services and providers and potentially an increase in out-of-pocket expenditures related to such excluded services, as well as an exclusion of benefits that in many cases consumers do not believe are worth their cost (which could be one reason why many consumers, possibly even those receiving subsidies for Exchange plans, may switch to short-term, limited-duration policies rather than remain in individual market plans). Depending on state regulation, issuer plan design, and whether consumers decline to purchase a separate renewal guarantee product, consumers who purchase short-term, limited-duration insurance policies and then develop chronic conditions may face financial hardship as a result, until

they are able to enroll in individual market plans that will provide coverage for such conditions.

Since short-term, limited-duration insurance is not MEC, any individual enrolled in short-term, limited-duration coverage that lasts 3 months or longer in 2018 will potentially incur a tax liability for not having MEC during that year. Starting in 2019, the individual shared responsibility payment included in section 5000A of the Code is reduced to \$0, as provided under Public Law 115–97, and thus no tax liability could accrue in that year and thereafter for not having MEC. However, the tax liability is not the sole consequence of not having MEC. Because short-term, limited-duration insurance does not qualify as MEC, those individuals who lose coverage in these plans may not qualify for a special enrollment period in the individual market and may face a period of time in which they have no medical coverage, and this will continue to be the case even after 2018. Purchasing a renewal guarantee, however, may eliminate the need for a special enrollment period.

The Departments requested and received many comments on the potential costs of the proposed changes. Many commenters pointed out the possible negative impacts and costs associated with the proposed changes, especially the effect on consumers' out-of-pocket costs. Many commenters stated that consumers considering purchasing short-term, limited-duration insurance policies are unlikely to know the limitations of the policies and the non-applicability of the numerous PPACA consumer protections to these policies. Many commenters also stated that the comprehensiveness of items and services covered by short-term, limited-duration insurance coverage can be misleading; individuals who are expected to need expensive services because of preexisting conditions would likely either have services for those conditions excluded from coverage or be denied coverage altogether. Thus, consumer expectations for short-term, limited-duration insurance policies may be significantly different from the realities of these policies. Commenters are concerned that the differences between short-term, limited-duration insurance policies and plans offered in individual and group markets may not be clear to consumers. As a result they may be exposed to excessive out-of-pocket costs.

This final rule requires issuers to provide a notice in application materials and the contract to alert consumers to the potential limitations of short-term, limited-duration insurance. States also

have the flexibility to mandate the disclosure of additional information. This will help inform consumers about the limitations of short-term, limited-duration insurance and their choice of the coverage that best suit their needs. The notice language in the final rule provides more detail on the potential limitations of short-term, limited-duration insurance coverage than what was in the proposed rule to support informed coverage purchasing decisions by consumers, while those who are concerned about potential excessive out-of-pocket costs will continue to have the option to purchase individual market coverage that includes PPACA requirements.

Many commenters noted that short-term, limited-duration insurance often lacks consumer safeguards, generally excludes coverage for preexisting conditions, does not provide coverage for essential health benefits, often applies high deductibles and cost-sharing requirements, has lifetime and annual dollar caps on reimbursement for medical expenses, has no maximum limits on out-of-pocket costs, may be rescinded, and is generally available only for healthy consumers. As a result, consumers who purchase short-term, limited-duration insurance can experience significant financial hardship, especially if they require access to health care services not covered by their plan. These commenters noted that this is particularly problematic for people who have chronic or life-threatening conditions that require costly treatment, close monitoring and ongoing medication.

Commenters also stated that the potential risks of unreasonable copayments and severely limited health coverage associated with short-term, limited-duration insurance significantly outweigh the cost savings from enrollment in such plans. For example, according to one commenter, out-of-pocket costs for short-term, limited-duration insurance policies may be excessive in many markets: In Phoenix, AZ, the out-of-pocket cost-sharing limit for a 40-year-old male can be as high as \$30,000 for a 3-month period. While another commenter pointed out that in Georgia, a plan had a 3-month out-of-pocket limit of \$10,000, but did not include the deductible of \$10,000, resulting in an effective 3-month out-of-pocket maximum of \$20,000.

Some commenters are concerned about the lack of network adequacy requirements for short-term, limited-duration insurance. One commenter expressed concern that misleading claims related to provider networks

Experience Report", July 2017. Available at [http://www.naic.org/prod\\_serv/AHP-LR-17.pdf](http://www.naic.org/prod_serv/AHP-LR-17.pdf).

<sup>60</sup> Id.

<sup>61</sup> Scott E. Harrington, "Medical Loss Ratio Regulation under the Affordable Care Act", Inquiry, 2013. Available at <https://www.jstor.org/stable/23480894>.

could result in consumers purchasing plans later finding that the provider networks may be non-existent in their specific market, as short-term, limited-duration plans are not subject to the network adequacy protections, leading to higher out-of-pocket costs.

Many commenters stated that these policies could subject patients to catastrophic medical bills and medical bankruptcy. For example, short-term, limited-duration insurance enrollees suffering acute health emergencies, debilitating injuries that lead to permanent disabilities, or the onset of chronic conditions could end up facing financial hardship until they can enroll in an individual (or group) market plan that provides the coverage they need. Many commenters shared their past experience with short-term, limited-duration insurance (as well as pre-PPACA individual market coverage) and provided numerous examples of how annual and lifetime dollar limits resulted in consumers being left responsible for large medical bills and high out-of-pocket costs and concluded that short-term, limited-duration insurance is not really an affordable alternative to available individual market plans. Many commenters stated that the proposed changes would reduce access to maternity care, treatment for illnesses such as cancer, cystic fibrosis, multiple sclerosis, arthritis, eating disorders, visions and hearing loss and mental health and substance use disorders. Many commenters shared personal stories of struggles with illnesses such as cancer and the financial and emotional toll of such illnesses. These commenters expressed deep fears that as a result of this rule, they would lose coverage because issuers would stop offering individual market plans or because those plans would become too expensive. These commenters expressed fear of becoming bankrupt and losing their lives because of reduced access to the necessary health care.

Commenters expressed concern that this would reverse the health coverage gains over the last few years, especially in minority communities and amongst women. One commenter stated that the design of short-term, limited-duration insurance in the proposed rule will discourage the pursuit of preventive services, so the public health will suffer.

This rule will benefit individuals who have been harmed by the increasing premiums, deductibles, and cost-sharing associated with individual market plans and by limited choices. Individual market premiums increased 105 percent from 2013 to 2017, in the 39 states using

*Healthcare.gov* in 2017,<sup>62</sup> while the average monthly premium for the second-lowest cost silver plan for a 27-year-old increased by 37 percent from 2017 to 2018.<sup>63</sup> Individual market plans will continue to be available to individual consumers on a guaranteed availability basis and many individuals will have the opportunity to purchase the type of coverage that is most desirable and suitable for them and their families' health care and budget needs, unless states take actions to restrict the short-term, limited-duration market. Also, individuals who receive PTCs generally will not experience an increase in out-of-pocket costs for premiums. However, consumer expectations for individual market plans have often not been met due to high deductibles,<sup>64</sup> and short-term, limited-duration insurance provides an additional choice for individuals to consider, based on their own personal circumstances. In addition to dramatically higher premiums, high out-of-pocket costs have harmed many individual market plan enrollees, with deductibles that average nearly \$6,000 a year for bronze single coverage and more than \$12,000 a year for bronze family coverage in 2018 as well as more than \$4,000 a year for silver single coverage and more than \$8,000 a year for silver family coverage in 2018.<sup>65</sup> In addition, out-of-pocket maximums for individual market plans are only applicable to in-network care and thus actual out-of-pocket costs may be much higher for individuals who need to obtain care out of network. High deductibles may also be a deterrent to obtaining care for some individuals. In some cases, short-term, limited-duration insurance will provide a more desirable option for individuals and may be the only affordable alternative to being uninsured. To help consumers make informed coverage decisions, issuers of short-term, limited-duration insurance are required under this final rule to

provide a notice to alert consumers to the potential limitations of the coverage. The Departments' judgment is that individuals are in the best position to evaluate the tradeoffs between lower premiums and limitations of short-term, limited-duration insurance. This rule empowers consumers to make decisions on the benefits they want and to reduce potential overinsurance and underinsurance. As discussed below, rather than increase the number of individuals who are uninsured the total number of individuals purchasing either individual market or short-term, limited-duration insurance coverage is expected to increase, perhaps significantly. Uninsured individuals who purchase short-term, limited-duration insurance will experience an increase in financial protection and potentially an increase in access to health care. As previously mentioned, individual market plan networks may also be quite restrictive, and short-term, limited-duration plan networks may very well cover a broader or superior set of providers. State regulators have also taken compliance action against misleading claims regarding benefits and provider networks, which should act as a disincentive to such practices. In response to the concern raised regarding bankruptcy, the rule makes clear that individuals are free to purchase separate products that may provide protection against the possibility of getting sick in the future and facing higher premiums as a result.

