IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

ASSOCIATION FOR COMMUNITY AFFILIATED PLANS, *et al.*, *Plaintiffs*, v. UNITED STATES DEPARTMENT OF TREASURY, *et al.*, *Defendants.*	Civil Action No. 18-2133

REVISED JOINT ADMINISTRATIVE RECORD APPENDIX

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That airspace extending upward from 700 feet above the surface within a 6.4-mile radius of Lompoc Airport, and within 4 miles each side of the 090° bearing from the airport extending to 12.8 miles east of the airport, and within 4 miles each side of the 113° bearing from the airport extending to 20.4 miles southeast of the airport.

Issued in Seattle, Washington, on February 7, 2018.

B.G. Chew,

Acting Manager, Operations Support Group, Western Service Center.

[FR Doc. 2018–03415 Filed 2–20–18; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[REG–133491–17]

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–P]

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: Proposed rule.

SUMMARY: This rule contains proposals amending 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 period of short-term, limited-duration insurance, which will provide more affordable consumer choice for health coverage.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. EST on April 23, 2018.

ADDRESSES: In commenting, please refer to file code CMS–9924–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *https://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9924–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9924–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: Amber Rivers or Matthew Litton of the Department of Labor, at 202–693–8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317–5500; David Mlawsky, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at 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/cciio*) and information on health reform can be found at *www.HealthCare.gov.*

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that website to view public comments.

I. Background

This proposed rule contains 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),[1] 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,[2] the Paul Wellstone and Pete Domenici Mental Health Parity and

[1] Public Law 104–191, 110 Stat. 1936 (August 21, 1996).

[2] Public Law 104–204, 110 Stat. 2944 (September 26, 1996).

Addiction Equity Act of 2008,[3] the Newborns' and Mothers' Health Protection Act,[4] the Women's Health and Cancer Rights Act,[5] the Genetic Information Nondiscrimination Act of 2008,[6] the Children's Health Insurance Program Reauthorization Act of 2009,[7] Michelle's Law,[8] and the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA).[9]

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''.[10] 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 or pay the individual shared responsibility payment.[11] On December 22, 2017, the President signed tax reform legislation into law.[12] This legislation includes a provision under which the individual shared responsibility payment included in section 5000A of the Code is reduced to $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 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. Although short-term, limited-duration insurance is not an excepted benefit,[13] it is exempt from the PHS Act's individual-market requirements because it is not individual health insurance coverage.[14] 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.'' [15]

The PHS Act does not define short-term, limited-duration insurance. Under regulations implementing HIPAA, and that continued to apply through 2016, 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 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.'' [16]

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 pool for PPACA-compliant plans, the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (together, the Departments) [17] 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.''[18] The June 2016 proposed rule changed 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 (including any renewal period(s)).[19]

The June 2016 proposed rule also included a requirement that the following notice be prominently displayed in the contract and in any application materials provided in connection with enrollment in short-term, limited-duration insurance, in 14 point type:

THIS IS NOT QUALIFYING HEALTH COVERAGE (''MINIMUM ESSENTIAL COVERAGE'') THAT SATISFIES THE

[3] Public Law 110–343, 122 Stat. 3881 (October 3, 2008).

[4] Public Law 104–204, 110 Stat. 2935 (September 26, 1996).

[5] Public Law 105–277, 112 Stat. 2681–436 (October 21, 1998).

[6] Public Law 110–233, 122 Stat. 881 (May 21, 2008).

[7] Public Law 111–3, 123 Stat. 64 (February 4, 2009).

[8] Public Law 110–381, 122 Stat. 4081 (October 9, 2008).

[9] 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.

[10] 82 FR 48385.

[11] 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 minimum essential coverage 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 minimum essential coverage.

[12] Public Law 115–97, 131 Stat. 2054.

[13] Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the respective requirements of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code generally do not apply to certain types of benefits, known as ''excepted benefits.'' Excepted benefits are described in section 2791(c) of the PHS Act, section 733(c) of ERISA, and section 9832(c) of the Code. See also 26 CFR 54.9831–1(c), 29 CFR 2590.732(c), 45 CFR 146.145(b), and 45 CFR 148.220.

[14] The definition of short-term, limited-duration insurance has some limited relevance with respect to group health plans and group health insurance issuers. 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).

[15] 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 insurance that is sold in the group market and purports to be short-term, limited-duration insurance must comply with Part A of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code.

[16] 62 FR 16894 at 16928, 16942, 16958 (April 8, 1997), 69 FR 78720 (December 30, 2004).

[17] Note, however, that in section headings listing only 2 of the 3 Departments, the term ''Departments'' generally refers only to the 2 Departments listed in the heading.

[18] 81 FR 38019.

[19] 81 FR 38019, 38032–33.

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.[20]

Some stakeholders who submitted comments on the June 2016 proposed rule supported the rule and the Departments' stated goals. Several commenters agreed that the proposed rule would limit the number of consumers relying on short-term, limited-duration insurance as their primary form of coverage and improve the PPACA's individual market single risk pools. However, other commenters expressed concerns about restricting the use of short-term, limited-duration insurance (as originally defined under the HIPAA regulations) because it provides an additional, often much more affordable coverage option than an insurance policy that complies with all of the requirements of the PPACA. Some commenters explained that individuals who do not qualify for premium tax credits and need temporary coverage, or who cannot afford Consolidated Omnibus Budget Reconciliation Act[21] (COBRA) continuation coverage, or who missed an opportunity to sign up for coverage during open enrollment or special enrollment periods, might need to rely on short-term, limited-duration insurance coverage for 3 months or longer. Commenters highlighted how a person with just a less-than-3-month policy who develops a health condition might have no coverage options for the condition after their coverage expires until the beginning of the plan year that corresponds to the next individual market open enrollment period. Other commenters also expressed opposition to the proposed rule citing their belief that States are in the best position to regulate short-term, limited-duration insurance and that the proposed rule would limit State flexibility. Finally, several commenters observed that PPACA-compliant policies are often network-based but short-term, limited-duration insurance policies typically are not, thus offering consumers a greater choice of health care providers. This is particularly true in rural areas, one commenter stated.

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''.[22]

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'',[23] 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 in-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.

The Departments are also aware that, while individuals who qualify for premium tax credits are largely insulated from significant premium increases (that is, the government, and thus federal taxpayers, largely bear the cost of the higher premiums), individuals who are not eligible for subsidies 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 plan selections and data compiled from issuer regulatory filings at the State level, for the first quarters of 2016 and 2017, the number of off-Exchange and unsubsidized enrollees with individual market coverage fell by nearly 2 million, representing an almost 25 percent decrease.[24] Further, in 2018, about 26 percent of enrollees (living in 52 percent of counties) have access to just one insurer in the Exchange.[25] Short-term, limited-duration insurance has become increasingly attractive to some individuals as premiums have escalated for PPACA-compliant plans and affordable choices in the individual market have dwindled.

II. Overview of the Proposed Regulations

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, the Departments are proposing to amend the definition of short-term, limited-duration insurance so that it may offer a maximum coverage period of less than 12 months after the original effective date of the contract, consistent with the original definition in the 1997 HIPAA rule (that is, the proposed rule would expand the potential maximum coverage period by 9 months). This proposed definition states that the expiration date specified in the contract takes into account any extensions that may be elected by the policyholder without the issuer's consent.

In addition, this proposed rule would revise the required notice that must appear in the contract and any application materials for short-term, limited-duration insurance. The Departments are concerned that short-term, limited-duration insurance policies that provide coverage lasting almost 12 months may be more difficult for some individuals to distinguish from PPACA-compliant coverage which is typically offered on a 12-month basis. Accordingly, under this proposed rule, one of two versions (as explained below) of the following notice would be required to be prominently displayed (in at least 14 point type) in the contract and in any application materials

[20] 82 FR 38032.

[21] Public Law 99–272, 100 Stat. 82 (April 7, 1986).

[22] 81 FR 75316.

[23] 82 FR 26885.

[24] See Mark Farrah and Associates, ''A Brief Look at the Turbulent Individual Health Insurance Market,'' July 19, 2017. Available at: *http://www.markfarrah.com/healthcare-business-strategy-print/A-Brief-Look-at-the-Turbulent-Individual-Health-Insurance-Market.aspx.* Also, see the Centers for Medicare and Medicaid Services, ''2017 Effectuated Enrollment Snapshot,'' June 12, 2017. Available at: *https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf.*

[25] See Kaiser Family Foundation. ''Insurer Participation on ACA Marketplaces, 2014–2018,'' November 10, 2017. *http://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/.*

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.

As stated below, the Departments are proposing that the applicability date for this proposed rule, if finalized, would be 60 days after the publication of the final rule, and that policies sold on or after that date would have to meet the requirements of the final rule in order to constitute short-term, limited-duration insurance. As previously discussed, the individual shared responsibility payment is reduced to $0 for months beginning after December 2018. Consequently, the Departments propose that the final two sentences of the notice must appear only with respect to policies sold on or after the applicability date of the rule, if finalized, that have a coverage start date before January 1, 2019. The Departments solicit 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.

The current definition of short-term, limited-duration insurance applies for policy years beginning on or after January 1, 2017. In the October 2016 final rule, the Departments recognized that State regulators may have approved short-term, limited-duration insurance products for sale in 2017 that met the definition in effect prior to January 1, 2017.[26] Accordingly, HHS noted it would not take enforcement action against an issuer with respect to its sale of a short-term, limited-duration insurance product before April 1, 2017, on the ground that the coverage period is 3 months or more, provided that the coverage ended on or before December 31, 2017, and otherwise complies with the definition of short-term, limited-duration insurance in effect under the final rule.[27] As stated in the October 2016 final rule, States may also elect not to take enforcement actions against issuers with respect to such coverage sold before April 1, 2017. The current definition in the October 2016 final rule, and the non-enforcement policy as applied to policies sold before April 1, 2017, and that end on or before December 31, 2017, would continue to apply unless and until this rule is finalized.

Effective Date and Applicability Date

The Departments propose that this rule, if finalized, would be effective 60 days after publication of the final rule. With respect to the applicability date, the Departments propose 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 propose that group health plans and group health insurance issuers, to the extent they must distinguish between short-term, limited-duration insurance and individual market health insurance (such as for purposes of determining whether an individual has moved out of a health maintenance organization (HMO) service area in the individual market, which would trigger a special enrollment right into a group health plan or for purposes of offering limited wraparound coverage (which wraps around individual health insurance or the Basic Health Plan as an excepted benefit[28]), 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 propose conforming amendments to those rules as part of this rulemaking. The Departments also propose 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).[29] Given that the applicability date for the amendments to those sections has passed, it is no longer necessary to mention the ''future'' applicability date.[30] HHS similarly proposes to amend § 148.102 to remove the reference to the applicability date for amendments to § 148.220(b)(7) (regarding supplemental coverage excepted benefits).[31]

Request for Comments

The Departments seek comments on all aspects of this proposed rule, including whether the length of short-term, limited-duration insurance should be some other duration. The Departments seek 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 seek comments on 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. Among other things, the Departments solicit 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 definition of short-term, limited-duration insurance in the proposed rule to such practices. For example, an expedited process could involve setting minimum federal standards for what must be considered as part of the streamlined reapplication process while allowing insurers to consider additional factors in accordance with contract terms. The Departments are 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.

[26] 81 FR 75318 through 75319.

[27] This non-enforcement policy is limited to the requirement that short-term, limited-duration insurance must be less than 3 months. It does not relieve issuers of short-term, limited-duration insurance of the notice requirement, which applies for policy years beginning on or after January 1, 2017.

[28] See footnote 14.

[29] 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).

[30] The applicability date for these amendments (policy years and plan years beginning on or after January 1, 2017) remains unchanged.

[31] The applicability date for these amendments (policy years beginning on or after January 1, 2017) remains unchanged.

Because short-term, limited-duration insurance can be priced in an actuarially fair manner (by which the Departments mean 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), subject to State law, individuals who are likely to purchase short-term, limited-duration insurance are likely to be relatively young or healthy. Allowing such individuals to purchase policies that are not in compliance with PPACA may impact the individual market single risk pools. As explained in section III., ''Economic Impact and Paperwork Burden'' of this proposed rule, the Departments estimate that in 2019, after the elimination of the individual shared responsibility payment, between 100,000 and 200,000 individuals previously enrolled in Exchange coverage would purchase short-term, limited-duration insurance policies instead. This would cause the average monthly individual market premiums and average monthly premium tax credits to increase, leading to an increase in total annual advance payments of the premium tax credit (APTC) [32] in the range of $96 million to $168 million. The Departments seek comments on these estimates, and welcome other estimates of the increase in enrollment in short-term, limited-duration insurance under this proposal, and the health status and age of individuals who would purchase these policies.

The Departments also seek comments on the proposed effective and applicability dates of this rule, if finalized. The Departments seek comments on whether the proposed fixed applicability date, which would first impose the new definition of short-term, limited-duration insurance on group health plans and group health insurance issuers on a date that may occur in the middle of a plan year, would cause any special challenges for group health plans and group health insurance issuers.

III. Economic Impact and Paperwork Burden

A. Summary—Department of Labor and Department of Health and Human Services

This rule proposes to amend the definition of short-term, limited-duration insurance coverage so that the coverage (taking into account extensions elected by the policyholder without the issuer's consent) has a maximum period of less than 12 months after the original effective date of the contract. This rule also seeks comments on all aspects of this proposed rule, including whether the maximum length of short-term, limited-duration insurance should be some other duration; under what conditions issuers should be able to allow short-term, limited-duration insurance to continue for 12 months or longer with the issuer's consent; and on the proposed revisions to the notice that must appear in the contract and any application materials.

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—Department of Labor and Department of Health and Human Services

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

1. Need for Regulatory Action

This rule contains proposed amendments to the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage. 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 premium tax credits are largely insulated from significant premium increases, individuals who are not eligible for subsidies are harmed by increased premiums in the individual market due to a lack of other, more affordable alternative coverage options. The proposed rule would increase insurance options for individuals unable or unwilling to purchase PPACA-compliant plans.

2. Summary of Impacts

In accordance with OMB Circular A–4, Table 1 depicts an accounting statement summarizing the

[32] The Departments are using data on APTC as an approximation of premium tax credits since this is the data that is available for 2017.

Departments' assessment of the benefits, costs, and transfers associated with this regulatory action.

TABLE 1—ACCOUNTING TABLE

Benefits:

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

Costs:

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

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

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

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

Short-term, limited-duration insurance represents a small fraction of the health insurance market. Based on data from the National Association of Insurance Commissioners (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.[33]

Some public comments received in response to the June 2016 proposed rule stated that the majority of the short-term, limited-duration insurance policies were sold as transitional coverage, particularly for individuals seeking to cover periods of unemployment or other gaps between employer-sponsored coverage, and that the policies typically provided coverage for less than 3 months. Accordingly, this proposed rule would have no effect on the consumers who purchase such coverage for less than 3 months and perhaps some issuers of those policies. While it is not clear how the October 2016 final rule affected the sales of short-term, limited-duration insurance, the sales of such coverage were increasing prior to the issuance of that rule. Given the prior trend and the recent increases in premiums in the individual market, the Departments anticipate that the rule, if finalized, would encourage more consumers to purchase short-term, limited-duration insurance for longer durations, including individuals who were previously uninsured and some who are currently enrolled in individual market plans, especially in 2019 and beyond, when the individual shared responsibility payment included in section 5000A of the Code is reduced to $0, as provided under Public Law 115–97.

Benefits

Consumers who would be likely to purchase short-term, limited-duration insurance for longer periods would benefit from increased insurance options at lower premiums, as the average monthly premium in the fourth quarter of 2016 for a short-term, limited-duration policy was approximately $124 compared to $393 for an unsubsidized PPACA-compliant plan.[34] This proposed rule would also benefit individuals who need coverage for longer periods for reasons previously discussed in the preamble, such as needing more than 3 months to find new employment, or finding PPACA-compliant plans to be unaffordable. Individuals who purchase short-term, limited-duration insurance as opposed to being uninsured would potentially experience improved health outcomes and have greater protection from catastrophic health care expenses. Individuals purchasing short-term, limited-duration policies could obtain broader access to health care providers compared to those PPACA-compliant plans that have narrow provider networks.[35] The Departments seek comments on how many consumers may purchase short-term, limited-duration insurance, rather than being uninsured or purchasing PPACA-compliant plans, and the benefits to

[33] 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.*

[34] *http://www.npr.org/sections/health-shots/2017/01/31/512518502/sales-of-short-term-insurance-plans-could-surge-if-health-law-is-relaxed.*

[35] The ability of short-term limited-duration plans to provide broad provider networks has been touted by some in the insurance community. *https://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539.*

them from having short-term, limited-duration insurance, as well as any impacts on the PPACA individual market single risk pools.

Issuers of short-term, limited-duration insurance would 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 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) and are not required to comply with PPACA medical loss ratio requirements for group and individual health insurance coverage.

Costs and Transfers

Short-term, limited-duration insurance policies would be unlikely to include all the elements of PPACA-compliant 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 PPACA-compliant plans would experience loss of access to some services and providers and an increase in out-of-pocket expenditures related to such excluded services, benefits that in many cases consumers do not believe are worth their cost (which could be one reason why many consumers, even those receiving subsidies for PPACA-compliant plans, may switch to short-term, limited-duration policies rather than remain in PPACA-compliant plans). The Departments seek comments on the value of such excluded services to individuals who switch coverage. Depending on plan design, consumers who purchase short-term, limited-duration insurance policies and then develop chronic conditions could face financial hardship as a result, until they are able to enroll in PPACA-compliant plans that would provide coverage for such conditions. Additionally, since short-term, limited-duration insurance does not qualify as minimum essential coverage, any individual enrolled in a short-term, limited-duration plan that lasts 3 months or longer in 2018 would potentially incur a tax liability for not having minimum essential coverage 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.

Because short-term, limited-duration insurance policies can be priced in an actuarially fair manner, subject to State law, individuals who are likely to purchase such coverage are likely to be relatively young or healthy. Allowing such individuals to purchase policies that do not comply with PPACA, but with term lengths that may be similar to those of PPACA-compliant plans with 12-month terms, could potentially weaken States' individual market single risk pools. As a result, 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 insurer in roughly half of all counties, this proposed rule may further reduce choices for individuals remaining in those individual market single risk pools. The Departments seek comments on these and any other potential costs.

The Departments anticipate that most of the individuals who switch from individual market plans to short-term, limited-duration insurance would be relatively young or healthy and would also not be eligible to receive APTC. If individual market single risk pools change as a result, it would result in an increase in premiums for the individuals remaining in those risk pools. An increase in premiums for individual market single risk pool coverage would result in an increase in Federal outlays for APTC.

Beginning 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. This would compound the effects of the provisions of this proposed rule (one potential exception being the impact on APTC payments). In order to estimate the impact on the individual market and APTC payments, the Departments used enrollment, premium and APTC data for 2017, observed rate increases for 2018, and assumed that 2019 rates will increase in line with medical expenditures and assumed the relative morbidities of the individuals leaving the individual market single risk pool to those remaining in the risk pool to be 75 percent. The Congressional Budget Office estimates that 3 million people will drop coverage in 2019 from the individual market and premiums will increase 10 percent on average, as a result of the change to the individual shared responsibility payment.[36] The Departments seek comments on how many of these individuals may purchase short-term, limited-duration insurance instead. Based on enrollment trends prior to the October 2016 final rule, the Departments project that approximately 100,000 to 200,000 additional individuals would shift from the individual market to short-term, limited-duration insurance in 2019. Most of these individuals would be young or healthy and only about 10 percent of them would have been subsidized by eligibility for APTC if they maintained their Exchange coverage. While the reduction in the number of subsidized enrollees would tend to reduce total APTC payments, increases in premiums would tend to increase them. The proposed rule's net effect on total APTC payments is uncertain, but federal outlays for APTC are estimated to increase by between $96 million ($54,948 million − $54,852 million) and $168 million ($55,020 million − $54,852 million) annually. Table 2 depicts the effects on average premiums[37] and APTC payments.

TABLE 2—ESTIMATED EFFECT ON INDIVIDUAL MARKET EXCHANGES IN 2019

	Estimated number of subsidized enrollees in exchanges	Estimated number of unsubsidized enrollees in exchanges	Estimated average monthly premium	Estimated average monthly APTC	Estimated total monthly APTC	Estimated total annual APTC
No change in policy	8,459,000	4,671,000	$649	$512	$4,331,000,000	$51,972,000,000

[36] See Congressional Budget Office, Repealing the Individual Health Insurance Mandate: An Updated Estimate, November 2017, available at *https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf.*

[37] Percent Premium Increase = (Total Enrollment (Morbidity(75%) * Number Switching)) / (Total Enrollment Number Switching).

TABLE 2—ESTIMATED EFFECT ON INDIVIDUAL MARKET EXCHANGES IN 2019—Continued

	Estimated number of subsidized enrollees in exchanges	Estimated number of unsubsidized enrollees in exchanges	Estimated average monthly premium	Estimated average monthly APTC	Estimated total monthly APTC	Estimated total annual APTC
$0 individual shared responsibility payment	8,122,000	1,608,000	714	563	4,573,000,000	54,852,000,000
100,000 People switching to short-term, limited-duration insurance	8,112,000	1,518,000	716	564	4,579,000,000	54,948,000,000
200,000 People switching to short-term, limited-duration insurance	8,102,000	1,428,000	718	566	4,585,000,000	55,020,000,000

There is significant uncertainly regarding these estimates, because changes in enrollment and premiums would depend on a variety of economic factors and it is difficult to predict how consumers and issuers would react to the proposed policy changes.

C. Regulatory Alternatives

One regulatory alternative would be to set the maximum duration for short-term, limited-duration insurance to a 6 month or 9 month period. However, this alternative would not adequately increase choices for individuals unable or unwilling to purchase PPACA-compliant plans.

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

This proposed rule would revise the required notice that must be prominently displayed in the contract and in any application materials for short-term, limited-duration insurance. The Departments have proposed the exact text for this notice requirement and the language would 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 proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. 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 revenues of more than 3 to 5 percent.

This proposed rule would impact health insurance issuers, especially those in the individual market. The Departments believe that health insurance issuers would 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 these North American Industry Classification System codes. 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.[38] 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 Medical Loss Ratio (MLR) annual report submissions for the 2015 MLR reporting year,[39] approximately 92 out of over 530 issuers of health insurance coverage nationwide had total premium revenue of $38.5 million or less, of which 64 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 50 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 would result in their revenues exceeding $38.5 million. Therefore, the Departments certify that this proposed rule would 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 603 of the RFA. This proposed rule will not affect small rural hospitals. Therefore, the Departments have determined that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

F. Special Analysis—Department of the Treasury

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory impact assessment is not required. Pursuant to Executive Order 13789, the Treasury Department and OMB are currently reviewing the scope and implementation of the existing

[38] ''Table of Small Business Size Standards Matched to North American Industry Classification System Codes'', effective October 1, 2017, U.S. Small Business Administration, available at *https://www.sba.gov/sites/default/files/files/Size_Standards_Table_2017.pdf.*

[39] Available at *https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.*

exemption. Pursuant to section 7805(f) of the Code, this proposed rule has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

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 proposed 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. Currently, that threshold is approximately $148 million. This proposed rule does not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, that may impose an annual burden that exceeds that threshold.

H. Federalism—Department of Labor and Department of Health and Human Services

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 issue of the term length of short-term, limited-duration insurance with State regulatory officials. This proposed 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 proposed in this proposed rule. States may continue to apply such State law requirements.

I. Congressional Review Act

This proposed 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. This proposed rule, if finalized as proposed, is expected to be an Executive Order 13771 deregulatory action.

IV. Statutory Authority

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

The Department of Labor regulations are proposed to be 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 proposed to be 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.

Kirsten B. Wielobob,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Signed this 8th day of February 2018.

Preston Rutledge,

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

Dated: February 1, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: February 9, 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 proposed to be amended as follows:

PART 54—PENSION AND EXCISE TAX

■ **Par. 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 (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;

(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 following:

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.;

and

(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 following:

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.

* * * * *

■ **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 [DATE 60 DAYS AFTER DATE OF PUBLICATION OF THE FINAL RULE IN THE **FEDERAL REGISTER**].

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons stated in the preamble, the Department of Labor proposes to amend 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 (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;

(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 following:

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.;

and

(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 following:

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.

* * * * *

■ 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 [DATE 60 DAYS AFTER DATE OF PUBLICATION OF THE FINAL RULE IN THE **FEDERAL REGISTER**].

DEPARTMENT OF HEALTH AND HUMAN SERVICES

For the reasons stated in the preamble, the Department of Health and Human Services proposes to amend 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: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 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 (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;

(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 following:

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.;

and

(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 following:

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.

* * * * *

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

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

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the Public Health Service Act (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 [DATE 60 DAYS AFTER DATE OF PUBLICATION OF THE FINAL RULE IN THE **FEDERAL REGISTER**].

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

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

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (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 [DATE 60 DAYS AFTER DATE OF PUBLICATION OF THE FINAL RULE IN THE **FEDERAL REGISTER**].

[FR Doc. 2018–03208 Filed 2–20–18; 8:45 am]

BILLING CODE 4150–28–P; 4510–29–P; 6325–64–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

RIN 0648–BG83

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Reef Fish Fishery of the Gulf of Mexico; Amendment 36A

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notification of availability; request for comments.

SUMMARY: The Gulf of Mexico (Gulf) Fishery Management Council (Council) has submitted Amendment 36A to the Fishery Management Plan for the Reef Fish Resources of the Gulf of Mexico (Reef Fish FMP) for review, approval, and implementation by NMFS. Amendment 36A would require owners or operators of federally permitted commercial Gulf reef fish vessels landing any commercially caught, federally managed reef fish from the Gulf to provide notification prior to landing and to land at approved locations; require shares of red snapper individual fishing quota (IFQ) (RS–IFQ) program and groupers and tilefishes IFQ (GT–IFQ) program from non-activated accounts to be returned to NMFS for redistribution; and allow NMFS to hold back a portion of IFQ allocation at the start of the fishing year in anticipation of a commercial quota reduction. The purpose of Amendment 36A is to improve compliance and increase management flexibility in the RS–IFQ and GT–IFQ programs, and increase the likelihood of achieving optimum yield (OY) for reef fish stocks managed under these programs.

DATES: Written comments on Amendment 36A must be received by April 23, 2018.

ADDRESSES: You may submit comments on the amendment identified by ''NOAA–NMFS–2017–0060'' by either of the following methods:

- *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2017-0060,* click the ''Comment Now!'' icon, complete the required fields, and enter or attach your comments.
- *Mail:* Submit written comments to Peter Hood, NMFS Southeast Regional Office, 263 13th Avenue South, St. Petersburg, FL 33701.

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by NMFS. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, etc.), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NMFS will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous).

Electronic copies of Amendment 36A may be obtained from *www.regulations.gov* or the Southeast Regional Office website at *http://sero.nmfs.noaa.gov/sustainable_fisheries/gulf_fisheries/reef_fish/2017/A36A_comm_IFQ/am36Aindex.html.* Amendment 36A includes an environmental assessment, fishery impact statement, regulatory impact review, and Regulatory Flexibility Act analysis.

FOR FURTHER INFORMATION CONTACT: Peter Hood, NMFS Southeast Regional Office, telephone: 727–824–5305, or email: *peter.hood@noaa.gov.*

SUPPLEMENTARY INFORMATION: The Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) requires each regional fishery management council to submit any FMP or amendment to NMFS for review and approval, partial approval, or disapproval. The Magnuson-Stevens Act also requires that NMFS, upon receiving a plan or amendment, publish an announcement in the **Federal Register** notifying the public that the FMP or amendment is available for review and comment.

Amendment 36A to the Reef Fish FMP was prepared by the Council and, if approved, would be implemented by NMFS through regulations at 50 CFR

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/cciio*) and information on health reform can be found at *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) [1] 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,[2] the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,[3] the Newborns' and Mothers' Health Protection Act,[4] the Women's Health and Cancer Rights Act,[5] the Genetic Information Nondiscrimination Act of 2008,[6] the Children's Health Insurance Program Reauthorization Act of 2009,[7] Michelle's Law,[8] and the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA).[9]

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.'' [10] 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.[11] On December 22, 2017, the President signed tax reform legislation into law.[12] This legislation includes a provision under which the individual shared responsibility payment under section 5000A of the Code is reduced to

[1] Public Law 104–191, 110 Stat. 1936 (August 21, 1996).

[2] Public Law 104–204, 110 Stat. 2944 (September 26, 1996).

[3] Public Law 110–343, 122 Stat. 3881 (October 3, 2008).

[4] Public Law 104–204, 110 Stat. 2935 (September 26, 1996).

[5] Public Law 105–277, 112 Stat. 2681–436 (October 21, 1998).

[6] Public Law 110–233, 122 Stat. 881 (May 21, 2008).

[7] Public Law 111–3, 123 Stat. 64 (February 4, 2009).

[8] Public Law 110–381, 122 Stat. 4081 (October 9, 2008).

[9] 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.

[10] 82 FR 48385.

[11] 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.

[12] Public Law 115–97, 131 Stat. 2054.

$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.'' [13] 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.[14] 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.'' [15]

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.'' [16] 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.[17]

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.[18]

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.'' [19]

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,'' [20] 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,

[13] 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.

[14] 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).

[15] 62 FR 16894 at 16928, 16942, 16958 (April 8, 1997); *see also* 69 FR 78720 (December 30, 2004).

[16] 81 FR 38019.

[17] 81 FR 38019, 38032.

[18] Id. at 38032.

[19] 81 FR 75316 (October 31, 2016).

[20] 82 FR 26885.

average monthly enrollment for individuals without PTCs declined by 1.3 million, or 20 percent, between 2016 and 2017.[21] Some of this decline is likely a response to increased premiums.[22] Further, in 2018, about 26 percent of enrollees (living in 52 percent of counties) have access to just one issuer in the Exchange.[23] 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.[24] 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 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.[25]

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

[21] 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*.

[22] 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*.

[23] 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/*.

[24] 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*.

[25] 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.[26] 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.[27] 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.[28] 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

[26] *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.

[27] 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.

[28] *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.[29] 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

[29] *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 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.[30] 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 [31] 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

[30] CMS Exchanges Trend Report, July 2, 2018.

[31] 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 [32] 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.[33] 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

[32] 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.*

[33] *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.[34] 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

[34] 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.[35] 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,[36] 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.[37] 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.[38] 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

[35] 26 U.S.C. 4980B(f), 29 U.S.C. 1161–1168, 42 U.S.C. 300bb–1—300bb–8.

[36] 5 U.S.C. 8905(a).

[37] Section 2703 of the PHS Act; *see also* 42 U.S.C. 300gg–42.

[38] *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.[39] 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[40] 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-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.[41] 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.[42] 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 re-setting 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

[39] 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.*

[40] *See* section 2792(b)(1) of the PHS Act.

[41] 81 FR 75318.

[42] 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.[43] 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.

[43] *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.[44]

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

[44] *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).[45] 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.[46] 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).[47]

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 rules 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

[45] 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).

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

[47] The applicability date for these amendments (policy years beginning on or after January 1, 2017) remains unchanged.

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.[48] 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 [49] 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.[50] 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.[51]

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.[52] 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.[53] While there is a significant difference in the premiums for short-term, limited-duration

[48] 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.*

[49] 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.*

[50] National Association of Insurance Commissioners, ''2017 Accident and Health Policy Report'', July 2018. Available at *https://naic.org/prod_serv/AHP-LR-18.pdf.*

[51] 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.*

[52] 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.*

[53] 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.[54] 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.[55] 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.[56]

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.[57] 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

[54] 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/.*

[55] Id.

[56] 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.

[57] 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,[58] 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.[59] For the top 10 issuers

[58] 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.*

[59] 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.[60] 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.[61] 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.*

[60] Id.

[61] 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,[62] 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.[63] 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,[64] 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.[65] 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

[62] ASPE ''Data Point—Individual Market Premium Changes: 2013–2017'', May 23, 2017. Available at *https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf.*

[63] 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.*

[64] 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.*

[65] 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.[66] 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.[67] 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.[68] 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'',[69] 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[70] 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

[66] Karen Pollitz, ''Surprise Medical Bills'', Kaiser Family Foundation, March 17, 2016. Available at *https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/*.

[67] 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/*.

[68] 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.

[69] 83 FR 28912.

[70] 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 [71] 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.[72] 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

[71] 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/*.

[72] 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.[73]

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,[74] 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.[75] 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

[73] Id.

[74] 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).

[75] 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.*

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.[76]

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[77] 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[78] 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.[79] 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.[80] 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 [1]	0.3	0.7	0.8	0.8	0.8	0.8	0.7	0.7	0.7	0.7	.....

[76] 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.

[77] 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.

[78] The Departments used data on Advance PTC as an approximation of PTC since this is the data that is available for 2017.

[79] 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.*

[80] 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 [2]	6%	11%	14%	14%	14%	14%	14%	14%	14%	14%	.....
Short-term, limited-duration.											
Gross Premium [3]	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

[1] 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.

[2] 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.

[3] 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''.[81] 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.[82] Additionally, CBO projected higher overall enrollment in short-term, limited-duration coverage, 2 million people in 2023 compared to OACTs 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.[83]

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.[84] Specifically the Urban Institute found that in 2019 ''4.3 million would enroll in expanded short-term limited-duration plans.'' [85] ''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-

[81] 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.*

[82] 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.''

[83] CBO and JCT did not separately break out the budget effects of the AHP rule and the short-term, limited-duration rule.

[84] 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.*

[85] Id.

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.[86] 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.[87] The Commonwealth Fund 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 [88] 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,[89] focusing on the District of Columbia's individual and small group markets, estimated that the 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 [90] 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,

[86] 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.''

[87] 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.* 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.

[88] 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.*

[89] 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.*

[90] 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://hbex.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 [91]—and in such a scenario, high-end enrollment estimates would be less likely.

As discussed earlier in this rule, there is significant uncertainly 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

[91] 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/.*

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.[92] 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,[93] 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

[92] 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.*

[93] 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.[94] Individuals in rural areas enrolled in individual market plans are more likely to receive PTC[95] 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.

[94] 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/.*

[95] 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.

[FR Doc. 2018–16568 Filed 8–1–18; 8:45 am]

BILLING CODE 4150–29–P 4830–01–P 4120–01–P 6325–64–P

found at *http://www2.epa.gov/laws-regulations/laws-and-executive-orders.*

A. Executive Order 12866: Regulatory Planning and Review and Executive Order 13563: Improving Regulation and Regulatory Review

This action is not a significant regulatory action and was therefore not submitted to the Office of Management and Budget (OMB) for review.

B. Paperwork Reduction Act (PRA)

This action does not impose an information collection burden under the PRA because this action does not impose additional requirements beyond those imposed by state law.

C. Regulatory Flexibility Act (RFA)

I certify that this action will not have a significant economic impact on a substantial number of small entities under the RFA. This action will not impose any requirements on small entities beyond those imposed by state law.

D. Unfunded Mandates Reform Act (UMRA)

This action does not contain any unfunded mandate as described in UMRA, 2 U.S.C. 1531–1538, and does not significantly or uniquely affect small governments. This action does not impose additional requirements beyond those imposed by state law. Accordingly, no additional costs to State, local, or tribal governments, or to the private sector, will result from this action.

E. Executive Order 13132: Federalism

This action does not have federalism implications. It will not have substantial direct effects on the states, on the relationship between the national government and the states, or on the distribution of power and responsibilities among the various levels of government.

F. Executive Order 13175: Coordination With Indian Tribal Governments

This action does not have tribal implications, as specified in Executive Order 13175, because the SIP is not approved to apply on any Indian reservation land or in any other area where the EPA or an Indian tribe has demonstrated that a tribe has jurisdiction, and will not impose substantial direct costs on tribal governments or preempt tribal law. Thus, Executive Order 13175 does not apply to this action.

G. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks

The EPA interprets Executive Order 13045 as applying only to those regulatory actions that concern environmental health or safety risks that the EPA has reason to believe may disproportionately affect children, per the definition of "covered regulatory action" in section 2–202 of the Executive Order. This action is not subject to Executive Order 13045 because it does not impose additional requirements beyond those imposed by state law.

H. Executive Order 13211: Actions That Significantly Affect Energy Supply, Distribution, or Use

This action is not subject to Executive Order 13211, because it is not a significant regulatory action under Executive Order 12866.

I. National Technology Transfer and Advancement Act (NTTAA)

Section 12(d) of the NTTAA directs the EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. The EPA believes that this action is not subject to the requirements of section 12(d) of the NTTAA because application of those requirements would be inconsistent with the CAA.

J. Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Population

The EPA lacks the discretionary authority to address environmental justice in this rulemaking.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, New Source Review, Ozone, Particulate matter, Reporting and recordkeeping requirements, Volatile organic compounds.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: May 19, 2017.

Alexis Strauss,

Acting Regional Administrator, Region IX.

[FR Doc. 2017–12134 Filed 6–9–17; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Chapter IV

Office of the Secretary

45 CFR Subtitle A

[CMS–9928–NC]

RIN 0938–ZB39

Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices To Empower Patients

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for information.

SUMMARY: The Department of Health and Human Services (HHS) is actively working to reduce regulatory burdens and improve health insurance options under Title I of the Patient Protection and Affordable Care Act. Executive Order 13765, "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal," directs the Secretary of Health and Human Services to achieve these aims. HHS seeks comment from interested parties to inform its ongoing efforts to create a more patient-centered health care system that adheres to the key principles of affordability, accessibility, quality, innovation, and empowerment.

DATES: Comments must be submitted on or before July 12, 2017.

ADDRESSES: You may submit comments in one of three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments to *http://www.regulations.gov.* Follow the "Submit a comment" instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9928–NC, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9928–NC,

Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

FOR FURTHER INFORMATION CONTACT: Vanessa Jones, (202) 690–7000.

SUPPLEMENTARY INFORMATION:

Submission of Comments: All submissions received must include the Agency name CMS–9928–NC for this notice. All comments received may be posted without change to *http://www.regulations.gov*, including any personal information provided.

I. Background

On January 20, 2017, President Trump issued Executive Order 13765, "Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal," to minimize the unwarranted economic and regulatory burdens of the Patient Protection and Affordable Care Act (PPACA) (Pub. L. 111–148). To meet these objectives, the President directed the Secretary of Health and Human Services (the Secretary) and the heads of all other executive departments and agencies with authorities and responsibilities under the PPACA, to the maximum extent permitted by law, to afford the States more flexibility and control to create a more free and open health care market; provide relief from any provision or requirement of the PPACA that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals, families, health care providers, health insurers, patients, recipients of health care services, purchasers of health insurance, or makers of medical devices, products, or medications; provide greater flexibility to States and cooperate with them in implementing health care programs; and encourage the development of a free and open market in interstate commerce for the offering of health care services and health insurance, with the goal of achieving and preserving maximum options for patients and consumers.

The Department of Health and Human Services (HHS) is the federal government's principal agency charged with protecting the health of all Americans and providing essential human services. HHS's responsibilities include Medicare, Medicaid, increasing access to care and private health coverage, support for public health preparedness and emergency response, biomedical research, substance abuse and mental health treatment and prevention, assurance of safe and effective drugs and other medical products, protection of our Nation's food supply, assistance to low income families, the Head Start program, services to older Americans, and direct health services delivery. HHS is comprised of staff divisions and operating divisions, many of which are responsible for promulgating regulations pursuant to HHS's statutory authority.

Among HHS's goals is to establish a robust and resilient framework for each HHS division to undertake a periodic, thoughtful analysis of its significant existing regulations issued under Title I of the PPACA, to determine whether each rule advances or impedes HHS priorities of stabilizing the individual and small group health insurance markets; empowering patients and promoting consumer choice; enhancing affordability; and returning regulatory authority to the States. We seek public input on changes that could be made, consistent with current law, to existing regulations under HHS's jurisdiction that would result in a more streamlined, flexible, and less burdensome regulatory structure, including identifying regulations that eliminate jobs or inhibit job creation; are outdated, unnecessary, or ineffective; impose costs that exceed benefits; or create a serious inconsistency or otherwise interfere with regulatory reform initiatives and policies.

Since the first weeks of the Administration, HHS has worked to reduce burdens and improve health insurance options under the provisions of Title I of the PPACA for which HHS has jurisdiction. On February 17, 2017, HHS published a proposed rule in the **Federal Register** entitled, "Patient Protection and Affordable Care Act; Market Stabilization," (82 FR 10980) containing regulatory changes that are critical to stabilizing the individual and small group health insurance markets. After receiving and considering public comment, HHS published the Patient Protection and Affordable Care Act; Market Stabilization Final rule on April 18, 2017 (82 FR 18346). The new rules will place downward pressure on premiums, curb abuses, and encourage full-year enrollment by expanding pre-enrollment verification of eligibility for new exchange enrollees using special enrollment periods; encourage patients to avoid coverage lapses; provide greater flexibility to issuers related to actuarial value of plans; return to the States the authority and means to assess issuer network adequacy; revise the timeline for qualified health plan (QHP) certification and rate review to give issuers flexibility to incorporate benefit changes and maximize the number of coverage options available to patients; and more closely align the open enrollment period for the individual market with the employer-sponsored insurance market and Medicare, thus helping to lower prices for Americans by reducing adverse selection. We have also taken a number of other steps to reduce burden, improve choices, and stabilize the insurance market:

- Issued guidance announcing HHS's intent to propose new health coverage enrollment options for small businesses enrolling through the Federally-facilitated Small Business Health Options Program (FF–SHOP), reducing burdens and making it easier for small employers and their employees to purchase coverage.
- Announced a new streamlined and simplified direct enrollment process for consumers signing up for individual market coverage with the assistance of web-brokers or issuers in states with Exchanges that rely on HealthCare.gov for their eligibility and enrollment functions.
- Issued guidance to States explaining their freedom to seek innovative approaches to lowering premiums and protecting consumers via State innovation waivers under section 1332 of the PPACA, which included new information to help states seek waivers from requirements in Title I of the PPACA, and establish high-risk pools/state-operated reinsurance programs.
- Extended the HHS Risk Adjustment and Data Validation (HHS–RADV) pilot by another year, providing needed flexibility for issuers to adapt to the new HHS–RADV audit tool and protocols to ensure that lessons learned from the first pilot year are implemented effectively, and enabling the Centers for Medicaid & Medicare Services (CMS) to ensure that issuers are compliant with all HHS–RADV requirements, increasing the stability of the markets and the integrity of risk adjustment transfers.
- Adjusted the QHP certification calendar, to provide issuers additional time to prepare and States additional time to review 2018 products and rates with greater certainty in response to recent policy changes.
- Issued guidance to issuers allowing patients to keep their transitional individual and small group insurance plans in 2018.