A few commenters also mentioned the potential increase in uncompensated care and the financial burdens that the increased use of short-term, limited-duration insurance could place on hospitals. Commenters stated that the proposed changes could have a devastating impact on hospital emergency rooms, since they are required to provide care regardless of coverage status or one's ability to pay. If more consumers enroll in short-term, limited-duration policies that do not cover treatments received in emergency departments, it will result in an increase in uncompensated care. In addition, the lack of coverage of essential health benefits may also lead to an increased reliance on emergency departments as consumers delay or do not seek primary care, exacerbating existing acute and chronic conditions. One commenter stated that this may also lead to increased boarding of mental health patients in emergency departments, where mental health patients presenting to an emergency department have an average stay of 18 hours, compared to an

<sup>62</sup> ASPE "Data Point—Individual Market Premium Changes: 2013–2017", May 23, 2017. Available at <https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf>.

<sup>63</sup> ASPE "Health Plan Choice and Premiums in the 2018 Federal Health Insurance Exchange", October 30, 2017. Available at <https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2018-federal-health-insurance-exchange>.

<sup>64</sup> Robert Pear, "Many Say High Deductibles Make Their Health Law Insurance All but Useless", *The New York Times*, November 14, 2015. Available at <https://www.nytimes.com/2015/11/15/us/politics/many-say-high-deductibles-make-their-health-law-insurance-all-but-useless.html>.

<sup>65</sup> HealthPocket, "Average Market Premiums Spike Across Obamacare Plans in 2018", October 27, 2017. Available at <https://www.healthpocket.com/healthcare-research/infostat/2018-obamacare-premiums-deductibles>.

average of only four hours for all emergency department patients.

The Departments acknowledge that if a short-term, limited-duration insurance policy excludes treatment in hospital emergency rooms, there is the possibility that there could be increases in uncompensated care provided by hospitals. However, the Departments have no reason to believe that all short-term, limited-duration insurance policies will exclude such coverage. The Departments note that individuals enrolled in individual market plans also frequently experience unexpected high out-of-pocket costs due to balance billing (charges arising when an insured individual receives care from an out-of-network provider, the balance bill being the difference between the total charges incurred and what the issuer ultimately pays), when obtaining care at emergency departments and when treating providers are not part of in-network hospitals.<sup>66</sup> Very few states have laws that protect consumers from this practice; 15 states offer limited balance billing protections, while only six provide comprehensive balance billing protections for consumers.<sup>67</sup> In addition, for people who would otherwise have been uninsured and now purchase short-term, limited-duration insurance, the final rule will likely result in a decrease in uncompensated care. The Departments have no evidence that this rule will lead to increased emergency department boarding times for mental health patients in emergency departments.

A few commenters stated that short-term, limited-duration insurance coverage also poses a threat to the student health insurance market. Students may buy the cheaper, short-term, limited-duration insurance erroneously thinking that it is comprehensive coverage. Commenters believe that losses to this insurance pool would result in increased premiums for student health coverage for those students that choose or need to stay on their campus student health insurance plan and this could also place considerable stress on the institutions'

student health and wellness departments.

The Departments believe that all consumers, including but not limited to students, should have access to additional, more affordable coverage options. In fact, these policies may significantly benefit students since premiums for the young have risen most dramatically as a result of PPACA. However, since most educational institutions require students to obtain insurance through individual market plans or group coverage and often provide relatively inexpensive options to students, the Departments believe that losses to this insurance pool will be limited. As previously stated, the Departments believe that the notice, provided at the time of application and in the contract with the language specified in this final rule, will help consumers understand what they are purchasing. Consumers may also be able to obtain additional guidance and assistance from brokers and agents as well as additional plan documents in order to understand the products they seek to purchase. The Departments generally defer to the states' authority over agents and brokers licensed in their respective jurisdictions, including taking appropriate action in response to unfair or deceptive practices, which should act as a disincentive to such practices.

Some commenters stated that the proposed changes would be harmful for solo entrepreneurs and small business employees by raising rates for individuals dependent on the individual market Exchanges, which is where many small business employees and solo entrepreneurs purchase health coverage. These commenters asserted that in order for employees of small businesses to be able to receive affordable coverage, individual market risk pools must be robust and well balanced.

The Departments acknowledge that the changes finalized in this rule may lead to a small increase in premiums for individual market plans and possibly a reduction in net premiums for Exchange plans. The CMS Office of the Actuary (OACT) estimated that the average net premium paid by Exchange enrollees is expected to decline by 14 percent as a result of the rule.<sup>68</sup> The Departments note, however, that other regulations, such as this rule and the recently finalized rule titled "Definition of "Employer" under Section 3(5) of

ERISA—Association Health Plans",<sup>69</sup> issued by the Department of Labor, will increase access to other alternative, less expensive options for small businesses and solo entrepreneurs. Moreover, many small business employees and solo entrepreneurs stand to benefit from this rule. States also maintain flexibility under this final rule to pursue innovative strategies to strengthen and protect their respective risk pools.

Some commenters stated that these changes could result in counties with no Exchange plans available, otherwise known as bare counties. Many commenters stated that these changes would increase the number of uninsured.

The Departments acknowledge that due to the potential increase in risk segmentation, in which healthier individuals choose products outside the individual market may result in an individual market risk pool with higher medical expenses, it is possible that fewer issuers may offer plans in the individual market. However, the impact on issuer participation in the individual market will vary depending on a number of different factors, such as the unique demographic and other characteristics of a state's population, regulatory environment and insurance markets. Further, as a result of silver loading<sup>70</sup> and dramatically higher premiums as well as pricing power from markets with limited competition from other issuers, issuers have begun to turn a profit in the individual market and some issuers are looking to enter the individual market. Further, many enrollees already had access to just one issuer for Exchange coverage. In addition, as discussed below, it is expected that the total number of individuals with some type of health insurance coverage will increase, perhaps significantly.

In response to the request for comments on the value of excluded services to individuals who switch from individual market coverage to short-term, limited-duration coverage, one commenter expressed concern about the suggestion that consumers would be willing to switch from individual market plans that provide more robust coverage to short-term, limited-duration insurance policies that provide less generous coverage because consumers do not believe the more generous benefits are worth the cost. The commenter stated that the Departments

<sup>66</sup> Karen Pollitz, "Surprise Medical Bills", Kaiser Family Foundation, March 17, 2016. Available at <https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/>.

<sup>67</sup> Kevin Lucia, Jack Hoadley, and Ashley Williams, "Balance Billing by Health Care Providers: Assessing Consumer Protections Across States", The Commonwealth Fund, June 13, 2017. Available at: <https://www.commonwealthfund.org/publications/issue-briefs/2017/jun/balance-billing-health-care-providers-assessing-consumer> and Berta Alicia Bustamante, "Most States Still Don't Have Comprehensive Balance Billing Legislation", insideARM, October 3, 2017. Available at: <https://www.insidearm.com/news/00043325-most-states-still-dont-have-comprehensive/>.

<sup>68</sup> The net premium reduction is a result of unsubsidized and less-subsidized enrollees exiting the market, leaving the remaining population receiving more premium tax credit, on average. Net premiums for individual enrollees do not fall.

<sup>69</sup> 83 FR 28912.

<sup>70</sup> Silver loading refers to issuers including the entire cost of un-funded cost sharing reduction (CSR) payments on silver metal tier plans which offer CSR plan variants, rather than spread the cost over all metal tier plans.



have not offered any evidence to support such a suggestion and the commenter stated that recent polling indicates the opposite. The commenter referred to a poll<sup>71</sup> where 84 percent of respondents in the individual market stated that they would prefer to stay with their current plan rather than enroll in short-term, limited-duration insurance coverage, when asked if they would like to enroll in coverage that was less generous but with a lower premium. The commenter was also concerned that consumers, when faced with cost concerns, new plan choices, non-transparent plan information, and a confusing enrollment process will not be able to tell whether they are enrolling in a comprehensive plan or not—and consequently will end up with far less coverage than they thought they had.

Many commenters stated that the negative consequences of short-term, limited-duration insurance are not limited to individuals with preexisting conditions; even healthy individuals may be harmed by choosing cheaper, skimpier coverage. If individuals are unable to receive or pay for care solely on the basis of having a less comprehensive health plan, they may put off needed care, and may lose the ability to have cost-effective choice over their health care decisions. Many commenters also stated that enrollees in short-term, limited-duration insurance will face financial hardship if they have an accident or become sick and find out that these policies do not cover benefits such as prescription drugs or some surgeries and that the policies can deny claims that should have been covered or that the enrollees were lead to believe were covered.

One commenter stated that individuals who want the services that are excluded in short-term, limited-duration insurance have the choice to buy individual market plans. If they cannot afford those policies, however, the commenter stated that they would not be able to get the excluded services in the first instance.

One commenter suggested that the proposed changes fail to address (and will likely exacerbate) the most critical needs in the health care and health insurance markets to put downward pressure on the rapidly rising costs of health care in the U.S. and to spread

risk across larger, more diverse populations. One commenter stated that the proposals would worsen the inequality between the low and moderate income populations in the individual insurance market.

This rule makes no changes to the federal individual market requirements. The Departments acknowledge that individuals will be able to continue to purchase and renew individual market plans, instead of switching to short-term, limited-duration insurance. Of note, the turbulence of the first several years of the Exchanges with persistent issuer exit resulted in many individuals being unable to renew their individual market plans. Under this final rule, individuals who prefer less expensive coverage, or those that do not qualify for PTCs or otherwise find individual market coverage unattractive, will generally have greater flexibility to purchase short-term, limited-duration insurance and obtain coverage for services they want and exclude services they determine they do not need. The Departments believe that individuals reveal their preferences with their actions and consumers who switch to short-term, limited-duration insurance from individual market plans will do so because they do not value the individual market coverage at the cost. In addition, allowing people to purchase what they view as an efficient amount of coverage leads to less third-party payments, and third-party payments can drive up health care spending as consumers and producers are insensitive to price when third-party payers are paying the bill. Consumers can use their savings from lower premiums toward buying health care services when they are active, informed consumers, looking for the best possible deals.

Because short-term, limited-duration insurance policies can, subject to state law, be priced in an actuarially fair manner (by which the Departments mean that is the policies are priced so that the premium paid by an individual reflects the risks associated with insuring the particular individual or individuals covered by that policy) individuals who purchase such coverage are likely to be relatively young or relatively healthy. Allowing such individuals to purchase a policy that does not comply with PPACA, but with an initial contract term of less than 12-months with renewals or extensions up to maximum duration of 36 months, may weaken states' individual market single risk pools. The degree to which individuals purchase separate renewal guarantee products will serve to strengthen individual market pools and

could reduce Exchange premiums and spending—as at least one commenter pointed out. If the individual market deteriorates because of people choosing other types of coverage, individual market issuers could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market. Although choices of plans available in the individual market have already been reduced to plans from a single issuer in roughly half of all counties, this final rule may further reduce choices for individuals remaining in those individual market single risk pools. However, as a result of silver loading and the tightening of special enrollment periods, some issuers, aware of the Association Health Plan rule and the short-term, limited-duration insurance proposals, have indicated they will expand their presence in the individual market next year.

#### Impact on Individual Market Risk Pool

This final rule allows short-term, limited-duration insurance policies to be renewed or extended such that the maximum duration of a policy, including the initial term specified in the contract and renewals or extensions under the same insurance contract, is no longer than 36 months. Depending on state rating requirements, issuers of such coverage may be able to introduce new plans every year at low rates that only healthy individuals would be able to purchase, while imposing large renewal rate increases for less healthy enrollees in existing plans. This could lead to further worsening of the risk pool by keeping healthy individuals out of the individual market for longer periods of time, increasing premiums for individual market plans and may cause an increase in the number of individuals who are uninsured. Previous academic research on the pre-PPACA individual market suggests this is unlikely to happen, however, as premium increases generally reflect the entire pool's experience with less healthy individuals effectively subsidized by healthier individuals through market forces.<sup>72</sup> This impact may be further mitigated by the degree that individuals purchase separate renewal guarantee products which may provide another mechanism for consumers to continue coverage under separate short-term, limited-duration

<sup>71</sup> Kaiser Family Foundation. Poll: "Survey of the Non-Group Market Finds Most Say the Individual Mandate Was Not a Major Reason They Got Coverage in 2018, And Most Plan to Continue Buying Insurance Despite Recent Repeal of the Mandate Penalty", April 3, 2018. Available at <https://www.kff.org/health-reform/press-release/poll-most-non-group-enrollees-plan-to-buy-insurance-despite-repeal-of-individual-mandate-penalty/>.

<sup>72</sup> Michael F. Cannon, "Short-Term Plans Would Increase Coverage, Protect Conscience Rights & Improve ObamaCare Risk Pools", Cato Institute, July 2, 2018. Available at <https://www.cato.org/blog/short-term-plans-reducing-uninsured-protecting-conscience-rights-improving-obamacares-risk>.

insurance policies for a longer period of time.<sup>73</sup>

Further, as detailed elsewhere in this rule, the Departments are finalizing a notice requirement to inform consumers about the limitations of short-term, limited-duration insurance to help individuals make informed coverage purchasing decisions that best suits their needs—whether that is comprehensive individual market coverage or short-term, limited-duration insurance. This notice will also assist consumers of short-term, limited-duration insurance in further understanding the products being offered and can be used to combat misleading marketing and aggressive sales tactics that some brokers, agents, or issuers may employ as a result of potentially higher profits and commissions for short-term, limited-duration insurance.

In response to the request for comments on any impacts on PPACA individual market single risk pools, some commenters who supported the proposed rule expressed confidence that the rule would not adversely impact the single risk pools. One commenter stated that the short-term, limited-duration insurance market has been in existence for over three decades and was not accused in the pre-PPACA market of being a destabilizing influence. According to the commenter, the market's modest size, which they estimated to be between 650,000 and 850,000 enrollees before the October 2016 final rule became effective, represents a niche within the broader private health insurance market.

Many commenters, however, expressed concern that extending the maximum duration of short-term, limited-duration coverage would weaken the single risk pools and destabilize the individual market by syphoning young, healthy individuals to the short-term, limited-duration insurance market, leaving only those with higher expected health costs and those receiving subsidies in the individual market. Commenters suggested that the resulting market segmentation and adverse selection would increase premiums for individual market plans and may decrease the number of plans available as issuers exit the individual market, potentially leading to “bare counties”. Commenters also suggested that this would transform individual markets into high risk pools and would create a parallel insurance market, undercutting the comprehensive, major medical policies offered to individuals and families.

Many commenters stated that the combination of increased availability of short-term, limited-duration insurance and the reduction of the individual shared responsibility payment to \$0, in conjunction with the proposed Association Health Plan rule,<sup>74</sup> could exacerbate adverse selection in the individual market. One commenter stated that premium and cost-sharing subsidies are available only for individual market plans sold on Exchanges, providing incentives for healthy lower-income individuals to remain in such plans and therefore limiting the deterioration of the individual market risk pool. Individuals eligible for premium subsidies would generally be shielded from the premium increases as federal premium subsidies would increase. For unsubsidized individuals who are healthy, higher premiums for individual market plans would increase the attractiveness of lower-premium short-term, limited-duration insurance.