These initial steps will help issuers and States work with HHS to achieve shared goals, including stabilizing the individual and small group health insurance markets; empowering patients and promoting consumer choice; enhancing affordability; and affirming the traditional authority of the States in regulating the business of health insurance. In this Request for Information, HHS now seeks input from the public on other changes within its

authority and consistent with the law to further achieve these aims.

II. Solicitation of Comments

HHS is interested in soliciting public comments about changes to existing regulations or guidance, or other actions within HHS's authority, that could further the following goals with respect to the individual and small group health insurance markets:

1. *Empowering patients and promoting consumer choice.* What activities would best inform consumers and help them choose a plan that best meets their needs? Which regulations currently reduce consumer choices of how to finance their health care and health insurance needs? Choice includes the freedom to choose how to finance one's healthcare, which insurer to use, and which provider to use.

2. *Stabilizing the individual, small group, and non-traditional health insurance markets.* What changes would bring stability to the risk pool, promote continuous coverage, increase the number of younger and healthier consumers purchasing plans, reduce uncertainty and volatility, and encourage uninsured individuals to buy coverage?

3. *Enhancing affordability.* What steps can HHS take to enhance the affordability of coverage for individual consumers and small businesses?

4. *Affirming the traditional regulatory authority of the States in regulating the business of health insurance.* Which HHS regulations or policies have impeded or unnecessarily interfered with States' primary role in regulating the health insurance markets they know best?

This is a request for information only. Respondents are encouraged to provide complete but concise responses to the questions outlined above. We note that a response to every question is not required. This request for information is issued solely for information and planning purposes; it does not constitute a notice of proposed rulemaking or request for proposals, applications, proposal abstracts, or quotations. This request for information does not commit the United States Government ("Government") to contract for any supplies or services or make a grant award. Further, HHS is not seeking proposals through this request for information and will not accept unsolicited proposals. Respondents are advised that the Government will not pay for any information or administrative costs incurred in response to this request for information; all costs associated with responding to this request for information will be solely at the interested party's expense. Not responding to this request for information does not preclude participation in any future rulemaking or procurement, if conducted. It is the responsibility of the potential responders to monitor this request for information announcement for additional information pertaining to this request. We also note that HHS will not respond to questions about the policy issues raised in this request for information. HHS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review request for information responses. Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract or issue a grant. Information obtained as a result of this request for information may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This request for information should not be construed as a commitment or authorization to incur cost for which reimbursement would be required or sought. All submissions become Government property and will not be returned. HHS may publically post the comments received, or a summary thereof. While responses to this request for information do not bind HHS to any further actions related to the response, all submissions will be made publicly available on *http://www.regulations.gov*.

III. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping or third-party disclosure requirements. This request for information constitutes a general solicitation of comments. In accordance with the implementing regulations of the Paperwork Reduction Act (PRA) at 5 CFR 1320.3(h)(4), information subject to the PRA does not generally include "facts or opinions submitted in response to general solicitations of comments from the public, published in the **Federal Register** or other publications, regardless of the form or format thereof, provided that no person is required to supply specific information pertaining to the commenter, other than that necessary for self-identification, as a condition of the agency's full consideration of the comment." 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.*).

Dated: June 6, 2017.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: June 7, 2017.

Thomas E. Price,

Secretary, Department of Health and Human Services.

[FR Doc. 2017–12130 Filed 6–8–17; 4:15 pm]

BILLING CODE 4120–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[MB Docket No. 11–54; RM–11624; DA 17–510]

Television Broadcasting Services; Augusta, Georgia

AGENCY: Federal Communications Commission.

ACTION: Proposed rule; withdrawal.

SUMMARY: The Commission has before it a petition for rulemaking filed by Southern Media Holdings, Inc. (SMH), the former licensee of WFXG, Augusta, Georgia, requesting the substitution of channel 51 for channel 31 at Augusta. WFXG License Subsidiary, LLC (Licensee) is now the licensee of WFXG. Station WFXG was allotted channel 51 as its post-transition DTV channel and operated a licensed facility on that channel. In 2008, SMH filed a petition for rulemaking requesting that channel 31 be substituted for channel 51, and the Commission granted that request. SMH subsequently requested that the Commission change its channel back to channel 51 and we issued a Notice of Proposed Rulemaking, which was contested. On April 28, 2017, Licensee filed a letter withdrawing its pending request to substitute channel 51 for channel 31, explaining that it had licensed the channel 31 facility and that WFXG was reassigned to channel 36 in connection with the post-incentive auction repacking of the broadcast television spectrum.

DATES: The proposed rule published on April 4, 2011 (76 FR 18497) is withdrawn as of June 12, 2017.

FOR FURTHER INFORMATION CONTACT: Joyce Bernstein, *Joyce.Bernstein@fcc.gov*, Media Bureau, (202) 418–1647.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's *Order*, MB Docket No. 11–54, adopted May 25, 20017, and released May 25, 2017. The full text of this document is available for

inspector, the manager of the local flight standards district office/certificate holding district office.

(2) *Contacting the Manufacturer:* For any requirement in this AD to obtain corrective actions from a manufacturer, the action must be accomplished using a method approved by the Manager, International Branch, ANM–116, Transport Airplane Directorate, FAA; or the European Aviation Safety Agency (EASA); or EADS CASA's EASA Design Organization Approval (DOA). If approved by the DOA, the approval must include the DOA-authorized signature.

(i) Related Information

(1) Refer to Mandatory Continuing Airworthiness Information (MCAI) EASA Airworthiness Directive 2017–0036, dated February 21, 2017, for related information. This MCAI may be found in the AD docket on the Internet at *http://www.regulations.gov* by searching for and locating Docket No. FAA–2017–0623.

(2) For more information about this AD, contact Shahram Daneshmandi, Aerospace Engineer, International Branch, ANM–116, Transport Airplane Directorate, FAA, 1601 Lind Avenue SW., Renton, WA 98057–3356; telephone: 425–227–1112; fax: 425–227–1149. Information may be emailed to: *9-ANM-116-AMOC-REQUESTS@faa.gov*.

(3) For service information identified in this AD, contact Airbus Defense and Space Services/Engineering Support, Avenida de Aragón 404, 28022 Madrid, Spain; telephone +34 91 585 55 84; fax +34 91 585 31 27; email *MTA.TechnicalService@airbus.com*. You may view this service information at the FAA, Transport Airplane Directorate, 1601 Lind Avenue SW., Renton, WA. For information on the availability of this material at the FAA, call 425–227–1221.

Issued in Renton, Washington, on June 19, 2017.

John P. Piccola, Jr.,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 2017–13357 Filed 6–26–17; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Chapter IV

Office of the Secretary

45 CFR Subtitle A

[CMS–9928–CN]

RIN 0938–ZB39

Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices To Empower

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for information; correction.

SUMMARY: This document corrects an error that appeared in the request for information notice published in the Federal Register on June 12, 2017 entitled "Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower."

DATES: This correction is effective June 26, 2017.

FOR FURTHER INFORMATION CONTACT: Chanda McNeal (301) 492–4132 or Jamaca Mitchell (301) 492–4177.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Doc. 2017–12130 of June 12, 2017 (82 FR 26885), there was an error that is identified and corrected in the Correction of Errors section of this correction notice. The correction in this document is effective as if it had been included in the document published on June 12, 2017. Accordingly, the correction is effective (June 26, 2017).

II. Summary of Errors

On page 26886, we inadvertently included the incorrect contact information in the **FOR FURTHER INFORMATION CONTACT** section. Therefore, we are correcting this error to provide the public with the correct point of contact's name and phone number for issues related to the June 12, 2017 request for information notice.

III. Correction of Errors

In FR Doc. 2017–12130 of June 12, 2017 (82 FR 26885), make the following correction.

On page 26886, in the first column, under the **FOR FURTHER INFORMATION CONTACT**, the contact name and phone number for "Vanessa Jones, (202) 690–700" is deleted and replaced with, "Chanda McNeal, (301) 492–4132, or Jamaca Mitchell, (301) 492–4177."

Dated: June 21, 2017.

Ann C. Agnew,

Executive Secretary to the Department, Department of Health and Human Services.

[FR Doc. 2017–13417 Filed 6–26–17; 8:45 am]

BILLING CODE 4120–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[T.D. 8716]

RIN 1545–AV05

DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

29 CFR Part 2590

RIN 1210–AA54

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

45 CFR Subtitle A, Parts 144 and 146

RIN 0938–AI08

Interim Rules for Health Insurance Portability for Group Health Plans

AGENCIES: Internal Revenue Service, Department of the Treasury; Pension and Welfare Benefits Administration, Department of Labor; Health Care Financing Administration, Department of Health and Human Services.

ACTION: Interim rules with request for comments.

SUMMARY: This document contains interim rules governing access, portability and renewability requirements for group health plans and issuers of health insurance coverage offered in connection with a group health plan. The rules contained in this document implement changes made to certain provisions of the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) enacted as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Interested persons are invited to submit comments on the interim rules for consideration by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury (Departments) in developing final rules. The rules contained in this document are being adopted in an interim basis to accommodate statutorily established time frames intended to ensure that sponsors and administrators of group health plans, participants and beneficiaries, States, and issuers of group health insurance coverage have timely guidance concerning compliance with the recently enacted requirements of HIPAA.

DATES: *Effective date:* These interim rules are effective on June 7, 1997.

Comment dates: Written comments on these interim rules are invited and must be received by the Departments on or before July 7, 1997.

Applicability dates: For group health plans maintained pursuant to one or more collective bargaining agreements ratified before August 21, 1996, the rules (other than the certification requirements) do not apply to plan years beginning before the later of July 1, 1997 or the date on which the last collective bargaining agreement relating to the plan terminates without regard to any extension agreed to after August 21, 1996.

The rules implementing the certification provisions do not require any action to be taken before June 1, 1997, although certain certification requirements apply to periods of coverage and events that occur after June 30, 1996. The certification requirement for events that occurred on or after October 1, 1996 and before June 1, 1997 may be satisfied using an optional notice described in this preamble.

Information collection: Affected parties do not have to comply with the information collection requirements in these interim rules until the Departments publish in the **Federal Register** the control numbers assigned by the Office of Management and Budget (OMB) to these information collection requirements. Publication of the control numbers notifies the public that OMB has approved these information collection requirements under the Paperwork Reduction Act of 1995. The Departments have asked for OMB clearance as soon as possible, and OMB approval is anticipated by the applicable effective date.

ADDRESSES: Written comments should be submitted with a signed original and three copies to any of the addresses specified below. All comments will be available for public inspection and copying in their entirety. Interested persons are invited to submit written comments on these interim rules to:

Health Care Financing Administration, Department of Health and Human Services, Attention: [BPD–890–IFC], P.O. Box 26688, Baltimore, Maryland 21207

Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N–5669, 200 Constitution Avenue, NW., Washington, DC 20210. Attention: Interim Portability and Renewability Rules

CC:DOM:CORP:T:R (REG–253578–96), Room 5228, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044

Alternatively, comments may be submitted electronically via the Internet by selecting the ''Tax Regs'' option on the IRS Home Page, or by submitting comments directly to the IRS Internet site at http://www.irs.ustreas.gov/tax__regs/comments.html

In the alternative:

Written comments for the Department of Health and Human Services may be hand delivered from 8:30 a.m. to 5:00 p.m. to:

Room 309–G, Hubert Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–09–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850

Written comments for the Department of Labor may be hand delivered from 8:15 a.m. to 4:45 p.m. to the above address for the Pension and Welfare Benefits Administration, U.S. Department of Labor.

Written comments for the Internal Revenue Service may be hand delivered between the hours of 8 a.m. and 5 p.m. to:

CC:DOM:CORP:T:R(REG–253578–96), Courier's Desk, Internal Revenue Service, room 5228, 1111 Constitution Avenue, NW., Washington, DC.

All submissions to the Department of Health and Human Services will be open to public inspection as they are received, generally beginning three weeks after publication, in room 309–G of the Department of Health and Human Services offices at 200 Independence Avenue, SW., Washington, DC, from 8:30 a.m. to 5:00 p.m. All submissions to the Department of Labor will be open to public inspection at the Public Documents Room, Pension and Welfare Benefits Administration, U.S. Department of Labor, Room N–5638, 200 Constitution Avenue NW., Washington, DC, from 8:30 a.m. to 5:30 p.m. All submissions to the Internal Revenue Service will be open to public inspection and copying in room 1621, 1111 Constitution Avenue, NW., Washington, DC, from 9:00 a.m. to 4:00 p.m.

FOR FURTHER INFORMATION CONTACT: Julie Walton, Health Care Financing Administration, at 410–786–1565; Mark Connor, Office of Regulations and Interpretations, Pension and Welfare Benefits Administration, Department of Labor, at 202–219–4377; Diane Pedulla, Plan Benefits Security Division, Office of the Solicitor, Department of Labor, at 202–219–4377; or Russ Weinheimer, Internal Revenue Service, at 202–622–

4695. These are not toll-free numbers.

CUSTOMER SERVICE INFORMATION: Individuals interested in obtaining a copy of the Department of Labor's booklet entitled ''Questions and Answers: Recent Changes in Health Care Law'' may obtain a copy by calling the following toll-free number 1–800–998–7542.

SUPPLEMENTARY INFORMATION:

A. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104–191, was enacted on August 21, 1996. HIPAA amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 (Code) to provide for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with employment. Sections 102(c)(4), 101(g)(4), and 401(c)(4) of HIPAA require the Secretaries of Health and Human Services, Labor, and the Treasury, each to issue regulations necessary to carry out these provisions.[1]

B. Overview of HIPAA and the Interim Rules

Area of Guidance. The access, portability, and renewability provisions of HIPAA affect group health plans and health insurance issuers. Group health plans are generally plans sponsored by employers or employee organizations or both. These HIPAA provisions are designed to improve the availability and portability of health coverage by:

- Limiting exclusions for preexisting medical conditions;
- Providing credit for prior health coverage and a process for transmitting certificates and other information concerning prior coverage to a new group health plan or issuer;
- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage or have a new dependent;
- Prohibiting discrimination in enrollment and premiums against employees and their dependents based on health status;
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage in both the small and large group markets; and
- Preserving, through narrow preemption provisions, the States' traditional role in regulating health insurance, including State flexibility to provide greater protections.

The regulations provide guidance with respect to these provisions. In implementing these new rules, the regulations provide protections for individuals seeking health coverage while minimizing burdens on employers and insurers.

Reducing Burdens. The regulations reduce burdens by:

- Providing for a simple model certificate that can be used by plans and issuers;
- Reducing unnecessary duplication in the issuance of certificates;
- Including flexible rules for dependents to receive the coverage information they need;
- Allowing coverage information to be provided by telephone if all parties agree;
- Relieving plans and issuers of the need to report the starting date of coverage and waiting period information where a certificate shows 18 months of credible coverage;
- Including a transition rule permitting plans and issuers to give individuals a notice in lieu of a certificate where coverage ended before June 1, 1997; and
- Providing for a model notice that may be used to satisfy the transition rule and a model notice for information relating to categories of benefits provided under a plan.

Implementing Individual Protections. The regulations protect and assist participants and their dependents by:

- Ensuring that individuals are notified of the length of time that a preexisting condition exclusion clause in any new health plan may apply to them after taking into account their prior creditable coverage;
- Ensuring that individuals are notified of their rights to special enrollment under a plan;
- Permitting individuals to obtain a certificate before coverage under a plan ceases; and
- Creating practical ways for individuals to demonstrate creditable coverage to a new plan (where the individual's prior plan fails to provide the certificate).

C. Overview of Coordination of Group Market Regulation Among Departments

The HIPAA portability provisions relating to group health plans and health insurance coverage offered in connection with group health plans (referred to below as the ''group market'' provisions) are set forth under a new Part A of Title XXVII of the PHS Act, a new Part 7 of Subtitle B of Title I of ERISA, and a new Subtitle K of the Internal Revenue Code. HIPAA also added provisions governing insurance in the individual market that are contained only in the PHS Act, and thus are not within the regulatory jurisdiction of the Department of Labor or the Department of the Treasury. (These portability provisions are referred to below as the ''individual market'' provisions.)

In general, the group market provisions create concurrent jurisdiction for the Secretaries of Health and Human Services, Labor, and the Treasury. The provisions include similar rules relating to preexisting conditions exclusions, special enrollment rights, and prohibition of discrimination against individuals based on health status-related factors. (These group market provisions are referred to below as the ''shared group market'' provisions.) Accordingly, the three Departments share regulatory responsibility for most, but not all, of the group market provisions.

The shared group market provisions are substantially similar, except as follows:

- The shared group market provisions in the PHS Act apply generally to insurance issuers that offer health insurance in connection with group health plans (subject to an exception that may apply for plans with fewer than two participants who are current employees (''very small plans'')), and certain State and local government plans. Only the PHS Act contains group market provisions relating to availability and renewability of health insurance.[2] In addition, the PHS Act imposes certification requirements on certain federal entities not otherwise subject to the HIPAA portability provisions. Further, the States, in the first instance, will enforce the PHS Act with respect to issuers. In addition, individuals may be able to pursue claims through State mechanisms. Only if a State does not substantially enforce any provisions under its insurance laws, will the Department of Health and Human Services enforce the provisions, through the imposition of civil money penalties. (The group market provisions relating to guaranteed renewability for multiemployer plans and multiple employer welfare arrangements

[1] In addition to the group market regulations in this document, the Department of the Treasury is issuing a proposed Treasury regulation that cross-references these regulations and the Department of Labor is issuing an interim regulation relating to certain disclosure requirements under HIPAA. Each of these regulations appears separately in this issue of the **Federal Register**.

[2] The PHS Act does not include requirements on availability of insurance for employers in the large group market. Under section 2711(b)(3) of the PHS Act, however, the General Accounting Office (GAO) is to report to Congress on such availability in 1998.

(MEWAs) are in ERISA and the Internal Revenue Code, but not the PHS Act.)

- The ERISA shared group market provisions apply generally to all group health plans other than governmental plans, church plans, very small plans, and certain other plans. The shared group market provisions of ERISA also apply to health insurance issuers that offer health insurance in connection with such group health plans. Generally, the Secretary of Labor enforces the Provisions of HIPAA that amend ERISA, except that no enforcement action may be taken by the Secretary against issuers relating to the new shared group market provisions in part 7 of ERISA. However, individuals may generally pursue actions against issuers under ERISA and, in some circumstances, under State laws.
- The shared group market provisions in the Internal Revenue Code generally apply to all group health plans other than governmental plans and very small plans, but not to health insurance issuers. A taxpayer that fails to comply with these provisions may be subject to an excise tax under section 4980D of the Code. (The group market provisions relating to preemption and affiliation periods for HMOs are in the PHS Act and ERISA, but not in the Internal Revenue Code.)

The regulation being issued today by the Secretaries of Health and Human Services, Labor, and the Treasury have been developed on a coordinated basis by the Departments. Except to the extent needed to reflect the statutory differences described above, the shared group market provisions in these regulations of each Department are substantively identical. However, there are certain nonsubstantive differences. The PHS Act regulations are numbered and organized differently. Also, there are differences in the regulations that are necessary because of statutory provisions that are not common to all three Departments (in the definitions sections, for example). Further, the regulations reflect certain stylistic differences in language and structure to conform to conventions used by a particular Department. These differences have been minimized and any differences in wording are not intended to create any substantive difference, so that these regulations will have the same effect with respect to overlapping statutory provisions, as required by section 104 of HIPAA.

D. Special Information Concerning State Insurance Law

For purposes of the PHS Act and sections 144 through 148 in the PHS Act regulations, all health insurance coverage in a State generally is sold in one of two markets: the group market (See section 146) and the individual market (see section 148). The group market is further divided into the large group market and the small group market. Section 146 of the PHS Act regulations applies the group market provisions only to insurance sold to group health plans (which are generally plans sponsored by employers or employee organizations or both), regardless of whether State law provides otherwise. State law may expand the definition of the small group market to include certain coverage that, under the federal law, would otherwise be considered coverage in the large group market or the individual market.

The protections provided in the PHS Act to particular individuals and employers are different depending on whether the coverage involved is obtained in the small group market, the large group market, or the individual market. Small employers are guaranteed availability of insurance coverage sold in the small group market under the PHS Act. Small and large employers are guaranteed the right to renew their group coverage under the PHS Act, subject to certain exceptions. Eligible individuals are guaranteed availability of coverage sold in the individual market under the PHS Act, and all coverage in the individual market must be guaranteed renewable under the PHS Act.

Coverage that is provided to associations, but is not related to employment (so that the coverage is not in connection with a group health plan), is not coverage in the group market under HIPAA. This coverage is instead coverage in the individual market under the PHS Act, regardless of whether it is considered group coverage under State law.

E. Discussion of the Shared Group Market Provisions in the Regulations

The most significant items relating to the shared group market in these regulations are discussed in detail below.

Definitions—26 CFR 54.9801–2, 29 CFR 2590.701–2, 45 CFR 144.103

This section provides most of the definitions used in the regulations implementing the provisions of HIPAA that were added to the PHS Act, ERISA, and the Code, relating to the group market.[3] The definitions in this section of the regulations include both statutory definitions provided in HIPAA, as well as certain others used in the regulations.

Limitation on Preexisting Condition Exclusion Period—26 CFR 54.9801–3, 29 CFR 2590.71–3, 45 CFR 146.111

Definition of Preexisting Condition Exclusion

A preexisting condition exclusion is defined broadly to be any limitation or exclusion of benefits based on the fact the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. HIPAA imposes certain limitations (described below) on the use of such an exclusion in the group market (and also uses this definition for purposes of the individual market rules, under which no preexisting condition exclusion is permitted to be imposed on an eligible individual). HIPAA's broad definition of a preexisting condition exclusion is at variance with some State laws and regulations because the relevant National Association of Insurance Commissioners (NAIC) models, on which many State laws are based, have imposed limitations on coverage for preexisting conditions without use of such a definition.

New Limitations on Preexisting Condition Exclusions. Paragraph (a) of this section[4] of the regulations describes the limitations on the preexisting condition exclusion period. A group health plan, and a health insurance issuer offering group health insurance coverage, is permitted to impose a preexisting condition exclusion with respect to a participant or beneficiary only if the following conditions are met:

1. *6-month look-back rule.* The preexisting condition exclusion must relate to a condition (whether physical or mental, and regardless of the cause of the condition) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date. For these purposes, genetic information is not a condition.[5] In order

[3] The regulations for the PHS Act also contain certain definitions relating to those provisions added under the PHS Act regarding the individual market, in order to create a single, comprehensive reference for the definitions necessary under the PHS Act regulations.

[4] References to paragraphs of a section refer to paragraphs of each regulation section identified in the heading. For example, this reference is to paragraph (a) in each of 45 CFR 146.111, 29 CFR 2590.701–3, and 26 CFR 54.9801–3.

[5] The definition of genetic information in the regulations was developed taking into account hearing testimony related to genetic information given in connection with Senate Report 104–156, other legislative initiatives, and public comments (including those submitted in response to the request for information published by the Departments on December 30, 1996).

to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by the State law. Under the new HIPAA standard, a plan would generally determine that an individual has a preexisting condition through medical records (such as diagnosis codes on bills, a physician's notes of a visit or telephone call, pharmacy prescription records, HMO encounter data, or other records indicating that medical services were actually recommended or received during the 6-month look-back period). The ''prudent person'' standard of some State laws (under which a condition is taken into account if a prudent person would have sought care whether or not care is actually received) no longer may be used to determine a preexisting condition.

This 6-month ''look-back'' period is based on the 6-month ''anniversary date'' of the enrollment date. As a result, an individual whose enrollment date is August 1, 1998 has a 6-month look-back period from February 1, 1998 through July 31, 1998.

2. *Length of preexisting condition exclusion period.* The exclusion period cannot extend for more than 12 months (18 months for late enrollees) after the enrollment date. the 12- or 18-month ''look-forward'' period is also based on the anniversary date of the enrollment date. A late enrollee is defined as an individual who enrolls in a plan at a time other than at the first time the individual is eligible to enroll or during a special enrollment period (described below). If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the plan, then upon becoming eligible again due to resumption of employment or due to resumption of plan coverage, only the most recent period of eligibility is considered for purposes of determining whether the individual is a late enrollee.

3. *Reduction of preexisting condition exclusion period by prior coverage.* In general, the preexisting condition exclusion period is reduced by the individual's days of creditable coverage [6] as of the enrollment date. Creditable coverage is defined as coverage of an individual from a wide range of specified sources, including group health plans, health insurance coverage, Medicare, and Medicaid.

Definition of Enrollment Date. The limitations on preexisting condition exclusions are measured from an individual's ''enrollment date.'' The enrollment date is defined as the first day of coverage or, if there is a waiting period, the first day of the waiting period (typically the date employment begins).

The term ''first day of coverage'' is used in the regulations in place of the term ''date of enrollment'' in the statute, such as in the definitions of the terms ''preexisting condition exclusion'' and ''enrollment date.'' This is intended to clarify the difference between the statutory terms ''date of enrollment'' and ''enrollment date'' (which have no difference in common useage).

The term ''waiting period'' generally refers to the period in which there is a delay between the first day of employment and the first day of coverage under the plan. Accordingly, because the preexisting condition exclusion period runs from the enrollment date, any waiting period would run concurrently with any preexisting condition exclusion period. Further:

- The enrollment date for a late enrollee or anyone who enrolls on a special enrollment date (see the section on special enrollment periods below) is the first date of coverage. Thus, the time between the date a late enrollee or special enrollee first becomes eligible for enrollment under the plan and the first day of coverage is not treated as a waiting period.
- Because the 6-month look-back limitation runs from the beginning of any applicable waiting period, the current practice of some plans that require physical examinations prior to commencement of coverage for the purpose of identifying preexisting conditions may be affected. If the examination is conducted during the waiting period (after employment begins and before enrollment), rather than before employment begins, a plan may not exclude coverage for any condition identified in the examination (unless, independent of the examination, medical advice, diagnosis, care, or treatment was in fact recommended or received for the condition during the 6-month look-back period). The use of such examinations for other purposes, such as worker safety, is not affected.[7]

Elimination of Preexisting Condition Exclusion for Pregnancy and for Certain Children. A preexisting condition exclusion cannot apply to pregnancy. In addition, a preexisting condition exclusion period cannot be applied to a newborn, an adopted child under age 18, or a child placed for adoption under age 18, if the child becomes covered within 30 days of birth, adoption, or placement for adoption. This exception does not apply after the child has a significant break in coverage (63 or more consecutive days). (An example in paragraph (b)(1) of the regulations illustrates these rules.)

Rules Relating to Creditable Coverage—26 CFR 54.9801–4, 29 CFR 2590.701–4, 45 CFR 146.113

As noted above, a plan or issuer that imposes a preexisting condition exclusion must reduce the length of the exclusion by an individual's creditable coverage. This section defines the term ''creditable coverage'' and sets forth the rules for how creditable coverage is applied to reduce such an exclusion period.

Creditable coverage includes health insurance coverage and other health coverage, such as coverage under group health plans (whether or not provided through an issuer), Medicaid, Medicare, and public health plans, as well as other types of coverage set forth in HIPAA and the regulations. Comments are requested on whether the definition of a public health plan should include the public health systems of other countries.

Under the definition of creditable coverage, all forms of health insurance coverage are included, whether in the individual market or group market, and whether the coverage is short-term, limited-duration coverage or other coverage for benefits for medical care for which no certificate of creditable coverage is required. Creditable coverage does not include coverage consisting solely of excepted benefits as defined in the regulations and described below.[8]

Under paragraph (a)(3) of this section of the regulation, a group health plan or health insurance issuer offering group

[6] The phrase ''days of creditable coverage'' is used instead of the statutory phrase ''aggregate periods of creditable coverage'' for administrative ease in the calculation of creditable coverage. Use of days of creditable coverage also conforms to the practice of many States for crediting prior coverage under pre-HIPAA small group market reforms.

[7] However, to avoid violating the Americans with Disabilities Act, Pub. L. 101–336, as amended by Pub. L. 102–166, the examination should generally be conducted only after the employer has offered employment to the individual.

[8] However, if an individual has coverage of excepted benefits in addition to other forms of creditable coverage, coverage of excepted benefits is creditable coverage. This would make a difference only if a plan or issuer uses the alternative method of determining creditable coverage (described below) with respect to a category that includes excepted benefits. For example, coverage of excepted benefits such as limited vision or limited dental benefits, when offered in combination with other creditable coverage, may be used to offset a preexisting condition exclusion period for a category that includes those benefits under the alternative method in paragraph (c).

health insurance coverage may determine the amount of creditable coverage of an individual for purposes of reducing the period of a preexisting condition exclusion by using either the standard method described in paragraph (b) or the alternative method described in paragraph (c).

Standard Method

1. *Counting.* Under the standard method, the plan or issuer determines the amount of an individual's creditable coverage by determining all days during which the individual had one or more types of creditable coverage. This determination is made without regard to the specific benefits included in the coverage. If creditable coverage is derived from more than one source on a particular day, all of the creditable coverage that the individual had on that day is counted as one day of creditable coverage.

2. *Significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted by the plan or issuer in reducing a preexisting condition exclusion. A significant break in coverage means a period of 63 consecutive days during all of which the individual did not have any creditable coverage.

a. Waiting and affiliation periods. Waiting periods and affiliation periods, as defined in the regulation, are not taken into account in determining a significant break in coverage. This is the case regardless of whether the person ultimately fails to obtain coverage under the plan (such as, where termination of employment occurs before coverage begins). However, days in a waiting period or affiliation period are not counted as creditable coverage.

The regulations specify that the period between the date an individual files a substantially complete application for coverage in the individual market and the effective date of such coverage is a waiting period, so that the period is not taken into account in determining a significant break in coverage. In this way, an application processing delay or omission of details on a form would not cause an applicant to incur a significant break in coverage, which could adversely affect an individual who seeks coverage under a group health plan after purchasing coverage in the individual market.

However, the waiting period for purchase of an individual policy tolls a break in coverage only if the filing of the application for the individual market insurance actually results in purchase of the coverage by the individual. (See Examples 7 and 8 in paragraph (b)(2)(iv)). By contrast, days in a waiting period for coverage under a group health plan toll a significant break in coverage regardless of whether coverage under the plan is ultimately obtained. (See Example 6.) The rule regarding the individual market prevents an individual from avoiding a significant break in coverage by repeatedly submitting applications to individual market issuers without ever purchasing coverage. This rule responds to comments sent to the Departments in response to the December 30, 1996 request for public comments. The comments asked for clear rules on when a significant break is tolled in the case of an application for individual market insurance.

Issuers of health insurance coverage in the individual market are subject to the same certification requirements that apply to plans and issuers in the group market. Therefore, issuers in the individual market must provide individuals with certificates that reflect information regarding the beginning of the waiting period (the date of application), the effective date of coverage, and the date coverage ends. This will assist people with coverage in the individual market who later become covered by a group health plan in demonstrating their creditable coverage to the plan or issuer in the group market.

b. Effect of State insurance law. HIPAA provides that the significant break in coverage rule does not preempt State insurance laws that provide longer periods than 63 days for a break in coverage. (The preemption provisions are described more fully below.) Accordingly, while federal law may allow a plan to disregard prior coverage before a 63-day significant break in coverage, an issuer may be required to take such coverage into account in order to comply with State insurance law. As a result, application of the break rules can vary between issuers located in different States. Similarly, the break rules may vary between insured plans and self-insured plans (which are not subject to State insurance laws) within a State, as well as between the insured and self-insured portions of a single plan. As illustrated by Example 3 in paragraph (b)(2)(iv), the laws of the State applicable to the insurance policy that has the preexisting condition exclusion are determinative of which break rule applies.

Alternative Method. Under the alternative method of counting creditable coverage, the plan or issuer determines the amount of an individual's creditable coverage for any of five identified categories of benefits. Those categories are coverage for mental health, substance abuse treatment, prescription drugs, dental care, and vision care. The plan or issuer may use the alternative method for any or all of the categories and may apply a different preexisting condition exclusion period with respect to each category (as well as to coverage not within a category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. The standard method is used to determine an individual's creditable coverage for benefits that are not within any category for which the alternative method is being used. Disclosure statements concerning the plan must indicate that the alternative method is being used, and this disclosure must also be given to each enrollee at the time of enrollment. These statements must include a description of the effect of using the alternative method. Any issuer in the group market must provide similar statements to each employer at the time of offer or sale of the coverage.

For purposes of reducing the preexisting condition exclusion period under the alternative method, the plan or issuer determines under the standard method the amount of the individual's creditable coverage that can be counted, up to a total of 365 days of the most recent creditable coverage of the individual (546 days for a late enrollee). The period of this creditable coverage is referred to as the ''determination period.'' The plan or issuer counts all days of coverage within the applicable category that occurred during the determination period (without regard to any significant breaks in that category of coverage). Those days reduce the preexisting condition exclusion for coverage within that category.

The regulations do not provide detailed definitions of the benefit categories. Comments are invited on whether additional guidance is needed.

The regulations under the alternative method of counting creditable coverage do not include a category relating to significant differences in deductible amounts. Commentators expressed concerns about adverse selection if individuals can change from a high deductible plan when they become ill and obtain ''first dollar'' coverage from an HMO or other issuer that provides broad, comprehensive care with only low deductibles or copayments.[9] However, it is unclear how such a

[9] See also the discussion below under the heading ''HMO Affiliation as Alternative to Preexisting Condition Exclusion.''

category would be defined or applied. Accordingly, the Departments solicit comments on this issue.

Certificates and Disclosure of Previous Coverage—26 CFR 54.9801–5, 29 CFR 2590.701–5, 45 CFR 146.115

This section of the regulations sets forth guidance regarding the certification requirements and other requirements concerning disclosure of information relating to prior creditable coverage. The provision of a certificate and other disclosures of information are intended to enable an individual to establish his or her prior creditable coverage for purposes of reducing any preexisting condition exclusion imposed on the individual by any subsequent group health plan coverage.

Form of Certificate. In general, the certificate must be provided in writing, including any form approved by the Secretaries as a writing. In certain circumstances, where the individual requests that the certificate be sent to another plan or issuer instead of to the individual, and the other plan or issuer agrees, the certification information may be provided by other means, such as by telephone. In some States, issuers transfer coverage information by telephone. Comments are requested as to whether, and under what conditions, other methods of transmitting certification information (including electronic communication) should be permitted in future guidance.

Information in Certificate. Paragraph (a)(3) of this section of the regulations sets forth the information that must be included in a certificate. The regulations allow a plan or issuer in an appropriate case simply to state in the certificate that the individual has at least 18 months of creditable coverage that was not interrupted by a significant break in coverage and to indicate the date coverage ended. (A certificate would never have to reflect coverage in excess of 18 months without a 63-day break because this is the maximum creditable coverage that an individual could need under the preexisting condition exclusion rules and the rules for access to the individual market.) In any other case, the certificate must disclose (1) the date any waiting or affiliation period began,[10] (2) the date coverage began, and (3) the date coverage ended (or indicate if coverage is continuing).[11] For individuals with fewer than 18 months of coverage without a significant break in coverage, the information about specific dates is essential in order for a subsequent plan or issuer in the group or individual market to be able to apply the break rules, especially in light of the possibility that an individual may have other coverage from various sources and the potential differences among State break rules (described above).

Certification Events and Timing. Paragraph (a)(5) describes the rights of participants and dependents to receive certificates. In general, individuals have the right to receive a certificate automatically (an ''automatic certificate'') when they lose coverage under a plan and when they have a right to elect COBRA continuation coverage. The certificate must be furnished within the time periods described below:

- *First,* for an individual who is a qualified beneficiary entitled to elect COBRA continuation coverage, the certificate is required to be provided no later than when a notice is required to be provided for a qualifying event under COBRA.
- *Second,* for an individual who loses coverage under a group health plan and who is not a qualified beneficiary entitled to elect COBRA continuation coverage, the certificate is required to be provided within a reasonable time after the coverage ceases. (Typically, this would apply to small employers' plans that are not subject to COBRA.) This requirement is satisfied if the certificate is provided by the time a notice is required to be provided under a State program similar to COBRA.
- *Third,* for an individual who is a qualified beneficiary and has elected COBRA continuation coverage, the certificate is required to be provided within a reasonable time after either cessation of COBRA continuation coverage or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.

In each of these three events, the regulations require the certificate to reflect only the most recent period of continuous coverage under the plan.

Under COBRA, multiemployer plans may provide notices within such longer period of time as provided for such notices under the terms of the plan. Under the general certification timing rule described above, multiemployer plans may use the same extended time period for providing certificates. Comments are requested on how this may affect a multiemployer plan and its participants and their families.

A certificate may be mailed by first class mail to the participant's last known address. A certificate for a participant's spouse with an address different from the participant's is to be sent to the spouse's address. A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual, or if the information is not identical, a certificate may provide information sufficient to satisfy the requirements of the regulations with respect to each individual on one document.

A certificate is also required to be provided upon the request of, or on behalf of, an individual (whether the individual is a participant, the participant's spouse, or any other dependent) if the request is made within 24 months after the individual loses coverage under the plan. The certificate is required to be provided at the earliest time that the plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate. In this case, the certificate reflects each period of continuous coverage ending within the 24 months prior to the date of request.[12]

Responsibilities of Plans and Issuers. Paragraph (a)(1) clarifies the statutory obligation of plans and issuers to provide certificates. The statutory obligation to furnish a written certificate of information regarding creditable coverage is imposed on both the group health plan and the health insurance issuer offering group health insurance coverage. This dual obligation was the subject of many of the comments received by the three Departments in response to the December 30, 1996 request for public comments published in the **Federal Register**. Concerns were raised about superfluous, duplicate certificates being issued and the potential responsibility of issuers for reporting on an individual's coverage under the plan after one issuer has been replaced by another.

Paragraph (a)(1) addresses these concerns by providing that the obligation to furnish a certificate is imposed on both the plan and each health insurance issuer that provides group health insurance coverage under the plan, subject to four exceptions.

First, paragraph (a)(1)(ii) provides that an entity required to provide a certificate is deemed to have satisfied this requirement to the extent that any other party provides the certificate and the certificate discloses the creditable coverage (including the waiting period

[10] Because the ending date for a waiting or affiliation period will always be the date coverage begins, the ending date does not have to be separately stated in a certificate.

[11] These dates would include any period of COBRA continuation coverage. A COBRA continuation coverage period does not have to be separately identified.

[12] For example, for participation who has had a number of interruptions in coverage, a requested certificate could consist of copies of all of the automatic certificates that were previously provided to the individual for each of these periods.

information) that was to be provided by the entity.

Second, paragraph (a)(1)(iii) provides that a plan is deemed to have satisfied its obligation if there is an agreement between an issuer and a plan under which the issuer agrees to provide certificates for individuals covered under the plan.

Third, paragraph (a)(1)(iv)(A) provides that an issuer is not required to provide any coverage information regarding coverage periods for which it was not responsible.

Fourth, paragraph (a)(1)(iv)(B) provides that if an individual switches from one issuer to another option allowed under the plan, or an issuer is replaced by another before an individual's coverage in the plan ceases, the first issuer is required to provide sufficient information to the plan (or to another party designated by the plan), so that when the individual leaves the plan, a certificate can be provided that includes the period of coverage under the policy of the first issuer. In this situation, no certificate is required to be provided to the individual, but the issuer must also cooperate with the plan by providing any information that may be requested later pursuant to the alternative method. (This rule will reduce unnecessary and potentially misleading information from being received while the individual's coverage under the plan is uninterrupted.) An issuer may presume that it is the final issuer for an individual if the individual's coverage under the policy ends at a time other than in connection with the plan's open season.

Other Entities Issuing Certificates. Paragraph (a)(6) identifies the various statutory authorities that create responsibility for other entities (that are not subject to a particular Department's regulations) to provide certificates. As described above, there are forms of creditable coverage other than coverage provided by group health plans and health insurance coverage offered in connection with a group health plan. Accordingly, individuals who leave coverage provided by any such other entity are entitled to have that coverage counted by a group health plan and may in many cases receive certificates for their creditable coverage. This information is included in the regulations because plans that impose a preexisting condition exclusion may find it helpful to know when creditable coverage will be provable through presentation of a certificate and when other forms of documentation or attestation may be needed.

In cases where certifications are provided by entities not subject to ERISA's requirements, such as Medicaid, the Indian Health Service, and CHAMPUS, certain adjustments in the certification rules may be appropriate. The regulations do not address how the certification process applies to these other programs. Comments are requested on how the certification requirements may be adapted to entities responsible for providing this coverage.

Dependent Coverage Information. Dependents are entitled to a written certificate of creditable coverage. Concerns were raised in comments received from the public regarding the certification of dependent coverage where information regarding dependents of participants in plans was not available. Plans and issuers, the commenters stated, often do not know the existence of dependents or their coverage periods until claims are filed. To address these concerns, the regulations have adopted two special rules.

First, under a transition rule that lasts through June 30, 1998, a plan or issuer may satisfy its obligation to provide a written certificate regarding the coverage of a dependent of a participant by providing the name of the participant covered by the plan and specifying the type of coverage provided in the certificate (such as family coverage or employee-plus-spouse coverage). However, if asked to provide a certificate relating to a dependent, the plan must make reasonable efforts to obtain and provide the name of the dependent. This rule will provide plans and issuers with a transition period to update their data systems to include information on dependents.