A few commenters stated that these effects on the individual market risk pool could be limited in states that implement additional regulations limiting the length and availability of short-term, limited-duration policies or requiring that they meet rules governing individual market plans.

One commenter stated that if short-term, limited-duration issuers are allowed to increase premiums at renewal based on an individual's health conditions, individuals with new conditions will receive higher rate increases than enrollees without new conditions. The commenter further stated that if there are no limits on the allowable rate increases, premiums for some individuals could exceed those in the individual market. In such a case, the enrollee may move back to the individual market risk pool, increasing the health care costs of the pool.

Many commenters stated that a key element of any healthy, sustainable insurance market is that a broad pool of enrollees share in the spreading of risk. The effect of the proposed rule would be to undercut the individual market risk pool as more individuals leave their current health plans and purchase short-term, limited-duration insurance. This would further destabilize an already difficult market for individual and family coverage.

One commenter suggested the proposed rule assumed that consumers who purchase short-term, limited-

duration insurance and then find the insurance inadequate for a health problem that occurs during the term of this insurance will switch to more adequate coverage in the individual market. The commenter noted that the proposed rule fundamentally conceded that it will adversely affect the individual market that is a last resort for those with serious health issues at the same time “the agencies tout the fail safe function of those markets”.

Some commenters gave examples where state policies allowing segmentation of the risk pool has led to higher premiums and problems with issuer participation. These commenters mentioned continuation of transitional plans in Iowa, Nebraska, North Carolina and large enrollment numbers in the Tennessee Farm Bureau as examples. A commenter noted that in 2016, the average plan liability risk scores for PPACA-compliant individual market plans in states that allowed the sale of transitional plans were 12.3 percent higher than risk scores for PPACA-compliant individual market plans in states that prohibited transitional policies.

The Departments acknowledge that relatively young, relatively healthy individuals in the middle-class and upper middle-class whose income disqualifies them from obtaining PTCs are more likely to purchase short-term, limited-duration insurance. As people choose these plans rather than individual market coverage, this could lead to adverse selection and the worsening of the individual market risk pool. As discussed below, the Departments estimate that the proportion of healthier individuals in the individual market Exchanges will decrease and by 2028 premiums for unsubsidized enrollees in the Exchanges will increase by 5 percent. The Congressional Budget Office (CBO) projects only a 2 percent to 3 percent impact on premiums in the small group and individual markets from the combined Association Health Plan and short-term, limited-duration insurance rules, even while projecting more people will exit the individual market for these alternatives.<sup>75</sup> Compared to CBO, the OACT analysis thereby represents a more conservative analysis. However, premium and cost-sharing subsidies are available only for individual market plans offered on Exchanges, which makes it likely that healthy lower-income individuals will

<sup>74</sup> The proposed rule, published in the **Federal Register** on January 5, 2018 (83 FR 614) was subsequently finalized and published in the **Federal Register** on July 12, 2018 (83 FR 28912).

<sup>75</sup> Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028,” May 23, 2018. Available at <http://cbo.gov/publication/53826>.

<sup>73</sup> Id.

remain in individual market plans even if they place a relatively low value on this coverage because the individual subsidized premium is so low, limiting the extent of adverse selection. To the extent that individuals purchase separate renewal guarantee products, and continue to use short-term, limited-duration insurance, they very well may not return to the individual market risk pool if they get sick. This will limit the adverse effect on the individual market risk pool. In addition, as discussed below, the total number of individuals with coverage (including short-term, limited-duration insurance) is expected to increase. The impact on individual states' single risk pools will vary depending on state regulations, the current state of the individual market, and the unique demographic and other characteristics of a state's population and insurance markets.

The Departments anticipate that most of the individuals who switch from individual market plans to short-term, limited-duration insurance will be relatively young or relatively healthy and have an annual income—about \$48,000 for a single household and \$98,000 for a family-of-four—that makes them ineligible to receive PTCs. If the individual market single risk pools change, the change will result in an increase in gross premiums for the individuals remaining in those risk pools. An increase in premiums for individual market single risk pool coverage is expected to result in an increase in federal outlays for PTCs. However, individuals who receive PTCs will be largely insulated from these increases in premiums because a consumer's PTC amount generally increases as the price of the relevant benchmark plan increases. As discussed above, OACT's analysis projects that net premiums in PPACA-compliant markets will decline.<sup>76</sup>

Impact Estimates

The economic impact analysis in the proposed rule provided that because short-term, limited-duration insurance can, subject to state law, be priced in an actuarially fair manner (by which the Departments meant that it is priced so that the premium paid by an individual reflects the risks associated with insuring the particular individual or individuals covered by that policy) individuals who are likely to purchase short-term, limited-duration insurance are likely to obtain a better value than they receive from individual health insurance coverage. The economic impact analysis of the proposed rule also provided that allowing individuals greater choice of policies that do not comply with all of the PPACA market requirements would impact the individual market single risk pools. The Departments<sup>77</sup> estimated that in 2019, between 100,000 and 200,000 individuals previously enrolled in individual market coverage would purchase short-term, limited-duration insurance policies instead. The Departments estimated that this would cause the average monthly individual market premiums and average monthly PTCs to increase, leading to an increase in total annual advance payments of the PTC<sup>78</sup> in the range of \$96 million to \$168 million in 2019. Other entities project greater enrollment and have different views on whether or not this increases the deficit. The Departments also noted that enrollment in short-term, limited-duration insurance and the resulting reductions in individual market enrollment and increases in individual market premiums in future years are uncertain.

OACT performed an analysis of the financial effects of the proposed rule on April 6, 2018.<sup>79</sup> An updated estimate has been performed by OACT where the baseline was updated to the President's Fiscal Year 2019 Mid-Session Review. As stated in the April 6th estimate, the assumptions and methods used in the

updated estimate are the same as those used in OACT's previous health reform modelling.<sup>80</sup> The updated estimate includes the policy to allow renewability up to 36 months. This policy was estimated to have a negligible impact. In addition, consideration was given to some states taking action to prohibit or limit the sale of short-term, limited-duration insurance policies. The original estimate also assumed a 4-year transition to short-term, limited-duration insurance policies with roughly two-thirds of the impact occurring in 2019, while the new estimate assumes a 3-year transition with one-third of the impact occurring in 2019.

Using these updated assumptions yields an estimate that 2019 enrollment in short-term, limited-duration insurance will increase by 600,000. Exchange enrollment in 2019 is expected to decrease by 200,000, while enrollment in off-Exchange plans is expected to decrease by 300,000. The remaining 100,000 increase in short-term, limited-duration enrollment is largely accounted for by new consumers who were previously uninsured. By 2028, enrollment in individual market plans is projected to decrease by 1.3 million, while enrollment in short-term, limited-duration insurance will increase by 1.4 million. The net result will be an increase in the total number of people with some type of coverage by 0.1 million in 2020 and by 0.2 million by 2028. Premiums for unsubsidized enrollees in the Exchanges are expected to increase by 1 percent in 2019 and by 5 percent in 2028. Individuals who choose to purchase short-term, limited-duration insurance are expected to pay a premium that is approximately half of the average unsubsidized premium in the Exchange. Since individual market plan premiums are expected to increase the study estimates that PTCs will increase by \$0.2 billion in 2019 and by a net total of \$28.2 billion for fiscal years 2019–2028.

TABLE 2—ESTIMATED EFFECT OF SHORT-TERM, LIMITED-DURATION INSURANCE POLICY CHANGES 2019–2028

Calendar year	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019–28
Enrollment Impact:											
Exchange .....	-0.2	-0.4	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	.....
Off-Exchange <sup>1</sup> .....	-0.3	-0.7	-0.8	-0.8	-0.8	-0.8	-0.7	-0.7	-0.7	-0.7	.....

<sup>76</sup> The net premium reduction is a result of unsubsidized and less-subsidized enrollees exiting the market, leaving the remaining population receiving more premium tax credit, on average. Net premiums for individual enrollees do not fall.

<sup>77</sup> For purposes of the economic impact analysis in the proposed rule, the term “the Departments” was used to refer to HHS and the Department of Labor.

<sup>78</sup> The Departments used data on Advance PTC as an approximation of PTC since this is the data that is available for 2017.

<sup>79</sup> CMS Office of the Actuary, “Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule,” April 6, 2018. Available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf>.

<sup>80</sup> CMS Office of the Actuary, “Estimated Financial Effect of the “American Health Care Act of 2017”” June 13, 2017. Available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/AHCA20170613.pdf>.

TABLE 2—ESTIMATED EFFECT OF SHORT-TERM, LIMITED-DURATION INSURANCE POLICY CHANGES 2019–2028—  
Continued

Calendar year	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019–28
Short-term, limited-duration .....	0.6	1.3	1.6	1.6	1.5	1.5	1.5	1.5	1.5	1.4	.....
Total .....	0.0	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	
Premium Impact:											
Marketplace:											
Gross Premium .....	1%	3%	5%	5%	5%	5%	5%	5%	5%	5%	.....
Net Premium <sup>2</sup> .....	–6%	–11%	–14%	–14%	–14%	–14%	–14%	–14%	–14%	–14%	.....
Short-term, limited-duration:											
Gross Premium <sup>3</sup> .....	–41%	–45%	–49%	–49%	–49%	–49%	–49%	–49%	–49%	–49%	.....
Fiscal year	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019–28
Federal Impact [\$ Billions]:											
Premium Tax Credits .....	\$0.2	\$1.2	\$2.5	\$3.0	\$3.1	\$3.3	\$3.4	\$3.6	\$3.8	\$4.0	\$28.2

<sup>1</sup> Off-Exchange coverage includes enrollment in plans that we assume would meet the definition of insurance coverage. Most of these individuals are assumed to be enrolled in individual market plans.

<sup>2</sup> Net premium is the actual premium paid by the consumer after accounting for any subsidies such as premium tax credits. The net premium reduction is a result of unsubsidized and less-subsidized enrollees exiting the market, leaving the remaining population receiving more premium tax credit, on average. Net premiums for individual enrollees do not fall.

<sup>3</sup> The change in gross premium for those choosing a short-term, limited-duration policy is measured relative to the average gross premium in the Exchange.  
**Note:** Impact on Exchange enrollment in 2018 is expected to be minimal.

There is significant uncertainty regarding these estimates, because changes in enrollment and premiums will depend on a variety of economic and regulatory factors and it is difficult to predict how consumers and issuers will react to the changes finalized in this rule. In addition, the impact in any given state will vary depending on state regulations and the characteristics of that state’s markets and risk pools.

OACT was not the only entity to model the impacts of the proposed regulation. CBO, along with the Joint Committee on Taxation (CBO and JCT), the Urban Institute, and the Commonwealth Fund also looked at the impact. CBO and JCT estimated the impacts of the proposed regulation in their May 2018 report on “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028”.<sup>81</sup> CBO and JCT found that 2 million people would be covered by short-term, limited-duration insurance in 2023, and that “65 percent of the 2 million purchasing [short-term, limited-duration] plans would have been insured in the absence of the proposed rules”. This estimate projected higher uptake of short-term, limited-duration insurance among those that were not previously insured than OACT estimated.<sup>82</sup> Additionally, CBO

projected higher overall enrollment in short-term, limited-duration coverage, 2 million people in 2023 compared to OACT’s estimate of 1.5 million in 2023. Notably, CBO assumed an increase in short-term, limited-duration insurance policy duration to less than 12 months, but did not analyze the impacts of allowing extensions up to 36 months, which would have presumably increased their take-up rates even further. Also, notable is that when estimating the combined effects of this regulation and the recently finalized Association Health Plan rule, CBO found that “premiums are projected to be 2 percent to 3 percent higher in those markets [small group and individual market] in most years.” Despite higher take-up rates, CBO and JCT expect lower premium increases for coverage that complies with all of the PPACA market requirements than OACT. CBO and JCT also found that in combination, “the proposed rules [short term limited duration insurance and association health plans] would reduce the federal deficit by roughly \$1 billion over the 2019–2028 period if implemented as proposed.” They stated that, “over the 2019–2028 period, outlays for marketplace subsidies would increase on net by \$2 billion, and revenues would increase by \$3 billion. The net increase in marketplace subsidies reflects an increase in subsidies stemming from higher premiums, mostly offset by a reduction in the number of people receiving those subsidies.” CBO and JCT further stated that “On the basis of information obtained from stakeholders, CBO and JCT project that the rule on AHPs would

primarily affect the small-group market and that the rule on STLDI plans would primarily affect the non-group market.” Relative to OACT’s estimates, CBO and JCT estimated the impacts of this rule to result in more short-term, limited-duration plan take-up with a larger share of the take-up coming from people who were not previously insured, lower premium impacts for PPACA-compliant coverage, and a lower cost to the federal government.<sup>83</sup>

CBO and JCT were not the only entities to analyze the quantitative impacts of the proposed rule. The Urban Institute ran a state-level microsimulation model (taking into account market conditions in each state as well as regulatory differences) and also estimated that an extension of short-term, limited-duration insurance to less than 12 months would result in greater take-up of the plans than OACT estimated, as well as savings for the federal government.<sup>84</sup> Specifically the Urban Institute found that in 2019 “4.3 million would enroll in expanded short-term limited-duration plans.”<sup>85</sup> “About 1.7 million of the people buying [short-term, limited-duration insurance] policies would have been uninsured (in the traditional sense) under current law, and 2.6 million [short-term, limited-

<sup>83</sup> CBO and JCT did not separately break out the budget effects of the AHP rule and the short-term, limited-duration rule.

<sup>84</sup> L.J. Blumberg, M. Buettgens, R. Wang, “The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending,” Urban Institute, March 2018. Available at: [https://www.urban.org/sites/default/files/publication/96781/2001727\\_updated\\_finalized.pdf](https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf).

<sup>85</sup> Id.

<sup>81</sup> Congressional Budget Office, “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028,” May 23, 2018. Available at <http://cbo.gov/publication/53826>.

<sup>82</sup> CBO noted that, “of the 2 million additional enrollees in STLDI plans, fewer than 500,000 would purchase products not providing comprehensive financial protection against high-cost, low-probability medical events. CBO considers such people uninsured.”

duration] policy holders would otherwise have had insurance of some type.” They further found that “ACA-compliant non-group coverage would decrease by another 2.2 million people. About 70 percent of that decrease (1.6 million people) comes from fewer people buying PPACA-compliant coverage without a tax credit, and about 30 percent of the decrease (about 600,000 people) comes from fewer people buying non-group insurance with a tax credit.” As a result of their estimate of the decrease in the number of people receiving tax credits they estimated the policy to result in net savings to the federal government of \$721 million in 2019. The Urban Institute grouped the individual mandate penalty being reduced to \$0 and the short-term, limited-duration proposal to estimate the premium effects on individual market single risk pools, so it is difficult to know what just the policy impact of short term changes would have been to premiums in their analysis. In sum, relative to OACT’s analysis, Urban estimates savings to the federal government (rather than costs), as well as materially higher take-up (4.3 million in 2019 versus 1.4 million in 2028), including among those that previously did not have insurance (1.7 million in 2019 versus 0.2 million in 2028).

While CBO and the Urban Institute appear to have done robust work on the issue, other entities also provided estimates of the impact. The Commonwealth Fund concluded that if there are no behavioral barriers to enrollment in short-term, limited-duration plans, and under a baseline of no individual shared responsibility payment, extending the duration of short-term, limited-duration insurance would result in about 5.2 million people enrolled.<sup>86</sup> The Commonwealth Fund estimated that the average premium for a short-term, limited-duration insurance policy will be roughly 80 percent cheaper than silver plans and about 70 percent cheaper than bronze plans for a 40-year old.<sup>87</sup> The Commonwealth Fund

<sup>86</sup> Preethi Rao, Sarah A. Nowak, Christine Eibner, “What Is the Impact on Enrollment and Premiums if the Duration of Short-Term Health Insurance Plans Is Increased?”, Commonwealth Fund, June 5 2018. Available at <https://www.commonwealthfund.org/publications/fund-reports/2018/jun/what-impact-enrollment-and-premiums-if-duration-short-term>. Examples the Commonwealth Fund cited of behavioral barriers to enrollment include “increased marketing of plans to increase awareness, streamlining the application process, lack of concern over facing the mandate penalty.”