Second, the regulations include a special rule regarding dependent coverage that is not limited to the transition period. Under this rule, a plan or issuer must make a reasonable effort to collect the necessary information for dependents and include it on the certificate. However, under this special rule, an automatic certificate is not required to be issued until the plan or issuer knows (or, making reasonable efforts, should know) of the dependent's cessation of coverage. This information can be collected annually (during open enrollment).

Under the transition rule and the special rule, an individual may use the provisions described below to establish creditable coverage (and waiting and affiliation period information).

Information for Alternative Method of Counting Creditable Coverage. Following receipt of the certificate, an entity that uses the alternative method of counting creditable coverage may request that the entity that issued the certificate disclose additional information in order for the requesting entity to determine the individual's creditable coverage with respect to any category of benefits described in paragraph (b). The requested entity may charge the requesting entity the reasonable cost of disclosing the information. The requesting entity may ask for a copy of the summary plan description (SPD) that applied to the individual's coverage or may ask for more specific information. Set forth below is a model form that may be used for specific coverage information about the categories of benefits:

Information on Categories of Benefits

1. Date of original certificate: _____
2. Name of group health plan providing the coverage: _____
3. Name of participant: _____
4. Identification number of participant: ____
5. Name of individual(s) to whom this information applies: ____

6. The following information applies to the coverage in the certificate that was provided to the individual(s) identified above:

a. Mental Health: _____
b. Substance Abuse Treatment: _____
c. Prescription Drugs: _____
d. Dental Care: _____
e. Vision Care: _____

For each category above, enter ''N/A'' if the individual had no coverage within the category and either (i) enter both the date that the individual's coverage within the category began and the date that the individual's coverage within the category ended (or indicate if continuing), or (ii) enter ''same'' on the line if the beginning and ending dates for coverage within the category are the same as the beginning and ending dates for the coverage in the certificate.

Demonstration of Coverage if Certificate is Not Provided. Under HIPAA, in order to prevent an individual from being adversely affected if the individual does not receive a certificate, the individual has a right to demonstrate creditable coverage through the presentation of documentation or other means. For example, an individual may not have a certificate because: an entity failed to provide a certificate within the required time period; an entity was not required to provide a certificate; the coverage of the individual was for a period before July 1, 1996; or, the individual has an urgent medical condition that necessitates an immediate determination of creditable coverage by the plan or issuer. Under these circumstances, an individual may present evidence of creditable coverage through documents, records, third party statements, or other means, including telephone calls by the plan or issuer to a third party provider. The plan administrator is required to take into

account all information presented in determining whether to offset any or all of a preexisting condition exclusion. A plan or issuer is required to treat the individual as having furnished a certificate provided by a plan or issuer if the individual attests to the period of creditable coverage, the individual presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the plan's or issuer's efforts to verify the individual's coverage.

If an individual needs to demonstrate his or her status as a dependent of a participant, the plan or issuer is required to treat the individual as having furnished a certificate if an attestation to such dependency and the period of such status is provided, and if the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

Similar rules apply relating to determining creditable coverage under the alternative method.

Notice to Individual of Period of Preexisting Condition Exclusion. Within a reasonable time following the receipt of the certificate, information relating to the alternative method, or other evidence of coverage, a plan or issuer is required to make a determination regarding the length of any preexisting condition exclusion period that applies to the individual and notify the individual of its determination. Whether a determination and notification is made within a reasonable period of time depends upon the relevant facts and circumstances including whether the application of the preexisting condition exclusion period would prevent access to urgent medical services. The plan or issuer is required to notify the individual, however, only if, after considering the evidence, it has determined that a preexisting condition exclusion period will still be imposed on the individual. The basis of the determination, including the source and substance of any information on which the plan or issuer relied, must be included in the notification. The notification must also explain the plan's appeals procedures and the opportunity of the individual to present additional evidence.

The plan or issuer may reconsider and modify its initial determination if it determines that the individual did not have the claimed creditable coverage. In this circumstance, the plan or issuer must notify the individual of such reconsideration and, until a final determination is made, must act in accordance with its initial determination for purposes of approving medical services.

Model Certificate. The following model certificate has been authorized by the Secretary of each of the Departments. Use of the model certificate will satisfy the requirements of paragraph (a)(3)(ii) of the regulations.

Certificate of Group Health Plan Coverage

* IMPORTANT—This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____
2. Name of group health plan: _____
3. Name of participant: _____
4. Identification number of participant: ____
5. Name of any dependents to whom this certificate applies: _____
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate:

_____
_____
_____

7. For further information, call: _____
8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here_____ and skip lines 9 and 10.
9. Date waiting period or affiliation period (if any) began: _____
10. Date coverage began: _____
11. Date coverage ended: _____ (or check if coverage is continuing as of the date of this certificate: _____).

Note: Separate certificates will be furnished if information is not identical for the participant and each beneficiary.

Special Enrollment Periods—26 CFR 54.9801–6, 29 CFR 2590.701–6, 45 CFR 146.117

This section of the regulations provides guidance regarding the new enrollment rights provided to employees and dependents under HIPAA. A group health plan and a health insurance issuer offering group health insurance coverage are required to provide for special enrollment periods during which individuals who previously declined coverage are allowed to enroll (without having to wait until the plan's next regular open enrollment period). A special enrollment period can occur if a person with other health coverage loses that coverage or if a person becomes a dependent through marriage, birth, adoption, or placement for adoption.

A plan must provide a description of the special enrollment rights to anyone who declines coverage. The regulations provide a model of such a description.

A person who enrolls during a special enrollment period (even if the period also corresponds to a regular open enrollment period) is not treated as a late enrollee. (Accordingly, the plan or issuer may not impose a preexisting condition exclusion period longer than 12 months with respect to the person.)

Special Enrollment for Loss of Other Coverage. The special enrollment period for loss of other coverage is available to employees and their dependents who meet certain requirements. The employee or dependent must otherwise be eligible for coverage under the terms of the plan. When the coverage was previously declined, the employee or dependent must have been covered under another group health plan or must have had other health insurance coverage. The plan can require that, when coverage in the plan was previously declined, the employee must have declared in writing that the reason was other coverage, in which case the plan must at that time have provided notice of this requirement and the consequences of the employee's failure to provide the statement.

The special enrollment rights may apply with respect to an employee, a dependent of the employee, or both. An employee who has not previously enrolled can enroll under these rules if it is the employee who loses other coverage. An employee's dependent can be enrolled under these rules if it is the dependent who loses other coverage and the employee is already enrolled. In addition, both the employee and a dependent can be enrolled together under these rules if either the employee or the dependent loses other coverage.

If the other coverage is COBRA continuation coverage, the special enrollment can only be requested after exhausting COBRA continuation coverage. If the other coverage is not COBRA continuation coverage, special enrollment can only be requested after losing eligibility for the other coverage or after cessation of employer contributions for the other coverage. In each case, the employee has 30 days to request special enrollment. An individual does not have to elect COBRA continuation coverage or exercise similar continuation rights in order to preserve the right to special enrollment. However, an individual does not have a special enrollment right if the individual loses the other coverage as a result of the individual's

failure to pay premiums or for cause (such as making a fraudulent claim). Coverage under special enrollment must be effective no later than the first day of the month after an employee request the enrollment for himself or herself or on behalf of a dependent.

Special Enrollment for New Dependents. A special enrollment period also occurs if a person has a new dependent by birth, marriage, adoption, or placement for adoption. The election to enroll can be made within 30 days following the birth, marriage, adoption, or placement for adoption. In the case of a plan that does not offer any coverage for dependents and is then modified to offer dependent coverage, the election to enroll can instead be made during the 30 days beginning on the date dependent coverage is made available.

The special enrollment rules allow an eligible employee to enroll when he or she marries or has a new child (as a result of marriage, birth, adoption, or placement for adoption). A spouse of a participant can be enrolled separately at the time of marriage or when a child is born, adopted or placed for adoption. The spouse can be enrolled together with the employee when they marry or when a child is born, adopted, or placed for adoption. A child who becomes a dependent of a participant as a result of marriage, birth, adoption, or placement for adoption can be enrolled when the child becomes a dependent. Similarly, a child who becomes a dependent of an eligible employee as a result of marriage, birth, adoption, or placement for adoption can be enrolled if the employee enrolls at the same time.

In the case of a dependent special enrollment period, HIPAA provides that coverage with respect to a marriage is effective no later than the first day of the month after the date the request for enrollment is received and coverage with respect to a birth, adoption, or placement for adoption is effective on the date of the birth, adoption, or placement for adoption.

HMO Affiliation Period as Alternative to Preexisting Condition Exclusion—29 CFR 2590.701–7 and 45 CFR 146.119

This section of the regulations permits a group health plan offering health insurance through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, to impose an affiliation period, but only if certain other requirements are met. An ''affiliation period'' is defined in the regulations as a period of time that must expire before health insurance coverage provided by the HMO becomes effective, and during which the HMO is not required to provide benefits.

The regulations specify the following requirements for imposing an affiliation period:

- No preexisting condition exclusion may be imposed with respect to coverage through the HMO;
- No premium may be charged to a participant or beneficiary for the affiliation period;
- The affiliation period must be applied uniformly without regard to any health status-related factors; and
- The affiliation period must begin on the enrollment date, cannot exceed two months (three months for a late enrollee), and must run concurrently with any waiting period under the plan. The regulations provide for the affiliation period to begin on the enrollment date in the plan, not when coverage with the HMO begins. Accordingly, if a plan offers multiple coverage options simultaneously, the HMO cannot impose an affiliation period on plan participants who change to the HMO option. Comments are requested on this rule.

The regulations permit an HMO to use alternatives in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. Because an affiliation period may be imposed only if no preexisting condition exclusion is used, an alternative to an affiliation period may not encompass an arrangement that is in the nature of such an exclusion.[13]

While HMOs usually do not impose preexisting condition exclusions, they could choose to apply a preexisting condition exclusion period for all enrollees based on the alternative method of counting creditable coverage if the regulations were to add a category relating to deductibles. However, as described above under the heading ''Alternative Method,'' the regulations currently do not include such a category.

Nondiscrimination in Eligibility and Premiums in the Group Market—26 CFR 54.9802–1, 29 CFR 2590.702, 45 CFR 146.121

The regulations include provisions implementing the nondiscrimination provisions in HIPAA. Comments are welcomed on these provisions, and, in particular, comments are requested on whether guidance is needed concerning:

- The extent to which the statute prohibits discrimination against individuals in eligibility for particular benefits;
- The extent to which the statute may permit benefit limitations based on the source of an injury;
- The permissible standards for defining groups of similarly situated individuals;
- Application of the prohibitions on discrimination between groups of similarly situated individuals; and
- The permissible standards for determining bona fide wellness programs.

The Departments intend to issue further regulations on the nondiscrimination rules in the near future. In no event will the period for good faith compliance (specified in HIPAA sections 102(c)(5), 101(g)(5), and 401(c)(5)) with respect to section 2702 of the PHS Act, section 702 of ERISA, and section 9802 of the Code end before the additional guidance is provided.

A plan or issuer may not establish rules for eligibility (including continued eligibility) of an individual to enroll under the terms of the plan based on a health status-related factor. HIPAA and the regulations provide a list of health status-related factors. The Departments are considering interpreting the statutory language relating to eligibility to enroll so that a plan or issuer would be prohibited from providing lower benefits to certain individuals based on health status-related factors. Comments are welcomed on this interpretation.

Among the health status-related factors listed in the statute is ''evidence of insurability (including conditions arising out of acts of domestic violence).'' The Conference Report states that the inclusion of evidence of insurability in the list of health status-related factors ''is intended to ensure, among other things, that individuals are not excluded from health care coverage due to their participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing and other similar activities.'' However, HIPAA also provides that a plan or issuer is not required to provide particular benefits other than those provided under the terms of the plan. Moreover, HIPAA provides that a plan or issuer may establish limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan. Comments have been received indicating that some plans contain provisions that exclude coverage for benefits based on the source of injury (such as benefits for injuries sustained

[13] These alternative that may be used in lieu of an affiliation period to address adverse selection should not be confused with the use of the alternative method for counting creditable coverage discussed in the next paragraph.

in a motorcycle accident, injuries sustained in a motorcycle accident as the result of not wearing a helmet, or injuries sustained in the commission of a felony). Accordingly, comments are requested on how future guidance should treat benefit limitations based on the source of an injury.

The Conference Report also states that ''[t]he term 'similarly situated' means that a plan or coverage would be permitted to vary benefits available to different groups of employees, such as full-time versus part-time employees or employees in different geographic locations. In addition, a plan or coverage could have different benefit schedules for different collective bargaining units.'' Accordingly, comments are requested concerning the appropriate standards for determining ''similarly situated individuals,'' including whether a plan is permitted to vary benefits based on an employee's occupation. Because these standards could impact on the small group market, the Department of Health and Human Services is particularly interested in receiving comments from States with respect to how varying benefits based on occupation could affect rate setting.

The Departments also request comments regarding how the prohibitions on discrimination should be applied between groups of similarly situated individuals. For example, is guidance needed on whether a plan covering employees in two different locations could have a longer waiting period for employees at one location because the health status of those employees results in higher health costs?

A plan or issuer may not require any individual (as a condition of enrollment or continued enrollment) to pay a premium or contribution, that is greater than that for a similarly situated individual enrolled in the plan, based on a health status-related factor. However, this limitation does not restrict the amount that an issuer can charge an employer for the coverage. In addition, this limitation does not prevent a plan or issuer from establishing premium discounts or rebates or otherwise modifying applicable copayments or deductibles in return for adherence to programs of health promotion and disease prevention (bona fide wellness programs). Comments are requested regarding the standards for determining bona fide wellness programs, including whether such a program may provide a discount for non-smokers.

Special Rules—Excepted Plans and Excepted Benefits—26 CFR 54.9804–1, 29 CFR 2590.732, 45 CFR 146.145

This section of the regulations provides special rules for certain plans and certain benefits.

Very Small Plans. The group market requirements of HIPAA do not apply to a group health plan, or to group health insurance coverage offered in connection with a group health plan, for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees. However, a State may apply the group market provisions in the PHS Act to plans with fewer than two participants who are current employees. In this case, the State would apply its group market insurance law requirements to such small group plans (and such plans would not be subject to the individual market requirements).

Excepted Benefits. The group market provisions and the related regulations also do not apply to any group health plan or group health insurance issuer in relation to its provision of excepted benefits. The benefits identified in paragraph (b)(2) are generally not health insurance coverage and are excepted in all circumstances. In contrast, the benefits identified in paragraphs (b) (3), (4), and (5) are generally health insurance coverage but are excepted if certain conditions are met.

Limited-scope dental benefits, limited-scope vision benefits, and long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan. For this purpose, limited-scope dental coverage typically provides benefits for non-medical services such as routine dental cleanings, x-rays, and other preventive procedures. Such coverage may also provide discounts on the cost of common dental procedures such as fillings, root canals, crowns, full or partial plates, or orthodontic services. Limited-scope dental coverage typically does not provide benefits for medical services, such as those procedures associated with oral cancer or with a mouth injury that results in broken, displaced, or lost teeth.

Similarly, limited-scope vision coverage provides benefits for routine eye examinations or the fitting of eyeglasses or contact lenses. This coverage does not include benefits for such ophthalmological services as treatment of an eye disease (e.g., glaucoma or a bacterial eye infection) or an eye injury.

Noncoordinated benefits may be excepted benefits. The term ''noncoordinated benefits'' refers to coverage for a specified disease or illness (such as cancer-only coverage) or hospital indemnity or other fixed dollar indemnity insurance (such as insurance that pays $100/day for a hospital stay as its only insurance benefit) if three conditions are met. First, the benefits are provided under a separate policy, certificate, or contract for insurance. Second, there is no coordination between the provision of these benefits and another exclusion of benefits under a plan maintained by the same plan sponsor. Third, benefits are paid without regard to whether benefits are provided with respect to the same event under a group health plan maintained by the same plan sponsor.

Certain supplemental benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance. This category of excepted benefits includes Medicare supplemental (commonly called ''Medigap'' or ''MedSupp'') policies, CHAMPUS supplements, and supplements to certain employer group health plans. Such supplemental coverage cannot duplicate primary coverage and must be specifically designed to fill gaps in primary coverage, coinsurance, or deductibles.[14]

The regulations do not address section 2721(e) of the PHS Act or section 705(d) of ERISA relating to the treatment of partnerships (or the application of the Code's group market rules to partnerships). Comments are requested on these provisions, including how these provisions coordinate with other provisions relating to self-employed individuals and partnerships.

F. Other Group Market Provisions[15]

Guaranteed Renewability in Multiemployer Plans and Multiple Employer Welfare Arrangements—Section 703 of ERISA and Section 9803 of the Code

Requirements relating to guaranteed renewability in multiemployer plans

[14] Note that a group health plan, which provides primary coverage while an individual is an active employee, is often extended to retirees. When the retiree becomes eligible for Medicare, the group health plan commonly coordinates with Medicare and may serve a supplemental function similar to that of a Medigap policy. However, such employer-provided retiree ''wrap around'' benefits are not excepted benefits (because they are expressly excluded from the definition of a Medicare supplement policy in section 1882(g)(1) of the Social Security Act).

[15] In this section (''Other Group Market Provisions''), references conform to usage in 45 CFR Part 146, which uses ''HCFA'' in place of ''Department of Health and Human Services'' or ''Secretary of Health and Human Services'' and

Continued

and multiple employer welfare arrangements are set forth in section 703 of ERISA and section 9803 of the Code (but not in the PHS Act). These provisions state that a group health plan that is a multiemployer plan or that is a multiple employer welfare arrangement may not deny an employer whose employees are covered under such a plan continued access to the same or different coverage under the terms of such plan, other than for certain specified reasons. The Departments are not issuing regulations under section 703 of ERISA or section 9803 of the Code at this time, but anticipate issuing regulations under these sections and solicit comments regarding these sections.

In these provisions, the terms ''continued access'' and ''same or different coverage'' are not defined. Comments are requested on how rules under these provisions might address variations and changes in a plan's benefit packages and contribution rates, differences in the characteristics of multiemployer plans and multiple employer welfare arrangements, and any possible implications for the financial integrity of affected plans.

Preemption of State Laws; State Flexibility—29 CFR 2590.731 and 45 CFR 146.190

The McCarran-Ferguson Act of 1945 (Pub. L. 79–15) exempts the business of insurance from federal antitrust regulation to the extent that it is regulated by the States and indicates that no federal law should be interpreted as overriding State insurance regulation unless it does so explicitly. Section 514(a) of ERISA preempts State laws relating to employee benefit plans (including group health plans). However, section 514(b)(2) of the ERISA saves from preemption any State law that regulates insurance. Section 2723 of the PHS Act and section 731 of ERISA make clear that Part A of Title XXVII of the PHS Act and Part 7 of Subtitle B of Title I of ERISA do not in any way affect or modify section 514 of ERISA.

In addition, section 2723 of the PHS Act and section 731(a) of ERISA preempt State insurance laws to the extent such laws ''prevent the application of'' Part A of Title XXVII of the PHS Act and Part 7 of Subtitle B of Title I of ERISA. (There is no corresponding provision in the Code.) In this regard, the Conference Report states that the conferees intended the narrowest preemption of State laws with regard to health insurance issuers (not group health plans) with respect to all the provisions of Part A of Title XXVII of the PHS Act and Part 7 of Subtitle B of Title I of ERISA (except for preemption with respect to the provisions of section 2701 of the PHS Act and section 701 of ERISA.) Consequently, the Conference Report states that State laws with regard to health insurance issuers that are broader than federal requirements in certain areas would not ''prevent the application of'' the provisions of Part A of Title XXVII of the PHS Act or Part 7 of Subtitle B of Title I of ERISA.

However, the preemption is broader for the statutory requirements of section 2701 of the PHS Act and 701 of ERISA that limit the application of preexisting condition exclusions. State laws cannot ''differ'' from the preexisting condition exclusion requirements of section 2701 of the PHS Act or section 701 of ERISA, except as specifically permitted under section 2723(b)(2) of the PHS Act and section 731(b)(2) of ERISA. These specific exceptions permit a State to impose on health insurance issuers certain stricter limitations relating to preexisting condition exclusions.

Comments are also solicited on issues relating to the coordination of the new requirements under HIPAA and State requirements for associations that may be multiple employer welfare arrangements as defined in section 3(40) of ERISA.

Guaranteed Availability of Coverage for Small Employers Under the PHS Act Group Market Provisions—45 CFR 146.150

Rules relating to guaranteed availability of coverage for employers in the small group market appear only in the PHS Act (at section 2711). In general, this section requires health insurance issuers that offer coverage in the small group market to offer to any small employer all of the products they actively market in that market. This is generally referred to as an all-products guarantee. However, as allowed under applicable State law, the issuer can require that the employer make a minimum contribution toward the premium charged and have a minimum level of participation by eligible individuals. The issuer must also accept for enrollment every eligible individual without regard to health status. For purposes of this section, an eligible individual is one who meets the applicable requirements of the group health plan, the issuer, and State law for coverage under the plan.

Some States have, in recent years, made reforms in their small group markets that only require guaranteed issue of a basic and a standard policy, rather than an all-products guarantee. They have urged that an all-products guarantee not be adopted, arguing that the law does not specifically require it. However, sections 2711 and 2741 of the PHS Act, as added by HIPAA, contain virtually identical requirements requiring issuers that offer health insurance coverage in either the small group or individual market to make ''such coverage'' available to, respectively, small employers or eligible individuals. While section 2741 explicitly permits issuers to limit to two policies the offerings they are required to make in the individual market, the small group market provisions contain no similar exception. In fact, section 2713(b)(1)(D) requires that an issuer that offers health insurance to any small employer must provide information concerning ''the benefits and premiums available under *all* health insurance coverage for which the employer is qualified.'' (Emphasis added.) This indicates that Congress intended to require an all-products guarantee in the small group market. (However, a State that implements an ''alternative mechanism'' in the individual market under section 2744 of the PHS Act has the flexibility either to impose an all-products guarantee or to use a completely different mechanism for making insurance available to individuals guaranteed coverage under the statute.)

Various industry groups and persons responding to the notice that the three Departments published on December 30, 1996 asked that the term ''offer'' be interpreted to mean ''actively marketed,'' so that issuers would not be required to reopen closed blocks of business. The regulations make this clear.

Section 2711 also requires issuers to accept for enrollment any individuals who are eligible to enroll under the terms of the plan, and who satisfy the requirements of the issuer and applicable State law, during the period in which the individual ''first becomes eligible'' to enroll under the terms of the group health plan. Thus, the issuer is not required to accept late enrollees. The regulations make it clear that this protection extends to individuals if they ''first become eligible'' to enroll during a special enrollment period. The special enrollment provisions of the statute evidence the intent that individuals who qualify for special enrollment be given the same protections given to newly-hired employees and their dependents.

''HCFA regulations'' in place of ''PHS Act regulations.''

An issue has also been raised as to whether the statutory definitions of premium contributions and group participation rules, which are repeated in the regulations, related only to percentages of employees or premium dollars or to absolute numbers of employees or premium amounts. If the latter interpretation were permitted, the effect would be to undermine the all-products guarantee by allowing, for example, some products to be available to ''larger'' small employers, but not to the smallest employers. The regulations currently leave interpretation of this language to the States, but comments are welcomed on this issue.

Section 146.150 also includes rules regarding the circumstances under which issuers are permitted to deny coverage to employers. If the product is a network plan, under which services are furnished by a defined set of providers, the issuer can deny coverage to an employer whose eligible individuals do not live, work, or reside in the network plan's service area. It can also deny coverage if it has demonstrated to the State that its network does not have the capacity to deliver services to additional groups, but is then barred for 180 days from offering coverage in that service area. An issuer may also deny coverage if it demonstrates that it lacks sufficient financial reserves to underwrite additional coverage, but is barred for 180 days from offering coverage in the small group market in the State. Both of these exceptions must be applied to all employers uniformly without consideration of the health status or claims experience of an employer's employees or dependents. Neither of these exceptions relieves a network plan of its responsibility to continue servicing its in-force business under the guaranteed renewability requirements of the regulations.

Finally, § 146.150 provides that if the coverage is only made available to members of ''bona fide associations'' as that term is defined in the regulations, it is not subject to the guaranteed availability requirements. (Accordingly, the coverage does not have to be offered to non-members.) However, employers that obtain coverage through a bona fide association are assured of guaranteed access to the association's coverage options as long as they remain members of the association. This is because a bona fide association cannot condition membership in the association on health status-related factors. Moreover, it must offer coverage to all employers who are members without regard to health status-related factors relating to their employees or dependents. Therefore, an association cannot legally refuse enrollment to members on a selective basis so long as they meet the association's membership criteria.

Guaranteed Renewability of Coverage for Employers Under the PHS Act Group Market Provisions—45 CFR 146.152

Section 146.152 of the Health Care Financing Administration (HCFA) regulations implements section 2712 of the PHS Act, which requires issuers to renew or continue in force any coverage in the large or small group market at the option of the plan sponsor. The exceptions to this requirement include nonpayment of premiums, fraud, and violation of minimum participation or contribution rules, as permitted under applicable State law. Also, the issuer can cease to offer either a particular product or all coverage it offers in the particular market, and can refuse to renew if the group health plan's participants all leave the service area of a network plan, or if the coverage is provided through a bona fide association and the employer's membership ends.

Issuers that decide to discontinue offering a particular product or all coverage in the small or large group market are subject to certain requirements outlined in paragraphs (c) and (d) of this section of the regulations. Issuers discontinuing only a particular product must give 90 days' notice, must offer the plan sponsor the option to purchase other coverage the issuer offers in that market, and must discontinue the product uniformly, without regard to claims experience or health status of participants or dependents under a particular group health plan. If the issuer terminates all coverage in a market or markets, it must provide 180 days' notice to each plan sponsor, and it is prohibited from issuing coverage in the market(s) or State involved for five years following the date of discontinuation. Plans or issuers may modify the health insurance coverage at the time of coverage renewal, provided the modification is consistent with State law and, for the small group market, is effective uniformly among group health plans with coverage under that product.

Some States have asked whether an issuer that chooses to stop selling comprehensive products, such as a basic or standard policy, in a particular State's group market, must also cease selling policies consisting of excepted benefits. Because Congress permitted these types of supplemental policies and limited benefit plans to be excepted from the requirements of HIPAA in both the group and individual markets, HCFA intends to defer to the States' judgment on this issue, and solicit comments.

State law may limit the extent to which an issuer can abandon a product or market, and under what circumstances. For example, a State may choose to require an issuer vacating the market to transfer its business to another issuer through assumption reinsurance, or some other means permitted under State law.

Paragraph (g) of this section of the regulations provides that, with respect to group coverage offered only through associations, the option of guaranteed renewability extends to include employer members of an association. This provision means that all employers covered by an issuer through an association have the right to renew the coverage they received if the association ceases to serve its members, regardless of the reason.

Disclosure of Information by Issuers to Employers Seeking Coverage in the Small Group Market—45 CFR 146.160

Section 146.160 of the HCFA regulations implements section 2713 of the PHS Act by setting forth rules relating to disclosure of information by issuers to employers seeking coverage in the small group market. In its solicitation and sales materials, the issuer must make a reasonable disclosure that the specified information is available on request. The information that must be provided includes the issuer's right to change premium rates and the factors that may affect changes in premium rates, renewability of coverage, any preexisting condition exclusion (including use of the alternative method of counting creditable coverage), any affiliation periods applied by HMOs, the geographic areas served by HMOs, and the benefits and premiums available under all health insurance coverage for which the employer is qualified under minimum contribution and participation rules, as permitted by State law. The issuer is exempted from disclosing proprietary or trade secret information under applicable law.

''Factors that may affect changes in premium rates'' and ''proprietary and trade secret information under applicable law'' have not been defined. Comments are requested regarding whether they should be defined.

The information described in this section must be provided in language that is understandable by the average small employer and sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. This requirement can be satisfied by using as

a model the outlines of coverage provided under Medicare Supplement insurance. (These outlines are required to provide easy comparison of the coverage and cost of all available products.) Reasonable information includes rating schedules for each product to which more than one rate applies, and, with respect to network plans, maps of service areas or lists of counties served.

Exclusion of Certain Plans From the PHS Act Group Market Requirements—45 CFR 146.180

Section 146.180 of the HCFA regulations implements section 2721 of the PHS Act, which permits certain nonfederal governmental plans to elect to be exempted from some or all of the group market requirements of the HCFA regulations, although they are subject to the certification and disclosure requirements of § 146.115. With respect to nonfederal governmental plans that are collectively bargained, this section does not preempt State and local collective bargaining laws. The regulation establishes the form and manner of the election, and requires a nonfederal governmental plan making this election to notify plan participants, at the time of enrollment and on an annual basis, that it has made the election and what effect the election has. The participant notice and certification and disclosure obligations are integral parts of the election. Failure to comply with these obligations invalidates an election and subjects the nonfederal governmental plan to the requirements the election would have permitted the plan to avoid.

Only nonfederal governmental plans that are self-funded (in whole or in part) can make the election, and the election only applies to the self-funded portion. A health insurance issuer that sells insurance coverage to a nonfederal plan must comply with all the group market requirements.

Enforcement of PHS Act Requirements—45 CFR 146.184

Part 146 imposes requirements on health insurance issuers that offer coverage in the group market in a State, and on nonfederal governmental (i.e., State and local) group health plans. With respect to issuers, the statute makes it clear that it is solely within the discretion of the States, in the first instance, whether to take on the responsibility for enforcing those requirements or whether to leave enforcement to the federal government. HCFA anticipates that the States will choose to enforce the requirements. However, the statute also makes clear that if a State does not substantially enforce the requirements, HCFA must enforce them. The statute also requires HCFA to enforce the requirements applicable to nonfederal governmental plans.

Section 146.184(b)(2) sets forth the procedures that HCFA will follow if a question is raised about the State's enforcement with respect to issuers. Under the procedures, States are given every opportunity to demonstrate why federal enforcement is not required. The regulations also make it clear that the procedures will not be triggered unless HCFA is satisfied that there has first been a reasonable effort to exhaust any State remedies. However, if, after giving the State a reasonable opportunity to enforce, HCFA makes a final determination that a State is not substantially enforcing these requirements, HCFA will enforce the requirements using the civil money penalties provided for under the statute.

Parargarph (d) describes the process for imposing civil money penalties against issuers or nonfederal plans that fail to comply with the group market requirements in the PHS Act. If HCFA receives a complaint or other information that indicates that a right guaranteed by the group market rules is being denied, HCFA will first determine which entity is potentially responsible for any penalty. If the failure is by an issuer, the issuer will be responsible. If a nonfederal governmental plan is sponsored by a single employer, the employer will be liable, but if the plan is sponsored by two or more employers, the plan will be liable. If, after giving the entity or entities an opportunity to respond, HCFA assesses a penalty, the regulation provides appeal rights. The penalty can consist of up to $100 for each day, for each individual whose rights are violated.

Effective Dates—26 CFR 54.9806–1, 29 CFR 2590.736, 45 CFR 146.125

The group market provisions are generally effective for plan years beginning after June 30, 1997.[16] In many cases, no preexisting condition exclusion may be imposed with respect to an individual on the effective date because any permitted preexisting condition exclusion period is measured from the individual's enrollment date in the plan (even if the enrollment date is before the statutory effective date). An individual who has not completed the maximum permitted exclusion period under HIPAA before the effective date for his or her plan may use creditable coverage to reduce the remaining preexisting condition exclusion period. The regulations contain examples illustrating the effect of these rules.

The requirement that a plan or issuer provide certificates to show creditable coverage applies to events occurring on or after July 1, 1996, except that in no case is a certificate required to be provided before June 1, 1997 or to reflect coverage before July 1, 1996.

For events occurring on or after July 1, 1996 but before October 1, 1996, a certificate is required to be provided only upon a written request by or on behalf of the individual to whom the certificate applies. For events occurring on or after October 1, 1996 and before June 1, 1997, a certificate must be furnished no later than June 1, 1997 (or, if later, any date that would otherwise apply under the standard rules).

The regulations include an optional transition rule for events before June 1, 1997. (The transition rule applies to automatic certificate events; it does not apply where a certificate is requested.) A group health plan or health insurance issuer offering group health coverage is deemed to satisfy the automatic certificate requirements if a special notice is provided no later than June 1, 1997. The notice must be in writing and must include information substantially similar to the information included in a model notice authorized by the Secretaries. For this purpose, the following model notice is authorized:

IMPORTANT NOTICE OF YOUR RIGHT TO DOCUMENTATION OF HEALTH COVERAGE

Recent changes in Federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for preexisting medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. Under the law, a preexisting condition exclusion generally may not be imposed for more than 12 months (18 months for a late enrollee). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage. You are entitled to a certificate that will show evidence of your prior health coverage. If you buy health insurance other than through an employer group health plan, a certificate of prior coverage may help you obtain coverage without a preexisting condition exclusion. Contact your State insurance department for further information.

[16] In the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, the group market provision (other than the requirements to provide certifications) do not apply to plan years beginning before the later of July 1, 1997 or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension agreed to after August 21, 1996).

For employer group health plans, these changes generally take effect at the beginning of the first plan year starting after June 30, 1997. For example, if your employer's plan year begins on January 1, 1998, the plan is not required to give you credit for your prior coverage until January 1, 1998.

You have the right to receive a certificate or prior health coverage since July 1, 1996. You may need to provide other documentation for earlier periods of health care coverage. Check with your new plan administrator to see if your new plan excludes coverage for preexisting conditions and if you need to provide a certificate or other documentation of your previous coverage.

To get a certificate, complete the attached form and return it to:

[Insert Name of Entity:]
[Insert Address]:
For additional information contact: [Insert Telephone Number]

The certificate must be provided to you promptly. Keep a copy of this completed form. You may also request certificates for any of your dependents (including your spouse) who were enrolled under your health coverage.

REQUEST FOR CERTIFICATE OF HEALTH COVERAGE

Name of Participant: _____

Date: _____

Address: _____

Telephone Number: _____

Name and relationship of any dependents for whom certificates are requested (and their address if different from above):

_____

_____

The provisions in the regulations relating to method of delivery and entities required to provide a certificate apply with respect to the provision of the notice. If an individual requests a certificate following receipt of the notice, the certificate must be provided at the time of the request as set forth in the regulations relating to certificates provided upon request.

HIPAA provides that no enforcement action is to be taken against a group health plan or health insurance issuer with respect to a violation of the group market rules before January 1, 1998 if the plan or issuer has sought to comply in good faith with such requirements. Compliance with the regulations is deemed to be good faith compliance with the group market rules.

G. Interim Rules and Request for Comments

Section 707 of ERISA (redesignated as section 734 by section 603(a)(3) of the NMHPA), Section 2707 of the PHS Act, and Section 9806 of the Code added by HIPAA, provide, in part, that the Secretaries of Labor, Treasury and HHS may promulgate any interim final rules as they determine are appropriate to carry out the portability provisions of HIPAA.

Under Section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) a general notice of proposed rulemaking is not required when the agency, for good cause, finds that notice and public comment thereon are impracticable, unnecessary or contrary to the public interest.

These rules are being adopted on an interim basis because the Secretaries have determined that without prompt guidance, some members of the regulated community will have difficulty complying with the HIPAA's certification requirements, and will be in violation of the statute. Congress expressly intended that the certification and prior creditable coverage provisions serve as the mechanism for increasing the portability of health coverage for plan participants and their beneficiaries. Without the Departments' guidance, plans would likely be unable to produce the necessary amendments to plan documents reflecting HIPAA's new requirements, as well as the appropriate certifications of prior coverage that would help participants and beneficiaries reduce any applicable preexisting condition exclusion periods imposed by a new health plan. Thus, without the Departments' prompt guidance, participants and beneficiaries will not have the benefit of a convenient certificate of prior coverage to present upon changing health coverage, and will likely have greater difficulty proving that they are entitled to health coverage immediately, or soon after joining a new health plan.

Moreover, HIPAA's portability requirements will affect the regulated community in the immediate future. HIPAA's certification requirements are effective for all group health plans on June 1, 1997. HIPAA's underlying requirements concerning establishing periods of prior creditable coverage, pre-existing condition exclusion provisions, and the special enrollment requirements, are generally applicable for group health plans for plan years beginning on or after July 1, 1997. Plan administrators and sponsors, and participants and beneficiaries will need guidance on how to comply with the new statutory provisions before these effective dates. These rules have been written in order to ensure that plan sponsors and administrators of group health plans, as well as participants and beneficiaries, are provided timely guidance concerning compliance with these recently enacted amendments to ERISA, the PHS Act and the Code. These rules provide guidance on these statutory changes, and are being adopted on an interim basis because the Departments find that issuance of such regulations in interim final form with a request for comments is appropriate to carry out the new regulatory structure imposed by HIPAA on group health plans and health insurance issuers. In addition, these rules are necessary to ensure that plan sponsors and administrators of group health plans, as well as participants and beneficiaries, are provided timely guidance concerning compliance with new and important disclosure obligations imposed by HIPAA.

Sections 101(g)(4), 102(c)(4), and 401(c)(4) of HIPAA also mandate that the Secretaries issue regulations necessary to carry out the portability amendments by April 1, 1997. Issuance of a notice of proposed rule making with pubic comment thereon prior to issuing a final rule could delay significantly the issuance of essential guidance and prevent the Departments from complying with their statutory rule making deadline. Furthermore, these rules are being adopted on an interim basis and the Departments are inviting interested persons to submit written comments on the rules for consideration in the development of the final rules relating to HIPAA. Such final rules may be issued in advance of January 1, 1998, after affording the public an opportunity to review and comment.

For the foregoing reasons, the Departments find that the publication of a proposed regulation, for the purpose of notice and public comment thereon, would be impracticable, unnecessary, and contrary to the public interest.

H. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to rules which would have significant economic impact on a substantial number of small entities. Section 603 of the RFA requires an agency publishing a general notice of proposed rulemaking (NPRM) under section 553 of the APA to present at the time of the publication of its NPRM an initial regulatory flexibility analysis, describing the impact of the rule on small entities, and seeking public comment on such impact.

Small entities include small business, non-profit organizations, and governmental agencies. A ''rule'' under the Regulatory Flexibility Act is one for which a general notice of proposed rulemaking is required under section 553(b) of the APA.

Since these rules are issued as interim rules, and not as a general notice of

proposed rulemaking, for the reasons stated above, an Initial Regulatory Flexibility analysis has not been prepared.

While these rules are being promulgated as interim final rules, the Departments nevertheless invite interested persons to submit comments for consideration in the development of the final rules regulating to HIPAA. Consistent with the policy of the Regulatory Flexibility Act, the public is encouraged to submit comments that suggest alternative rules that accomplish the stated purpose of the statute and minimize the impact on small entities. Specifically, the public in encouraged to address:

- What information relating to prior coverage, preexisting condition exclusion, health status, waiting periods and similar issues do employers, plans and issuers currently rely on in maintaining health care coverage systems?
- What are the estimated costs of complying with the statute's requirements on certification of periods of prior creditable coverage?
- How many small issuers offer products that may be subject to the regulations? Is there an anticipated effect on these small companies' competitiveness due to the regulations?
- To what extent do group health plans currently use service providers to fulfill the administrative obligations, including reporting and disclosure, previously imposed by ERISA? To what extent would group health plans also use service providers to comply with this regulation's certification requirements?

I. Executive Order 12866, the Unfunded Mandates Reform Act and the Small Business Regulatory Enforcement Fairness Act of 1995

These rules have been determined to be a significant regulatory action under Section 3(f) of Executive Order 12866. The following analysis is consistent with Section 6(a)(3)(C) of the Order.

These rules are not subject to the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), because they are interim final rules. However, consistent with the policy embodied in the Unfunded Mandates Reform Act, the regulation has been designed to be the least burdensome alternative for state, local and tribal governments and the private sector, while achieving the objectives of HIPAA. In addition, the following analysis provides information concerning the effects of the regulation on state, local, and tribal governments and the private sector.

Throughout the regulatory process, HHS met and consulted with representatives of affected state, local and tribal governments. These groups include the National Association of Insurance Commissioners, the National Governors' Association, the National Council for State Legislatures, the Indian Health Service, and the American Public Welfare Association. HHS also provided technical advice regarding its interpretation of the statute to state insurance commissioners and state legislatures at their request. Generally, these groups have concerns regarding:

- The statute's preemption of state laws that would prevent the implementation of statutory provisions;
- The burden on issuers and plans to implement the statutory provisions, especially with regard to certification of prior creditable coverage; and
- State's desires to have considerable flexibility in complying with the statue, and continuing their traditional role as regulators of insurance.

After serious consideration of these concerns, HHS narrowly interpreted the preemption of state law, taking the least burdensome alternatives provided states considerable flexibility in complying with the statute, and recognized the limited authority of federal agencies in the regulation of health insurance.

The Administrator of the Office of Information and Regulatory Affairs of the Office of Management and Budget has determined that this is a major rule for purposes of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. Section 801 *et seq.*).

Set forth below is a discussion regarding the impact of the statute and a discussion of the costs and benefits of the regulations implementing the statute.

J. Extensions of Coverage Under the Statute

These regulations implement certain provisions of HIPAA. The statute was enacted to, among other things, ''improve portability and continuity of health care coverage in the group and individual markets,'' as stated in the Conference Report. The statute accomplishes these goals by instituting reforms in the group and individual insurance markets, including provisions limiting the use of pre-existing condition exclusions, and requiring guaranteed access to health care coverage and guaranteed renewability for certain groups and individuals. There are also non-discrimination provisions and special enrollment rights in the statute.

The pre-existing condition exclusion periods that HIPAA restricts are widespread. According to the Bureau of Labor Statistics (BLS), 46 percent of participants in private-sector, employer-sponsored health plans are in plans with pre-existing condition exclusions (1993–1994 data). The same is true of 41 percent of participants in state and local government employer-sponsored plans (1994 data.)

The duration of exclusion periods varies from plan to plan. Based on Peat Marwick's 1995 employer survey, an estimated 57 percent of participants in plans with exclusions are in plans with exclusions that last 12 months. The remainder are distributed as follows: 13 percent in plans with 3-month exclusions, 22 percent in plans with 6-month exclusions, 7 percent in plans with 9-month exclusions, and 1 percent in plans with exclusions that last more than 12 months.

HIPAA's portability provisions resemble provisions of many current state laws. Importantly, however, HIPAA extends these provisions of self-insured ERISA plans which federal law shields from state regulation. In addition, it sets a minimum uniform threshold for insured group plans and individual markets across all states.

HIPAA's portability provisions will result in both direct and social costs and benefits.

In general, direct costs and benefits arise directly from the application of HIPAA's insurance portability and access provisions. Direct costs and benefits are often best understood as transfers of resources among economic agents, which do not necessarily represent changes in overall social welfare. Stated differently, they represent changes in how the economic pie is divided (in this case, mainly with respect to health care), and not changes in the size of the pie. Direct costs and benefits are often easier to quantify than social costs, as they are often directly observable as transactions in the marketplace.

With respect to HIPAA's portability and access provisions, direct costs and benefits arise from the extension of insurance coverage to individuals and conditions not otherwise covered. Direct benefits to individuals include the payment of individuals' claims for those services and conditions. Direct costs of individuals include the premiums associated with that coverage. Some available estimates of these direct costs and benefits are presented below.

Social costs and benefits, in contrast, do result in net changes in overall social welfare. Social benefits generally reflect social welfare gains that arise in

connection with statutory or regulatory interventions that remedy market failure. Likewise, social costs generally reflect welfare losses arising from interventions in otherwise efficient markets. Social welfare changes often play out through a complex set of behavorial responses to interventions. They are more difficult to quantify than direct costs and benefits.

With respect to HIPAA, social welfare changes generally arise indirectly from HIPAA's portability and access provisions. They reflect dynamic behavioral responses to HIPAA's portability and access provisions. Expected social benefits, primarily improved access to health insurance and also improved job mobility, cannot be meaningfully quantified. Expected social costs, which could include erosions in coverage arising from direct premium costs, are expected to be small. Since no measures of HIPAA's many social welfare effects are available, a mostly qualitative discussion of major effects is offered below. A more quantitative discussion of direct costs and benefits follows later.

1. Social Welfare Effects of HIPAA's Portability and Access Provisions

The primary direct benefits of the law are improved access to insurance coverage, and more comprehensive coverage, through employers and in the individual insurance market. Increased access and comprehensiveness helps protect individuals from catastrophic expenses.

There are a number of social benefits associated with improved access:

- It reduces individual's risk of incurring large out-of-pocket costs;
- It is often more cost effective to provide timely preventive and remedial care than to delay care until conditions worsen. Therefore, to the extent that individuals receive more timely and appropriate care as a result of HIPAA, over time, the long-term, cumulative cost of their care may be lower. This has the potential to reduce premiums for all individuals within a risk pool, not just the individuals directly affected by HIPAA. Similarly, the Medicare program may benefit from reduced expenditures because more individuals who become newly entitled to Medicare will have had insurance coverage during the course of their working life or through the individual insurance market.
- To the extent that more timely care results in improved health, worker attendance and productivity might improve.
- HIPAA's portability provisions likewise help individuals transitioning from state and federal welfare programs to paid work. Individuals with health conditions can offset their new health plan's preexisting condition exclusions against prior coverage from any source, including Medicaid.
- Reductions in job benefit both individuals and the economy at large. Increased mobility can boost individual workers' career opportunities. Increased mobility also strengthens U.S. economic efficiency and competitiveness;
- HIPAA's federal minimum standards for small group and individual access to insurance coverage may improve the functioning of small group and individual markets. The standards will alleviate disruptions that might otherwise arise when ''riskier'' groups and individuals are denied or dropped from coverage.
- To the extent that HIPAA results, on net, in more insurance payment for otherwise uncompensated care, cost-shifting and associated inefficiencies in health care markets could be reduced.

HIPAA's group-to-individual portability provisions may provide a benefit for employees who move to jobs without health coverage. Some small employers that do not currently offer health care coverage may be able to do so more easily under HIPAA's guaranteed issue provisions. This may help level the playing for small employers to compete with larger ones in recruiting employees. While premium increases resulting from HIPAA may reduce the affordability of coverage for some employers, this effect is expected to be small, as noted below.

HIPAA also requires that issuers offering health insurance coverage in the individual market renew coverage for all individuals purchasing health insurance coverage in the individual market, not only eligible individuals. However, when an eligible individual elects family coverage, the issuer may apply a pre-existing condition exclusion, under applicable State law, to any of the individual's family members who are not eligible individuals under the statute.

The group-to-group portability regulation is likely to benefit individuals who maintain employer-sponsored health benefit coverage and change jobs or health plans, the dependents of such individuals, and workers who face ''job lock'' due to health coverage concerns.

Under HIPAA, health insurance coverage provided under a COBRA continuation policy qualifies as group health coverage. This distinction is particularly important for individuals moving from the group to the individual market, or from one group health plan to another, since electing this coverage would enable these individuals to maintain continuous creditable coverage. In addition, individuals seeking coverage in the individual market must elect and exhaust COBRA continuation coverage in order to qualify as an ''eligible individual'' in the individual market.

Thus, the statute provide an additional incentive for those individuals who lose coverage when they change jobs to elect COBRA continuation coverage in order to avoid a break in coverage. The statute also provides an incentive for those individuals who are seeking coverage in the individual market without a preexisting condition exclusion. Consequently, we expect more individuals to elect COBRA continuation coverage.

Absent HIPAA's group-to-group portability standards, individuals with employer-sponsored health coverage who have preexisting medical conditions and who change health plans could be denied coverage for their conditions. In that case, individuals would have to pay out of pocket for necessary medial services, or forgo some services, thereby risking adverse health consequences and higher future costs. Other individuals with preexisting medical conditions who change health plans and face preexisting condition exclusions may pay for COBRA continuation coverage in addition to paying for their new health plan to ensure coverage for the preexisting condition. Other workers who are concerned about losing health care coverage would stay in their jobs or turn down job offers.

According to the U.S. General Accounting Office, over 20 million individuals changed jobs in 1993 (General Accounting Office, Report HEHS–95–257, ''Health Insurance Portability: Reform Could Ensure Continued Coverage for up to 25 Million Americans,'' September 1995, pg. 7). Approximately 12 million of these workers had employer-sponsored health care coverage. Additionally, nearly 7 million non-working dependents received employer-sponsored health care coverage through these job changers. According to GAO, many of these 20 million could benefit from the regulation's requirement that prior health care coverage be credited against a new health plan's preexisting condition exclusion period. GAO concludes that the statute will allow approximately 9 million job changers (who have at least 12 months of prior creditable coverage), with 5 million dependents, to change jobs without the

risk of facing any preexisting condition exclusions. Another 3 million workers who change jobs (who have some smaller amount of prior coverage), with 2 million dependents, would face reduced waiting periods before receiving full coverage.

The number of workers and dependents actually gaining coverage for a preexisting condition due to credit for prior coverage following a job change under HIPAA will be smaller than this, however. GAO's estimates of people who could benefit include all job changers with prior coverage and their dependents, irrespective of whether their new employer offers a plan, whether their new plan imposed a preexisting condition exclusion period, and whether they actually suffer from a preexisting condition. Accounting for these narrower criteria, as discussed below, CBO estimates that 100,000 will actually receive additional coverage under HIPAA's credit for prior coverage at any point in time.

In addition, employers, especially smaller employers, that offer health care benefits to their employees often change health insurance issuers, exposing workers or their dependents with preexisting medical conditions to gaps in coverage. Small employers generally change insurance issuers every 3 to 4 years (Senate Committee on Labor and Human Resources, Report 104–156, Oct. 12, 1995, pg. 4). The provisions of the statute that allow crediting of prior coverage should reduce the likelihood of gaps in coverage.

One of the benefits of HIPAA to individuals is that it alleviates ''job lock.'' That is, employees who have stayed in a particular job in order to continue health care coverage can now change to a job that the person might not otherwise have taken because he or she (or a dependent) would have been subject to a pre-existing condition exclusion; or the person can seek coverage in the individual insurance market as a result of HIPAA's provisions requiring guaranteed issue for individuals coming from the group market. According to the GAO, there are one to four million Americans ''who at some time have been unwilling to leave their jobs because of concerns about losing their health care coverage'' (*Health Insurance Portability: Reform Could Ensure Continued Coverage for Up to 25 Million Americans,* HEHS–95–257, September 1995). The GAO notes that ''surveys have found that between 11 and 30 percent of individuals report that they or a family member have remained in a job at some time because they did not want to lose health care coverage.'' Among those individuals, twenty percent stated that pre-existing conditions exclusions constituted the basis for their reluctance to change jobs.

These figures, reflecting individuals stated intentions, may not accurately predict their behavior under different circumstances, however. Moreover, HIPAA's portability provisions will alleviate only some causes of ''job lock''—for example, employees might still be somewhat impeded from taking jobs where no coverage is offered. Eligible individuals might benefit in this case from HIPAA's group-to-individual portability provisions, but would have to pay the premium themselves. Therefore, many individuals who report job lock will not necessarily change jobs as a result of HIPAA.

There also appears to be a difference by age categories of the extent of job lock. The Health and Retirement Study (HRS), conducted by the University of Michigan's Institute for Social Research, which provides an emerging portrait of Americans age 51 through 61 and their spouses, found that job flexibility is a key issue for this age group. ''Almost three-quarters of HRS respondents would prefer to phase down from full-time work to part-time work when they retire, in sharp contrast to actual behavior, where most people who retire leave the workforce entirely. About one-third of the people who would not look for another job are victims of 'job lock,' unable to leave because they might give up valuable pensions or health insurance benefits if they switched employers'' (HRS National Institute on Aging Press Release, June 17, 1993).

Empirical evidence for job lock is mixed. Buchmueller and Valletta found strong evidence of job lock among women but weak evidence among men (''The Effects of Employer-provided Health Insurance on Worker Mobility,'' *Industrial and Labor Relations Review,* volume 49, number 3, April 1996). Monheit and Cooper conclude that the magnitude and importance of job lock, which some studies report as causing a 20 to 40 percent reduction in mobility, is not as great as generally thought (''Health Insurance and Job Mobility: Theory and Evidence,'' *Industrial and Labor Relations Review,* volume 48, number 1, October 1994). Kapur found that job lock does not have a significant effect on job mobility (''The Impact of Pre-existing Health Conditions on Job Mobility: A Measure of Job Lock,'' WP–95–25, Institute for Policy Research), while Gruber and Madrian found that COBRA continuation provisions, and similar state laws (allowing individuals to continue coverage through their employer group health plan for a specified period), have led to a significant increase in job mobility (''Health Insurance and Job Mobility: the Effects of Public Policy on Job-lock,'' *Industrial and Labor Relations Review,* volume 48, number 1, October 1994).

CBO does not quantify potential relief from ''job lock,'' which is a social, rather than a direct, benefit of HIPAA. Because people freed from job lock are going from one type of insurance to another (moving to a different group health plan or to an individual insurance policy under HIPAA portability), CBO also views freedom from job lock as consisting of ''insured expenses * * * transferred among different insurers * * * [that] * * * are not * * * direct costs.''

The majority of evidence indicates that job lock is a concern for many workers. HIPAA will address this concern, though the number of workers who will gain an advantage is unclear and how the value of the benefit can be measured is also unclear.

As the forgoing discussion illustrates, HIPAA's social benefits are expected to be far ranging, but they cannot be meaningfully quantified.

HIPAA might also pose social costs. In particular, increases in premiums under HIPAA's portability and access provisions could erode coverage. These costs are expected to be small, however, particularly in the group market where premium increases are estimated to be very small relative to the overall market.

In summary, HIPAA's portability and access provisions are expected to result in a number of largely unquantifiable social benefits. These include greater continuity of coverage, improved access to health care and possible corollary improvements in health and productivity, improved stability and efficiency in insurance health care markets, eased movement from public assistance to work, and gains in job mobility that are favorable to individual careers and to U.S. competitiveness.

2. Direct Costs and Benefits of HIPAA's Portability and Access Provisions

HIPAA's portability and access provisions impose direct costs and provide direct benefits to a broad range of entities, as well as to individual citizens. Costs will be incurred by employers, group plans, insurance companies and managed care plans (''issuers''); states, in their capacity as regulators, and states and localities as entities providing health care coverage for their employees, retirees and dependents; the federal government as regulator and as the source of health care coverage for employees, annuitants and dependents, and for others through programs such as Medicaid and

Medicare. Benefits will accrue to individuals and to small employers whose access to comprehensive insurance is improved.

A number of studies have evaluated the direct economic impact of the law. The CBO found that ''to the extent that states have not already implemented similar rules, these changes would clarify the insurance situation and possibly reduce gaps in coverage for many people.''

The CBO notes that because HIPAA does not impose limits on premiums issuers may charge, insurance coverage, though available, may be expensive. Consequently, CBO observes that the law would ''make insurance more portable for some people, [but] it would not dramatically increase the availability of insurance in general.'' The controversial question of the extent to which there will be increases in issuer premiums is discussed more extensively below.

CBO prepared estimates of the direct effects of the provisions of the legislation included in these regulations (Letter to the Honorable Bill Archer, August 1, 1996; notes are also from earlier CBO cost estimates; see table below). The direct cost estimates can reasonably be read as representing direct benefits as well, since they generally reflect transfers from a pre-HIPAA payer to a post-HIPAA payer. Certain medical expenses that individuals would pay out of pocket absent HIPAA will be paid by insurance programs under HIPAA. In CBO's estimates, this is reflected as a similar transfer in responsibility for payment from individuals to insurance programs. However, the actual transfer would be more complex. For example, to pay the additional claims, insurers must collect additional premiums, which in turn will be paid by the individuals gaining greater coverage and (in most cases) by other covered individuals, or by their employers. CBO's estimates represent gross costs to plans and gross benefits to individuals, and do not account for these complexities.

CBO Cost Estimates and Number of People Affected

Provision	Yearly cost (direct cost to private sector)	Number of people affected	Other effects; comments
Group: Limiting Length of Pre-Existing Condition Exclusions to 12 Months.	$50 million in first year (1997); $200 million per year in subsequent years.	300,000 people ''would gain coverage'' at any point in time, or 0.3% of people with private employment-based coverage.	Assumes ''surge'' in claims costs; state laws taken into account.
Group: Creditable Coverage Reducing Pre-Ex.	$25 million in first year; $100 million per year thereafter.	100,000 people ''would receive added coverage'' at any point in time.	Small No. of people affected reflects ''restrictive eligibility criteria''.
Group: Above two combined	$300 million	Comments: about .2% of total premiums in group and employer-sponsored market; but may be overstated because HMOs, now the dominant option, often do not use pre-ex exclusions.	
Individual (group-to-individual portability, no pre-existing condition exclusion, no denial because of health condition, guaranteed renewal). First year estimates.	$50 million	45,000 people covered by end of first year.	Provisions would apply in states that currently have 5.4 million of estimated 13.4 million people in indiv. market (but see analyses below).
Individual: Subsequent years	$200 million by fifth year	''In about four years, the number of people covered; would plateau at around 150,000''.	Level of premiums to be charged is unknown; states may limit allowable premiums, but such limits may impose indirect costs.

Virtually all of the insurance market reform provisions of HIPAA that are implemented through these regulations have the potential to increase premiums in the group market. Group plans may have to bear higher costs because of the statutory limits on pre-existing condition exclusions and the creditable coverage provisions reducing the application of permissible pre-existing condition exclusions. CBO has estimated the total costs of these two provisions at $300 million annually after full implementation, or 0.2% of total premiums in the group market. This reflects coverage for services which would have been excluded under current law due to pre-existing condition exclusions in insurance contracts, but which would be covered under HIPAA due to HIPAA's 12-months cap on exclusions and its provisions requiring credit for prior coverage.

CBO's $300 million cost figure reflects only the costs of the statute's limits on pre-existing conditions exclusion, and its prior creditable coverage provisions. It does not include the administrative costs to plans and issuers of the HIPAA's certification requirement, which the Department of Labor has measured in its Paperwork Reduction Act analysis below. Similarly, CBO's $300 million figure does not include any other increased premium costs that might be associated with the statute's health status nondiscrimination or guaranteed renewability provisions. CBO's figure does try to estimate (a) how many people would benefit from the statute's limits on preexisting condition exclusions, and its prior creditable coverage provision, and (b) the average cost to insurers of the extension of coverage to those individuals.

Preexisting condition exclusion limitation: CBO derived its $300 million figure by estimating that approximately 300,000 people with private employment-based coverage would gain coverage under the statute's preexisting condition exclusion limitation provision, at a direct private sector cost of $200 million per year. CBO adjusted this estimate to exclude people who reported being limited by a preexisting condition restriction, but who also had secondary health coverage to pick up the cost of their preexisting condition. CBO reasoned that under these circumstances, the preexisting condition exclusion limitation would not raise the aggregate costs imposed on employment-based plans. CBO likewise adjusted its estimate to reflect the existence of state laws which limited preexisting condition exclusion limitations to one year or less and require that previous coverage be credited against those exclusions. These state laws generally apply to group plans of 50 or fewer employees, and do

not include self-funded health benefit plans subject to ERISA rather than state laws. Since plans covered by such state laws would not have to change their provisions as a result of HIPAA, CBO lowered its initial estimate of the people affected by the bill.

Crediting Prior Coverage: CBO's $300 million figure also includes an estimate that 100,000 people, at a private sector cost of about $100 million per year, would receive some added coverage as a result of HIPAA's prior creditable coverage provision.

CBO reports that these estimates are subject to considerable uncertainty for several reasons. First, they are based on individuals' responses to surveys, which should be treated with caution. Likewise, unforeseen changes in the health insurance market, such as changes in medical costs or the growth of managed care plans, could raise or lower the direct costs of the law. Increases in medical costs would obviously raise the costs, while the expansion of HMO penetration in the market would tend to reduce the law's effect, since HMOs generally do not use preexisting condition exclusions.

CBO also reports that in particular, distribution of the costs these provisions would be uneven across health plans. CBO notes that ''[o]nly plans that currently use pre-existing condition exclusions of more than 12 months would face the $200 million direct costs of the statute's exclusion limitation.'' Data from a Peat Marwick survey used by CBO indicate that 2.5% of employees are in such plans. Consequently, ''the costs to health plans that use long preexisting condition exclusions would be about 4.5% of their premium costs.'' Likewise, only those plans that use preexisting condition exclusions would face the $100 million direct cost of the mandate to credit prior coverage against the preexisting conditions exclusion. CBO reports that ''almost half of employees are in such plans—implying that the plans directly affected by this mandate would have direct costs equal to about one-tenth of one percent of their premiums'' absent the statute.

The increased costs may be shared by insurers, plans, and insured individuals. Additionally, costs also may be borne directly by plans that an issuer ''experience rates,'' i.e. the insurer determines rates according to the utilization of the group being insured. Costs may also be borne by others insured through an issuer that uses some form of community rating, which spreads risk over a greater number of ''insured lives'' beyond the particular group that is the source of the additional costs. To a certain extent, a group may have a choice in the degree of burden: if the group knows that its members incur lower costs than the average of the issuer's pool, the group can avoid a community-rated pool by becoming self-insured.

There is also the possibility that group market premiums may increase as a result of the HIPAA reforms in the individual market if insurers spread the costs of claims in the individual market across a pool that includes group members. HIPAA expressly provides for this possibility as one of the elements of an acceptable state alternative mechanism. (Such issues relating to the individual market are discussed in more detail below.)

Assuming that the CBO is correct in projecting that the premium effect translates into 0.2 percent of total premiums in the group market, a minimal premium effect is likely.

CBO did not quantify the cost of nondiscrimination or special enrollment provisions.

With respect to nondiscrimination, approximately 135,000 workers reported in 1993 that they were excluded from their employer's health plan because of their health, according to DOL tabulations of the April 1993 Current Population Survey. In general, HIPAA would require plans to offer benefits to such individuals.

With respect to special enrollments, HIPAA provides that individuals, under certain conditions, are permitted to enroll for health coverage on the same terms as new participants, rather than as late enrollees. The conditions triggering eligibility for special enrollment generally include events in which an individual loses coverage (such as when a spouse changes jobs when couples legally separate or divorce) or joins a family that is eligible for coverage (through marriage, birth, or adoption).

Special enrollment requirements benefit individuals. Absent this provision, eligible individuals could be subject to pre-existing conditions exclusion periods of up to 18 months, and therefore would might need 18 months of prior creditable coverage to fully offset a preexisting condition exclusion period. Under the provision, eligible individuals' exclusion periods are limited to 12 months. This special enrollment provision also permits eligible individuals to enroll immediately in plans which otherwise prohibit late enrollment, or which allow late enrollments only during annual open enrollment periods.

Considering some of the major groups that could benefit, the Departments estimate that 734,000 families would gain eligibility for special enrollments due to marriage, as would 701,000 due to births, and 292,000 due to job changes in the family. These estimates, based on the Survey of Income and Program Participation, reflect an annual count of such events following which the relevant spouse or new born was uninsured, or covered under an individual policy or Medicaid.

Special enrollments may result in a marginal increase in aggregate premiums and claims paid, but no change in average premium levels for any one individual, since eligible individuals are not likely to have any higher health care costs than the average new health plan participant.

In summary, HIPAA's portability and access provisions will result in a number of direct costs and benefits. These direct costs represent transfers among parties and not changes in overall social welfare. CBO estimates that HIPAA's group portability provisions will result in $300 million of additional annual direct costs to insurance programs, which in turn represents a direct benefit of $300 million in added coverage for individuals. Additional direct costs and benefits will arise from similar extensions of coverage under HIPAA's group-to-individual portability, special enrollment, and nondiscrimination provisions. Various estimates of the costs and benefits of the group-to-individual provisions are offered below. Costs and benefits of the special enrollment and nondiscrimination provisions have not been quantified.

3. Affected Market Segments

(1). Impact on State, Local and Tribal Governments

The statute establishes federal standards and allows for federal enforcement in an area that has traditionally been the domain of the states, the regulation of insurance. However, the statute also permits states to use alternative, state-specific mechanisms to achieve greater portability and continuity in a manner similar to the federal standards. Many states have undertaken insurance reforms similar to the HIPAA provisions and are likely to seek approval for the continuation of these alternative mechanisms. The statute provides that enforcement of the requirements of the law will be the responsibility of the states (for those states implementing alternative mechanisms as well as for those states implementing the federal standards), unless a state is unwilling or unable to enforce the law. Only in the latter case of unwillingness or inability to enforce the law will the federal

government implement and enforce the law in a given state. It is highly unlikely that there will be any instance of the federal government assuming such a role, with the exception perhaps of the territories. There is no federal financial assistance or resources to implement these provisions.

The CBO has generally determined that there will be a negligible impact on these governmental entities, even in the event that, in their capacity as sponsor of employee health care coverage, they choose not to ''opt out'' of having certain provisions of the statute apply to them. HIPAA provides that states and localities that self-insure their health care coverage for employees, are permitted, under the statute, to ''opt out'' of the provisions of the law affecting them with respect to rules governing pre-existing condition limitations. Some entities that have the option available will ''opt out.'' However, this does not relieve them of the responsibility of providing certifications of creditable coverage for their covered individuals. HIPAA does not preempt state and local government collective bargaining laws. If there were no opt-out entities, CBO projects that state and local governments would see an increase in health care costs of less than $50 million, or 0.1% of the $40 billion annually in state and local total health insurance expenditures.

Those who would benefit from the imposition of HIPAA requirements on state and local governments are individuals who are subject to a pre-existing condition exclusion that would have been shortened in length by HIPAA either under the 12-month limit or the crediting or prior creditable coverage provision. As the CBO points out, this benefit (for some) is coupled with a cost to (all covered) individuals because it is assumed that states and localities would pass the cost off to their employees through reduced compensation or benefits.

According to CBO, the impact of the law on the states in their capacity as regulators enforcing new insurance provision is marginal. For states that have been enacting insurance reform measures in the small group and individual markets, it could be argued that HIPAA provides a benefit to the extent that the introduction of federal standards facilitates the states' ability to continue insurance reforms in these markets. According to the Intergovernmental Health Policy Project (IHPP), in a report dated June of 1996, all but two states had enacted some type of small group market reform, and 35 states had enacted some type of individual insurance market reform. The presence of a federal standard that may be viewed as constituting a ''floor'' of requirements imposed on issuers in these two markets may also benefit the states.

The individual insurance market has traditionally been regulated by the states, and Congress intended that, to the maximum extent possible, the states should continue this regulatory role. To this end, the law provides states with these options: (1) implement an alternative, state-specific mechanism to ensure access to individual health care coverage; (2) adopt and administer the federal standards of HIPAA; or (3) allow the federal government to administer the law.

In devising the first option, the implementation of an alternative mechanism, Congress afforded states a good deal of flexibility in establishing an alternative mechanism. At least 30 states are expected to implement alternative mechanism, each unique to the state's demographics and market conditions. States are encouraged to explore innovative options and intend to afford states as much flexibility as possible in the design of their alternative mechanisms. Throughout the process of reviewing proposed alternative mechanisms, the states' need for flexibility must be balanced with the rights of the individuals afforded protection under the law.

Our main concern is that the primary goal of HIPAA be achieve: that eligible individuals are guaranteed coverage in the individual market, to the extent that policies are available, without a preexisting condition exclusion period. HHS intends to review states' mechanisms with this goal in mind; so the information presented should present a clear picture of the mechanism's impact on eligible individuals. The information requested in these regulations (section 148.126(h)) closely parallels the statutory provisions. While such information collection requirements may impose a burden on each state that chooses to implement an alternative mechanism, such information is necessary in order to effectively evaluate the mechanism and ensure that the mechanism will provide eligible individuals the protection guaranteed by the law.

The states are unlikely to choose the option whereby the Secretary (HCFA) implements and enforces HIPAA in the states. Eight states, however, may choose the ''federal fall-back'' option of incorporating the HIPAA standards into state law rather than developing an alternative mechanism.

The statutes provides that a state is presumed to be implementing an acceptable alternative mechanism as of January 1, 1998, unless the Secretary of HHS notifies a state of her disapproval of the mechanism by July 1, 1997. In states where the legislature does not meet in a regular session between August 21, 1996 and August 20, 1997, the state is presumed to be implementing an acceptable alternative mechanism as of July 1, 1998. To our knowledge, only Kentucky qualifies for this exception. The statute also provides an extension. Before making an initial determination, HHS intend to make every effort to consult with the appropriate state officials. After consultation with appropriate state officials, should there still be cause for disapproval, HHS will allow the state a reasonable opportunity to revise the mechanism or submit a new mechanism. Throughout this process, HHS may require further information from state officials regarding particular aspects of their insurance market reform. While such requests for information may also impose an additional burden on the state, this information will be necessary to insure that the mechanism will provide the protections guaranteed to eligible individuals under the law.

As required by law, the Secretary of HHS will review each alternative mechanism every three years. In this respect, the regulation adheres closely to the statutory burden and merely clarified that resubmission is required on every three-year anniversary of the last submission date. HHS has also provided a process for review of future mechanisms, should a state may wish to revise an existing mechanism or propose a new mechanism.

In addition to implementing an alternative mechanism, a state may choose to adopt and administer the federal statutory provisions. Our regulations in this regard do not differ from the statutory provisions. As noted above, it is likely that up to eight states would choose this option.

Finally, a state may choose to allow the federal government to administer the federal statutory provisions in the state. Although this is a possibility contemplated in the statute, it is unlikely that any state would choose this option. However, the impact of the regulations that implement this option is discussed below.

In states that have an acceptable alternative mechanism for ensuring access to individual insurance or health care coverage, the implementation of laws and determination of compliance with those laws is exclusively a state matter. For other states, HIPAA gives the Secretary authority to issue

regulations to carry out the implementation and enforcement of HIPAA provisions for the states that choose the ''federal fallback'' option (using federal standards), and for states in which the federal government will directly administer the HIPAA provisions. These regulations specify the following:

- Documentation that must be submitted to the state (federal default) or to HCFA (direct regulation by the federal government) demonstrating compliance with the statute;
- The manner in which an insurer markets individual policies;
- The procedure and time frames the issuer follows in determining whether someone is an eligible individual, and the effective date of the individual's coverage;
- The procedure to follow for a request to limit enrollment in the case of an HMO's or insurer's capacity limitations (network capacity or financial capacity); and
- The procedure for determining whether the benefit packages offered in the individual market are consistent with statutory requirements.

In states electing the federal fall-back approach, the state determines the level of documentation required to establish compliance with the HIPAA provisions. The Departments do not know the extent of burden states will impose on plans as a result of HIPAA. Although there is not likely to be direct federal enforcement in any state, in those states in which HCFA does administer the law, issuers have 90 days after July 1, 1997, to provide documentation concerning individual policy forms the issuer already markets; and 90 days prior to the beginning of the calendar year prior to marketing a new policy form. With regard to these time frames, the 90-day period should not be burdensome. Much of the information required to be submitted regarding the policy forms in the individual market is material the issuer will generally have filed with a state insurance commissioner (''information on all products offered in the individual market''; marketing material, often submitted to states on a ''file and use,'' or informational basis). For such information the submission to the federal government is burdensome only in that it is duplicative of material given to the state. The HIPAA-specific materials are generally not duplicative and constitute a burden on issuers to provide HCFA with the following information:

- An explanation of how the issuer is complying with the provisions of HIPAA, including how the issuer will inform eligible individuals of available policy forms;
- Premium volumes or actuarial values (depending on which election is made regarding compliance with rules on the type of policy to be offered); and
- A description of the risk spreading/financial subsidization mechanism to be used for individual policy forms.

The last two items represent requirements of the statute, while the first item is necessary to ensure that there is effective implementation of the statute. For the first item, issuers will have to become familiar with the provisions of HIPAA in order to comply with the documentation requirement, which can be a considerable burden, but the other information requirements should not be burdensome. One way in which these regulations lessen the burden for plans electing to offer ''representative coverage'' rather than the most popular policy forms is by not prescribing the method of determining the actuarial value of representative coverage. Issuers may make their own determinations of actuarial value and present them to HCFA for verification.

(2). Impact of the Law in Different States

The impact of the law on individuals, employers, group plans, and issuers may vary somewhat from state to state. Many state reforms resemble HIPAA's portability provisions, often meeting or exceeding particular HIPAA standards. The CBO notes that it ''lowered its initial estimate of the number of people affected by the bill'' in recognition of such state reforms. Where state laws resembling HIPAA exist, the marginal impact of HIPAA is reduced.

The degree to which a state's reforms lessen the impact of HIPAA's portability provisions depends on the degree to which the state's requirements exceed these provisions, and on what proportion of insured individuals in the state are covered by the state's reforms. In general, individuals not covered by state reforms are those enrolled in programs for which such state reforms are preempted by federal law. These include individuals enrolled in federal programs such as Medicare and the Federal Employees Health Benefits Program or in self-insured ERISA plans. Individuals enrolled in ERISA plans that are not self insured are covered by such state reforms that are specifically saved from preemption by HIPAA.

According to a study by Jacob Klerman of RAND, *New Estimates of the Effect of Kassebaum-Kennedy's Group-to-Individual Conversion Provision on Premiums for Individual Health Insurance* (1996), 42 states have guaranteed issue rules in the individual market or a high-risk pool that could qualify the states as meeting the alternative mechanism requirements of HIPAA. This is consistent with other information the Departments have received to the effect that only eight states may adopt the federal HIPAA standards (to be administered by the states). (The individual market issues are discussed in greater detail below.)

An analysis prepared by staff of the Pension and Welfare Benefits Administration (PWBA) of the Department of Labor found, for the group market, that 41 states have small group guaranteed issue; of that number five do not conform with (or are not more generous than) HIPAA rules on guaranteed issue, and 21 define a small group differently from HIPAA by starting the small group category at three individuals (rather than HIPAA's two)—the situation in 11 states—or by extending the provisions to groups not reaching HIPAA's 50 (4 states define a small group as up to 49; one as 40; and ten as either 24 or 25). These states are likely to make relatively small changes as necessary to conform their laws to HIPAA standards. The National Association of Insurance Commissioners has also engaged in extensive efforts to help the states conform their laws.

Thirty-one states already have provisions which require that group health plans offer additional enrollment opportunities to employees under circumstances similar to HIPAA's special enrollment opportunities. The statute expands the state baseline by adding legal separation as a grounds for special enrollment eligibility, and expressly includes COBRA as prior group health coverage. The statute further requires retroactive coverage for newborns and adopted children if special enrollment is requested within 30 days of birth, placement for adoption, or adoption. Current state requirements reduce the overall economic impact of the special enrollment requirements on the group health market.

For pre-existing conditions limitations in group health plans, HIPAA provides that the maximum allowable period is 12 months (''look-forward''), or 18 months for a late enrollee (someone enrolling outside of an initial or special enrollment period) for conditions arising within the six months (''look-back'') preceding the enrollment date in a group health plan. HIPAA also provides that prior coverage for which there was not a break in coverage of 63 days or more would be credited against the pre-existing condition exclusion. Using the PWBA analysis and information from the IHPP,

as of mid-1996, 30 states had time limits on pre-existing condition exclusion periods that are the same as, or more favorable to individuals, than the HIPAA provisions for the group market; and 14 other states have limits on pre-existing condition time limits. Among these 44 states, ten states allow crediting or prior coverage for which the duration of the break in coverage equals or exceeds 63 days (more generous than HIPAA); eight states allowed breaks in coverage of 60 days; 18 states allowed 30 or 31 days of a break in coverage; and four states had no crediting of prior coverage. State laws which exceed HIPAA standards will not be pre-emptied by HIPAA.

(3). Group Plans

HIPAA sets minimum standards for all group health plans, including self-funded plans that are shielded by ERISA from states' HIPAA-like requirements. The General Accounting Office has estimated that about 27% of the Nation's population received health care coverage through ERISA self-funded plans (17%).

Although the GAO report indicated that the number of people covered by self-insured plans is increasing, other data indicate that there has been a decline in such coverage because of the increasing number of individuals covered by HMOs that operate as insured plans. However, an HMO network may constitute an exclusive provider organization for a self-insured plan. Liston and Patterson (*Analysis of the Number of Workers Covered by Self-Insured Health Plans Under the Employee Retirement Income Security Act of 1974—1993 and 1995,* prepared for the Henry J. Kaiser Family Foundation, August 1996) found that from 1993 to 1995 the number of Americans covered by fully or partly self-insured plans declined from 37.6 million to 32.5 million (a 14% decline). The rate of decline was greatest in smaller firms: for firms with fewer than 100 workers, the number of workers covered under fully or partially self-insured plans declined form 8.2 million to 5.4 million (a 34% decline). For firms with 25 or fewer employees, the numbers declined from 2.9 million to 2.2 million from 1993 to 1995 (a 24% decline).

The relevance of these numbers to an analysis of HIPAA has to do both with the number of people that can potentially benefit from the HIPAA provisions (if the employees moving to ERISA-insured plans are in states that already have provisions similar to HIPAA, effects will be smaller), as well as the related issue (partially a consequence of the former) of the extent to which the small group market in a given state may be ''disrupted'' because of the effects of HIPAA. (For example, will the HIPAA provisions create a situation in which either insurers will abandon markets or employers will discontinue health care coverage?) Although the Departments' economic impact analysis does not contain a state-by-state analysis of the relationship between employees covered under self-insured plans (and any changes in those numbers) and the states that have reforms similar to HIPAA, Liston and Patterson found that the South was the only region of the country in which there was an increase in the number of employees covered by self-insured or partially self-insured (reflecting the lower penetration of HMOs in Southern states). Data about individual states do not appear to be available. A recent GAO report notes that ''no analysis exists on the number of individuals affected by these state [insurance] reforms'' (*Health Insurance Portability: Reform Could Ensure Continued Coverage for Up to 25 Million Americans,* HEHS–95–257, September 1995).

For 1995, the South (stretching, under the Liston-Patterson definition, from the South Atlantic states to the West South Central states of Arkansas, Louisiana, Oklahoma and Texas) had 35% of all employees covered by self-insured or partially self-insured plans, while those same states had 30% of the private-sector employees with health care coverage. Three of the seven states that had no pre-existing condition limitations regulations in the PWBA analysis were Southern states; of the 11 states that had no guaranteed renewal provisions for group health plans, four were in Southern states. It would appear then, that to the extent that practices in the ERISA small group market in Southern states diverge significantly from HIPAA provisions employers will have to adhere to, there are possible major impacts of HIPAA in those markets.

(4). The Individual Insurance Market

In the individual insurance market the statute provides for guaranteed issue of a policy to ''eligible individuals'' (individuals coming from the group market, who have 18 months of aggregate creditable coverage, from any of various types of health care coverage). In addition to this guaranteed issue requirement, insurers are not permitted to apply any per-existing condition exclusions to this group. Individual policies are guaranteed renewable except under certain circumstances. The statute does not place any limits on the premiums insurers may charge for the policies made available to eligible individuals. States are permitted to have alternative mechanisms that achieve the same ends as the HIPAA requirements, though any alternative is required to have no pre-existing condition exclusions.

The individual insurance market reforms are of greatest benefit to individuals who voluntarily or involuntarily leave their jobs and wish to maintain some level of health insurance. As discussed above, the availability of individual insurance may decrease ''job lock'' by allowing people to maintain continuous protection as they move between jobs. Individuals who enter the individual market from the group market may choose to do so because their new employer may not offer insurance or the employer's coverage is limited; or they may expect to be without a job for a period of time (for example, because they are ''early retirees'' who do not yet have Medicare entitlement and do not have employment-based retiree health care coverage). The CBO projects, in data cited above, that the number of people benefiting from the HIPAA (getting coverage when it would have been denied absent HIPAA) individual market reforms would ''plateau'' at the 150,000 range by the fourth year of the law. The GAO (HEHS–95–257, cited above) determined that about two million people each year could convert to individual insurance from group coverage, based on turnover rates among small employers and rates of COBRA continuation of coverage.

Individual market premium effects vary by state. In state regulatory activity, fewer states have provisions similar to HIPAA's in the individual market as compared to state reforms in the small group market. HIPAA will affect the individual insurance markets in many states. The RAND and IHPP data indicate that only eleven states have guaranteed issue laws for the individual market. Eight additional states have an insurer (Blue Cross-Blue Shield) offering open enrollment in the individual market. Twenty-three states have laws limiting the period of pre-existing condition exclusions, but only one state allows no such exclusion period, with most states allowing a 12-month exclusion period with a 6- or 12-month ''look back.''

One of the most contentious issues in discussions of HIPAA's effect on the individual insurance market has been the issue of premiums in that market. HIPAA does not impose any rating requirements on insurers in the

individual market, meaning that the insurers are free to price their individual products in any manner that is consistent with state law. IHPP data show that for the individual market, seven states have rating bands (premiums must be within certain upper and lower bounds in relation to a ''standard'' premium), and eight states require community rating of some form (a form of rating that can be roughly described as rating across a larger pool of insured individuals, for example, across all of an issuer's insured individuals, across defined age categories, etc.). Rating bands and community rating requirements have the same intended effect as HIPAA, to increase the availability of insurance, but they additionally seek to assure affordable coverage. There will be interactions between the HIPAA approach to increased availability (guaranteed issue and elimination of pre-existing condition exclusions for certain individuals with prior coverage) and the rating approach in those states in which guaranteed issue rules and pre-existing condition exclusion rules differ from HIPAA's provisions.

Affordability of individual coverage is a significant issue with HIPAA. The Health Insurance Association of America (HIAA) has projected that the individual market reform provisions of HIPAA will cause an eventual 22% increase in premiums in that market (''The Cost of Ending 'Job Lock' or How Much Would Health Insurance Costs Go Up If 'Portability' of Health Insurance Were Guaranteed?'', February 20, 1996). HIAA projects, on that basis, that eventually 500,000 to one million people would leave the individual insurance market because of rate increases necessitated by the HIPAA reforms. HIAA bases this estimate on the current number of people insured in the individual market, the number of new entrants in the market, their costs, and the price-sensitivity of purchasers of insurance.

Other studies have arrived at conclusions that are very different from the HIAA conclusions. The main difference with other studies is that HIAA assumes that HIPAA will cause states to impose restrictions on the level of premiums insurers may charge in the individual market. There are no such requirements in HIPAA. The HIAA assumes that people currently covered in the individual market will be included in the rating pool that includes individuals who are newly insured under HIPAA provisions. The American Academy of Actuaries (AAA), for example, found that the premium increases in the individual market would be in the range of two to five percent, and the increases would take effect over a longer time span that one year. The AAA took into account current state laws, including state laws related rate restrictions in the small group market.

Jacob Klerman, or RAND, examined HIAA's assumptions and methodology and found that (a) using HIAA's assumptions, but employing more up-to-date or otherwise improved data (''better estimates of the underlying figures''), the increase in individual premiums would be 5.7%; and (b) using different assumptions, the premium effect would be 2.3% and may be as little as 1% or less (*New Estimates of the Effect of Kassebaum-Kennedy's Group-to-Individual Conversion Provision on Premiums for Individual Health Insurance,* RAND, 1996). For the latter projections, Klerman assumed a different level of claims costs for new entrants (150%, based on studies of the costs for COBRA continuation policies, versus the HIAA's 200%), that the premium pricing for the new policies would not be pooled with others in the individual market, and that state laws would have effects that the HIAA analysis did not consider. Note that, as with the GAO report quoted above, these analyses are based on an earlier version of an insurance reform bill, S. 1028, in which the guaranteed issue was available only to those with 18 months of group coverage. This analysis does not measure how many more people are encompassed in the larger HIPAA ''eligible individual'' group comprising individuals whose last type of coverage was group coverage but who had prior coverage during the 18-month period from a different source; this will slightly increase the cost.

Another study, done for HHS, by Actuarial Research Corporation (ARC), had results that were similar to the RAND results. ARC projects possible increases in individual premiums ranging from 1.4 percent to 2.8 percent.