<sup>87</sup> Preethi Rao, Sarah A. Nowak, Christine Eibner, “What Is the Impact on Enrollment and Premiums if the Duration of Short-Term Health Insurance Plans Is Increased?”, Commonwealth Fund, June 5

estimated that “the age-specific premium for a silver plan increases by 0.9 percent (from \$7,308 to \$7,377) relative to current law when the individual mandate is lifted, and by 3.6 percent (from \$7,308 to \$7,568) when the mandate is lifted and behavioral barriers are removed” (implying the marginal effect of adding short term plans in a scenario with limited behavior barriers was roughly 2.7 percent). The Commonwealth Fund did not provide estimates of cost impacts to the federal government.

In response to the Departments’ request for comments on how many consumers may choose to purchase short-term, limited-duration insurance, rather than being uninsured or purchasing individual market plans, many commenters submitted or referred to studies that estimated the impact of the proposed changes. Some of these studies and findings have been described above. Another study conducted by the Wakely Consulting Group<sup>88</sup> estimated that, as a result of the proposed changes and the reduction of the individual shared responsibility payment to \$0, premiums would increase by 0.7 percent to 1.7 percent and enrollment would decrease by 2.7 percent to 6.4 percent in the individual market in 2019. In addition, the study estimated that premiums for individual market plans would increase 2.2 percent to 6.6 percent and enrollment would decrease by 8.2 percent to 15 percent in 4 to 5 years, when the full impact of the proposed changes can be felt. A study by Oliver Wyman,<sup>89</sup> focusing on the District of Columbia’s individual and small group markets, estimated that the

2018. Available at <https://www.commonwealthfund.org/publications/fund-reports/2018/jun/what-impact-enrollment-and-premiums-if-duration-short-term>. In a scenario with behavioral barriers in place, they estimated a materially lower number of 0.3 million in take-up. Examples the Commonwealth Fund cited of behavioral barriers to enrollment include “increased marketing of plans to increase awareness, streamlining the application process, lack of concern over facing the mandate penalty.” Market forces may well come up with ways of addressing these behavioral barriers—such as by marketing the plans aggressively, providing a high quality customer experience in a streamlined application process, and clarifying the applicability of the mandate penalty.

<sup>88</sup> Michael Cohen, Michelle Anderson, Ross Winkelman, “Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market,” Wakely Consulting Group, April, 2018. Available at: <http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf>.

<sup>89</sup> Oliver Wyman, “Potential Impact of Short-Term Limited Duration Plans,” April 11, 2018. Available at: <https://hbx.dc.gov/sites/default/files/dc/sites/hbx/publication/attachments/OWReview%20of%20Impact%20of%20Short%20Term%20Duration%20Plans%204.11.2018%20%28002%29.pdf>.

combined effect of the proposed changes and the reduction of the individual shared responsibility payment to \$0 would be an increase in claims costs by 11.7 percent to 21.4 percent and a decrease in enrollment in individual and small group plans of 3,800 to 6,100 in Washington, DC. Notably Washington DC’s individual market is highly idiosyncratic in terms of the number of people in it not receiving subsidies, so the effects on that market are unlikely to be comparable with other states. A study by Covered California<sup>90</sup> concluded that the combined effect of the proposed Association Health Plan rule and the short-term, limited-duration rule would increase premiums by 0.3 percent to 1.3 percent in the individual market in California in 2019.

Many commenters stated that the proposed rule likely underestimates the number of people who would enroll in short-term, limited-duration insurance and thus underestimates the premium and risk pool impact of the proposed changes. Commenters suggested that it is insufficient to look at prior data on short-term, limited-duration insurance enrollment to predict what would happen as a result of the proposed change in federal rules, since conditions for the short-term, limited-duration insurance market are poised to differ markedly from recent years. Commenters noted that in 2019, the individual shared responsibility payment will be reduced to \$0, removing one factor that has likely kept more people from enrolling in short-term, limited-duration insurance. Commenters also noted that the federal government is actively promoting short-term, limited-duration insurance and pulling back on its outreach efforts for individual market plans, a reversal of prior policy that is likely to increase short-term, limited-duration insurance enrollment, and that major issuers have already expressed interest in offering or expanding offerings of short-term, limited-duration plans.

One commenter stated that the total enrollment in short-term, limited-duration insurance was actually close to 500,000 covered lives in December 2016 after accounting for association-based sales. The commenter further noted that as a result of the reduction of the individual shared responsibility payment to \$0 beginning in 2019, the cost differential between short-term,

<sup>90</sup> Covered California, “Individual Markets Nationally Face High Premium Increases in Coming Years Absent Federal or State Action, With Wide Variation Among States,” March 8, 2018. Available at [http://hbx.coveredca.com/data-research/library/CoveredCA\\_High\\_Premium\\_Increases\\_3-8-18.pdf](http://hbx.coveredca.com/data-research/library/CoveredCA_High_Premium_Increases_3-8-18.pdf).

limited-duration insurance and individual market plans will increase, and enrollment in short-term, limited-duration insurance is likely to grow beyond what it was in 2016. The commenter estimated that each percentage point increase in premiums for individual market plans as a result of the policies in the proposed rule would increase federal spending on PTCs by \$800 million in 2019. Another commenter cited a report stating that enrollment in short-term, limited-duration coverage may be closer to one million.

One commenter expected that the mostly uninsured or off-Exchange insured group of consumers who may purchase short-term, limited-duration insurance policies will follow the age distribution of those who currently purchase short-term, limited-duration insurance, which is an average of approximately 41.3 years of age.

The Departments are unable to verify the conclusions of the different studies submitted and referred to by commenters. However, the studies, in sum suggest that the rule may significantly reduce the number of people without any type of health insurance and will likely only result in a small average increase to premiums in the individual and group markets.

Enrollment in short-term, limited-duration insurance will depend in large part on how issuers respond to this final rule and to external factors such as the reduction to \$0 of the individual shared responsibility payment starting in 2019. If issuers respond by offering a substantially greater range of plan designs than those currently available in the market for short-term, limited-duration insurance in order to attract consumers with a wide range of medical needs, then total enrollment is more likely to align with high-end estimates. Alternatively, if states impose restrictions on short-term, limited-duration insurance or issuers do not substantially alter existing short-term, limited-duration insurance plan designs, then consumers may experience only a moderate increase in convenience as a result of this final rule since short-term, limited-duration insurance is already available and can be purchased as four separate less than 3-month insurance policies<sup>91</sup>—and in

such a scenario, high-end enrollment estimates would be less likely.

As discussed earlier in this rule, there is significant uncertainty regarding all of these estimates, because changes in enrollment and premiums will depend on a variety of factors and it is difficult to predict how consumers and issuers will react to the policy changes finalized in this rule. In addition, the impact in any given state will vary depending on state regulations and the characteristics of that state's markets and risk pools. In addition, some of these studies estimate the impacts of the proposed rule and some of them present combined effects of the Association Health Plan proposed rule or the reduction of the shared responsibility payment to \$0. The study by Oliver Wyman may not be generally applicable to the rest of the country, because the District of Columbia is not representative of other markets insofar as it is very small and because a very small percentage of the District's enrollees receive PTCs.

### C. Regulatory Alternatives

The Departments considered not changing the federal standards for short-term, limited-duration insurance or increasing the initial contact term to 6 or 8 months, as suggested by some commenters. However, this alternative would not adequately increase choices for individuals unable or unwilling to purchase individual market health insurance coverage. Extending the maximum initial contract term to less than 12 months ensures that deductibles are not reset and premiums do not increase every 3 (or 6, or 8) months for consumers who purchase short-term, limited-duration insurance and conditions that develop during the coverage period continue to be covered for a longer period of time until the consumer can switch to an individual market plan, if needed.