K. Statutory Provisions Affecting Administrative Processes

While these rules implement the statute's goal of expanding coverage and portability of coverage by reducing the use of pre-existing condition exclusions, for purposes of performing this economic impact analysis, it is appropriate to break the regulations down into the following components: certifications and notices informing individuals of their right to request a certification; notification of the application of a pre-existing condition exclusion period; alternative methods of crediting coverage; and guidelines for implementing the statue's special enrollment requirements. The notice and notification requirements are largely a result of this rulemaking. The certification requirements are largely prescribed by HIPAA, with certain aspects that mitigate the impact of the statute resulting from this rulemaking. While the alternative method of counting compliance is authorized by HIPAA, the classes and categories of coverage to be measured were created at the discretion of the three Departments.

1. Staggered Effective Dates

In general, the effective dates of HIPAA's group health plan provisions are tied to plans' fiscal years and to the expiration of collective bargaining agreements under which some plans are maintained. Provisions whose effective dates are so tied included those pertaining to pre-existing condition exclusions, crediting prior coverage, and special enrollments. (The effective dates of HIPAA's certification provisions are not so tied.) Non-collectively bargained plans become subject to these provisions of HIPAA in the first plan year beginning on or after the July 1, 1997. Collectively bargained plans become subject the first plan year beginning on or after the later of July 1, 1997 or the expiration of a collective bargaining agreement that was in place prior to HIPAA's date of enactment, August 21, 1996.

More than one-half of plans begin their fiscal years on January 1. Therefore, there is a large concentration of plans and participants that become subject to HIPAA in January 1998. Overall, the proportions of participants and plans (respectively) that become subject to HIPAA in 1997 are 15 percent and 24 percent; in 1998, 68 percent and 69 percent; in 1999, 11 percent and 4 percent; and in 2000, 5 percent and 2 percent.

The compliance costs of these regulations regarding certification and notice, pre-existing condition exclusion notification, and notice of enrollment rights was estimated based upon information in the public domain and data available to the Departments on industry practices. To derive data on health coverage and employment shifts of individuals, for the purposes of this analysis the Departments referred to data collected from the Census Bureau's Current Population Survey and Survey of Income and Program Participation, as well as the National Health Interview Survey and the Department of Labor's database of 1993 Form 5500 information, the most current available. Supplemental data on employer-sponsored health care was obtained

from the Peat Marwick Benefits Survey and the BLS Employee Benefits Survey.

2. Initial vs. Ongoing Costs

Costs may be separated into initial costs and ongoing costs. Initial costs of the new certification, notice, pre-existing condition exclusion notification, and special enrollment requirements have several components, including capital costs of preparations for collecting information such as purchasing or upgrading computers and software, and record storage facilities. Initial costs may also be expected to include programming or reprogramming automated systems to track periods of prior creditable coverage, and to track plan participants and the type of coverage they hold, e.g. individual or family coverage. Initial costs also include up-front expenditures for revisions of plan documents to comply with the new statutory and regulatory requirements. These costs were annualized over the estimated ''life'' of the regulation, 10 years, in order to show such costs on an annual basis. It is estimated that the 15,604 plans that will process certifications internally (rather than use a service provider) will incur an average cost of $5,000 per plan to revise their automated records systems to accommodate this information for a total cost of $78 million over 10 years beginning in 1997. Presented here as direct costs, initial costs are a component of overall social costs.

Ongoing expenditures incurred annually include the costs to group health plans, health insurance issuers and self-funded plans of performing the continuing administrative tasks of calculating periods of creditable coverage, printing forms for notices, preparing an original and a copy of notices and certifications for participants with dependants having identical coverage, and mailing these documents to individuals. Also included in ongoing expenditures is the cost to plans which use pre-existing condition exclusions to notify participants of the plans' provisions, and calculating periods of pre-existing condition exclusions for new participants, and issuing an individualized notification, as necessary, to each individual who would be subject to a pre-existing condition exclusion of any duration. Total annualized initial costs and ongoing costs were aggregated to estimate total annual costs.

3. The Certification Process

The statute specifies that every individual leaving a group health plan, ending COBRA coverage, ending individual insurance coverage, or leaving other types of health coverage must receive a written certification of creditable coverage containing specific information about the individual and his or her coverage, including information on the coverage of dependents. This requirement constitutes a burden in information collection and processing.

Despite recent incremental state reforms in the laws affecting the group health insurance market, no states have required group health plans or health insurance issuers to provide participants and their dependents with certifications or notices regarding prior health coverage. Therefore, the statute imposes discrete new burdens on all group health plans and health insurance issuers in connection with providing certifications, and issuing to individuals of their right to receive a certification.

Respondents preparing certification forms must collect the appropriate information about a person, prepare a certification form, and, in most cases, mail the information. One certification can serve to provide information about dependents covered under the same policy. The respondent may have to prepare multiple certification forms for an individual, or for dependents, in the event that the certificate is lost or misplaced. The process may require the development of new information systems or, more likely, modifications to existing information systems, to collect and process the necessary information.

The statute makes the certification requirement a key implementation component of the portability provision in both the group and individual markets.

The cost of providing certifications for private group plans (absent the regulatory relief described below) is estimated to be at least $98 million for 69 million certifications in 1997 and $84 million for 59 million in each subsequent year. Absent transition relief provided under the regulations, early year costs could be far higher. The direct cost of certifications contributes to the overall social cost of the statute.

L. Impact of Regulatory Discretion

These regulations mitigate the impact of the statutory requirements on the regulated public, while preserving protections, in several ways. These regulations will reduce implementation costs.

The Departments exercised discretion in connection with group plan provisions, as follows:

First, intermediate issuers will not have to issue a certification when an individual changes options under the same health plan. In lieu of the certification, they could simply transfer the start and stop dates of coverage to the plan. An individual would retain the right to get a certification upon request if they leave the plan.

Second, telephonic certification will fulfill the requirement to sent a certification if the receiving plan and the prior plan mutually agree to that arrangement. The individual can always get a written certification upon request.

Third, the requirement to send certifications on June 1, 1997 to those who have left plans between October 1, 1996 and May 31, 1997 can be satisfied by sending a notice; the Departments have offered a model notice in these regulations for that purpose.

Fourth, until July 1, 1998, plans and issuers that do not collect individual information on dependants can comply with the requirement to send each dependant a separate certification by simply listing the category of coverage (e.g., individual, spouse or family).

Fifth, in situations where the issuer and the plan contract for the issuer to complete the certifications, the plan would not remain liable if the issuer failed to send the certifications.

Thus, plans would not need to keep data and files on this information.

Sixth, the period of coverage listed on automatic certifications will only be the last continuous period of coverage without any break. This is the most efficient and simplest method of record keeping for plans and issuers.

Seventh, the period of coverage contained in the on-request certification will be all periods of coverage ending within 24 months before the date of the request. Essentially, a plan may simply look back two years and send copies of any automatic certifications issued during that period.

The above reductions in burdens on plans and issuers may cause more frequent circumstances in which participants are required to prove creditable coverage and the status of their dependants. In order to help offset some of the additional burdens that will be shifted to the participants, the regulations provide the following protections:

First, if an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status, and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

Second, a plan shall treat an individual as having furnished a certificate if the individual attests to the period of creditable coverage, and the individual also presents relevant corroborating evidence of some creditable coverage during the period and the individual cooperates with the plan's efforts to verify the individual's coverage.

Third, plans and issuers that impose preexisting condition exclusions periods must notify participants of this fact. They must also explain that prior creditable coverage can reduce the length of a preexisting condition exclusion period and offer to request a certification on the participant's behalf. An exclusion may not be imposed until this notice is given. This is beneficial to participants insofar as it forewarns them of potential claim denials and enables them to more easily exercise their right to protection from such denials under HIPAA's portabliity provisions.

Fourth, a plan that imposes a preexisting condition exclusion must notify a participant if the individual's creditable coverage is not enough to completely offset the exclusion period, and give the individual the option to provide additional information. An exclusion may not be imposed until this notice is given. This provides participants an opportunity to correct any failure to establish credit for prior coverage before a claim is denied.

Under the regulation, in the group health plan enrollment materials ordinarily provided to most new participants, plans that contain pre-existing condition exclusion provisions must also provide notice that the plan contains these provisions, that the participant has the right to prove prior creditable coverage, including the right to secure a certificate from a prior plan or issuer, and that the new plan will assist in obtaining the certificate. Those plans using the alternative method of crediting coverage also must disclose their methods to the participant, including an identification of the categories of coverage used.

In addition, a plan seeking to impose a pre-existing condition exclusion on a participant or dependant must inform them in writing of the determination that they lack adequate prior coverage, and provide an opportunity for the individual to submit additional materials regarding prior creditable coverage, and provide an explanation of any appeals procedure.

The annual cost of these disclosure procedures to private group plans is estimated to be $280,000 in 1997, $2.1 million in 1998, and $1.9 million in 1999 (about 20 cents per notice). The same costs for state group plans would be $25,500, $51,000, and $51,000, respectively. For local plans, they would be $42,000, $84,000, and $84,000. The Departments believe the marginal burden of the notice will be modest because, irrespective of the notice requirement, under the statute plans must make this determination before imposing a preexisting condition exclusion. Comments are encouraged as to whether this assumption is appropriate. These costs do not include any burdens attributable to the use of the alternative method of crediting coverage, since it is assumed that any plans incorporating this method will do so only if the net cost is less than using the standard method. Under the alternative method of crediting coverage, the regulation allows the prior plan to charge the receiving plan using the alternative method for the reasonable costs of providing evidence of classes and categories of prior health coverage.

On balance, to the extent that the Departments have exercised regulatory discretion, they have acted to reduce compliance costs. This is particulary true with respect to the certification process.

These regulations attempt to reduce the burden of certifications by limiting the amount of information that needs to be reported and offering a model form that can be used to satisfy the requirement of the law. In the absence of a written certification, the regulations allow for alternative means of establishing creditable coverage, which includes having the individual present documentation of coverage or conducting telephone verification with the entity that previously covered the individual.

During a transition period, respondents may provide individuals with a notice that they have the right to receive a certificate of creditable coverage, a requirement that can be met by including the information in an evidence of coverage or other generic document individuals receive that contains information about their policy. This notice may be provided in lieu of a certificate for events that occur on or after October 1, 1996 but before June 1, 1997.

The cost to issuers of the certification requirement is primarily in the paperwork production of the certification form. All health insurance issuers are likely to have the kinds of systems in place to be able to produce the information necessary for a certification, although there will be moderate systems start-up costs, and some systems modifications for insurers and HMOs. Systems modifications may also be necessary to retain the data for the certificates for several years, but, like the other requirements, this burden should also be limited. The model certification form of the Preamble contains the kind of information that is routinely used as the basis for claims processing by a health insurance issuer or by an HMO (for example, in adjudicating an out-of-network claim).

For example, in order to deny a claim dating from a period prior to the beginning date of coverage of a particular individual, the issuer's information system could determine that (1) a particular individual was covered by the issuer; (2) the issuer identification number submitted with the claim is correct; (3) the individual was insured on the date the health care service was provided; (4) the service was provided during a waiting period or affiliation period before coverage was available; and (5) coverage may have ended prior to the date of service. The issuer's information system would also determine the limitations of coverage (e.g. high or low option coverage, with or without specific riders). The remaining information of the certification form could also be available to the issuer, especially for COBRA-eligible individuals: whether COBRA continuation coverage is involved (given that the premium is charged directly to the individual at a specified rate); the beginning and ending dates of coverage and waiting periods; and the name, address, phone number and contact person (or Department) for information.

Respondents may need to modify their systems to determine whether, for a given insurer's coverage of a particular individual, there was a 63-day period of interrupted coverage for purposes of specifying this information on a certification form. As noted above, the Departments have taken into consideration the difficulties insurers have in identifying dependents under family coverage, and the regulations make appropriate accommodations, in recognition of the need for a transition period during which information about dependent coverage information may be unavailable from issuers.

The cost of producing and issuing certifications (or notices in lieu of certifications where permitted) for private group plans is estimated to be $57 million for 53 million certifications in 1997, $64 million for 44 million in 1998, and $66 million for 44 million in each subsequent year. Medicaid programs would provide 10 million certifications annually at an annual cost of $600,000. Medicare would issue

92,000 annually at a cost of $115,000. (Should HHS decide to allow the Medicare award and termination letters to suffice as certifications, then there would be no cost to the Medicare program for the HIPAA certification requirements.) By 1999, the annual cost and volume would total $500,000 and 200,000 for OPM, $2.9 million and 1.9 million for state plans, and $6.1 million and 4.1 million for local plans, and $4.7 million and 2.9 million for individual market issuers.

Relative to the cost implied by the statute alone, regulatory provisions directed at the certification process reduce private group plans' cost of compliance by a minimum of $41 million (or 42 percent) in 1997, $20 million (or 24 percent) in 1998, and $18 million (or 21 percent) in 1999 and later years, through the creation of transitional rules, safe harbors and good faith compliance periods. The regulation acts to reduce parallel burdens on issuers and state and local government group plans in similar proportion.

In another discretionary provision, these regulations require group plans to notify eligible new employees of their special enrollment rights. This provision is necessary to make sure employees are sufficiently informed to exercise their rights within the 30-day window provided in the statute. The cost of this disclosure is expected to be small, since it is a uniform disclosure that can accompany ordinary materials provided to new participants. In order to minimize the burden, the preamble to these regulations provides model language for the notice adequate for meeting the statutory obligation. The cost, which would reach $1.72 million in 1999 for private group plans, is described in the PRA analysis. In 1999, the cost for State plans would reach $167,000; the cost for local plans would reach $290,000.

The direct cost of certifications and notices contribute to the overall social cost of the statute and regulations.

HHS has exercised regulatory discretion regarding two specific provisions that will be enforced exclusively by HHS (also referred to as the ''non-shared group market'' provisions).

These two areas are as follows:

Guaranteed Availability of Coverage for Employers in the PHS Act Group Health Market Provisions

The group market provisions include rules relating to guaranteed availability of coverage for employers in the small group market that are only in the PHS Act (not in ERISA or the Code). Section 146.150 of the HHS regulations implements section 2711 of the PHS Act. In general, this section requires health insurance issuers that offer coverage in the small group market to offer all policy forms to any eligible small employer and to accept for enrollment every eligible individual without regard to health status. HHS has interpreted this guaranteed availability requirement to apply to all products offered in the small group market. Some States and issuers argue that the statute would permit guaranteed availability of an issuer's basic and standard plan, as opposed to all products offered by the issuer in the small group market. HHS does not agree with this interpretation and have proposed our interpretation in the regulation. Depending upon State law, this decision may provide the benefit of additional choices to small employers purchasing coverage in the small group market, while adding some potential costs for issuers offering coverage in the small group market.

Exclusion of Certain Plans From the PHS Act Group Market Requirements

The group market provisions also include rules under which certain plans are excluded from the group market provisions that are only in the PHS Act (not in ERISA or the Code). Section 146.180 of the HHS regulations implements section 2721 of the PHS Act. Section 146.180(b) includes rules pertaining to non-federal governmental plans, which are permitted under HIPAA to elect to be exempted from some or all of HIPAA's requirements in the PHS Act. HHS has exercised regulatory discretion by prescribing the form and manner of the election and the contents of the notice. HHS has also required a non-federal governmental plan making this election to notify plan participants, at the time of enrollment and on an annual basis, of the fact and consequences of the election. HHS has exercised this regulatory authority in order to ensure adequate documentation of a non-federal governmental plan's proper and appropriate election without placing an undue burden on the plan. In addition, HHS has provided a non-federal governmental plan the flexibility to elect to opt out of specific provisions of the statute and have allowed for this flexibility in the contents of the notice. The cost of providing these notices for non-federal governmental would range from $79,000 to $158,000 in 1997 and from $158,000 to $315,000 in 1999.

HHS has also exercised regulatory discretion in connection with individual market provisions by specifying that college health plans are treated as bona fide associations. Since, under HIPAA, coverage offered through a bona fide association is creditable coverage, individuals covered under a college plan would receive credit for this coverage. However, because this coverage is offered though a bona fide association (as defined in Part 144 of the group market rules), the issuer benefits because it does not have to make the coverage available in the individual market to eligible individuals, and does not have to renew coverage for a student who leaves the association. This regulatory provision is expected to minimally disrupt business practices for those college plans.

HHS also exercised regulatory discretion in connection with individual market provisions. When an eligible individual applies for coverage in the individual market, the effective date of such coverage is deemed, in the regulations, to be the date on which the individual applies for such coverage, and assuming the individual's application for coverage was accepted.

The impact of this regulatory provision is that an individual who wishes to maintain creditable coverage may delay, for up to 63 days, an application for coverage in the individual insurance market, especially if he or she is assured of being covered by an issuer (e.g., if the person is guaranteed issuance of an individual product as an individual coming from group coverage, under the Act's guaranteed availability provisions). The individual may forego medical treatment during the 63-day period of non-coverage, resulting in a deterioration of health on entering the new health plan, with a potential for greater costs incurred by the insurer or health plan.

The regulation could have required that the individual apply for coverage within a reasonable time period in advance of the 63-day period, such as 30 days after the end of prior coverage (which is similar to the statutory requirement for a request for enrollment in a group health plan following exhaustion of COBRA coverage or other exhaustion of coverage); or, the insurer could have been required to begin coverage within some specified time period after application. However, the approach taken in the regulation is consistent with statutory provisions regarding the treatment of waiting periods or HMO affiliation periods, which the statute specifically excludes from being considered breaks in coverage. The regulatory provision also accords the same status to all individuals in any circumstance by making a 63-day period the maximum during which an individual can be

without coverage and still receive credit for creditable coverage.

M. Paperwork Reduction Act—Department of Labor and Department of the Treasury

The Department of Labor and the Department of the Treasury have submitted this emergency processing public information collection request (ICR), consisting of three distinct ICRs, to the OBM for review and clearance under the Paperwork Reduction Act of 1995 (Pub. L. 104–13, 44 U.S.C. Chapter 35). The Departments have asked for OMB clearance as soon as possible, and OMB approval is anticipated by or before June, 1, 1997.

These regulations contain three distinct ICRs. Two of them (Establishing Prior Creditable Coverage and Notice of Enrollment Rights) are prescribed by the statute.

The first ICR implements statutorily prescribed requirements necessary to establish prior creditable coverage. This is accomplished primarily through the issuance of certificates of prior coverage by group health plans or by service providers that the group health plans contract with in order to provide these documents. In addition, this ICR permits the use of a notice that may be used by the plans to meet their obligations in connection with periods of coverage ending during the transition period, October 1, 1996 through May 31, 1997, saving the respondents both hours and cost during that period. This ICR also covers the requests that certain plans will make regarding additional information they require because they are using the Alternative Method of Crediting Coverage. Finally, this ICR also includes the occasional circumstances where a participant is unable to secure a certificate and needs to provide some supplemental form of documentation in order to establish prior creditable coverage.

The second ICR, Notice of Special Enrollment Rights, implements the statutorily prescribed disclosure obligation of the plans to inform a participant, at the time of enrollment, of the plan's special enrollment rules.

The third ICR, Notice of Pre-Existing Condition Exclusion, concerns the disclosure requirements on those plans that contain pre-existing condition exclusion provisions. This ICR has two components: a notice to all participants at the time of enrollment stating the terms of the plan's pre-exisiting condition provisions, the participant's right to demonstrate creditable coverage, and that the plan or issuer will assist in securing a certificate if necessary; and notice by the plan of its determination that an exclusion period applies to an individual.

1. Establishing Prior Creditable Coverage

i. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed information collection requests (ICR) in accordance with the Paperwork Reduction Act of 1995 (PRA 95) (Pub. L. 104–13, 44 U.S.C. chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed new collection of Establishing Prior Creditable Coverage.

Dates: Written comments must be submitted to the office listed in the addressee section below on or before May 31, 1997. In light of the request for OMB clearance by June 1, 1997, submission of comments within the first 30 days is encouraged to ensure their consideration.

The Department of Labor is particularly interested in comments which:

- evaluate whether the proposed collection is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- enhance the quality, utility, and clarity of the information to be collected; and
- minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Addressee: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N–5647, Washington, DC 20210. Telephone: 202–219–4782 (this is not a toll-free number). Fax: 202–219–4745.

ii. Department of the Treasury

The collection of information is in Section 54.9801–5T. This information is required by the statute so that participants will be informed about their rights under HIPAA and about the amount of creditable coverage that they have accrued under a group health plan. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are mandatory.

Books or records relating to a collection of information must be retained as long as their contents may be come material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received by May 31, 1997. In light of the request for OMB clearance by June 1, 1997, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How to enhance the quality, utility, and clarity of the information to be collected;

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and

Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

Additonal PRA 95 Information:

I. *Background:* In order to meet HIPAA's goal of improving access to and portability of health care benefits,

the statute provides that, after the submission of evidence establishing prior creditable coverage, a subsequent health insurance provider would be limited in the extent to which it could use pre-existing condition exclusions to limit coverage. This ICR covers the submission of materials sufficient to establish prior creditable coverage.

II. *Current Actions:* Under 29 CFR 2590.701–5 and 26 CFR 54.9801–5T of the interim rule, a group health plan offering group health insurance coverage is obligated to provide a written certificate of information suitable for establishing the prior creditable coverage of a participant or beneficiary. To the extent that a certification is not available or inadequate to prove prior creditable coverage, paragraph (c) provides other methods for establishing creditable coverage. During the transition period for certification (29 CFR 2590.710(e) and 26 CFR 54.9806–1T(e)), plans have the option of providing notices regarding participant's rights to certification rather than the certification itself; plans then provide certificates only to those participants who request them. 29 CFR 2590.701–5(a)(7) and 26 CFR 54.9801–5T(a)(7) provides special rules for establishing prior coverage of defendants, and 29 CFR 2590.701–5(b) and 26 CFR 54.9801–5T(b) provides guidance on providing evidence of coverage to those plans that use the alternative method of crediting coverage.

These regulations offer model certification and notice forms to be used by group health plans and health insurance issuers, containing the minimum information mandated by the statute. Based on past experience, the staff believes that most of the materials required to be exchanged under the certification procedure will be prepared by contract service providers such as insurance companies and third-party administrators.

Type of Review: New

Agencies: U.S. Department of Labor, Pension and Welfare Benefits Administration; U.S. Department of the Treasury, Internal Revenue Service.

Title: Establishing Prior Creditable Coverage

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions; Group Health Plans.

Frequency: On occasion

Burden:

Year	Total respondents	Total responses	Average time per response (range) (minutes)	Burden hours (range)	Cost (range)
1997	2,600,000	51,799,410	3.23	502,080	$57,180,000
	.....	.....	6.12	950,710	84,590,000
1998	2,600,000	44,431,970	5.04	672,120	64,480,000
	.....	.....	11.77	1,569,390	119,310,000
1999	2,600,000	44,399,150	5.27	702,360	66,310,000
	.....	.....	12.01	1,599,630	121,140,000
Totals	.....	.....	.....	.....	.....

Start up costs: It is estimated that the 15,604 plans that will perform these functions internally (rather than use a service provider) will incur an average cost of $5,000 per plan to revise their automated records systems to accommodate this information for a total cost of $78 million over 10 years beginning in 1997.

Estimated total cost:

Comments submitted in response to this notice will be summarized and/or included in the request for Office of Management and Budget approval of the information collection request; they will also become a matter of public record.

2. Notice of Enrollment Rights

i. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed information collection requests (ICR) in accordance with the Paperwork Reduction Act of 1995 (PRA 95) (Pub. L. 104–13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed new collection of Notice of Enrollment Rights.

Dates: Written comments must be submitted to the office listed in the addressee section below on or before May 31, 1997. In light of the request for OMB clearance by June 1, 1997, submission of comments within the first 30 days is encouraged to ensure their consideration.

The Department of Labor is particularly interested in comments which:

- evaluate whether the proposed collection is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- enhance the quality, utility, and clarity of the information to be collected; and
- minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Addressee: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N–5647, Washington, D.C. 20210. Telephone: 202–219–4782 (this is not a toll-free number). Fax: 202–219–4745.

ii. Department of the Treasury

The collection of information is in Section 54.9801–6T. This information is required by the statute so that participants will be informed about their rights under HIPAA and about the amount of creditable coverage that they have accrued under a group health plan.

The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartly trusts. Responses to this collection of information are mandatory.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Office of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received by May 31, 1997. In light of the request for OMB clearance by June 1, 1997, submission of comments within the first 30 days is encouraged to ensure their consideration. Comments are specially requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How to enhance the quality, utility, and clarity of the information to be collected;

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and

Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

Additional PRA 95 Information:

I. *Background:* In order to improve participants' understanding of their rights under an employer's welfare benefits plan, the statute provides that, a participant be provided with a description of a plan's special enrollment rules on or before the time when a participant is offered the opportunity to enroll in a group health plan.

II. *Current Actions:* Under 29 CFR 2590.701–6 and 26 CFR 54.9801–6T of the interim rule, a group health plan offering group health insurance coverage is obligated to provide a description of the plans' special enrollment rules. The special enrollment rules generally apply in circumstances when the participant initially declined to enroll in the plan, and subsequently would like to have coverage.

These regulations offer a model form to be used by group health plans and health insurance issuers, containing the minimum information mandated by the statute. Based on past experience, the staff believes that most of the materials required to be supplied under this ICR will be prepared by contract service providers such as insurance companies and third-party administrators.

Type of Review: New.

Agencies: U.S. Department of Labor, Pension and Welfare Benefits administration; U.S. Department of the Treasury, Internal Revenue Service.

Title: Notice of Enrollment Rights.

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions; Group Health Plans.

Frequency: On occasion.

Burden:

Year	Total respondents (000)	Total responses	Average time per response (minutes)	Burden hours	Cost
1997	2,600,000	499,080	.50	750	100,000
1998	2,600,000	7,622.010	.50	11,430	1,460,000
1999	2,000,000	8,959,380	.50	13,440	1,720,000
Totals					

3. Notice of Pre-Existing Condition Exclusion

i. Department of Labor

The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and federal agencies with an opportunity to comment on proposed information collection requests (ICR) in accordance with the Paperwork Reduction Act of 1995 (PRA 95) (Pub. L. 104–13, 44 U.S.C. Chapter 35) and 5 CFR 1320.11. This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed new collection of Notice of Pre-Existing Condition Exclusion.

Dates: Written comments must be submitted to the office listed in the addressee section below on or before May 31, 1997. In light of the request for OMB clearance by June 1, 1997, submission of comments within the first 30 days is encouraged to ensure their consideration.

The Department of Labor is particularly interested in comments which:

- evaluate whether the proposed collection is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- enhance, the quality, utility, and clarity of the information to be collected; and
- minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

Addressee: Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, Room N–5647, Washington, D.C. 20210. Telephone: 202–219–4782 (this is not a toll-free number) Fax: 202–219–4745.

ii. Department of the Treasury

The collection of information is in Sections 54.9801–3T, 54.9801–4T, and 54.9801–5T. This information is required by the statute so that participants will be informed about their rights under HIPAA and about the amount of creditable coverage that they have accrued under a group health plan. The likely respondents are business or other for-profit institutions, non-profit institutions, small businesses or organizations, and Taft-Hartley trusts. Responses to this collection of information are mandatory.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Comments on the collection of information should be sent to the Office of Management and Budget, Attn: Desk Officer for the Department of the Treasury, Officer of Information and Regulatory Affairs, Washington, DC 20503, with copies to the Internal Revenue Service, Attn: IRS Reports Clearance Officer, T:FP, Washington, DC 20224. Comments on the collection of information should be received by May 31, 1997. In light of the request for OMB clearance by June 1, 1997, submission of comments within the first 30 days in encouraged to ensure their consideration. Comments are specifically requested concerning:

Whether the proposed collection of information is necessary for the proper performance of the functions of the Internal Revenue Service, including whether the information will have practical utility;

The accuracy of the estimated burden associated with the proposed collection of information;

How to enhance the quality, utility, and clarity of the information to be collected;

How to minimize the burden of complying with the proposed collection of information, including the application of automated collection techniques or other forms of information technology; and

Estimates of capital or start up costs and costs of operation, maintenance, and purchase of services to provide information.

Additional PRA 95 Information:

I. *Background:* In order to meet HIPAA's goal of improving portability of health care coverage, participants needs to understand their rights to show prior creditable coverage when entering a group health plan that contain pre-existing condition exclusion provisions. In addition, participants entering plans that use the alternative method of crediting coverage also need to be informed of the plan's provisions. Therefore, the Department has determined that plans that contain these provisions must disclose that fact to new participants, as well as inform individual participants of the extent to which a pre-existing condition exclusion applies to them.

II. *Current Actions:* 29 CFR 2590.701–3(c) and 26 CFR 54.9801–3T(c) requires that a group health plan or health insurance issuer offering group health insurance under the plan may not impose any pre-existing condition exclusions on a participant unless the participant has been notified in writing that the plan contains per-existing condition exclusions, that a participant has the right to demonstrate any period of prior creditable coverage, and that the plan or issuer will assist the participant in obtaining a certificate of prior coverage from any prior plan or issuer, if necessary. 29 CFR 2590.701–4(c)(4) and 26 CFR 54.9801–4T(c)(4) requires that plans that use the alternative method of crediting coverage disclose their method at the time of enrollment in the plan. No additional cost of preparing or distributing this information has been included in this analysis because plans would only pursue this option if it were, on net, less costly than the standard method.

In addition, 29 CFR 2590.701–5(d)(2) and 26 CFR 54.9801–5T(d)(2) requires that before a plan or issuer imposes a pre-existing condition exclusion on a particular participant, it must first disclose that determination in writing, including the basis for the decision, and an explanation of any appeal procedure established by the plan or issuer.

Type of Review: New.

Agencies: U.S. Department of Labor, Pension and Welfare Benefits Administration; U.S. Department of the Treasury, Internal Revenue Service.

Title: Notice of Pre-Existing Exclusion Provisions.

Afffected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions; Group Health Plans.

Frequency: On occasion.

Burden:

Cite/reference	Total respondents	Total responses	Average time per responses (minutes)	Burden hours	Cost
Notice at time of enrollment:					
1997	1,261,450	500,800	0.70	2,470	$180,000
1998	1,261,450	7,626,880	0.54	16,300	1,700,000
1999	1,261,450	8,959,700	0.50	13,750	1,730,000
Notice of pre-existing condition causing lack of coverage:					
1997	1,261,450	57,900	2.27	1,800	100,000
1998	1,261,450	862,830	0.84	6,160	410,000
1999	1,261,450	1,008,810	0.52	1,830	210,000
Totals	.....	.....	.....	.....	.....

Estimated Total Burden Cost:

N. Paperwork Reduction Act—Department of Health and Human Services

Under the Paperwork Reduction Act of 1995, HHS is required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.

• The quality, utility, and clarity of the information to be collected.

• Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are, however, requesting an emergency review of this notice. In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, we have submitted to the Office of Management and Budget (OMB) the following requirement for emergency review. We are requesting an emergency review because the collection of this information is needed before the expiration of the normal time limits under OMB's regulations at 5 CFR, Part 1320, to ensure compliance with section 111 of the HIPAA necessary to implement congressional intent with respect to guaranteeing availability of individual health insurance coverage to certain individuals with prior group coverage. We cannot reasonably comply with the normal clearance procedures because public harm is likely to result because eligible individuals will not receive the health insurance protections under the statute.

We are requesting that OMB provide a 30-day public comment period from the date of the publication, with OMB review and approval by June 1, 1997, and a 180-day approval. During this 180-day period, we will publish a separate **Federal Register** notice announcing the initiation of an extensive 60-day agency review and public comment period on these requirements. We will submit the requirements for OMB review and an extension of this emergency approval.

Type of Information Request: New collection.

Title of Information Collection: Information Requirements Referenced in HIPAA for Group Health Plans.

Form Number: HCFA–R–206.

Use: This regulation and related information collection requirements will ensure that group health plans provide individuals with documentation necessary to demonstrate prior creditable coverage, and that group health plans notify individuals of their special enrollment rights in the group health insurance market.

Frequency: On occasion.

Affected Public: State and local governments, Business or other for profit, not-for-profit institutions, individuals or households, Federal government.

Number of Respondents: 1,430.

Total Annual Responses: Due to the rolling effective dates in the statute, the number of annual responses is estimated to be 32.5 million in 1997, but will increase to 41 million in 1998 and 42.5 million in 1999.

Total Annual Hours Requested: 1.8 million to 3.6 million hours in 1997; 2.3 million to 5.8 million hours in 1998; and 2.6 million to 5.9 million hours in 1999.

Total Annual Costs: $36.8 million to $53.9 million in 1997; $42.4 million to $76.3 million in 1998; and $43.5 million to $77.3 million in 1999. 45 CFR §§ 146.120, 146.122, 146.150, 146.152, 146.160, and 146.180 of this document contain information collection requirements.

45 CFR 146.120 Certificates and Disclosure of Previous Coverage

Certificates and Disclosure of Prior Coverage. This section sets forth guidance regarding the certification and other disclosure of information requirements relating to prior creditable coverage of an individual. In general, the certificate must be provided in writing and must include the following information: (1) The date any waiting or affiliation period began, (2) the date coverage began, and (3) the date coverage ended (or indicate if coverage is continuing). The regulations also allow a plan or issuer in an appropriate case to simply state in the certificate that the individual has at least 18 months of creditable coverage that is not interrupted by a significant break and indicate the date coverage ended. In general, individuals have the right to receive a certificate automatically (an automatic certificate) when they lose coverage under a plan and when they have a right to elect COBRA continuation coverage.

We anticipate that approximately 1,400 issuers will be required to produce 30 million certifications per year based on the model certificate provided. Our estimate of issuers (1,400) includes commercial insurers and HMOs, but does not include some types of issuers, such as Preferred Provider Organizations (PPOs); however, these types of issuers are small in number. The time estimate includes the time required to gather the pertinent information, create a certificate, and mail the certificate to the plan participant. This time estimate is based on discussions with industry individuals. We believe that, as a routine business practice, the issuers' administrative staff have the necessary information readily available to generate the required certificates. In addition, we have determined that the majority of issuers have or will have the capability to automatically computer generate and disseminate the necessary certification when appropriate.

These estimates include the certificates required by issuers acting as service providers on behalf of group health plans and state and local government health plans. We anticipate that most, if not all, state and local government health plans will contract with an issuer to develop the certificate.

ESTIMATES FOR CERTIFICATIONS

Year	Total respondents	Total responses	Average time per response (range)	Burden hours (range)	Cost (range)
1997	1,400	32,698,845	3.32 min	1,809,119 hrs	$36,366,106
		6.34min	3,456,036 hrs	53,434,628.	
1998	1,400	28,072,131	5.19 min	2,242,866 hrs	40,928,939
			12.23 min	5,720,198 hrs	74,859,759
1999	1,400	28,055,984	5.37 min	2,510,461 hrs	42,124,907
			12.41 min	5,804,408 hrs	75,760,119

NOTE: The costs above include the costs associated with issuers acting as service providers for group health plans. The costs are also included in the Department of Labor's estimates.

Notice to all participants: Under this section, issuers are required to notify all participants at the time of enrollment stating the terms of the issuer's pre-existing condition exclusion provisions, the participant's right to demonstrate creditable coverage, and that the issuer will assist in securing a certificate if necessary.

We have estimated the burden associated with this information collection requirement to be the time required for issuers to develop standardized language outlining the existence and terms of any preexisting condition exclusion under the plan and the rights of individuals to demonstrate creditable coverage. In specific, we anticipate that issuers will be required to develop approximately 660,000 notices in 1997; 5.6 million notices in 1998; and 6.2 million notices in 1999. At 30 seconds for each notice, we estimate the total hour burden to be 4,400 hours in 1997; 30,000 hours in 1998; and 34,000 hours in 1999. The respective costs will be $49,000 in 1997; $330,000 in 1998; and $377,000 in 1999. These estimates and subsequent estimates are based on an hourly wage of $11 for issuers and $15 for State and local government employees. These estimates include the notices required by issuers on behalf of state and local government health plans, since we anticipate that most, if not all state and local government health plans will contract with an issuer to develop the notice. The estimates have been disaggregated below:

Year	Issuers	State health plans	Local health plans	Total notices
Total notices:				
1997	320,000	129,826	214,880	664,706
1998	4,878,200	259,653	429,761	5,567,614
1999	5,734,300	259,653	429,761	6,189,714
Total burden hours:				
1997	1,592	1,078	1,784	4,454
1998	24,293	2,155	3,567	30,015
1999	28,557	2,155	3,567	34,279

Notice to individual of period of preexisting condition exclusion. Within a reasonable time following the receipt of the certificate, information relating to the alternative method, or other evidence of coverage, a plan or issuer is required to make a determination regarding the length of any preexisting condition exclusion period that applies to the individual and notify the individual of its determination. Whether a determination and notification is made within a reasonable period of time will depend upon the relevant facts and circumstances including whether the application of the preexisting condition exclusion period would prevent access to urgent medical services. The individual need only be notified, however, if, after considering the evidence, a preexisting condition exclusion period will be imposed on the individual. The basis of the determination, including the source and substance of any information on which the plan or issuer relied, must be included in the notice. The plan's appeals procedures and the opportunity of the individual to present additional evidence must also be explained in the notification.

We estimate that issuers will be required to develop approximately 29,000 notices in 1997; 425,000 notices in 1998; and 498,000 notices in 1999. At 2 minutes for each notice, we estimate the total hour burden to be 960 hours in 1997; 14,000 hours in 1998; and 16,600 hours in 1999. We estimate the respective costs associated with these burdens to be $10,600 in 1997; $156,000 in 1998; and $183,000 in 1999. These estimates include the notices required by issuers on behalf of state and local government health plans, since we anticipate that most, if not all state and local government health plans will contract with an issuer to develop the notice. The estimates have been disaggregated below:

Year	Issuers	State health plans	Local health plans	Total notices
Total notices:				
1997	27,650	588	766	29,004
1998	422,136	1,176	1,531	425,143
1999	496,182	1,176	1,531	498,889
Total burden hours:				
1997	921	20	25	966
1998	14,057	40	51	14,148
1999	16,553	40	51	16,644

45 CFR 146.122 Special Enrollment Periods

This section in the regulation provides guidance regarding new enrollment rights that employees and dependents have under HIPAA. A health insurance issuer offering group health insurance coverage is required to provide a description of the special enrollment rights to anyone who declines coverage at the time of enrollment. The regulations provide a model of such a description containing the minimum information mandated by the statute.

The first burden associated with this requirement is the time required for health insurance issuers and state and local government health plans to incorporate the model notice into the plan's standard policy information. We estimate the burden to be 2 hours annually per issuer, for a total burden of 2,800 hours. The cost associated with this hour burden is estimated to be $30,800 annually.

The second burden associated with this requirement is the time required to disseminate the notice to new enrollees. We estimate that issuers will be required to develop approximately 1 million notices in 1997; 5.3 million notices in 1998; and 5.9 million notices in 1999. At 30 seconds for each notice, we estimate the total hour burden to be 8,300 hours in 1997; 43,000 hours in 1998; and 48,000 hours in 1999. We have estimated the costs associated with these hour burdens to be $91,000 in 1997; $469,000 in 1998; and $527,000 in

1999. These estimates include the notices required by issuers on behalf of state and local government health plans, since we anticipate that most, if not all state and local government health plans will contract with an issuer to develop the notice. The estimates have been disaggregated below:

Year	Issuers	State health plans	Local health plans	Total notices
Total notices:				
1997	245,508	287,938	500,750	1,034,196
1998	3,750,024	575,875	1,001,500	5,327,399
1999	4,407,828	575,875	1,001,500	5,985,203
Total burden hours:				
1997	1,964	2,304	4,006	8,273
1998	30,000	4,607	8,012	42,619
1999	35,263	4,607	8,012	47,881

45 CFR 146.150 Guaranteed Availability of Coverage for Employers in the PHS Act Group Market Provisions

This section allows a health insurance issuer to deny health insurance coverage in the small group market if the issuer has demonstrated to the applicable State authority (if required by the State authority) that it does not have the financial reserves necessary to underwrite additional coverage and that it is applying this denial uniformly to all employers in the small group market in the State consistent with applicable State law and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to those employees and dependents. Thus, issuers are only required to report to the applicable State authority if they are discontinuing coverage in the small group market.

This requirement exists in the absence of this regulation because under current insurance practices, State insurance departments oversee discontinuance of insurance products in their State as a normal business practice. Therefore, these information collection requirements are exempt from the PRA under 5 CFR 1320.3(b)(2) and 5 CFR 1320.3(b)(3). However, under HIPAA, States must review policies during their oversight process to make sure there is a guaranteed availability clause in each policy. For the 37 States that currently require guaranteed availability, it is our understanding that this is normal business practice. For the other 18 States, however, we see this State burden to be about 10 minutes per policy, since States already review policies for other requirements and this process does not prescribe a timetable for reviewing the policies. We see this as a total burden of 10,850 hours. We have estimated the cost associated with this hour burden to be $163,000. If the State identifies a violation and a State has to take some action, we believe that each State will be required to initiate fewer than 10 administrative actions on an annual basis against specific individuals or entities who failed to implement the Federal guarantee availability requirements.

45 CFR 146.152 Guaranteed Renewability of Coverage for Employers in the PHS Act Group Market Provisions

In this section issuers are only required to report if they are discontinuing a particular type of coverage or discontinuing all coverage. This requirement exists in the absence of this regulation because under current insurance practices, State insurance departments oversee discontinuance of insurance products in their State as a normal business practice. Therefore, these information collection requirements are exempt from the PRA under 5 CFR 1320.3(b)(2) and 5 CFR 1320.3(b)(3). However, under HIPAA, States must review policies during their oversight process to make sure there is a guaranteed availability clause in each policy. For the 43 States that currently require guaranteed renewability, it is our understanding that this is normal business practice. For the other 12 States, however, we see this State burden to be about 10 minutes per policy, since States already review policies for other requirements and this process does not prescribe a timetable for reviewing the policies. We see this as a total burden of 6,700 hours. We have estimated the cost associated with this hour burden to be $100,500. If the State identifies a violation and a State has to take some action, we believe that each State will be required to initiate fewer than 10 administrative actions on an annual basis against specific individuals or entities who failed to implement the Federal guarantee renewability requirements.

45 CFR 146.160 Disclosure of Information by Issuers to Employers Seeking Coverage in the Small Group Market in the PHS Act Provisions

This section requires issuers to disclose information to employers seeking coverage in the small group market. This section requires information to be provided by a health insurance issuer offering any health insurance coverage to a small employer. This information includes the issuer's right to change premium rates and the factors that may affect changes in premium rates, renewability of coverage, any preexisting condition exclusion, any affiliation periods applied by HMOs, the geographic areas served by HMOs, and the benefits and premiums available under all health insurance coverage for which the employer is qualified. The issuer is exempted from disclosing information that is proprietary or trade secret information under applicable law.

The information described in this section must be language that is understandable by the average small employer and sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. This requirement is satisfied if the issuer provides an outline of coverage, the minimum contribution and group participation rules that apply to any particular type of coverage, and any other information required by the State. An outline of coverage is defined as a general description of benefits and premiums. This would include an outline of coverage similar to the manner in which Medigap policies are presented, allowing the employer to easily compare one policy form to another to determine what is covered and how much the coverage will cost.

We have estimated the total burden associated with this activity to be 2,400 hours. We anticipate that 1,200 issuers will be required to provide disclosure to small employers on an annual basis. We

estimate this time to be approximately 2 hours for each issuer to develop and update the standard information related to the general description of benefits and premiums on an annual basis and include this information in their policy information. We have estimated the cost associated with this hour burden to be $36,000.

45 CFR 146.180 Exclusion of Certain Plans From the PHS Act Group Market Requirements

Section 145.180(b) includes rules pertaining to nonfederal governmental plans, which are permitted under HIPAA to elect to be exempted from some or all of HIPAA's requirements in the PHS Act. The regulation establishes the form and manner of the election. In particular, a nonfederal governmental plan making this election is required to notify plan participants, at the time of enrollment and on an annual basis, of the fact and consequences of the election. The burden imposed by this is the requirement for plans to disseminate standard notification language describing the plans' election and the consequences of this election. We anticipate that between 3,500 and 5,000 nonfederal governmental plans will make this election and will therefore be required to disseminate notifications to their participants on an annual basis. Since this is standard language that will be incorporated into plans' existing policy documents, we see the burden as approximately 2 hours per plan to develop and update this standardized disclosure statement on an annual basis. Thus, we estimate the total burden for this activity to range from 7,000 to 10,000 hours. We estimate the cost associated with these hourly burdens to range from $77,000 to $110,000 per year.

The above estimate does not include the cost of disseminating the notices to all plan participants on an annual basis and to new enrollees at the time of enrollment. Although we do not have an accurate estimate of the number of nonfederal governmental plans will choose to opt out of these provisions, we have provided for a range of 50 to 100 percent. Using these ranges, we estimated 400,000 to 800,000 of these notices would need to be produced in 1997 and 800,000 to 1.6 million in 1998 and 1999. At 30 seconds per notice, we estimate the total burden hours to range from 3,400 to 6,800 in 1997; and 6,800 to 13,600 in 1998 and 1999. We have estimated the costs associated with these hour burdens to range from $37,400 to $74,800 in 1997; and from $74,800 to $149,600 in 1998 and 1999.

We have submitted a copy of this rule to OMB for its review of these information collections. A notice will be published in the **Federal Register** when approval is obtained. Interested persons are invited to send comments regarding this burden or any other aspect of these collections of information. If you comment on these information collection and record keeping requirements, please mail copies directly to the following addresses:

Health Care Financing Administration, Office of Financial and Human Resources, Management Planning and Analysis Staff, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850. Attn: John Burke

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer.

Statutory Authorities

The Department of Labor interim final rule is adopted pursuant to the authority contained in Section 707 of ERISA (Pub. L. 93–406, 88 Stat. 894; 29 U.S.C. 1135) as amended by HIPAA, (Pub. L. 104–91; 101 Stat. 1936; 29 U.S.C. 1181).

The Department of Health and Human Services interim final rule is adopted pursuant to the authority contained in Sections 2701, 2702, 2711, 2712, 2713, and 2792 of the PHS Act, as established by HIPAA, (Pub. L. 104–191, 42 U.S.C. 300gg–1 through 300gg–13, and 300gg–92).

The Department of the Treasury temporary rule is adopted pursuant to the authority contained in Section.

List of Subjects

26 CFR Part 54

Excise taxes, Health insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Employee benefit plans, Employee Retirement Income Security Act, Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Parts 144 and 146

Health care, Health insurance, Reporting and recordkeeping requirements, State regulation of health insurance.

Amendments to the Regulations

Internal Revenue Service

26 CFR Chapter 1

Accordingly, 26 CFR part 54 is amended as follows:

PART 54—PENSION EXCISE TAXES

Paragraph 1. The authority citation for part 54 is amended by adding entries in numerical order to read as follows:

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

Section 54.9801–1T also issued under 26 U.S.C. 9806.

Section 54.9801–2T also issued under 26 U.S.C. 9806.

Section 54.9801–3T also issued under 26 U.S.C. 9806.

Section 54.9801–4T also issued under 26 U.S.C. 9806.

Section 54.9801–5T also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9806

Section 54.9801–6T also issued under 26 U.S.C. 9806.

Section 54.9802–1T also issued under 26 U.S.C. 9806.

Section 54.9804–1T also issued under 26 U.S.C. 9806.

Section 54.9806–1T also issued under 26 U.S.C. 9806.

Par. 2. Sections 54.9801–1T, 54.9801–2T, 54.9801–3T, 54.9801–4T, 54.9801–5T, 54.9801–6T, 54.9802–1T, 54.9804–1T, and 54.9806–1T are added to read as follows:

§ 54.9801–1T Basis and scope (temporary).

(a) *Statutory basis.* Sections 54.9801–1T through 54.9801–6T, 54.9802–1T, 54.9804–1T, and 54.9806–1T (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

(b) *Scope.* A group health plan may provide greater rights to participants and beneficiaries than those set forth in these portability sections. These portability sections set forth minimum requirements for group health plans concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to creditable coverage.

(4) Special enrollment periods.

(c) *Similar Requirements Under the Public Health Service Act and Employee Retirement Income Security Act.* Sections 2701, 2702, 2721, and 2791 of the Public Health Service Act and sections 701, 702, 703, 705, and 706 of the Employee Retirement Income Security Act of 1974 impose requirements similar to those imposed under Chapter 100 of Subtitle K of the Code with respect to health insurance issuers offering group health insurance coverage. See 45 CFR parts 144, 146 and 148 and 29 CFR part 2590. See also Part B of Title XXVII of the Public Health Service Act and 45 CFR part 148 for other rules applicable to health insurance offered in the individual market (defined in § 54.9801–2T).

§ 54.9801–2T Definitions (temporary).

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 54.9801–1T through 54.9801–6T, 54.9802–1T, 54.9804–1T, and 54.9806–1T.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601–608 of the ERISA, section 4980B of the Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), and Title XXII of the PHSA.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis; or

(ii) When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual.

Condition means a medical condition.

Creditable coverage means *creditable coverage* within the meaning of § 54.9801–4T(a).

Employee Retirement Income Security Act of 1974 (ERISA) means the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

Enroll means to become covered for benefits under a group health plan (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to enroll in the plan. For this purpose, an individual who has health insurance coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (enrollment date and *first day of coverage)* are set forth in § 54.9801–3T(a)(2) (i) and (ii).

Excepted benefits means the benefits described as excepted in § 54.9804–1T(b).

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of *individual market* in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. However, benefits described in § 54.9804–1T(b)(2) are not treated as benefits consisting of medical care.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHSA);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited duration insurance. For this purpose, short-term, limited duration insurance means 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 within 12 months of the date such contract becomes effective. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHSA, such term also includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

Issuer means a health insurance issuer.

Late enrollment definitions (late enrollee and *late enrollment*) are set forth in § 54.9801–3T(a)(2) (iii) and (iv).

Medical care has the meaning given such term by section 213(d) of the Internal Revenue Code, determined without regard to section 213(d)(1)(C) and so much of section 213(d)(1)(D) as relates to qualified long-term care insurance.

Medical condition on *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan

document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible/limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the preenrollment period.

Public health plan means *public health plan* within the meaning of § 54.9801–4T(a)(1)(ix).

Public Health Service Act (PHSA) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Significant break in coverage means a *significant break in coverage* within the meaning of § 54.9801–4T(b)(2)(iii).

Special enrollment date means a *special enrollment date* within the meaning of § 54.9801–6T(d).

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 54.9801–4T(a)(1)(vii).

Waiting period means the period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

§ 54.9801–3T Limitations on preexisting condition exclusion period (temporary).

(a) *Preexisting condition exclusion*—(1) *In general.* Subject to paragraph (b) of this section, a group health plan may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a) are satisfied. (See PHSA section 2701 and ERISA section 701 under which this prohibition is also imposed on a health insurance issuer offering group health insurance coverage.)

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date.

(A) For purposes of this paragraph (a)(1)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(1)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(1)(i) are illustrated by the following examples:

Example 1. (i) Individual *A* is treated for a medical condition 7 months before the enrollment date in Employer *R*'s group health plan. As part of such treatment, *A*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *A* does not receive a follow-up examination and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *A* or received by *A* during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan.

(ii) In this *Example 1,* Employer *R*'s plan may not impose a preexisting condition exclusion period with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

Example 2. (i) Same facts as *Example 1* except that Employer *R's* plan learns of the condition and attaches a rider to *A*'s policy excluding coverage for the condition. Three months after enrollment, *A*'s condition recurs, and Employer *R*'s plan denies payment under the rider.

(ii) In this *Example 2,* the rider is a preexisting condition exclusion and Employer *R*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

Example 3. (i) Individual *B* has asthma and is treated for that condition several times during the 6-month period before *B*'s enrollment date in Employer *S*'s plan. The plan imposes a 12-month preexisting condition exclusion. *B* has no prior creditable coverage to reduce the exclusion period. Three months after the enrollment date, *B* begins coverage under Employer *S*'s plan. Two months later, *B* is hospitalized for asthma.

(ii) In this *Example 3,* Employer *S*'s plan may exclude payment for the hospital stay and the physician services associated with this illness because the care is related to a medical condition for which treatment was received by *B* during the 6-month period before the enrollment date.

Example 4. (i) Individual *D,* who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as a foot condition caused by poor circulation and retinal degeneration (both of which are conditions that may be directly attributed to diabetes). After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) In this *Example 4,* the leg fracture is not a condition related to *D*'s diabetes, even though poor circulation in *D*'s extremities and poor vision may have contributed towards the accident. However, any additional medical services that may be needed because of *D*'s preexisting diabetic condition that would not be needed by another patient with a broken leg who does not have diabetes may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion (the look-forward rule).* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For purposes of this paragraph (a)(1)(ii), the 12-month and 18-month periods after the enrollment date are determined by reference to the anniversary of the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage.* The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 54.9801–4T. For purposes of § 54.9801–1T through § 54.9801–6T, the phrase ''days of creditable coverage'' has the same meaning as the phrase

''aggregate of the periods of creditable coverage'' as such term is used in section 9801(a)(3) of the Internal Revenue Code.

(iv) *Other standards.* See § 54.9802–1T for other standards that may apply with respect to certain benefit limitations or restrictions under a group health plan.

(2) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

(ii)(A) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan in the group market, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy.

(B) The following example illustrates the rule of paragraph (a)(2)(ii)(A) of this section:

Example. (i) Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and then on October 14, 1998 completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) In this *Example, E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E,* the 6-month period in paragraph (a)(1)(i) would be the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan could apply a preexisting condition exclusion under paragraph (a)(1)(ii) would be the period from October 13, 1998 through October 12, 1999, and this period would be reduced under paragraph (a)(1)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

(iii) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(iv) (A) *Late enrollment* means enrollment under a group health plan other than on—

(*1*) The earliest date on which coverage can become effective under the terms of the plan; or

(*2*) A special enrollment date for the individual.

(B) If an individual ceases to be eligible for coverage under the plan by terminating employment, and then subsequently becomes eligible for coverage under the plan by resuming employment, only eligibility during the individual's most recent period of employment is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(v) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999, but elects not to enroll in the plan until April 1, 1999. April 1, 1999 is not a special enrollment date for *F.*

(ii) In this *Example 1, F* would be a late enrollee with respect to *F*'s coverage that became effective under the plan on April 1, 1999.

Example 2. (i) Same as *Example 1,* except that *F* does not enroll in the plan on April 1, 1999 and terminates employment with Employer *W* on July 1, 1999, without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) In this *Example 2, F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—

(i) *In general.* Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion with regard to a child who, as of the last day of the 30-day period beginning with the date of birth, is covered under any creditable coverage. Accordingly, if a newborn is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion with regard to the child.

(ii) *Example.* The rule of this paragraph (b)(1) is illustrated by the following example:

Example. (i) Seven months after enrollment in Employer *W*'s group health plan, Individual *E* has a child born with a birth defect. Because the child is enrolled in Employer *W*'s plan with in 30 days of birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Three months after the child's birth, *E* commences employment with Employer *X* and enrolls with the child in Employer *X*'s plan 45 days after leaving Employer *W*'s plan. Employer *X*'s plan imposes a 12-month exclusion for any preexisting condition.

(ii) In this *Example,* Employer *X*'s plan may not impose any preexisting condition exclusion with respect to *E*'s child because the child was covered within 30 days of birth and had no significant break in coverage. This result applies regardless of whether *E*'s child is included in the certificate of creditable coverage provided to *E* by Employer *W* indicating 300 days of dependent coverage or receives a separate certificate indicating 90 days of coverage. Employer *X*'s plan may impose a preexisting condition exclusion with respect to *E* for up to 2 months for any preexisting condition of *E* for which medical advice, diagnosis, care, or treatment was recommended or received by *E* within the 6-month period ending on *E*'s enrollment date in Employer *X*'s plan.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage.

(4) *Pregnancy.* A group health plan may not impose a preexisting condition exclusion relating to pregnancy as a preexisting condition.

(5) *Special enrollment dates.* For special enrollment dates relating to new dependents, see § 54.9801–6T(b).

(c) *Notice of plan's preexisting condition exclusion.* A group health plan may not impose a preexisting condition exclusion with respect to a participant or dependent of the participant before notifying the participant, in writing, of the existence and terms of any preexisting condition exclusion under the plan and of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods) as required by § 54.9801–5T. The description of the rights of individuals to demonstrate creditable coverage includes a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

§ 54.9801–4T Rules relating to creditable coverage (temporary).

(a) *General rules*—(1) *Creditable coverage.* For purposes of this section,

except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 54.9801–2T.

(ii) Health insurance coverage as defined in § 54.9801–2T (whether or not the entity offering the coverage is subject to chapter 100 of Subtitle K, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a State health benefits risk pool means—

(A) An organization qualifying under section 501(c)(26);

(B) A qualified high risk pool described in section 2744(c)(2) of the PHSA; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health insurance coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO; or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) *Excluded coverage.* Creditable coverage does not include coverage consisting solely of coverage of expected benefits (described in § 54.9804–1T).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 54.9801–3T(a)(1)(iii), a group health plan determines the amount of an individual's creditable coverage by using the standard method described in paragraph (b) of this section, except that the plan may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section or may provide that a health insurance issuer offering health insurance coverage under the plan may use the alternative method of counting creditable coverage.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, a group health plan determines the amount of creditable coverage without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period, a group health plan determines the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. Accordingly, if on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Definition of significant break in coverage.* A significant break in coverage means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. (See section 731(b)(2)(iii) of ERISA and section 2723(b)(2)(iii) of the PHSA which exclude from preemption State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State law.)

(iv) *Examples.* The following examples illustrate how creditable coverage is counted in reducing preexisting condition exclusion periods under this paragraph (b)(2):

Example 1. (i) Individual *A* works for Employer *P* and has creditable coverage under Employer *P*'s plan for 18 months before *A*'s employment terminates. *A* is hired by Employer *Q*, and enrolls in Employer *Q*'s group health plan, 64 days after the last date of coverage under Employer *P*'s plan. Employer *Q*'s plan has a 12-month preexisting condition exclusion period.

(ii) In this *Example 1,* because *A* had a break in coverage of 63 days, Employer *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusions period.

Example 2. (i) Same facts as *Example 1*, except that *A* is hired by Employer *Q*, and enrolls in Employer *Q*'s plan, on the 63rd day after the last date of coverage under Employer *P*'s plan.

(ii) In this *Example 2*, *A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, Employer *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion as it applies to *A*.

Example 3. (i) Same facts as *Example 1*, except that Employer *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) In this *Example 3*, the issuer that provides group health insurance to Employer *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break.

Example 4. (i) Same facts as *Example 3*, except that Employer *Q*'s plan is a self-insured plan, and, thus is not subject to State insurance laws.

(ii) In this *Example 4*, the plan is not governed by the longer break rules under State insurance law and *A*'s previous coverage may be disregarded.

Example 5. (i) Individual *B* begins employment with Employer *R* 45 days after terminating coverage under a prior group health plan. Employer *R*'s plan has a 30-day waiting period before coverage begins. *B* enrolls in Employer *R*'s plan when first eligible.

(ii) In this *Example 5*, *B* does not have a significant break in coverage for purposes of determining whether *B*'s prior coverage must be counted by Employer *R*'s plan. *B* has only a 44-day break in coverage because the 30-day waiting period is not taken into account in determining a significant break in coverage.

Example 6. (i) Individual *C* works for Employer *S* and has creditable coverage under Employer *S*'s plan for 200 days before *C*'s employment is terminated and coverage ceases. *C* is then unemployed for 51 days before being hired by Employer *T*. Employer *T*'s plan has a 3-month waiting period. *C* works for Employer *T* for 2 months and then terminates employment. Eleven days after terminating employment with Employer *T*, *C* begins working for Employer *U*. Employer

U's plan has no waiting period, but has a 6-month preexisting condition exclusion period.

(ii) In this *Example 6*, *C* does not have a significant break in coverage because, after disregarding the waiting period under Employer *T*'s plan, *C* had only a 62-break in coverage (51 days plus 11 days). Accordingly, *C* has 200 days of creditable coverage and Employer *U*'s plan may not apply its 6-month preexisting condition exclusion period with respect to *C*.

Example 7. (i) Individual *D* terminates employment with Employer *V* on January 13, 1998 after being covered for 24 months under Employer *V*'s group health plan. On March 17, the 63rd day without coverage, *D* applies for a health insurance policy in the individual market. *D*'s application is accepted and the coverage is made effective May 1.

(ii) In this *Example 7,* because *D* applied for the policy before the end of the 63rd day, coverage under the policy ultimately became effective, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 107 days.

Example 8. (i) Same facts as *Example 7,* except that *D*'s application for a policy in the individual market is denied.

(ii) In this *Example 8,* because *D* did not obtain coverage following application, *D* incurred a significant break in coverage on the 64th day.

(v) *Other permissible counting methods—(A) Rule.* Notwithstandng any other provision of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 54,9801–5T), a group health plan may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(v) is illustrated by the following example:

Example. (i) Individual *F* has coverage under group health plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by group health plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion period.

(ii) In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraph (b)(2) (i), (ii), and (iii), that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion period will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of her enrollment (May 1)), For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion period will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method—(1) Specific benefits considered.* Under the alternative method, a group health plan determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan may use the alternative method for any or all the categories. The plan may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan. A plan that provides benefits through one or more insurance policies (or in part through one or more insurance policies) will not fail the uniform application requirement of this paragraph (c)(2) if the alternative method is used (or not used) separately with respect to participants and beneficiaries under any policy, provided that the alternative method is applied uniformly with respect to all coverage under that policy. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;
(ii) Substance abuse treatment;
(iii) Prescription drugs;
(iv) Dental care; or
(v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Disclosure of information on previous benefits.* See § 54.9801–5T(b) for special rules concerning disclosure of coverage to a plan (or issuer) using the alternative method of counting creditable coverage under this paragraph (c).

(6) *Counting creditable coverage—(i) In general.* Under the alternative method, the group health plan counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, this is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(6) are illustrated by the following example:

Example. (i) Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) In this *Example,* Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

§ 54.9801–5T Certification and disclosure of previous coverage (temporary).

(a) *Certificate of creditable coverage—(1) Entities required to provide certificate—(i) In general.* A group

health plan is required to furnish certificates of creditable coverage in accordance with this paragraph (a) of this section. (See PHSA section 2701(e) and ERISA section 701(e) under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a)(1) for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. For example, a group health plan is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if any other entity actually provides a certificate that includes the information required under paragraph (a)(3) of this section with respect to the participant or beneficiary.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirements under this paragraph (a)(1) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and the employer sponsoring the plan under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the plan does not violate the certification requirements of this paragraph (a) (though the issuer would have violated the certification requirements pursuant to section 2701(e) of the PHSA and section 701(e) of ERISA).

(iv) *Special rules relating to issuers providing coverage under a plan*—(A)(*1*) *Responsibility of issuer for coverage period.* See 29 CFR 2590.701–5 and 45 CFR 146.115, under which an issuer is not required to provide information regarding coverage provided to an individual by another party.

(*2*) *Example.* The rule referenced by this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) In this *Example,* if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B) (*1*) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy ceases before the individual's coverage under the plan ceases, the issuer is required (under section 2701(e) of the PHSA and section 701(e) of ERISA) to provide sufficient information to the plan (or to another party designated by the plan) to enable a certificate to be provided by the plan (or other party), after cessation of the individual's coverage under the plan, that reflects the period of coverage under the policy. The provision of that information to the plan will satisfy the issuer's obligation to provide an automatic certificate for that period of creditable coverage for the individual under paragraph (a)(2)(ii) and (3) of this section. In addition, an issuer providing that information is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). If the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy ceases, the issuer must provide an automatic certificate under paragraph (a)(2)(ii) of this section. An issuer may presume that an individual whose coverage ceases at a time other than the effective date for changing enrollment options has ceased to be covered under the plan.

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example:

Example. (i) A group health plan provides coverage under an HMO option and an indemnity option with a different issuer, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide automatic certificates as permitted under paragraph (a)(2)(ii) of this section.

(ii) In this *Example,* if an employee switches from the indemnity option to the HMO option on January 1, the issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance*—*(i) Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 4980B(g)(1)) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 4980B(f)(6) (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual ceases to be covered under the plan. A plan satisfies this requirement if it provides the automatic certificate within a reasonable time period thereafter. In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time period after the cessation of coverage under the plan.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases. A plan satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* Requests for certificates are permitted to be made by, or on behalf of, an individual within 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The following examples illustrate the rules of this paragraph (a)(2):

Example 1. (i) Individual *A* terminates employment with Employer *Q*. *A* is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer *q*'s group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) In this *Example 1*, the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2., (i) Same facts as *Example 1*, except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A*.

(ii) In this *Example 2*, the automatic certificate may be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) Employer *R* maintains an insured group health plan. *R* has never had 20 employees and thus *R*'s plan is not subject to the COBRA continuation coverage provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R*'s plan.

(ii) In this *Example 3*, the automatic certificate may be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) Individual *C* terminates employment with Employer *S* and receives both a notice of *C*'s rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S*'s group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, *S*'s group health plan determines that *C*'s COBRA continuation coverage has ceased due to failure to make a timely payment for continuation coverage.

(ii) In this *Example 4*, the plan must provide an updated automatic certificate to *C* within a reasonable time after the end of the grace period.

Example 5. (i) Individual *D* is currently covered under the group health plan of Employer *T*. *D* requests a certificate, as premitted under paragraph (a)(2)(iii). Under the procedure for Employer *T*'s plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) In this *Example 5*, the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate*—(i) *Written certificate*—(A) *In general.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (including any form approved by the Secretary as a writing).

(B) *Other permissible forms.* No written certificate is required to be provided under paragraph (a) with respect to a particular event described in paragraph (a)(2) (ii) or (iii) of this section if——

(*1*) An individual is entitled to receive a certificate;

(*2*) The individual requests that the certificate be sent to another plan or issuer instead of to the individual;

(*3*) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (e.g., by telephone); and

(*4*) The receiving plan or issuer receives such information from the sending plan or issuer in such form within the time periods required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following——

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(*1*) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(*2*) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began; and

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

(iii) *Periods of coverage under certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual or, if the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 54.9804–1T. In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 54.9801–4T(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate

may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section.

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated party. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated party.

(5) *Special rules concerning dependent coverage*—(i)(A) *Reasonable efforts.* A plan is required to use reasonable efforts to determine any information needed for a certificate relating to the dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) In this *Example,* the plan has satisfied the standard in this paragraph (a)(5)(i) of this section that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c)(4) of this section for demonstrating dependent status. In addition, an individual may, if necessary, use these procedures to demonstrate that a child was enrolled within 30 days of birth, adoption, or placement for adoption. See § 54.9801–3T(b), under which such a child would not be subject to a preexisting condition exclusion.

(iii) *Transition rule for dependent coverage through June 30, 1998*—(A) *In general.* A group health plan that cannot provide the names of dependents (or related coverage information) for purposes of providing a certificate of coverage for a dependent may satisfy the requirements of paragraph (a)(3)(ii)(C) of this section by providing the name of the participant covered by the group health plan and specifying that the type of coverage described in the certificate is for dependent coverage (e.g., family coverage or employee-plus-spouse coverage).

(B) *Certificates provided on request.* For purposes of certificates provided on the request of, or on behalf of, an individual pursuant to paragraph (a)(2)(iii) of this section, a plan must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate where such information is requested to be provided. If a certificate does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c) of this section for submitting documentation to establish that the credible coverage in the certificate applies to the dependent.

(C) *Demonstrating a dependent's creditable coverage.* See paragraph (c)(4) of this section for special rules to demonstrate dependent status.

(D) *Duration.* This paragraph (a)(5)(iii) is only effective for certifications provided with respect to events occurring through June 30, 1998.

(6) *Special specification rules for entities not subject to Chapter 100 of Subtitle K of the Internal Revenue Code*—(i) *Issuers.* For rules requiring that issuers in the group and individual markets provide certificates consistent with the rules in this section, see section 701(e) of ERISA and sections 2701(e), 2721(b)(1)(B), and 2743 of the PHSA.

(ii) *Other entities.* For special rules requiring that certain other entities, not subject to Chapter 100 of Subtitle K of the Internal Revenue Code, provide certificates consistent with the rules in the section, see section 2791(a)(3) of the PHSA applicable to entities described in sections 2701(c)(1) (C), (D), (E), and (F) (relating to Medicare, Medicaid, CHAMPUS, and Indian Health Service), section 2721(b)(1)(A) of the PHSA applicable to nonfederal governmental plans generally, and section 2721(b)(2)(C)(ii) of the PHSA applicable to nonfederal governmental plans that elect to be excluded from the requirements of Subparts 1 and 3 of Part A of Title XXVII of the PHSA.

(b) *Disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage*—(1) *In general.* If an individual enrolls in a group health plan with respect to which the plan (or issuer) uses the alternative method of counting creditable coverage described in § 54.9801–4T(c), the individual provides a certificate of coverage under paragraph (a) of this section, and the plan (or issuer) in which the individual enrolls so requests, the entity that issued the certificate (the prior entity) is required to disclose promptly to a requesting plan (or issuer) (the requesting entity) the information set forth in paragraph (b)(2) of this section.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs to order to determine the individual's creditable coverage with respect to any such category. The prior entity is required to disclose promptly to the requesting entity the creditable coverage information so requested.

(3) *Charge for providing information.* The prior entity furnishing the information under paragraph (b) of this section may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information*—(1) *In general.* The rules in this paragraph (c) implement section 9801(c)(4), which permits individuals to establish creditable coverage through means other than certificates, and section 9801(e)(3), which requires the Secretary to establish rules designed to prevent an

individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time period;

(ii) The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The coverage is for a period before July 1, 1996;

(iv) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(v) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(2) *Evidence of creditable coverage*—(i) *Consideration of evidence.* A plan is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion period. A plan shall treat the individual as having furnished a certificate under paragraph (a) of this section if the individual attests to the period of creditable coverage, the individual also presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the plan's efforts to verify the individual's coverage. For this purpose, cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting period or affiliation period information) may also be established through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(2) are illustrated by the following example:

Example. (i) Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. Employer *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, Employer *W*, and requests a certificate. However, *F* (and Employer's *X*'s plan, on *F*'s behalf) is unable to obtain a certificate from Employer *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under Employer *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from Employer *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) In this *Example,* based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under Employer *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(3) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(4) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

(d) *Determination and notification of creditable coverage*—(1) *Reasonable time period.* In the event that a group health plan receives information under paragraph (a) of this section (certifications), paragraph (b) of this section (disclosure of information relating to the alternative method), or paragraph (c) of this section (other evidence of creditable coverage), the plan is required, within a reasonable time period following receipt of the information, to make a determination regarding the indivdiual's period of creditable coverage and notify the individual of the determination in accordance with paragraph (d)(2) of this section. Whether a determination and notification regarding an individual's creditable coverage is made within a reasonable time period is determined based on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical services.

(2) *Notification to individual of period of preexisting condition exclusion.* A plan seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan relied. In addition, the plan is required to provide the individual with a written explanation of any appeal procedures established by the plan, and with a reasonable opportunity to submit additional evidence of creditable coverage. However, nothing in this paragraph (d) or paragraph (c) of this section prevents a plan from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(i) A notice of such reconsideration, as described in this paragraph (d), is provided to the individual; and

(ii) Until the final determination is made, the plan, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

(3) *Examples.* The following examples illustrate this paragraph (d):

Example 1. (i) Individual *G* is hired by Employer *Y*. Employer *Y*'s group health plan

imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. Employer *Y*'s plan determines that *G* is subject to a 4-month preexisting condition exclusion, based on a certificate of creditable coverage that is provided by *G* to Employer *Y*'s plan indicating 8 months of coverage under *G*'s prior group health plan.

(ii) In this *Example 1,* Employer *Y*'s plan must notify *G* within a reasonable period of time following receipt of the certificate that *G* is subject to a 4-month preexisting condition exclusion beginning on *G*'s enrollment date in *Y*'s plan.

Example 2. (i) Same facts as in *Example 1,* except that Employer *Y*'s plan determines that *G* has 14 months of creditable coverage based on *G*'s certificate indicating 14 months of creditable coverage under *G*'s prior plan.

(ii) In this *Example 2.* Employer *Y*'s plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

Example 3. (i) Individual *H* is hired by Employer *Z*. Employer *Z*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. *H* develops an urgent health condition before receiving a certificate of prior coverage. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf.

(ii) In this *Example 3,* Employer *Z*'s plan must review the evidence presented by *H.* In addition, the plan must make a determination and notify *H* regarding any preexisting condition exclusion period that applies to *H* (and the basis of such determination) within a reasonable time period following receipt of the evidence that is consistent with the urgency of *H's health condition* (this determination may be modified as permitted under paragraph (d)(2) of this section).

§ 54.9801–6T Special enrollment periods (temporary).

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In general.* A group health plan is required to permit employees and dependents described in paragraph (a)(2), (3) or (4) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(5) of this section are satisfied and the enrollment is requested within the period described in paragraph (a)(6) of this section. The enrollment is effective at the time described in paragraph (a)(7) of this section. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (See PHSA section 2701(f)(1) and ERISA section 701(f)(1) under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Special enrollment of an employee only.* An employee is described in this paragraph (a)(2) if the employee is eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee under the plan and was declined by the employee, the employee was covered under another group health plan or had other health insurance coverage.

(3) *Special enrollment of dependents only.* A dependent is described in this paragraph (a)(3) if the dependent is a dependent of an employee participating in the plan, the dependent is eligible, but not enrolled, for coverage under the terms of the plan, and, when enrollment was previously offered under the plan was declined, the dependent was covered under another group health plan or had other health insurance coverage.

(4) *Special enrollment of both employee and dependent.* An employee and any dependent of the employee are described in this paragraph (a)(4) if they are eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee or dependent under the plan and was declined, the employee or dependent was covered under another group health plan or had other health insurance coverage.

(5) *Conditions for special enrollment.* An employee or dependent is eligible to enroll during a special enrollment period if each of the following applicable conditions is met:

(i) When the employee declined enrollment for the employee or the dependent, the employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment. This paragraph (a)(5)(i) applies only if—

(A) The plan required such a statement when the employee declined enrollment; and

(B) The employee is provided with notice of the requirement to provide the statement in this paragraph (a)(5)(i) (and the consequences of the employee's failure to provide the statement) at the time the employee declined enrollment.

(ii)(A) When the employee declined enrollment for the employee or dependent under the plan, the employee or dependent had CORRA continuation coverage under another plan and COBRA continuation coverage under that other plan has since been exhausted; or

(B) If the other coverage that applied to the employee or dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated. For this purpose, loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Thus, for example, if an employee's coverage ceases following a termination of employment and the employee is eligible for but fails to elect COBRA continuation coverage, this is treated as a loss of eligibility under this paragraph (a)(5)(ii)(B). However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). In addition, for purposes of this paragraph (a)(5)(ii)(B), employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

(6) *Length of special enrollment period.* The employee is required to request enrollment (for the employee or the employee's dependent, as described in paragraph (a) (2), (3), or (4) of this section) not later than 30 days after the exhaustion of the other coverage described in paragraph (a)(5)(ii)(A) of this section or termination of the other coverage as a result of the loss of eligibility for the other coverage for items described in paragraph (a)(5)(ii)(B) of this section or following the termination of employer contributions toward that other coverage. The plan may impose the same requirements that apply to employees who are otherwise eligible under the plan to immediately request enrollment for coverage (e.g., that the request be made in writing).

(7) *Effective date of enrollment.* Enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *In general.* A group health plan that makes coverage available with respect to dependents of a participant is required to provide a special enrollment period to permit individuals described in paragraph (b) (2), (3), (4), (5), or (6) of this section to be enrolled for coverage under the terms of the plan if the enrollment is requested within the time

period described in paragraph (b)(7) of this section. The enrollment is effective at the time described in paragraph (b)(8) of this section. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Special enrollment of an employee who is eligible but not enrolled.* An individual is described in this paragraph (b)(2) if the individual is an employee who is eligible, but not enrolled, in the plan, the individual would be a participant but for a prior election by the individual not to enroll in the plan during a previous enrollment period, and a person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

(3) *Special enrollment of a spouse of a participant.* An individual is described in this paragraph (b)(3) if either—

(i) The individual becomes the spouse of a participant; or

(ii) The individual is a spouse of the participant and a child becomes a dependent of the participant through birth, adoption or placement for adoption.

(4) *Special enrollment of an employee who is eligible but not enrolled and the spouse of such employee.* An employee who is eligible, but not enrolled, in the plan, and an individual who is a dependent of such employee, are described in this paragraph (b)(4) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and either—

(i) The employee and the individual become married; or

(ii) The employee and individual are married and a child becomes a dependent of the employee through birth, adoption or placement for adoption.

(5) *Special enrollment of a dependent of a participant.* An individual is described in this paragraph (b)(5) if the individual is a dependent of a participant and the individual becomes a dependent of such participant through marriage, birth, or adoption or placement for adoption.

(6) *Special enrollment of an employee who is eligible but not enrolled and a new dependent.* An employee who is eligible, but not enrolled, in the plan, and an individual who is a dependent of the employee, are described in this paragraph (b)(6) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and the dependent becomes a dependent of the employee through marriage, birth, or adoption or placement for adoption.

(7) *Length of special enrollment period.* The special enrollment period under paragraph (b)(1) of this section is a period of not less than 30 days and begins on the date of the marriage, birth, or adoption or placement for adoption (except that such period does not begin earlier than the date the plan makes dependent coverage generally available).

(8) *Effective date of enrollment.* Enrollment is effective—

(i) In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan;

(ii) In the case of a dependent's birth, the date of such birth; and

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(9) *Example.* The rules of this paragraph (b) are illustrated by the following example:

Example. (i) Employee *A* is hired on September 3, 1998 by Employer *X,* which has a group health plan in which *A* can elect to enroll either for employee-only coverage, for employee-plus-spouse coverage, or for family coverage, effective on the first day of any calendar quarter thereafter. *A* is married and has no children. *A* does not elect to join Employer *X's* plan (for employee-only coverage, employee-plus-spouse coverage, or family coverage) on October 1, 1998 or January 1, 1999. On February 15, 1999, a child is placed for adoption with *A* and *A*'s spouse.

(ii) In this *Example,* the conditions for special enrollment of an employee with a new dependent under paragraph (b)(2) of this section are satisfied, the conditions for special enrollment of an employee and a spouse with a new dependent under paragraph (b)(4) of this section are satisfied, and the conditions for special enrollment of an employee and a new dependent under paragraph (b)(6) of this section are satisfied. Accordingly, Employer *X*'s plan will satisfy this paragraph (b) if and only if it allows *A* to elect, by filing the required forms by March 16, 1999, to enroll in Employer *X*'s plan either with employee-only coverage, with employee-plus-spouse coverage, or with family coverage, effective as of February 15, 1999.

(c) *Notice of enrollment rights.* On or before the time an employee is offered the opportunity to enroll in a group health plan, the plan is required to provide the employee with a description of the plan's special enrollment rules under this section. For this purpose, the plan may use the following model description of the special enrollment rules under this section:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(d) (1) *Special enrollment date definition.* A special enrollment date for an individual means any date in paragraph (a)(7) or (b)(8) of this section on which the individual has a right to have enrollment in a group health plan become effective under this section.

(2) *Examples.* The rules of this section are illustrated by the following examples:

Example 1. (i)(A) Employer *Y* maintains a group health plan that allows employees to enroll in the plan either—

(*1*) Effective on the first day of employment by an election filed within three days thereafter;

(*2*) Effective on any subsequent January 1 by an election made during the preceding months of November or December; or

(*3*) Effective as of any special enrollment date described in this section.

(B) Employee *B* is hired by Employer *Y* on March 15, 1998 and does not elect to enroll in Employer *Y*'s plan until January 31, 1999 when *B* loses coverage under another plan. *B* elects to enroll in Employer *Y*'s plan effective on February 1, 1999, by filing the completed request form by January 31, 1999, in accordance with the special rule set forth in paragraph (a) of this section.

(ii) In this *Example 1, B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) of this section.

Example 2. (i) Same facts as *Example 1,* except that *B*'s loss of coverage under the other plan occurs on December 31, 1998 and *B* elects to enroll in Employer *Y*'s plan effective on January 1, 1999 by filing the completed request form by December 31, 1998, in accordance with the special rule set forth in paragraph (a) of this section.

(ii) In this *Example 2, B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) of this section (even though this date is also a regular enrollment date under the plan).

§ 54.9802–1T Prohibiting discrimination against participants and beneficiaries based on a health status-related factor (temporary).

(a) *In eligibility to enroll*—(1) *In general.* Subject to paragraph (a)(2) of this section, a group health plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following

health status-related factors in relation to the individual or a dependent of the individual:

(i) Health status.

(ii) Medical condition (including both physical and mental illnesses), as defined in § 54.9801–2T.

(iii) Claims experience.

(iv) Receipt of health care.

(v) Medical history.

(vi) Genetic information, as defined in § 54.9801–2T.

(vii) Evidence of insurability (including conditions arising out of acts of domestic violence).

(viii) Disability.

(2) *No application to benefits or exclusions.* To the extent consistent with section 9801 and § 54.9801–3T, paragraph (a)(1) of this section shall not be construed—

(i) To require a group health plan to provide particular benefits other than those provided under the terms of such plan; or

(ii) To prevent such a plan from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) *Construction.* For purposes of paragraph (a)(1) of this section, rules for eligibility to enroll include rules defining any applicable waiting (or affiliation) periods for such enrollment and rules relating to late and special enrollment.

(4) *Example.* The following example illustrates the rules of this paragraph (a):

Example. (i) An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, individuals who do not enroll in the first 30 days cannot enroll later unless they pass a physical examination.

(ii) In this *Example,* the plan discriminates on the basis of one or more health status-related factors.

(b) *In premiums or contributions*—(1) *In general.* A group health plan may not require an individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health status-related factor, in relation to the individual or a dependent of the individual.

(2) *Construction.* Nothing in paragraph (b)(1) of this section shall be construed—

(i) To restrict the amount that an employer may be charged by an issuer for coverage under a group health plan; or

(ii) To prevent a group health plan from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to a bona fide wellness program. For purposes of this section, a bona fide wellness program is a program of health promotion and disease prevention.

(3) *Example.* The rules of this paragraph (b) are illustrated by the following example:

Example. (i) Plan *X* offers a premium discount to participants who adhere to a cholesterol-reduction wellness program. Enrollees are expected to keep a diary of their food intake over 6 weeks. They periodically submit the diary to the plan physician who responds with suggested diet modifications. Enrollees are to modify their diets in accordance with the physician's recommendations. At the end of the 6 weeks, enrollees are given a cholesterol test and those who achieve a count under 200 receive a premium discount.

(ii) In this *Example,* because enrollees who otherwise comply with the program may be unable to achieve a cholesterol count under 200 due to a health status-related factor, this is not a bona fide wellness program and such discounts would discriminate impermissibly based on one or more health status-related factors. However, if, instead, individuals covered by the plan were entitled to receive the discount for complying with the diary and dietary requirements and were not required to pass a cholesterol test, the program would be a bona fide wellness program.

§ 54.9804–1T Special rules relating to group health plans (temporary).

(a) *General exception small group health plans.* The requirements of Chapter 100 of Subtitle K of the Internal Revenue Code do not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

(b) *Excepted benefits*—(1) *In general.* The requirements of §§ 54.9801–1T through 54.9801–6T and 54.9802–1T do not apply to any group health plan in relation to its provision of the benefits described in paragraph (b) (2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar insurance;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—

(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan, as defined in paragraph (b)(3)(ii) of this section.

(ii) *Integral.* For purposes of paragraph (b)(3)(i) of this section, benefits are deemed to be an integral part of a plan unless a participate has the right to elect not to receive coverage for the benefits and, if the participant elects to receive coverage for the benefits, the participant pays an additional premium or contribution for that coverage.