The Departments considered finalizing the notice language as proposed. The Departments decided to revise the notice language based on commenter feedback to include more details regarding what the policy may or may not cover. States also have the option to require more information than what is included in the federal notice.

The Departments considered not allowing renewals or extensions of short-term, limited-duration insurance policies beyond 12 months, as well as not permitting renewals or extensions. However, upon review of comments, the Departments determined that allowing renewals or extensions of a policy up to a maximum duration of 36 months increases consumer choices, provides additional protection, and ensures that

consumers can maintain coverage under their short-term, limited-duration insurance policy after the expiration of the initial contract term if it is the most desirable option. As many commenters pointed out, to the extent that the maximum duration of short-term, limited-duration insurance is limited to a relatively short period of time, for example, less than 3 months, or even less than 12 months, without permitting renewals or extensions, this would mean that every 3 months or every 12 months, an individual purchasing short-term, limited-duration insurance would be subject to re-underwriting, and would possibly have his or her premium greatly increased as a result. Also, to the extent the policy excluded preexisting conditions for a specified period of time or imposed a waiting period on specific benefits, the individual would not get credit for the amount of time he or she had the previous coverage. The issuer could also decline to issue a new policy to the consumer based on preexisting medical conditions. The Departments find all of these to be compelling reasons in favor of permitting renewals and extensions as set forth in the final rule, such that the maximum duration under a single short-term, limited-duration insurance policy may be 36 months (including renewal or other extension periods), as opposed to less than 12 months. As mentioned earlier in the preamble, in determining the appropriate limits on the permissible range of renewals or extensions in giving meaning to the term "limited-duration," the Departments were informed by other circumstances under which Congress authorized temporary limited coverage options.

In addition to the applicability date set forth in the proposed rule, the Departments also considered an applicability date of January 1, 2020, as suggested by some commenters. The Departments chose the applicability date of 60 days after the date the rule was published in the **Federal Register** to ensure that states that want to expand access to short-term, limited-duration insurance and individuals who wish to purchase such coverage can begin to benefit from the changes as soon as possible.

Some commenters criticized the Departments for not adequately, or failing to, consider other alternatives. Some commenters stated that the Departments failed to explore the options presented in the regulatory alternatives section and should engage in a more robust discussion of regulatory alternatives. One commenter stated that the Departments indicated that the only alternatives to this

<sup>91</sup> Karen Pollitz, Michelle Long, Ashley Semansky, and Rabah Kamal, "Understanding Short-Term Limited Duration Health Insurance", Kaiser Family Foundation, April 23, 2018. Available at <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

proposal would be to lengthen the duration of short-term, limited-duration plans to either 6 or 9 months and dismissed both options without any explanation. This suggested, the commenter stated, that the Departments did not adequately consider other options. The commenter suggested that there are other options that will actually lead to expanded access and will not destabilize the private health insurance market, such as to fund cost-sharing reductions. Another option suggested by a commenter was to take no action since, in the commenter's view, the proposed action would not expand access to comprehensive coverage, would lead to more discrimination against people with preexisting conditions, and would destabilize private health insurance markets.

The Departments disagree. In addition to considering maintaining the less than 3 month (including renewals) standard in the October 2016 final rule, as well as the proposed less than 12 month standard in the proposed rule, the Departments also considered maximum durations of 6 months or 8 months. Recognizing the myriad number of potential approaches the Departments could consider to establish federal standards for short-term, limited-duration insurance, the Departments also solicited comments on all aspects of the proposed rule. In addition, we have added a more detailed discussion of regulatory alternatives considered for this final regulation. The Departments have chosen the alternatives that we believe will benefit individuals who have been harmed by the increasing premiums, deductibles and cost-sharing associated with individual market plans and limited choices. As discussed previously, this rule will also increase the number of people with some type of coverage by 0.2 million by 2028.

#### *D. Paperwork Reduction Act— Department of Health and Human Services*

This final rule revises the required notice that must be prominently displayed in the contract and in any application materials for short-term, limited-duration insurance. The Departments are providing the exact text for this notice requirement and the language will not need to be customized. The burden associated with these notices is not subject to the Paperwork Reduction Act of 1995 in accordance with 5 CFR 1320.3(c)(2) because they do not contain a "collection of information" as defined in 44 U.S.C. 3502(3). Consequently, this document need not be reviewed by the Office of Management and Budget under

the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

#### *E. Regulatory Flexibility Act*

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a final rule is not likely to have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires that the agency prepare a final regulatory flexibility analysis describing the impact of the rule on small entities. Small entities include small businesses, organizations and governmental jurisdictions.

The RFA generally defines a "small entity" as—(1) a proprietary firm meeting the size standards of the Small Business Administration (13 CFR 121.201); (2) a nonprofit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of "small entity"). The Departments use as their measure of significant economic impact on a substantial number of small entities a change in costs or revenues of more than 3 to 5 percent.

This final rule will impact health insurance issuers, especially those in the individual market. The Departments believe that health insurance issuers will be classified under the North American Industry Classification System code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of \$38.5 million or less are considered small entities for this North American Industry Classification System codes. Some issuers could possibly be classified in 621491 (Health Maintenance Organization Medical Centers) and, if this is the case, the SBA size standard is \$32.5 million or less.<sup>92</sup> The Departments believe that few, if any, insurance companies selling comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental

discount policies) fall below these size thresholds. Based on data from MLR annual report submissions for the 2016 MLR reporting year,<sup>93</sup> approximately 85 out of over 520 issuers of health insurance coverage nationwide had total premium revenue of \$38.5 million or less, of which 51 issuers offer plans in the individual market. This estimate may overstate the actual number of small health insurance companies that may be affected, since almost 79 percent of these small companies belong to larger holding groups, and many if not all of these small companies are likely to have non-health lines of business that will result in their revenues exceeding \$38.5 million. Therefore, the Departments certify that this final rule will not have a significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security Act requires agencies to prepare a regulatory impact analysis if a rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. This final rule will not have a direct effect on rural hospitals, though there might be an indirect impact. However, as discussed below, there are mitigating factors. Therefore, the Departments have determined that this final rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

One commenter disagreed with the statement in the proposed rule that "[t]his proposed rule will not affect small rural hospitals." The commenter stated that issuer withdrawal from the individual market caused by the proposed changes would especially have a catastrophic impact on rural families who already have limited plan choices, as well as on the rural hospitals and other providers who "rely on razor-thin financial margins to deliver care." The commenter urged the Departments to prioritize market stabilization and to pay special attention to the impacts in rural communities.

The total number of individuals purchasing either individual market plans or short-term, limited-duration insurance coverage is expected to increase, which will limit or reduce the amount of uncompensated care provided by hospitals. Moreover, people in rural areas have generally been most harmed by the reduction in choice that as resulted from PPACA and likely stand to disproportionately receive benefit from this rule. The Departments

<sup>92</sup> U.S. Small Business Administration, "Table of Small Business Size Standards Matched to North American Industry Classification System Codes", Effective October 1, 2017. Available at [https://www.sba.gov/sites/default/files/files/Size\\_Standards\\_Table\\_2017.pdf](https://www.sba.gov/sites/default/files/files/Size_Standards_Table_2017.pdf).

<sup>93</sup> Available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.



acknowledge there is a possibility that due to adverse selection and changes to the individual market risk pool, fewer issuers may offer individual market plans in certain states, leading to reduced choices for consumers remaining in the individual market risk pools. However, individuals in rural areas are more likely to be low-income and less likely to receive employer sponsored coverage compared to those living in other areas and a large percentage of rural individuals (24 percent of the nonelderly population) are covered by Medicaid.<sup>94</sup> Individuals in rural areas enrolled in individual market plans are more likely to receive PTC<sup>95</sup> because, generally, incomes in these areas are typically lower than 400% of the Federal Poverty Line and therefore relatively young or healthy individuals are less likely to leave the individual market risk pool in these areas, thereby limiting the effects on the risk pool. State regulations may also limit the impact on the individual market risk pools.

#### *F. Impact of Regulations on Small Business—Department of the Treasury*

Pursuant to section 7805(f) of the Code, the proposed rule that preceded this final rule was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business, and no comments were received.