(iii) *Limited scope.* Limited scope dental or vision benefits are dental or vision benefits that are sold under a separate policy or rider and that are limited in scope in a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefit packages.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care insurance services; as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Covered for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed dollar indemnity insurance (for example, $100/day) is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) *Conditions.* Benefits are described in paragraph (b)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is not coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the

event under any group health plan maintained by the same plan sponsor.

(5) *Supplemental benefits.* The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(ii) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as CHAMPUS supplemental programs); and

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(c) *Treatment of partnerships.* [Reserved]

§ 54.9806–1T Effective dates (temporary).

(a) *General effective dates*—(1) *Non-collectively-bargained plans.* Except as otherwise provided in this section, Chapter 100 of Subtitle K of the Internal Revenue Code and §§ 54.9801–1T through 54.9804–1T apply with respect to group health plans for plan years beginning after June 30, 1997.

(2) *Collectively bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Chapter 100 of Subtitle K of the Internal Revenue Code and §§ 54.9801–1T through 54.9804–1T do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). For these purposes, any plan amendment made pursuant to a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such part, is not treated as a termination of the collective bargaining agreement.

(3)(i) *Preexisting condition exclusion periods for current employees.* Any preexisting condition exclusion period permitted under § 54.9801–3T is measured from the individual's enrollment date in the plan. Such exclusion period, as limited under § 54.9801–3T, may be completed prior to the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject to Chapter 100 of Subtitle K of the Internal Revenue Code, no preexisting condition exclusion may be imposed with respect to an individual beyond the limitation in § 54.9801–3T. For an individual who has not completed the permitted exclusion period under HIPPA, upon the effective date for his or her plan, the individual may use creditable coverage that the individual had prior to the enrollment date to reduce the remaining preexisting condition exclusion period applicable to the individual.

(ii) *Examples.* The following examples illustrate the rules of this paragraph (a)(3):

Example 1. (i) Individual *A* has been working for Employer *X* and has been covered under Employer *X*'s plan since March 1, 1997. Under Employer *X*'s plan, as in effect before January 1, 1998, there is no coverage for any preexisting condition. Employer *X*'s plan year begins on January 1, 1998. *A*'s enrollment date in the plan is March 1, 1997 and *A* has no creditable coverage before this date.

(ii) In this *Example 1*, Employer *X* may continue to impose the preexisting condition exclusion under the plan through February 28, 1998 (the end of the 12-month period using anniversary dates).

Example 2. (i) Same facts as in *Example 1,* except that *A*'s enrollment date was August 1, 1996, instead of March 1, 1997.

(ii) In this *Example 2,* on January 1, 1998, Employer *X*'s plan may no longer exclude treatment for any preexisting condition that *A* may have; however, because Employer *X*'s plan is not subject to HIPAA until January 1, 1998, *A* is not entitled to claim reimbursement for expenses under the plan for treatments for any preexisting condition of *A* received before January 1, 1998.

(b) *Effective date for certification requirement*—(1) *In general.* Subject to the transitional rule in § 54.9801–5T(a)(5)(iii), the certification rules of § 54.9801–5T apply to events occurring on or after July 1, 1996.

(2) *Period covered by certificate.* A certificate is not required to reflect coverage before July 1, 1996.

(3) *No certificate before June 1, 1997.* Notwithstanding any other provision of § 54.9801–5T, in no case is a certificate required to be provided before June 1, 1997.

(c) *Limitation on actions.* No enforcement action is to be taken, pursuant to Chapter 100 of Subtitle K of the Internal Revenue Code, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by Chapter 100 of Subtitle K of the Internal Revenue Code before January 1, 1998 if the plan or issuer has sought to comply in good faith with such requirements. Compliance with these regulations is deemed to be good faith compliance with the requirements of Chapter 100 of Subtitle K.

(d) *Transition rules for counting creditable coverage.* An individual who seeks to establish creditable coverage for periods before July 1, 1996 is entitled to establish such coverage through the presentation of documents or other means in accordance with the provisions of § 54.9801–5T(c). For coverage relating to an event occurring before July 1, 1996, a group health plan and a health insurance issuer is not subject to any penalty or enforcement action with respect to the plan's or issuer's counting (or not counting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under § 54.9801–5T(c).

(e) *Transition rules for certificates of creditable coverage*—(1) *Certificates only upon request.* For events occurring on or after July 1, 1996 but before October 1, 1996, a certificate is required to be provided only upon a written request by or on behalf of the individual to whom the certificate applies.

(2) *Certificates before June 1, 1997.* For events occurring on or after October 1, 1996 and before June 1, 1997, a certificate must be furnished no later than June 1, 1997, or any later date permitted under § 54.9801–5T(a)(2) (ii) and (iii).

(3) *Optional notice*—(i) *In general.* This paragraph (e)(3) applies with respect to events described in § 54.9801–5T(a)(5)(ii), that occur on or after October 1, 1996 but before June 1, 1997. A group health plan or health insurance issuer offering group health coverage is deemed to satisfy § 54.9801–5T(a) (2) and (3) if a notice is provided in accordance with the provisions of paragraphs (e)(3) (i) through (iv) of this section.

(ii) *Time of notice.* The notice must be provided no later than June 1, 1997.

(iii) *Form and content of notice.* A notice provided pursuant to this paragraph (e)(3) must be in writing and must include information substantially similar to the information included in a model notice authorized by the Secretary. Copies of the model notice are available at the following website—http://www.irs.ustreas.gov (or call (202) 622–4695).

(iv) *Providing certificate after request.* If an individual requests a certificate following receipt of the notice, the certificate must be provided at the time of the request as set forth in § 54.9801–5T(a)(5)(iii).

(v) *Other certification rules apply.* The rules set forth in § 54.9801–5T(a)(4)(i) (method of delivery) and

54.9801–5T(a)(1) (entities required to provide a certificate) apply with respect to the provision of the notice.

Dated: March 24, 1997.

Margaret Milner Richardson,

Commissioner of Internal Revenue.

Approved:

Donald C. Lubick,

Assistant Secretary of the Treasury.

Pension and Welfare Benefits Administration

29 CFR Chapter XXV

For the reasons set forth above, Chapter XXV of Title 29 of the Code of Federal Regulations is amended as set forth below:

1. A new Subchapter L, consisting of Part 2590, is added to read as follows:

Subchapter L—Health Insurance Portability and Renewability for Group Health Plans

PART 2590—RULES AND REGULATIONS FOR HEALTH INSURANCE PORTABILITY AND RENEWABILITY FOR GROUP HEALTH PLANS

Subpart A—Requirements Relating to Access and Renewability of Coverage, and Limitation on Preexisting Condition Exclusion Periods

Sec.

Subpart B—Other Requirements

Subpart C—General Provisions

Authority: Sec. 29 U.S.C. 1027, 1059, 1135, 1171, 1194; Sec. 101, Pub. L. 104–191, 101 Stat. 1936 (29 U.S.C. 1181); Secretary of labor's Order No. 1–87, 52 FR 13139, April 21, 1987.

Subpart A—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

§ 2590.701–1 Basis and scope.

(a) *Statutory basis.* This subpart implements Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (hereinafter ERISA or the Act).

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this subpart. This subpart A sets forth minimum requirements for group health plans and health insurance issuers offering group health insurance coverage concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to counting creditable coverage.

(4) Special enrollment periods.

(5) Use of an affiliation period by an HMO as an alternative to a preexisting condition exclusion.

§ 2590.701–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 2590.701 through 2590.734.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601–608 of the Act, section 4980B of the Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), and Title XXII of the PHSA.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis; or

(ii) When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual.

Condition means a medical condition.

Creditable coverage means creditable coverage within the meaning of § 2590.701–4(a).

Enroll means to become covered for benefits under a group health plan (i.e., when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to enroll in the plan. For this purpose, an individual who has health insurance coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (*enrollment date* and *first day of coverage*) are set forth in § 2590.701–3(a)(2) (i) and (ii).

Excepted benefits means the benefits described as excepted in § 2590.732(b).

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of individual market in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or

reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Act). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHSA);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited duration insurance. For this purpose, short-term, limited-duration insurance means 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 within 12 months of the date such contract becomes effective. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHSA, such term also includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

Internal Revenue Code (Code) means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

Issuer means a health insurance issuer.

Late enrollment definitions (late enrollee) and *late enrollment)* are set forth in § 2590.701–3(a)(2) (iii) and (iv).

Medical care means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person terminates upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible/limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan means *public health plan* within the meaning of § 2590.701–4(a)(1)(ix).

Public Health Service Act (PHSA) means the Public Health Service Act (42 U.S.C. 201, *et seq.).*

Significant break in coverage means a significant break in coverage within the meaning of § 2590.701–4(b)(2)(iii).

Special enrollment date means a special enrollment date within the meaning of § 2590.701–6(d).

State means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State health benefits risk pool means a State health benefits risk pool within the meaning of § 2590.701–4(a)(1)(vii).

Waiting period means the period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

§ 2590.701–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *In general.* Subject to paragraph (b) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a) are satisfied.

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date.

(A) For purposes of this paragraph (a)(1)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(1)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date

of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(1)(i) are illustrated by the following examples:

Example 1. (i) Individual *A* is treated for a medical condition 7 months before the enrollment date in Employer *R*'s group health plan. As part of such treatment, *A*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation. *A* does not receive a follow-up examination and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *A* or received by *A* during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan.

(ii) In this *Example 1,* Employer *R*'s plan may not impose a preexisting condition exclusion period with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

Example 2. (i) Same facts as *Example 1,* except that Employer *R*'s plan learns of the condition and attaches a rider to *A*'s policy excluding coverage for the condition. Three months after enrollment, *A*'s condition recurs, and Employer *R*'s plan denies payment under the rider.

(ii) In this *Example 2,* The rider is preexisting condition exclusion and Employer *R*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

Example 3. (i) Individual *B* has asthma and is treated for that condition several times during the 6-month period before *B*'s enrollment date in Employer *S*'s plan. The plan imposes a 12-month preexisting condition exclusion. *B* has no prior creditable coverage to reduce the exclusion period. Three months after the enrollment date, *B* begins coverage under Employer *S*'s plan. Two months later, *B* is hospitalized asthma.

(ii) In this *Example 3,* Employer *S*'s plan may exclude payment for the hospital stay and the physician services associated with this illness because the care is related to a medical condition for which treatment was received by *B* during the 6-month period before the enrollment date.

Example 4. (i) Individual *D,* who is subject to a preexisting exclusion imposed by Employer *U*'s plan, has diabetes, as well as a foot condition caused by poor circulation and retinal degeneration (both of which are conditions that may be directly attributed to diabetes). After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) In this *Example 4,* the leg is fracture is not a condition related to *D*'s diabetes, even though poor circulation in *D*'s extremities and poor vision may have contributed towards the accident. However, any additional medical services that may be needed because of *D*'s preexisting diabetic condition that would not be needed by another patient with a broken leg who does not have diabetes may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion (the look-forward rule).* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For purposes of this paragraph (a)(1)(ii), the 12-month and 18-month periods after the enrollment date are determined by reference to the anniversary of the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage.* The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 2590.701–4. For purposes of this subpart the phrase ''days of creditable coverage'' has the same meaning as the phrase ''aggregate of the periods of creditable coverage'' as such term is used in section 701(a)(3) of the Act.

(iv) *Other Standards.* See § 2590.702 for other standards that may apply with respect to certain benefits limitations or restrictions under a group health plan.

(2) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

(ii)(A) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan in the group market, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy.

(B) The following example illustrates the rule of paragraph (a)(2)(ii)(A) of this section:

Example. (i) Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer's *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and then on October 14, 1998 completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) In this *Example,* E's enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E,* the 6-month period in paragraph (a)(1)(i) would be the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan could apply a preexisting condition exclusion under paragraph (a)(1)(ii) would be in the period from October 13, 1998 through October 12, 1999, and this period would be reduced under paragraph (a)(1)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

(iii) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(iv)(A) *Late enrollment* means enrollment under a group health plan other than on—

(*1*) The earliest date on which coverage can become effective under the terms of the plan; or

(*2*) A special enrollment date for the individual.

(B) If an individual ceases to be eligible for coverage under the plan by terminating employment, and then subsequently becomes eligible for coverage under the plan by resuming employment, only eligibility during the individual's most recent period of employment is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(v) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) Employee *F* first becomes eligible to be covered by Employer *W's* group health plan on January 1, 1999, but elects not to enroll in the plan until April 1, 1999. April 1, 1999 is not a special enrollment date for *F.*

(ii) In this *Example 1, F* would be a late enrollee with respect to *F's* coverage that became effective under the plan on April 1, 1999.

Example 2. (i) Same as *Example 1,* except that *F* does not enroll in the plan on April 1, 1999 and terminates employment with Employer *W* on July 1, 1999, without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W's* plan effective on January 1, 2000.

(ii) In this *Example 2, F* would not be a late enrollee with respect to *F's* coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions—(1) Newborns*—(i) *In general.* Subject to

paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion with regard to a child who, as of the last day of the 30-day period beginning with the date of birth, is covered under any creditable coverage. Accordingly, if a newborn is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion with regard to the child.

(ii) *Example.* The rule of this paragraph (b)(1) is illustrated by the following example:

Example. (i) Seven months after enrollment in Employer *W's* group health plan, Individual *E* has a child born with a birth defect. Because the child is enrolled in Employer *W's* plan within 30 days of birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W's* plan. Three months after the child's birth, *E,* commences employment with Employer *X* and enrolls with the child in Employer *X's* plan 45 days after leaving Employer *W's* plan. Employer *X's* plan imposes a 12-month exclusion for any preexisting condition.

(ii) In this *Example,* Employer *X's* plan may not impose any preexisting condition exclusion with respect to *E's* child because the child was covered within 30 days of birth and had no significant break in coverage. This result applies regardless of whether *E's* child is included in the certificate of creditable coverage provided to *E* by Employer *W* indicating 300 days of dependent coverage or receives a separate certificate indicating 90 days of coverage. Employer *X's* plan may impose a preexisting condition exclusion with respect to *E* for up to 2 months for any preexisting condition of *E* for which medical advice, diagnosis, care, or treatment was recommended or received by *E* within the 6-month period ending on *E's* enrollment date in Employer *X's* plan.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage.

(4) *Pregnancy.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to pregnancy as a preexisting condition.

(5) *Special enrollment dates.* For special enrollment dates relating to new dependents, see § 2590.701–6(b).

(c) *Notice of plan's preexisting condition exclusion.* A group health plan, and health insurance issuer offering group health insurance under the plan, may not impose a preexisting condition exclusion with respect to a participant or dependent of the participant before notifying the participant, in writing, of the existence and terms of any preexisting condition exclusion under the plan and of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods) as required by § 2590.701–5. The description of the rights of individuals to demonstrate creditable coverage includes a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

§ 2590.701–4 Rules relating to creditable coverage.

(a) *General rules—*

(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 2590.701–2.

(ii) Health insurance coverage as defined in § 2590.701–2 (whether or not the entity offering the coverage is subject to Part 7 of Subtitle B of Title I of the Act, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a State health benefits risk pool means—

(A) An organization qualifying under section 501(c)(26) of the Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHSA; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health insurance coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) *Excluded coverage.* Creditable coverage does not include coverage consisting solely of coverage of excepted benefits (described in § 2590.732).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 2590.701–3(a)(1)(iii), a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of an individual's creditable coverage by using the standard method described in paragraph (b) of this section, except that the plan, or issuer, may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of creditable

coverage without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period, a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. Accordingly, if on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Definition of significant break in coverage.* A significant break in coverage means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. (See section 731(b)(2)(iii) of the Act and section 2723(b)(2)(iii) of the PHSA which exclude from preemption State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State law.)

(iv) *Examples.* The following examples illustrate how creditable coverage is counted in reducing preexisting condition exclusion periods under this paragraph (b)(2):

Example 1. (i) Individual *A* works for Employer *P* and has creditable coverage under Employer *P*'s plan for 18 months before *A*'s employment terminates. *A* is hired by Employer *Q,* and enrolls in Employer *Q*'s group health plan, 64 days after the last date of coverage under Employer *P*'s plan. Employer *Q*'s plan has a 12-month preexisting condition exclusion period.

(ii) In this *Example 1,* because *A* had a break in coverage of 63 days, Employer *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion period.

Example 2. (i) Same facts as *Example 1,* except that *A* is hired by Employer *Q,* and enrolls in Employer *Q*'s plan, on the 63rd day after the last date of coverage under Employer *P*'s plan.

(ii) In this *Example 2, A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, Employer *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period as it applies to *A.*

Example 3. (i) Same facts as *Example 1,* except that Employer *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) In this *Example 3,* the issuer that provides group health insurance to Employer *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break.

Example 4. (i) Same facts as *Example 3,* except that Employer *Q*'s plan is a self-insured plan, and, thus, is not subject to State insurance laws.

(ii) In this *Example 4,* the plan is not governed by the longer break rules under State insurance law and *A*'s previous coverage may be disregarded.

Example 5. (i) Individual *B* begins employment with Employer *R* 45 days after terminating coverage under a prior group health plan. Employer *R*'s plan has a 30-day waiting period before coverage begins. *B* enrolls in Employer *R*'s plan when first eligible.

(ii) In this *Example 5, B* does not have a significant break in coverage for purposes of determining whether *B*'s prior coverage must be counted by Employer *R*'s plan. *B* has only a 44-day break in coverage because the 30-day waiting period is not taken into account in determining a significant break in coverage.

Example 6, (i) Individual *C* works for Employer *S* and has creditable coverage under Employer *S*'s plan for 200 days before *C*'s employment is terminated and coverage ceases. *C* is then unemployed for 51 days before being hired by Employer *T.* Employer *T*'s plan has a 3-month waiting period. *C* works for Employer *T* for 2 months and then terminates employment. Eleven days after terminating employment with Employer *T, C* begins working for Employer *U.* Employer *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion period.

(ii) In this *Example 6, C* does not have a significant break in coverage because, after disregarding the waiting period under Employer *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). Accordingly, C has 200 days of creditable coverage and Employer *U*'s plan may not apply its 6-month preexisting condition exclusion period with respect to *C.*

Example 7. (i) Individual *D* terminates employment with Employer *V* on January 13, 1998 after being covered for 24 months under Employer *V*'s group health plan. On March 17, the 63rd day without coverage, *D* applies for a health insurance policy in the individual market. *D*'s application is accepted and the coverage is made effective May 1.

(ii) In this *Example 7,* because *D* applied for the policy before the end of the 63rd day, and coverage under the policy ultimately became effective, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 107 days.

Example 8. (i) Same facts as *Example 7,* except that *D*'s application for a policy in the individual market is denied.

(ii) In this *Example 8,* because *D* did not obtain coverage following application, *D* incurred a significant break in coverage on the 64th day.

(v) *Other permissible counting methods*—(A) *Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 2590.701–5), a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(v) is illustrated by the following example:

Example. (i) Individual *F* has coverage under group health plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by group health plan *Z. F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion period.

(ii) In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraph (b)(2) (i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion period will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion period will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered.* Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the

standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or policy. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(iv) Dental care; or

(v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Disclosure of information on previous benefits.* See § 2590.701–5(b) for special rules concerning disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage under this paragraph (c).

(6) *Counting creditable coverage*—(i) *In general.* Under the alternative method, the group health plan or issuer counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan or issuer counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(6) are illustrated by the following example:

Example. (i) Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) In this *Example,* Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

§ 2590.701–5 Certification and disclosure of previous coverage.

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *In general.* A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to furnish certificates of creditable coverage in accordance with this paragraph (a) of this section.

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a)(1) for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. For example, in the case of a group health plan funded through an insurance policy, the issuer is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if the plan actually provides a certificate that includes the information required under paragraph (a)(3) of this section with respect to the participant or beneficiary.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirements under this paragraph (a)(1) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and the plan sponsor under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the issuer, but not the plan, violates the certification requirements of this paragraph (a).

(iv) *Special rules for issuers*—(A)(*1*) *Responsibility of issuer for coverage period.* An issuer is not required to provide information regarding coverage provided to an individual by another party.

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) In this *Example*, if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B)(*1*) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan (or to another party designated by the plan) to enable a certificate to be provided by the plan (or other party), after cessation of the individual's coverage under the plan, that reflects the period of coverage under the policy. The provision of that information to the plan will satisfy the issuer's obligation to provide an automatic certificate for that period of creditable coverage for the individual under paragraph (a) (2)(ii) and (3) of this section. In addition, an issuer providing that information is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). If the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy ceases, the issuer must provide an automatic certificate under paragraph (a)(2)(ii) of this section. An issuer may presume that an individual whose coverage ceases at a time other than the effective date for changing enrollment

options has ceased to be covered under the plan.

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example.

Example. (i) A group health plan provides coverage under an HMO option and an indemnity option with a different issuer, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide automatic certificates as permitted under paragraph (a)(2)(ii) of this section.

(ii) In this *Example,* if an employee switches from the indemnity option to the HMO option on January 1, the issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance*—(i) *Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 607(3) of the Act) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan or issuer satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 606 of the Act (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual ceases to be covered under the plan. A plan or issuer satisfies this requirement if it provides the automatic certificate within a reasonable time period thereafter. In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time period after the cessation of coverage under the plan.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases. A plan, or issuer, satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* Requests for certificates are permitted to be made by, or on behalf of, an individual within 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The following examples illustrate the rules of this paragraph (a)(2):

Example 1. (i) Individual *A* terminates employment with Employer *Q*. *A* is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer *Q*'s group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) In this *Example 1,* the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2. (i) Same facts as *Example 1,* except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A*.

(ii) In this *Example 2,* the automatic certificate may be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) Employer *R* maintains an insured group health plan. R has never had 20 employees and thus *R*'s plan is not subject to the COBRA continuation coverage provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R*'s plan.

(ii) In this *Example 3,* the automatic certificate may be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) Individual *C* terminates employment with Employer *S* and receives both a notice of *C*'s rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S*'s group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, *S*'s group health plan determines that *C*'s COBRA continuation coverage has ceased due to failure to make a timely payment for continuation coverage.

(ii) In this *Example 4,* the plan must provide an updated automatic certificate to *C* within a reasonable time after the end of the grace period.

Example 5. (i) Individual *D* is currently covered under the group health plan of Employer *T*. *D* requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for Employer *T*'s plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) In this *Example 5,* the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate*—(i) *Written certificate*—(A) *In general.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (including any form approved by the Secretary as a writing).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraph (a)(2) (ii) or (iii) of this section, if—

(*1*) An individual is entitled to receive a certificate;

(*2*) The individual requests that the certificate be sent to another plan or issuer instead of to the individual;

(*3*) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (e.g., by telephone); and

(*4*) The receiving plan or issuer receives such information from the sending plan or issuer in such form within the time periods required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following—

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(*1*) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(*2*) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began; and

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

(iii) *Periods of coverage under certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual or, if the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan or issuer provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 2590.732. In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 2590.701–4(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section.

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated party. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated party.

(5) *Special rules concerning dependent coverage*—(i)(A) *Reasonable efforts.* A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to the dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan or issuer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5) are illustrated by the following example:

Example. (i) A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) In this *Example,* the plan has satisfied the standard in this paragraph (a)(5)(i) of this section that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c)(4) of this section for demonstrating dependent status. In addition, an individual may, if necessary, use these procedures to demonstrate that a child was enrolled within 30 days of birth, adoption, or placement for adoption. See § 2590.701–3(b), under which such a child would not be subject to a preexisting condition exclusion.

(iii) *Transaction rule for dependent coverage through June 30, 1998*—(A) *In general.* A group health plan or health insurance issuer that cannot provide the names of dependents (or related coverage information) for purposes of providing a certificate of coverage for a dependent may satisfy the requirements of paragraph (a)(3)(ii)(C) of this section by providing the name of the participant covered by the group health plan or health insurance issuer and specifying that the type of coverage described in the certificate is for dependent coverage (e.g., family coverage or employee-plus-spouse coverage).

(B) *Certificates provided on request.* For purposes of certificates provided on the request of, or on behalf of, an individual pursuant to paragraph (a)(2)(iii) of this section, a plan or issuer

must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate where such information is requested to be provided. If a certificate does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c) of this section for submitting documentation to establish that the creditable coverage in the certificate applies to the dependent.

(C) *Demonstrating a dependent's creditable coverage.* See paragraph (c)(4) of this section for special rules to demonstrate dependent status.

(D) *Duration.* This paragraph (a)(5)(iii) is only effective for certificates provided with respect to events occurring through June 30, 1998.

(6) *Special certification rules for entities not subject to Part 7 of Subtitle B of Title I of the Act*—(i) *Issuers.* For special rules requiring that issuers, not subject to part 7 of subtitle B of title I of the Act, provide certificates consistent with the rules in this section, including issuers offering coverage with respect to creditable coverage described in sections 701(c)(1)(G) through (c)(1)(J) of the Act (coverage under a State health benefits risk pool, the Federal Employees Health Benefits Program, a public health plan, and a health benefit plan under section 5(e) of the Peace Corps Act), see section 2721(b)(1)(B) of the PHSA (requiring certificates by issuers offering health insurance covering in connection with a group health plan, including a church plan or a governmental plan (including the Federal Employees Health Benefits Program (FEHBP)). In addition, see section 2743 of the PHSA applicable to health insurance issuers in the individual market. (However, this section does not require a certificate to be provided with respect to short-term limited duration insurance, as described in the definition of *individual health insurance coverage* in § 2590.701–2, that is not provided by a group health plan or issuer offering health insurance in connection with a group health plan.)

(ii) *Other entities.* For special rules requiring that certain other entities, not subject to part 7 of subtitle B of title I of the Act, provide certificates consistent with the rules in this section, see section 2791(a)(3) of the PHSA applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of PHSA (relating to Medicare, Medicaid, CHAMPUS, and Indian Health Service), section 2721(b)(1)(A) of the PHSA applicable to nonfederal governmental plans generally, section 2721(b)(2)(C)(ii) of the PHSA applicable to nonfederal governmental plans that elect to be excluded from the requirements of subparts 1 and 3 of part A of Title XXVII of the PHSA, and section 9805(a) of the Internal Revenue Code applicable to group health plans, which includes church plans (as defined in section 414(e) of the Internal Revenue Code).

(b) *Disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage*—(1) *In general.* If an individual enrolls in a group health plan with respect to which the plan, or issuer, uses the alternative method of counting creditable coverage described in § 2590.701–4(c) the individual provides a certificate of coverage under paragraph (a) of this section, and the plan or issuer in which the individual enrolls so requests, the entity that issued the certificate (the prior entity) is required to disclose promptly to a requesting plan or issuer (the requesting entity) the information set forth in paragraph (b)(2) of this section.

(2) *Information to be disclosed.* Information to be disclosed. The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category. The prior entity is required to disclose promptly to the requesting entity the creditable coverage information so requested.

(3) *Charge for providing information.* The prior entity furnishing the information under paragraph (b) of this section may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information*—(1) *In general.* The rules in this paragraph (c) implement section 701(c)(4) of the Act, which permits individuals to establish creditable coverage through means other than certificates, and section 701(e)(3) of the Act, which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time period;

(ii) The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The coverage is for a period before July 1, 1996;

(iv) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(v) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(2) *Evidence of creditable coverage*—(i) *Consideration of evidence.* A plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion period. A plan or issuer shall treat the individual as having furnished a certificate under paragraph (a) of this section if the individual attests to the period of creditable coverage, the individual also presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the plan's or issuer's efforts to verify the individual's coverage. For this purpose, cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy,

records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting period or affiliation period information) may also be established through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(2) are illustrated by the following example:

Example. (i) Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. Employer *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, Employer *W*, and requests a certificate. However, *F* (and Employer *X*'s plan, on *F*'s behalf) is unable to obtain a certificate from Employer *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under Employer *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from Employer *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) In this *Example*, based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under Employer *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(3) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(4) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

(d) *Determination and notification of creditable coverage*—(1) *Resonable time period.* In the event that a group health plan or health insurance issuer offering group health insurance coverage receives information under paragraph (a) of this section (certifications), paragraph (b) of this section (disclosure of information relating to the alternative method), or paragraph (c) of this section (other evidence of creditable coverage), the entity is required, within a reasonable time period following receipt of the information, to make a determination regarding the individual's period of creditable coverage and notify the individual of the determination in accordance with paragraph (d)(2) of this section. Whether a determination and notification regarding an individual's creditable coverage is made within a reasonable time period is determined based on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical services.

(2) *Notification to individual of period of preexisting condition exclusion.* A plan or issuer seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan or issuer relied. In addition, the plan or issuer is required to provide the individual with a written explanation of any appeal procedures established by the plan or issuer, and with a reasonable opportunity to submit additional evidence of creditable coverage. However, nothing in this paragraph (d) or paragraph (c) of this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(i) A notice of such reconsideration, as described in this paragraph (d), is provided to the individual; and

(ii) Until the final determination is made, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

(3) *Examples.* The following examples illustrate this paragraph (d):

Example 1. (i) Individual *G* is hired by Employer *Y*. Employer *Y*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. Employer *Y*'s plan determines that *G* is subject to a 4-month preexisting condition exclusion, based on a certificate of creditable coverage that is provided by *G* to Employer *Y*'s plan indicating 8 months of coverage under *G*'s prior group health plan.

(ii) In this *Example 1,* Employer *Y*'s plan must notify *G* within a reasonable period of time following receipt of the certificate that *G* is subject to a 4-month preexisting condition exclusion beginning on *G*'s enrollment date in *Y*'s plan.

Example 2. (i) Same facts as in *Example 1,* except that Employer *Y*'s plan determines that *G* has 14 months of creditable coverage based on *G*'s certificate indicating 14 months of creditable coverage under *G*'s prior plan.

(ii) In this *Example 2,* Employer *Y*'s plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

Example 3. (i) Individual *H* is hired by Employer *Z*. Employer *Z*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. *H* develops an urgent health condition before receiving a certificate of prior coverage. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf.

(ii) In this *Example 3*, Employer *Z*'s plan must review the evidence presented by *H*. In addition, the plan must make a determination and notify *H* regarding any preexisting condition exclusion period that applies to *H* (and the basis of such determination) within a reasonable time period following receipt of the evidence that is consistent with the urgency of *H*'s health condition (this determination may be modified as permitted under paragraph (d)(2) of this section).

§ 2590.701–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In general.* A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, is required to permit employees and dependents described in paragraph (a) (2), (3), or (4) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(5) of this section are satisfied and the enrollment is requested within the period described in paragraph (a)(6) of this section. The enrollment is effective at the time described in paragraph (a)(7) of this section. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Special enrollment of an employee only.* An employee is described in this paragraph (a)(2) if the employee is eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee under the plan and was declined by the employee, the employee

was covered under another group health plan or had other health insurance coverage.

(3) *Special enrollment of dependents only.* A dependent is described in this paragraph (a)(3) if the dependent is a dependent of an employee participating in the plan, the dependent is eligible, but not enrolled, for coverage under the terms of the plan, and, when enrollment was previously offered under the plan and was declined, the dependent was covered under another group health plan or had other health insurance coverage.

(4) *Special enrollment of both employee and dependent.* An employee and any dependent of the employee are described in this paragraph (a)(4) if they are eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee or dependent under the plan and was declined, the employee or dependent was covered under another group health plan or had other health insurance coverage.

(5) *Conditions for special enrollment.* An employee or dependent is eligible to enroll during a special enrollment period if each of the following applicable conditions is met:

(i) When the employee declined enrollment for the employee or the dependent, the employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment. This paragraph (a)(5)(i) applies only if—

(A) The plan required such a statement when the employee declined enrollment; and

(B) The employee is provided with notice of the requirement to provide the statement in this paragraph (a)(5)(i) (and the consequences of the employee's failure to provide the statement) at the time the employee declined enrollment.

(ii)(A) When the employee declined enrollment for the employee or dependent under the plan, the employee or dependent had COBRA continuation coverage under another plan and COBRA continuation coverage under that other plan has since been exhausted; or

(B) If the other coverage that applied to the employee or dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage has been terminated. For this purpose, loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Thus, for example, if an employee's coverage ceases following a termination of employment and the employee is eligible for but fails to elect COBRA continuation coverage, this is treated as a loss of eligibility under this paragraph (a)(5)(ii)(B). However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). In addition, for purposes of this paragraph (a)(5)(ii)(B), employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

(6) *Length of special enrollment period.* The employee is required to request enrollment (for the employee or the employee's dependent, as described in paragraph (a) (2), (3), or (4) of this section) not later than 30 days after the exhaustion of the other coverage described in paragraph (a)(5)(ii)(A) of this section or termination of the other coverage as a result of the loss of eligibility for the other coverage for items described in paragraph (a)(5)(ii)(B) of this section or following the termination of employer contributions toward that other coverage. The plan may impose the same requirements that apply to employees who are otherwise eligible under the plan to immediately request enrollment for coverage (e.g., that the request be made in writing).

(7) *Effective date of enrollment.* Enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *In general.* A group health plan that makes coverage available with respect to dependents of a participant is required to provide a special enrollment period to permit individuals described in paragraph (b) (2), (3), (4), (5), or (6) of this section to be enrolled for coverage under the terms of the plan if the enrollment is requested within the time period described in paragraph (b)(7) of this section. The enrollment is effective at the time described in paragraph (b)(8) of this section. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Special enrollment of an employee who is eligible but not enrolled.* An individual is described in this paragraph (b)(2) if the individual is an employee who is eligible, but not enrolled, in the plan, the individual would be a participant but for a prior election by the individual not to enroll in the plan during a previous enrollment period, and a person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

(3) *Specil enrollment of a spouse of a participant.* An individual is described in this paragraph (b)(3) if either—

(i) The individual becomes the spouse of a participant; or

(ii) The individual is a spouse of the participant and a child becomes a dependent of the participant through birth, adoption or placement for adoption.

(4) *Special enrollment of an employee who is eligible but not enrolled and the spouse of such employee.* An employee who is eligible, but not enrolled, in the plan, and an individual who is a dependent of such employee, are described in this paragraph (b)(4) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and either—

(i) The employee and the individual become married; or

(ii) The employee and individual are married and a child becomes a dependent of the employee through birth, adoption or placement for adoption.

(5) *Special enrollment of a dependent of a participant.* An individual is described in this paragraph (b)(5) if the individual is a dependent of a participant and the individual becomes a dependent of such participant through marriage, birth, or adoption or placement for adoption.

(6) *Sepcial enrollment of an employee who is eligible but not enrolled and a new dependent.* An employee who is eligible, but not enrolled, in the plan, and an individual who is a dependent of the employee, are described in this paragraph (b)(6) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and the dependent becomes a dependent of the employee through marriage, birth, or adoption or placement for adoption.

(7) *Length of special enrollment period.* The special enrollment period under paragraph (b)(1) of this section is a period of not less than 30 days and begins on the date of the marriage, birth, or adoption or placement for adoption

(except that such period does not begin earlier than the date the plan makes dependent coverage generally available).

(8) *Effective date of enrollment.* Enrollment is effective—

(i) In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan;

(ii) In the case of a dependent's birth, the date of such birth; and

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(9) *Example.* The rules of this paragraph (b) are illustrated by the following example:

Example. (i) Employee *A* is hired on September 3, 1998 by Employer *X*, which has a group health plan in which *A* can elect to enroll either for employee-only coverage, for employee-plus-spouse coverage, or for family coverage, effective on the first day of any calendar quarter thereafter. *A* is married and has no children. *A* does not elect to join Employer *X*'s plan (for employee-only coverage, employee-plus-spouse coverage, or family coverage) on October 1, 1998 or January 1, 1999. On February 15, 1999, a child is placed for adoption with *A* and *A*'s spouse.

(ii) In this *Example,* the conditions for special enrollment of an employee with a new dependent under paragraph (b)(2) of this section are satisfied, the conditions for special enrollment of an employee and a spouse with a new dependent under paragraph (b)(4) of this section are satisfied, and the conditions for special enrollment of an employee and a new dependent under paragraph (b)(6) of this section are satisfied. Accordingly, Employer *X*'s plan will satisfy this paragraph (b) if and only if it allows *A* to elect, by filing the required forms by March 16, 1999, to enroll in Employer *X*'s plan either with employee-only coverage, with employee-plus-spouse coverage, or with family coverage, effective as of February 15, 1999.

(c) *Notice of enrollment rights.* On or before the time an employee is offered the opportunity to enroll in a group health plan, the plan is required to provide the employee with a description of the plan's special enrollment rules under this section. For this purpose, the plan may use the following model description of the special enrollment rules under this section:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(d)(1) *Special enrollment date definition.* A special enrollment date for an individual means any date in paragraph (a)(7) or (b)(8) of this section on which the individual has a right to have enrollment in a group health plan become effective under this section.

(2) *Examples.* The rules of this section are illustrated by the following examples:

Example 1. (i)(A) Employer *Y* maintains a group health plan that allows employees to enroll in the plan either—

(*1*) Effective on the first day of employment by an election filed within three days thereafter;

(*2*) Effective on any subsequent January 1 by an election made during the preceding months of November or December; or

(*3*) Effective as of any special enrollment date described in this section.

(B) Employee *B* is hired by Employer *Y* on March 15, 1998 and does not elect to enroll in Employer *Y*'s plan until January 31, 1999 when *B* loses coverage under another plan. *B* elects to enroll in Employer *Y*'s plan effective on February 1, 1999, by filing the completed request form by January 31, 1999, in accordance with the special rule set forth in paragraph (a) of this section.

(ii) In this *Example 1, B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) of this section.

Example 2. (i) Same facts as *Example 1,* except that *B*'s loss of coverage under the other plan occurs on December 31, 1998 and *B* elect to enroll in Employer *Y*'s plan effective on January 1, 1999 by filing the completed request form by December 31, 1998, in accordance with the special rule set forth in paragraph (a) of this section.

(ii) In this *Example 2, B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) of this section (even though this date is also a regular enrollment date under the plan).

§ 2590.701–7 HMO affiliation period as alternative to preexisting condition exclusion.

(a) *In general.* A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the requirements in paragraph (b) of this section is satisfied.

(b) *Requirements for affiliation period.* (1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is applied uniformly without regard to any health status-related factors.

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

(c) *Alternatives to affiliation period.* An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. Nothing in the part requires a State to receive proposals for or approve alternatives to affiliation periods.

§ 2590.702 Prohibiting discrimination against participants and beneficiaries based on a health status-related factor.

(a) *In eligibility to enroll*—(1) *In general.* Subject to paragraph (a)(2) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual.

(i) Health status.

(ii) Medical condition (including both physical and mental illnesses), as defined in § 2590.701–2.

(iii) Claims experience.

(iv) Receipt of health care.

(v) Medical history.

(vi) Genetic information, as defined in § 2590.701–2.

(vii) Evidence of insurability (including conditions arising out of acts of domestic violence).

(viii) Disability.

(2) *No application to benefits or exclusions.* To the extent consistent with section 701 of the Act and § 2590.701–3, paragraph (a)(1) of this section shall not be construed—

(i) To require a group health plan, or a health insurance issuer offering group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage; or

(ii) To prevent such a plan or issuer from establishing limitation or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) *Construction.* For purposes of paragraph (a)(1) of this section, rules for eligibility to enroll include rule defining any applicable waiting (or affiliation) periods for such enrollment and rules relating to late and special enrollment.

(4) *Example.* The following example illustrates the rules of this paragraph (a):

Example. (i) An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, individuals who do not enroll in the first 30 days cannot enroll later unless they pass a physical examination.

(ii) In this *Example,* the plan discriminates on the basis of one or more health status-related factors.

(b) *In premiums or contributions*—(1) *In general.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require an individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health status-related factor, in relation to the individual or a dependent of the individual.

(2) *Construction.* Nothing in paragraph (b)(1) of this section shall be construed—

(i) To restrict the amount that an employer may be charged by an issuer for coverage under a group health plan; or

(ii) To prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to a bona fide wellness program. For purposes of this section, a bona fide wellness program is a program of health promotion and disease prevention.

(3) *Example.* The rules of this paragraph (b) are illustrated by the following example:

Example. (i) Plan *X* offers a premium discount to participants who adhere to a cholesterol-reduction wellness program. Enrollees are expected to keep a diary of their food intake over 6 weeks. They periodically submit the diary to the plan physician who responds with suggested diet modifications. Enrollees are to modify their diets in accordance with the physician's recommendations. At the end of the 6 weeks, enrollees are given a cholesterol test and those who achieve a count under 200 receive a premium discount.

(ii) In this *Example,* because enrollees who otherwise comply with the program may be unable to achieve a cholesterol count under 200 due to a health status-related factor, this is not a bona fide wellness program and such discounts would discriminate impermissibly based on one or more health status-related factors. However, if, instead, individuals covered by the plan were entitled to receive the discount for complying with the diary and dietary requirements and were not required to pass a cholesterol test, the program would be a bona fide wellness program.

§ 2590.703 Guaranteed renewability in multiemployer plans and multiple employer welfare arrangements. [Reserved]

Subpart B—Other Requirements

§ 2590.711 Standard relating to benefits for mothers and newborns. [Reserved]

§ 2590.712 Parity in the application of certain limits to mental health benefits. [Reserved]

Subpart C—General Provisions

§ 2590.731 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part 7 of subtitle B of title I of the Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirements of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part 7 of subtitle B of title I of the Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules*—(1) *In general.* Subject to paragraph (c)(2) of this section, the provisions of part 7 of subtitle B of title I of the Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the ''6-month period'' described in section 701(a)(1) of the Act and § 2590.701–3(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the ''12 months'' and ''18 months'' described in section 701(a)(2) of the Act and § 2590.701–3(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the ''63 day period'' described in sections 701(c)(2)(A) and (d)(4)(A) of the Act and §§ 2590.701–3(a)(1)(iii) and 2590.701–4 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the ''30-day period'' described in sections 701 (b)(2) and (d)(1) of the Act and § 2590.701–3(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) of the Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 701(f) of the Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B) of the Act.