#### *G. Unfunded Mandates Reform Act*

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditures in any 1 year by a state, local, or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. In 2018, that threshold is approximately \$150 million. This final rule does not include any Federal mandate that may result in expenditures by state, local, or tribal governments, or by the private sector in excess of that threshold.

<sup>94</sup> Julia Foutz, Samantha Artiga, and Rachel Garfield, “The Role of Medicaid in Rural America”, Kaiser Family Foundation, April 25, 2017. Available at: <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america/>.

<sup>95</sup> Analysis of data on Exchange plan selections (non-canceled plan selections at a point-in-time) for the most recent open enrollment period shows that consumers in rural areas are 5 percent more likely to receive PTC compared to those who live in non-rural areas.

#### *H. Federalism*

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by Federal agencies in formulating and implementing policies that have “substantial direct effects” on the states, the relationship between the national government and states, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with state and local officials, and describe the extent of their consultation and the nature of the concerns of state and local officials in the preamble to the final regulation.

Federal officials have discussed the issues related to short-term, limited-duration insurance with state regulatory officials. This final rule has no federalism implications to the extent that current state law requirements for short-term, limited-duration insurance are the same as or more restrictive than the Federal standard in this final rule. States may continue to apply such state law requirements. States also have the flexibility to require additional consumer disclosures and to establish a different, shorter initial contact term and maximum duration (including renewals and extensions) under state law in response to market-specific needs or concerns.

#### *I. Congressional Review Act*

This final rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and will be transmitted to the Congress and to the Comptroller General for review in accordance with such provisions.

#### *J. Reducing Regulation and Controlling Regulatory Costs*

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017 and requires that the costs associated with significant new regulations “shall, to the extent permitted by law, be offset by the elimination of existing costs associated with at least two prior regulations.” This final rule is an Executive Order 13771 deregulatory action.

#### **IV. Statutory Authority**

The Department of the Treasury regulations are adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are adopted pursuant to the authority

contained in 29 U.S.C. 1135 and 1191c; and Secretary of Labor’s Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

The Department of Health and Human Services regulations are adopted pursuant to the authority contained in 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.

#### **List of Subjects**

##### *26 CFR Part 54*

Pension excise taxes.

##### *29 CFR Part 2590*

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

##### *45 CFR Parts 144 and 146*

Health care, Health insurance, Reporting and recordkeeping requirements.

##### *45 CFR Part 148*

Administrative practice and procedure, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

#### **Douglas W. O’Donnell,**

*Acting Deputy Commissioner for Services and Enforcement, Internal Revenue Service.*

Approved: July 26, 2018.

#### **David J. Kautter,**

*Assistant Secretary of the Treasury (Tax Policy).*

Signed this 26th day of July 2018.

#### **Preston Rutledge,**

*Assistant Secretary, Employee Benefits Security Administration, Department of Labor.*

Dated: July 24, 2018.

#### **Seema Verma,**

*Administrator, Centers for Medicare & Medicaid Services.*

Dated: July 25, 2018.

#### **Alex M. Azar II,**

*Secretary, Department of Health and Human Services.*

### **DEPARTMENT OF THE TREASURY**

#### **Internal Revenue Service**

For the reasons stated in the preamble, 26 CFR part 54 is amended as follows:

### **PART 54—PENSION AND EXCISE TAX**

■ **Paragraph 1.** The authority citation for part 54 continues to read in part as follows:

**Authority:** 26 U.S.C. 7805 \* \* \*.

■ **Par. 2.** Section 54.9801–2 is amended by revising the definition of “Short-

term, limited-duration insurance” to read as follows:

**§ 54.9801–2 Definitions.**

\* \* \* \* \*

*Short-term, limited-duration insurance* means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total;

(2) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 1, excluding the heading “Notice 1,” with any additional information required by applicable state law:

**Notice 1:**

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. 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.

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 2, excluding the heading “Notice 2,” with any additional information required by applicable state law:

**Notice 2:**

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions

or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. 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.

(4) If a court holds the 36-month maximum duration provision set forth in paragraph (1) of this definition or its applicability to any person or circumstances invalid, the remaining provisions and their applicability to other people or circumstances shall continue in effect.

\* \* \* \* \*

■ **Par. 3.** Section 54.9833–1 is amended by revising the section heading and the last sentence to read as follows:

**§ 54.9833–1 Applicability dates.**

\* \* \* Notwithstanding the previous sentence, the definition of “short-term, limited-duration insurance” in § 54.9801–2 applies October 2, 2018.

**DEPARTMENT OF LABOR**

**Employee Benefits Security Administration**

**29 CFR Chapter XXV**

For the reasons stated in the preamble, the Department of Labor amends 29 CFR part 2590 as set forth below:

**PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS**

■ **4.** The authority citation for part 2590 continues to read as follows:

**Authority:** 29 U.S.C. 1027, 1059, 1135, 1161–1168, 1169, 1181–1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104–191, 110 Stat. 1936; sec. 401(b), Pub. L. 105–200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110–343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111–148, 124 Stat. 119, as amended by Pub. L. 111–152, 124 Stat. 1029; Division M, Pub. L. 113–235, 128 Stat. 2130; Secretary of Labor’s Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

■ **5.** Section 2590.701–2 is amended by revising the definition of “Short-term, limited-duration insurance” to read as follows:

**§ 2590.701–2 Definitions.**

\* \* \* \* \*

*Short-term, limited-duration insurance* means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract that is less than 12 months after the original effective date of the

contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total;

(2) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 1, excluding the heading “Notice 1,” with any additional information required by applicable state law:

**Notice 1:**

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. 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.

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 2, excluding the heading “Notice 2,” with any additional information required by applicable state law:

**Notice 2:**

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. 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.

(4) If a court holds the 36-month maximum duration provision set forth in paragraph (1) of this definition or its

applicability to any person or circumstances invalid, the remaining provisions and their applicability to other people or circumstances shall continue in effect.

\* \* \* \* \*

■ 6. Section 2590.736 is amended by revising the last sentence to read as follows:

**§ 2590.736 Applicability dates.**

\* \* \* Notwithstanding the previous sentence, the definition of “short-term, limited-duration insurance” in § 2590.701–2 applies October 2, 2018.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR parts 144, 146, and 148 as set forth below:

**PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE**

■ 7. The authority citation for part 144 continues to read as follows:

**Authority:** 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

■ 8. Section 144.103 is amended by revising the definition of “Short-term, limited-duration insurance” to read as follows:

**§ 144.103 Definitions.**

\* \* \* \* \*

*Short-term, limited-duration insurance* means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract that is less than 12 months after the original effective date of the contract and, taking into account renewals or extensions, has a duration of no longer than 36 months in total;

(2) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the

following Notice 1, excluding the heading “Notice 1,” with any additional information required by applicable state law:

**Notice 1:**

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. 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.

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the language in the following Notice 2, excluding the heading “Notice 2,” with any additional information required by applicable state law:

**Notice 2:**

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. 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.

(4) If a court holds the 36-month maximum duration provision set forth in paragraph (1) of this definition or its applicability to any person or circumstances invalid, the remaining provisions and their applicability to other people or circumstances shall continue in effect.

\* \* \* \* \*

**PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET**

■ 9. The authority citation for part 146 is revised to read as follows:

**Authority:** 42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92.

■ 10. Section 146.125 is amended by revising the last sentence to read as follows:

**§ 146.125 Applicability dates.**

\* \* \* Notwithstanding the previous sentence, the definition of “short-term, limited-duration insurance” in § 144.103 of this subchapter applies October 2, 2018.

**PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET**

■ 11. The authority citation for part 148 continues to read as follows:

**Authority:** 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 12. Section 148.102 is amended by revising the section heading and the last sentence of paragraph (b) to read as follows:

**§ 148.102 Scope and applicability date.**

\* \* \* \* \*

(b) \* \* \* Notwithstanding the previous sentence, the definition of “short-term, limited-duration insurance” in § 144.103 of this subchapter is applicable October 2, 2018.

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