(d) *Definitions*—(1) *State law.* For purposes of this § 2590.736 the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a State law rather an a law of the United States.

(2) *State.* For purposes of this section the term *State* includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Island, or any agency or instrumentality of either.

§ 2590.732 Special rule relating to group health plans.

(a) *General exception for certain small group health plans.* The requirements of this part 7 of subtitle B of title I of the Act do not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

(b) *Excepted benefits*—(1) *In general.* The requirements of subparts A and C of this part do not apply to any group health plan (or any group health insurance coverage offered in connection with a group health plan) in relation to its provision of the benefits

described in paragraph (b)(92), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar insurance;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan, as defined in paragraph (b)(3)(ii) of this section.

(ii) *Integral.* For purposes of paragraph (b)(3)(i) of this section, benefits are deemed to be an integral part of a plan unless a participant has the right to elect not to receive coverage for the benefits and, if the participant elects to receive coverage for the benefits, the participant pays an additional premium or contribution for that coverage.

(iii) *Limited scope.* Limited scope dental or vision benefits are dental or vision benefits that are sold under a separate policy or rider and that are limited in scope to a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefit packages.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed dollar indemnity insurance (for example, $100/day) is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) *Conditions.* Benefits are described in paragraph (b)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(5) *Supplemental benefits.* The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(ii) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as CHAMPUS supplemental programs), and

(iii) Similar supplemental coverage provided to coverage under a group health plan.

(c) *Treatment of partnerships.* [Reserved]

§ 2590.734 Enforcement. [Reserved]

§ 2590.736 Effective dates.

(a) *General effective dates*—(1) *Non-collectively-bargained plans.* Except as otherwise provided in this section, part 7 of subtitle B of title I of the Act and subparts A and C of this part apply with respect to group health plans, including health insurance issuers offering health insurance coverage in connection with group health plans, for plan years beginning after June 30, 1997.

(2) *Collectively bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Part 7 of subtitle B of title I of the Act and subparts A and C of this part do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). For these purposes, any plan amendment made pursuant to a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such part, is not treated as a termination of the collective bargaining agreement.

(3)(i) *Preexisting condition exclusion periods for current employees.* Any preexisting condition exclusion period permitted under § 2590.701–3 is measured from the individual's enrollment date in the plan. Such exclusion period, as limited under § 2590.701–3, may be completed prior to the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject to part 7 of subtitle B of title I of the Act, no preexisting condition exclusion may be imposed with respect to an individual beyond the limitation of § 2590.701–3. For an individual who has not completed the permitted exclusion period under HIPAA, upon the effective date for his or her plan, the individual may use creditable coverage that the individual had prior to the enrollment date to reduce the remaining preexisting condition exclusion period applicable to the individual.

(ii) *Examples.* The following examples illustrate the rules of this paragraph (a)(3):

Example 1. (i) Individual *A* has been working for Employer *X* and has been covered under Employer *X*'s plan since March 1, 1997. Under Employer *X*'s plan, as in effect before January 1, 1998, there is no coverage for any preexisting condition. Employer *X*'s plan year begins on January 1, 1998. *A*'s enrollment date in the plan is March 1, 1997 and *A* has no creditable coverage before this date.

(ii) In this *Example 1,* Employer *X* may continue to impose the preexisting condition exclusion under the plan through February 28, 1998 (the end of the 12-month period using anniversary dates).

Example 2. (i) Same facts as in *Example 1,* except that *A*'s enrollment date was August 1, 1996, instead of March 1, 1997.

(ii) In this *Example 2,* on January 1, 1998, Employer *X*'s plan may no longer exclude treatment for any preexisting condition that *A* may have; however, because Employer *X*'s plan is not subject to HIPAA until January 1, 1998, *A* is not entitled to claim reimbursement for expenses under the plan for treatments for any preexisting condition of *A* received before January 1, 1998.

(b) *Effective date for certification requirement*—(1) *In general.* Subject to the transitional rule in § 2590.701–5(a)(5)(iii), the certification rules of

§ 2590.701–5 apply to events occurring on or after July 1, 1996.

(2) *Period covered by certificate.* A certificate is not required to reflect coverage before July 1, 1996.

(3) *No certificate before June 1, 1997.* Notwithstanding any other provision of subpart A or C of this part, in no case is a certificate required to be provided before June 1, 1997.

(c) *Limitation on actions.* No enforcement action is to be taken, pursuant to part 7 of subtitle B of title I of the Act, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by part 7 of subtitle B of title I of the Act before January 1, 1998, if the plan or issuer has sought to comply in good faith with such requirements. Compliance with this part is deemed to be good faith compliance with the requirements of part 7 of subtitle B of title I of the Act.

(d) *Transition rules for counting creditable coverage.* An individual who seeks to establish creditable coverage for periods before July 1, 1996 is entitled to establish such coverage through the presentation of documents or other means in accordance with the provisions of § 2590.701–5(c). For coverage relating to an event occurring before July 1, 1996, a group health plan and a health insurance issuer is not subject to any penalty or enforcement action with respect to the plan's or issuer's counting (or not counting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under § 2590.701–5(c).

(e) *Transition rules for certificates of creditable coverage*—(1) *Certificates only upon request.* For events occurring on or after July 1, 1996, but before October 1, 1996, a certificate is required to be provided only upon a written request by or on behalf of the individual to whom the certificate applies.

(2) *Certificates before June 1, 1997.* For events occurring on or after October 1, 1996 and before June 1, 1997, a certificate must be furnished no later than June 1, 1997, or any later date permitted under § 2590.701–5(a)(2) (ii) and (iii).

(3) *Optional notice*—(i) *In general.* This paragraph (e)(3) applies with respect to events described in § 2590.701–5(a)(5)(ii), that occur on or after October 1, 1996 but before June 1, 1997. A group health plan or health insurance issuer offering group health coverage is deemed to satisfy § 2590.701–5(a) (2) and (3) if a notice is provided in accordance with the provisions of paragraphs (e)(3) (i) through (iv) of this section.

(ii) *Time of notice.* The notice must be provided no later than June 1, 1997.

(iii) *Form and content of notice.* A notice provided pursuant to this paragraph (e)(3) must be in writing and must include information substantially similar to the information included in a model notice authorized by the Secretary. Copies of the model notice are available on the following website—http://www.dol.gov/dol/pwba/ (or call 1–800–998–7542).

(iv) *Providing certificate after request.* If an individual requests a certificate following receipt of the notice, the certificate must be provided at the time of the request as set forth in § 2590.701–5(a)(5)(iii).

(v) *Other certification rules apply.* The rules set forth in § 2590.701–5(a)(4)(i) (method of delivery) and § 2590.701–5(a)(1) (entities required to provide a certificate) apply with respect to the provision of the notice.

Signed at Washington, D.C., this 27 day of March, 1997.

Olena Berg,

Assistant Secretary, Pension and Welfare Benefits Administration, U.S. Department of Labor.

Department of Health and Human Services

45 CFR Subtitle A

45 CFR is amended as set forth below:

1. The heading for subtitle A is revised to read as follows:

SUBTITLE A—DEPARTMENT OF HEALTH AND HUMAN SERVICES

2. Existing parts 1 through 100 are designated as subchapter A of subtitle A and a new subchapter heading is added to read as follows:

SUBCHAPTER A—GENERAL ADMINISTRATION

3. New subchapter B, consisting of parts 140 through 199, is added to read as follows:

SUBCHAPTER B—REQUIREMENTS RELATING TO HEALTH CARE ACCESS

PARTS 140—143 [RESERVED]

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

Subpart A—General Provisions

Sec.

Subpart B—[Reserved]

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

Subpart A—General Provisions

§ 144.101 Basis and purpose.

Part 146 of this subchapter implements sections 2701 through 2723 of the Public Health Service Act (PHS Act, 42 U.S.C. 300gg, *et seq.*). Its purpose is to improve access to group health insurance coverage and to guarantee the renewability of all coverage in the group market. Part 148 of this subchapter implements sections 2741 through 2763 of the PHS Act. Its purpose is to improve access to individual health insurance coverage for certain eligible individuals who previously had group coverage, and to guarantee the renewability of all coverage in the individual market. Sections 2791 and 2792 of the PHS Act define terms used in the regulations in this subchapter and provide the basis for issuing these regulations, respectively.

§ 144.102 Scope and applicability.

(a) For purposes of 45 CFR parts 144 through 148, all health insurance coverage is generally divided into two markets—the group market (set forth in 45 CFR part 146) and the individual market (set forth in 45 CFR part 148). 45 CFR part 146 limits the group market to insurance sold to employment-related group health plans and further divides the group market into the large group market and the small group market. Federal law further defines the small group market as insurance sold to employer plans with 2 to 50 employees. State law, however, may expand the definition of the small group market to include certain coverage that would otherwise, under the Federal law, be considered coverage in the large group market or the individual market.

(b) The protections afforded under 45 CFR parts 144 through 148 to individuals and employers (and other sponsors of health insurance offered in connection with a group health plan) are determined by whether the coverage involved is obtained in the small group market, the large group market, or the individual market. Small employers, and individuals who are eligible to enroll under the employer's plan, are guaranteed availability of insurance coverage sold in the small group market. Small and large employers are guaranteed the right to renew their group coverage, subject to certain

exceptions. Eligible individuals are guaranteed availability of coverage sold in the individual market, and all coverage in the individual market must be guaranteed renewable.

(c) Coverage that is provided to associations, but is not related to employment, is not considered group coverage under 45 CFR parts 144 through 148. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under State law.

§ 144.103 Definitions applicable to both group (45 CFR part 146) and individual (45 CFR part 148) markets.

Unless otherwise provided, the following definitions apply:

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

Applicable State authority means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of 45 CFR parts 146 and 148 for the State involved with respect to the issuer.

Beneficiary has the meaning given the term under section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA), which states, ''a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit'' under the plan.

Bona fide association means, with respect to health insurance coverage offered in a State, an association that meets the following conditions:

(1) Has been actively in existence for at least 5 years.

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance.

(3) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee).

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(6) Meets any additional requirements that may be imposed under State law.

Church plan means a Church plan within the meaning of section 3(33) of ERISA.

COBRA definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601 through 608 of the Employee Retirement Income Security Act of 1974, section 4980B of the Internal Revenue Code of 1986 (other than paragraph (f)(1) of section 4980B insofar as it relates to pediatric vaccines), and Title XXII of the PHS Act.

(4) *Continuation coverage* means coverage under a COBRA continuation provision or a similar State program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar State program, but that does not satisfy all the requirements of that provision or program, will be deemed to be continuation coverage if it allows an individual to elect to continue coverage for a period of at least 18 months. Continuation coverage does not include coverage under a conversion policy required to be offered to an individual upon exhaustion of continuation coverage, nor does it include continuation coverage under the Federal Employees Health Benefits Program.

(5) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis; or

(ii) When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual.

(6) *Exhaustion of continuation coverage* means that an individual's continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted continuation coverage if—

(i) Coverage ceases due to the failure of the employer or other responsible entity to remit premiums on a timely basis, or

(ii) When the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other continuation coverage available to the individual.

Condition means a medical condition.

Creditable coverage has the meaning of 45 CFR 146.113(a).

Eligible individual, for purposes of—

(1) The group market provisions in 45 CFR part 146, subpart E, the term is defined in 45 CFR 146.150(b); and

(2) The individual market provisions in 45 CFR part 148, the term is defined in 45 CFR 148.103.

Employee has the meaning given the term under section 3(6) of ERISA, which states, ''any individual employed by an employer.''

Employer has the meaning given the term under section 3(5) of ERISA, which states, ''any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.''

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to enroll in the plan. For this purpose, an individual who has health insurance coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (*enrollment date* and *first day of coverage*) are set forth in 45 CFR 146.11(a)(2)(i) and (a)(2)(ii).

ERISA stands for the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

Excepted benefits for purposes of the—

(1) Group market provisions in 45 CFR part 146 subpart D, the term is defined in 45 CFR 146.145(b); and

(2) The individual market provisions in 45 CFR part 148, the term is defined in 45 CFR 148.220.

Federal government plan means a governmental plan established or maintained for its employees by the Government of the United States or by

any agency or instrumentality of such Government.

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Governmental plan means a governmental plan within the meaning of section 3(32) of ERISA.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan means an employee welfare benefit plan (as defined in section 3(1) of ERISA) to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the PHS Act and including items and services paid for as medical care) to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, unless otherwise provided under State law, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of ''individual market'' in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). This term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A Federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Health status-related factor means health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Indiviual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants as current employees on the first day of the plan year.

Internal Revenue Code (Code) means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

Issuer means a health insurance issuer.

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

Large group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer, unless otherwise provided under State law.

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in 45 CFR 146.111 (a)(2)(iii) and (a)(2)(iv).

Medical care or *condition* means amounts paid for any of the following:

(1) The diagnosis, cure, mitigation, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body.

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition.

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

Medical condition means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

NAIC stands for the National Association of Insurance Commissioners.

Network plan means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

Non-Federal governmental plan means a governmental plan that is not a Federal government plan.

Participant has the meaning given the term under section 3(7) of ERISA, which states, ''any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.''

PHS Act stands for the Public Health Service Act.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with the person terminates upon the termination of the legal obligation.

Plan sponsor has the meaning given the term under section 3(16)(B) of ERISA, which states ''(i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.''

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is:

(1) THe deductible/limit year used under the plan.

(2) If the plan does not impose deductibles or limits on a yearly basis, the plan year is the policy year.

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, the plan year is the employer's taxable year.

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any inclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan means ''public health plan'' within the meaning of 45 CFR 146.113(a)(1)(ix).

Short-term limited duration insurance means health insurance coverage provided under 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 within 12 months of the date the contract becomes effective.

Significant break in coverage has the meaning given the term in 45 CFR 146.113(b)(2)(iii).

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

Small group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

Special enrollment date has the meaning given the term in 45 CFR 146.117(d).

State means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State health benefits risk pool means a ''State health benefits risk pool'' within the meaning of 45 CFR 146.113(a)(1)(vii).

Waiting period means the period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

Subpart B—[Reserved]

PART 145—[RESERVED]

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

Subpart A—General Provisions

Sec.

Subpart B—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

Sec.

Subpart C—[Reserved]

Subpart D—Preemption and Special Rules

Sec.

Subpart E—Provisions Applicable to Only Health Insurance Issuers

Sec.

Subpart F—Exclusion of Plans and Enforcement

Sec.

Authority: Secs. 2701 through 2763, 2791, and 2792 of the PHS Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

Subpart A—General Provisions

§ 146.101 Basis and scope.

(a) *Statutory basis.* This part implements sections 2701 through 2723 of the PHS Act. Its purpose is to improve access to group health insurance coverage and to guarantee the renewability of all coverage in the group market. Sections 2791 and 2792 of the PHS Act define terms used in the regulations in this subchapter and provide the basis for issuing these regulations, respectively.

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this part.

(1) *Subpart B.* Subpart B of this part sets forth minimum requirements for group health plans and health insurance issuers offering group health insurance coverage concerning:

(i) Limitations on a preexisting condition exclusion period.

(ii) Certificates and disclosure of previous coverage.

(iii) Methods of counting creditable coverage.

(iv) Special enrollment periods.

(v) Use of an affiliation period by an HMO as an alternative to a preexisting condition exclusion.

(2) *Subpart D.* Subpart D of this part sets forth exceptions to the requirements of Subpart B for certain plans and certain types of benefits.

(3) *Subpart E.* Subpart E of this part implements sections 2711 through 2713 of the PHS Act, which set forth requirements that apply only to health insurance issuers offering health insurance coverage, in connection with a group health plan.

(4) *Subpart F.* Subpart F of this part addresses the treatment of non-Federal governmental plans, and sets forth enforcement procedures.

Subpart B—Requirements Relating to Access and Renewability of Coverage, and Limitations on Preexisting Condition Exclusion Periods

§ 146.111 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *General.* Subject to paragraph (b) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a) are satisfied.

(1) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the enrollment date.

(A) For purposes of this paragraph (a)(1)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(1)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The following examples illustrate the requirements of this paragraph (a)(1)(i).

Example 1: (i) Individual *A* is treated for a medical condition 7 months before the enrollment date in Employer *R*'s group health plan. As part of such treatment, *A*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *A* does not receive a follow-up examination and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *A* or received by *A* during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan.

(ii) In this *Example,* Employer *R*'s plan may not impose a preexisting condition exclusion period with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

Example 2: (i) Same facts as *Example 1* except that Employer *R*'s plan learns of the condition and attaches a rider to *A*'s policy excluding coverage for the condition. Three months after enrollment, *A*'s condition recurs, and Employer *R*'s plan denies payment under the rider.

(ii) In this *Example,* the rider is a preexisting condition exclusion and Employer *R*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *A* received treatment 7 months prior to the enrollment date.

Example 3: (i) Individual *B* has asthma and is treated for that condition several times during the 6-month period before *B*'s enrollment date in Employer *S*'s plan. The plan imposes a 12-month preexisting condition exclusion. *B* has no prior creditable coverage to reduce the exclusion period. Three months after the enrollment date, *B* begins coverage under Employer *S*'s plan. *B* is hospitalized for asthma.

(ii) In this *Example,* Employer *S*'s plan may exclude payment for the hospital stay and the physician services associated with this of illness because the care is related to a medical condition for which treatment was received by *B* during the 6-month period before the enrollment date.

Example 4: (i) Individual *D,* who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as a foot condition caused by poor circulation and retinal degeneration (both of which are conditions that may be directly attributed to diabetes). After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) In this *Example,* the leg fracture is not a condition related to *D*'s diabetes, even though poor circulation in *D*'s extremities and poor vision may have contributed towards the accident. However, any additional medical services that may be needed because of *D*'s preexisting diabetic condition that would not be needed by another patient with a broken leg who does not have diabetes may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion (the look-forward rule).* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For purposes of this paragraph (a)(1)(ii), the 12-month and 18-month periods after the enrollment date are determined by reference to the anniversary of the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage.* The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 146.113. For purposes of this part, the phrase ''days of creditable coverage'' has the same meaning as the phrase ''the aggregate of the periods of creditable coverage'' as such term is used in section 2701(a)(3) of the PHS Act.

(iv) *Other standards.* See § 146.121 for other standards that may apply with respect to certain benefit limitations or restrictions under a group health plan.

(2) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

(ii) (A) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan in the group market, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy.

(B) *Example.* The following example illustrates the requirements of paragraph (a)(2)(ii)(A) of this section:

Example: (i) Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and then on October 14, 1998 completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) In this *Example, E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E,* the 6-month period in paragraph (a)(1)(i) would be the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan could apply a preexisting condition exclusion under paragraph (a)(1)(ii) would be the period from October 13, 1998 through October 12, 1999, and this period would be reduced under paragraph (a)(1)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

(iii) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(iv) *Late enrollment* means enrollment under a group health plan other than on—

(A) The earliest date on which coverage can become effective under the terms of the plan; or

(B) A special enrollment date for the individual. If an individual ceases to be eligible for coverage under the plan by terminating employment, and subsequently becomes eligible for coverage under the plan by resuming employment, only eligibility during the individual's most recent period of employment is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(v) *Examples.* The following examples illustrate the requirements of this paragraph (a)(2):

Example 1: (i) Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999, but elects not to enroll in the plan until April 1, 1999. April 1, 1999 is not a special enrollment date for *F*.

(ii) In this *Example, F* would be a late enrollee with respect to *F*'s coverage that became effective under the plan on April 1, 1999.

Example 2: (i) Same as *Example 1,* except that *F* does not enroll in the plan on April 1, 1999 and terminates employment with Employer *W* on July 1, 1999, without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) In this *Example, F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—(i) *General rule.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion with regard to a child who, as of the last day of the 30-day period beginning with the date of birth, is covered under any creditable coverage. Accordingly, if a newborn is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage, the other plan may not impose any preexisting condition exclusion with regard to the child.

(ii) *Example.* The following example illustrates the requirements of this paragraph (b)(1).

Example: (i) Seven months after enrollment in Employer *W*'s group health plan, Individual *E* has a child born with a birth defect. Because the child is enrolled in Employer *W*'s plan within 30 days of birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Three months after the child's birth, *E* commences employment with Employer *X* and enrolls with the child in Employer *X*'s plan within 45 days of leaving Employer *W*'s plan. Employer *X*'s plan imposes a 12-month exclusion for any preexisting condition.

(ii) In this *Example*, Employer *X*'s plan may not impose any preexisting condition exclusion with respect to *E*'s child because the child was covered within 30 days of birth and had no significant break in coverage. This result applies regardless of whether *E*'s child is included in the certificate of creditable coverage provided to *E* by Employer *W* indicating 300 days of dependent coverage or receives a separate certificate indicating 90 days of coverage. Employer *X*'s plan may impose a preexisting condition exclusion with respect to *E* for up to 2 months for any preexisting condition of *E* for which medical advice, diagnosis, care, or treatment was recommended or received by *E* within the 6-month period ending on *E*'s enrollment date in Employer *X*'s plan.

(2) *Adopted Children.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining 18 years of age and who, as of the last day of the 30-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Break in coverage.* Paragraphs (b)(1) and (b)(2) of this section no longer apply to a child after a significant break in coverage.

(4) *Pregnancy.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to pregnancy as a preexisting condition.

(5) *Special enrollment dates.* For special enrollment dates relating to new dependents, see § 146.117(b).

(c) *Notice of plan's preexisting condition exclusion.* A group health plan, and health insurance issuer offering group health insurance under the plan, may not impose a preexisting condition exclusion with respect to a participant or dependent of the participant before notifying the participant, in writing, of the existence and terms of any preexisting condition exclusion under the plan and of the rights of individuals to demonstrate creditable coverage (and any applicable waiting periods) as required by § 146.115. The description of the rights of individuals to demonstrate creditable coverage includes a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

§ 146.113 Rules relating to creditable coverage.

(a) *General rules*)—(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2), the term creditable coverage means coverage of an individual under any of the following:

(i) A group health plan as defined in § 144.103.

(ii) Health insurance coverage as defined in § 144.103 (whether or not the entity offering the coverage is subject to the requirements of this part and 45 CFR part 148, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or part B of title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of title 10 U.S.C. chapter 55, ''uniformed services'' means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a State health benefits risk pool means—

(A) An organization qualifying under section 501(c)(26) of the Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health insurance coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO; or

(*2*) Are able to acquire such coverage only at a rate which is substantially in

excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under title 5 U.S.C. chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, county, or other political subdivision of a State that provides health insurance coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(2) *Excluded coverage.* Creditable coverage does not include coverage consisting solely of coverage of excepted benefits (described in § 146.145).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 146.111(a)(1)(iii), a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of an individual's creditable coverage by using the standard method described in paragraph (b), except that the plan, or issuer, may use the alternative method under paragraph (c) with respect to any or all of the categories of benefits described under paragraph (c)(3).

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period, a group health plan, and a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage by counting all the days that the individual has under one or more types of creditable coverage. Accordingly, if on a particular day, an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Further, any days in a waiting period for a plan or policy are not creditable coverage under the plan or policy.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Definition of significant break in coverage.* A significant break in coverage means a period of 63 consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. (See section 731(b)(2)(iii) of ERISA and section 2723(b)(2)(iii) of the PHS Act, which exclude from preemption State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State law.)

(iv) *Examples.* The following examples illustrate how creditable coverage is counted in reducing preexisting condition exclusion periods:

Example 1: (i) Individual *A* work for Employer *P* and has creditable coverage under Employer *P*'s plan for 18 months before *A*'s employment terminates. *A* is hired by Employer *O*, and enrolls in Employer *O*'s group health plan, 64 days after the last date of coverage under Employer *P*'s plan. Employer *O*'s plan has a 12-month preexisting condition exclusion period.

(ii) In this *Example*, because *A* had a break in coverage of 63 days, Employer *O*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion period.

Example 2: (i) Same facts as *Example 1*, except that *A* is hired by Employer *O*, and enrolls in Employer *O*'s plan, on the 63rd day after the last date of coverage under Employer *P*'s plan.

(ii) In this *Example*, *A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, Employer *O*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period as it applies to *A*.

Example 3: (i) Same facts as *Example 1*, except that Employer *O*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) In this *Example*, the issuer that provides group health insurance to Employer *O's* plan must count *A's* period of creditable coverage prior to the 63-day break.

Example 4: (i) Same facts as *Example 3*, except that Employer *O*'s plan is a self-insured plan, and thus is not subject to State insurance laws.

(ii) In this *Example*, the plan is not governed by the longer break rules under State insurance law and *A*'s previous coverage may be disregarded.

Example 5: (i) Individual *B* begins employment with Employer *R* 45 days after terminating coverage under a prior group health plan. Employer *R*'s group health plan has a 30-day waiting period before coverage begins. *B* enrolls in Employer *R*'s plan when first eligible.

(ii) In this *Example*, *B* does not have a significant break in coverage for purposes of determining whether *B*'s prior coverage must be counted by Employer *R*'s plan. *B* has only a 44-day break in coverage because the 30-day waiting period is not taken into account in determining a significant break in coverage.

Example 6: (i) Individual *C* works for Employer *S* and has creditable coverage under Employer *S*'s plan for 200 days before *C*'s employment is terminated and coverage ceases. *C* is then unemployed for 51 days before being hired by Employer *T*. Employer *T*'s plan has a 3-month waiting period. *C* works for Employer *T* for 2 months and then terminates employment. Eleven days after terminating employment with Employer *T, C* begins working for Employer *U*. Employer *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion period.

(ii) In this *Example*, *C* does not have a significant break in coverage because, after disregarding the waiting period under Employer *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). Accordingly, *C* has 200 days of creditable coverage and Employer *U*'s plan may not apply its 6-month preexisting condition exclusion period with respect to *C*.

Example 7: (i) Individual *D* terminates employment with Employer *V* on January 13, 1998 after being covered for 24 months under Employer *V*'s group health plan. On March 17, the 63rd day without coverage, *D* applies for a health insurance policy in the individual market. *D*'s application is accepted and the coverage is made effective May 1.

(ii) In this *Example,* because *D* applied for the policy before the end of the 63rd day, and coverage under the policy ultimately became effective, the period between the date of application and the first day of coverage is a waiting period, and no significant break in coverage occurred even though the actual period without coverage was 107 days.

Example 8: (i) Same facts as *Example 7,* except that *D*'s application for a policy in the individual market is denied.

(ii) In this *Example*, because *D* did not obtain coverage following application, *D* incurred a significant break in coverage on the 64th day.

(v) *Other permissible counting methods*—(A) *General rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 146.115), a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The following example illustrates the requirements of this paragraph (b)(2)(v):

Example: (1) Individual F has coverage under group health plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by group health plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion period.

(ii) In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in

paragraph (b)(2) (i), (ii), and (iii), that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion period will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion period will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered.* Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b).

(2) *Uniform application.* A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or policy. The use of the alternative method is set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for any of the following categories of benefits:

(i) Mental health.

(ii) Substance abuse treatment.

(iii) Prescription drugs.

(iv) Dental care.

(v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Issuer notice.* With respect to health insurance coverage offered by an issuer in the small or large group market, if the insurance coverage uses the alternative method, the issuer states prominently in any disclosure statement concerning the coverage, and to each employer at the time of the offer or sale of the coverage, that the issuer is using the alternative method, and include in such statements a description of the effect of using the alternative method. This applies separately to each type of coverage offered by the health insurance issuer.

(6) *Disclosure of information on previous benefits.* See § 146.115(b) for special rules concerning disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage under this paragraph (c).

(7) *Counting creditable coverage*—(i) *General.* Under the alternative method, the group health plan or issuer counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement, (as defined in section 106(c)(2) of the Internal Revenue Code), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, first determines the amount of the individual's creditable coverage that may be counted under paragraph (b), up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the ''determination period.'' Then, for the category specified under the alternative method, the plan or issuer counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The following example illustrates the requirements of this paragraph (c)(7):

Example: (i) Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2001 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) In this *Example,* Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had the equivalent of 90-days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

§ 146.115 Certification and disclosure of previous coverage.

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *General.* A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to certificates of creditable coverage in accordance with this paragraph (a).

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a)(1) for an individual is deemed to have satisfied the certification requirements for that individual if another party provides the certificate, but only to the extent that information relating to the individual's creditable coverage and waiting or affiliation period is provided by the other party. For example, in the case of a group health plan funded through an insurance policy, the issuer is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if the plan actually provides a certificate that includes the information required under paragraph (a)(3) with respect to the participant or beneficiary.

(iii) *Special rule for group health plan.* To the extent coverage under a plan consists of group health insurance coverage, the plan is deemed to have satisfied the certification requirements under this paragraph (a)(1) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and the plan sponsor under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the issuer, but not the plan, violates the certification requirements of this paragraph (a).

(iv) *Special rules for issuers*—(A) *Responsibility of issuer for coverage period*—(*1*) *General rule.* An issuer is

not required to provide information regarding coverage provided to an individual by another party.

(2) *Example.* The following example illustrates the requirements of this paragraph (a)(1)(iv)(A):

Example. (i) A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) In this *Example,* if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B) *Cessation of issuer coverage prior to cessation of coverage under a plan—*(*1*) *General rule.* If an individual's coverage under an issuer's policy ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan (or to another party designated by the plan) to enable a certificate to be provided by the plan (or other party), after cessation of the individual's coverage under the plan, that reflects the period of coverage under the policy. The provision of that information to the plan will satisfy the issuer's obligation to provide an automatic certificate for that period of creditable coverage for the individual under paragraphs (a)(2)(ii) and (a)(3) of this section. In addition, an issuer providing that information is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). If the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy ceases, the issuer must provide an automatic certificate under paragraph (a)(2)(ii) of this section. An issuer may presume that an individual whose coverage ceases at a time other than the effective date for changing enrollment options has ceased to be covered under the plan.

(*2*) *Example.* The following example illustrates the requirements of this paragraph (a)(1)(iv)(B):

Example: (i) A group health plan provides coverage under an HMO option and an indemnity option with a different issuer, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide automatic certificates as permitted under paragraph (a)(2)(ii) of this section.

(ii) In this *Example*, if an employee switches from the indemnity option to the HMO option on January 1, the issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom a certificate must be provided; timing of issuance—*(i) *Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) and (a)(2)(iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) of this section are referred to as ''automatic certificates.''

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 607(3) of ERISA, section 4980B(g)(1) of the Code, or section 2208 of the PHS Act) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan or issuer satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 606 of the Act, section 4980B(f)(6) of the Code and section 2206 of the PHS Act (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual ceases to be covered under the plan. A plan or issuer satisfies this requirement if it provides the automatic certificate within a reasonable time period thereafter. In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time period after the cessation of coverage under the plan.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual's coverage under the plan ceases. A plan, or issuer, satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* Requests for certificates are permitted to be made by, or on behalf of, an individual within 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan or issuer, acting in a reasonable or prompt fashion can provide the certificate. A certificate is to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The following examples illustrate the requirements of this paragraph (a)(2).

Example 1: (i) Individual *A* terminates employment with Employer *O*. *A* is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer *O*'s group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) In this *Example*, the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2: (i) Same facts as *Example 1*, except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A*.

(ii) In this *Example*, the automatic certificate may be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3: (i) Employer *R* maintains an insured group health plan. *R* has never had 20 employees and thus *R*'s plan is not subject to the COBRA continuation coverage provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R*'s plan.

(ii) In this *Example*, the automatic certificate may be provided not later than the time a notice is required to be furnished under the State program.

Example 4: (i) Individual *C* terminates employment with Employer *S* and receives both a notice of *C*'s rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S*'s group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, *S*'s group health plan determines that *C*'s COBRA continuation coverage has ceased due to failure to make a timely payment for continuation coverage.

(ii) In this *Example,* the plan must provide an updated automatic certificate to *C* within a reasonable time after the end of the grace period.

Example 5: (i) Individual *D* is currently covered under the group health plan of Employer *T*. *D* requests a certificate, as permitted under paragraph (a)(2)(iii). Under the procedure for Employer *T*'s plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) In this *Example*, the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate*—(i) *Written certificate*—(A) *General.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (including any form approved by HCFA as a writing).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraphs (a)(2)(ii) and (a)(2)(iii) of this section if all the following conditions are met:

(*1*) An individual is entitled to receive a certificate.

(*2*) The individual requests that the certificate be sent to another plan or issuer instead of to the individual.

(*3*) The plan or issuer that would otherwise receive the certificate agrees to accept the information in paragraph (a)(3) through means other than a written certificate (for example, by telephone).

(*4*) The receiving plan or issuer receives the information from the sending plan or issuer in such form within the time periods required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include all of the following:

(A) The date the certificate is issued.

(B) The name of the group health plan that provided the coverage described in the certificate.

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent.

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate.

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D)).

(F) Either—

(*1*) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(*2*) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began.

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate.

(iii) *Periods of coverage under certificate.* If an automatic certificate is provided under paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate under paragraph (a)(2)(iii) of this section, a certificate must be provided for each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual or, if the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan or issuer provides a certificate in accordance with a model certificate authorized by HCFA.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 146.145. In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 146.113(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a procedure for individuals to request and receive certificates under paragraph (a)(2)(iii) of this section.

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated party. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated party.

(5) *Special rules concerning dependent coverage*—(i) *Reasonable efforts*—(A) *General rule.* A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to the dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan or issuer knows (or making reasonable efforts should know) of the

dependent's cessation of coverage under the plan.

(B) *Example.* The following example illustrates the requirements of this paragraph (a)(5)(i):

Example: (i) A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) In this *Example*, the plan has satisfied the standard in this paragraph (a)(5)(i) that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c)(4) of this section for demonstrating dependent status. In addition, an individual may, if necessary, use these procedures to demonstrate that a child was enrolled within 30 days of birth, adoption, or placement for adoption. See § 146.111(b), under which such a child would not be subject to a preexisting condition exclusion.

(iii) *Transition rule for dependent coverage through June 30, 1998*—(A) *General.* A group health plan or health insurance issuer that cannot provide the names of dependents (or related coverage information) for purposes of providing a certificate of coverage for a dependent may satisfy the requirements of paragraph (a)(3)(ii)(C) of this section by providing the name of the participant covered by the group health plan or health insurance issuer and specifying that the type of coverage described in the certificate is for dependent coverage (for example, family coverage or employee-plus-spouse coverage).

(B) *Certificates provided on request.* For purposes of certificates provided on the request of, or on behalf of, an individual under paragraph (a)(2)(iii) of this section, a plan or issuer must make reasonable efforts to obtain and provide the names of any dependent covered by the certificate where such information is requested to be provided. It does not include the name of any dependent of an individual covered by the certificate, the individual may, if necessary, use the procedures described in paragraph (c) of this section for submitting documentation to establish that the creditable coverage in the certificate applies to the dependent.

(C) *Demonstrating a dependent's creditable coverage.* See paragraph (c)(4) of this section for special rules to demonstrate dependent status.

(D) *Duration.* This paragraph (a)(5)(iii) is only effective for certifications provided with respect to events occurring through June 30, 1998.

(6) *Special certification rules*—(i) *Issuers.* Issuers of group and individual health insurance are required to provide certificates of any creditable coverage they provide in the group or individual health insurance market, even if the coverage is provided in connection with an entity or program that is not itself required to provide a certificate because it is not subject to the group market provisions of this part, part 7 of subtitle B of title I of ERISA, or chapter 100 of subtitle K of the Internal Revenue Code. This would include coverage provided in connection with any of the following:

(A) Creditable coverage described in sections 2701 (c)(1)(G) through (c)(1)(J) of the PHS Act (coverage under a State health benefits risk pool, the Federal Employees Health Benefits Program, a public health plan, and a health benefit plan under section 5(e) of the Peace Corps Act),

(B) Coverage subject to section 2721(b)(1)(B) of the PHS Act (requiring certificates by issuers offering health insurance coverage in connection with any group health plan, including a church plan or a governmental plan (including the Federal Employees Health Benefits Program (FEHBP)).

(C) Coverage subject to section 2743 of the PHS Act applicable to health insurance issuers in the individual market. (However, this section does not require a certificate to be provided with respect to short-term limited duration insurance, which is excluded from the definition of ''individual health insurance coverage'' in 45 CFR 144.103 that is not provided in connection with a group health plan, as described in paragraph (a)(6)(i)(B) of this section.)

(ii) *Other entities.* For special rules requiring that certain other entities, not subject to this part, provide certificates consistent with the rules in this section, see section 2791(a)(3) of the PHS Act applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of the PHS Act (relating to Medicare, Medicaid, CHAMPUS, and Indian Health Service), section 2721(b)(1)(A) of the PHS Act applicable to non-Federal governmental plans generally, section 2721(b)(2)(C)(ii) of the PHS Act applicable to non-Federal governmental plans that elect to be excluded from the requirements of subparts 1 and 3 of part A of title XXVII of the PHS Act, and section 9805(a) of the Internal Revenue Code applicable to group health plans, which includes church plans (as defined in section 414(e) of the Internal Revenue Code).

(b) *Disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage*—(1) *General.* If an individual enrolls in a group health plan with respect to which the plan, or issuer, uses the alternative method of counting creditable coverage described in section 2701(c)(3)(B) of the PHS Act and § 146.113(c), the individual provides a certificate of coverage under paragraph (a) of this section, and the plan or issuer in which the individual enrolls so requests, the entity that issued the certificate (the ''prior entity'') is required to disclose promptly to a requesting plan or issuer (the ''requesting entity'') the information set forth in paragraph (b)(2) of this section.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category. The prior entity is required to disclose promptly to the requesting entity the creditable coverage information so requested.

(3) *Charge for providing information.* The prior entity furnishing the information under paragraph (b) of this section may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information*—(1) *General.* The rules in this paragraph (c) implement section 2701(c)(4) of the PHS Act, which permits individuals to establish creditable coverage through means other than certificates, and section 2701(e)(3) of the PHS Act, which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual. If the accuracy of a certificate is contested or a certificate is unavailable when needed by the individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time period;

(ii) The individual has creditable coverage but an entity may not be required to provide a certificate of the coverage under paragraph (a) of this section;

(iii) The coverage is for a period before July 1, 1996;

(iv) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(v) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(2) *Evidence of creditable coverage*—(i) *Consideration of evidence.* A plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage and is entitled to offset all or a portion of any preexisting condition exclusion period. A plan or issuer shall treat the individual as having furnished a certificate under paragraph (a) of this section if the individual attests to the period of creditable coverage, the individual also presents relevant corroborating evidence of some creditable coverage during the period, and the individual cooperates with the plan's or issuer's efforts to verify the individual's coverage. For this purpose, cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that may establish creditable coverage (and waiting periods or affiliation periods) in the absence of a certificate include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting period or affiliation period information) may also be established through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The following example illustrates the requirements of this paragraph (c)(2):

Example: (i) Employer *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, Employer *W,* and requests a certificate. However, *F* (and Employer *X*'s plan, on *F*'s behalf) is unable to obtain a certificate from Employer *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under Employer *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from Employer *W.* In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) In this *Example,* based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under Employer *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(3) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(4) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

(d) *Determination and notification of creditable coverage*—(1) *Reasonable time period.* In the event that a group health plan or health insurance issuer offering group health insurance coverage receives information in this section under paragraph (a) (certifications), paragraph (b) (disclosure of information relating to the alternative method), or paragraph (c) (other evidence of creditable coverage), the entity is required, within a reasonable time period following receipt of the information, to make a determination regarding the individual's period of creditable coverage and notify the individual of the determination in accordance with paragraph (d)(2) of this section. Whether a determination and notification regarding an individual's creditable coverage is made within a reasonable time period is determined based on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical services.

(2) *Notification to individual of period of preexisting condition exclusion.* A plan or issuer seeking to impose a preexisting condition exclusion is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan or issuer relied. In addition, the plan or issuer is required to provide the individual with a written explanation of any appeal procedures established by the plan or issuer, and with a reasonable opportunity to submit additional evidence of creditable coverage. However, nothing in this paragraph (d) or paragraph (c) of this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(i) A notice of the reconsideration is provided to the individual; and

(ii) Until the final determination is made, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

(3) *Examples.* The following examples illustrate this paragraph (d):

Example: (i) Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X. Example 1:* Individual *G* is hired by Employer *Y.* Employer *Y*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining credible coverage. Employer *Y*'s plan determines that *G* is subject to a 4-month preexisting condition exclusion, based on a certificate of creditable coverage that is provided by *G* to Employer *Y*'s plan indicating 8 months of coverage under *G*'s prior group health plan.

(ii) In this *Example,* Employer *Y*'s plan must notify *G* within a reasonable period of time following receipt of the certificate that *G* is subject to a 4-month preexisting condition exclusion beginning on *G*'s enrollment date in *Y*'s plan.

Example 2: (i) Same facts as in *Example 1,* except that Employer *Y*'s plan determines that *G* has 14 months of creditable coverage based on *G*'s certificate indicating 14 months of creditable coverage under *G*'s prior plan.

(ii) In this *Example,* Employer *Y*'s plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

Example 3: (i) Individual *H* is hired by Employer *Z*. Employer *Z*'s group health plan imposes a preexisting condition exclusion for 12 months with respect to new enrollees and uses the standard method of determining creditable coverage. *H* develops an urgent health condition before receiving a certificate of prior coverage. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf.

(ii) In this *Example,* Employer *Z*'s plan must review the evidence presented by *H*. In addition, the plan must make a determination and notify *H* regarding any preexisting condition exclusion period that applies to *H* (and the basis of such determination) within a reasonable time period following receipt of the evidence that is consistent with the urgency of *H*'s health condition (this determination may be modified as permitted under paragraph (d)(2)).

§ 146.117 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *General.* A group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, is required to permit employees and dependents described in this section in paragraph (a)(2), (a)(3), or (a)(4) to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(5) are satisfied and the enrollment is requested within the period described in paragraph (a)(6). The enrollment is effective at the time described in paragraph (a)(7). The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Special enrollment of an employee only.* An employee is described in this paragraph (a)(2) if the employee is eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee under the plan and was declined by the employee, the employee was covered under another group health plan or had other health insurance coverage.

(3) *Special enrollment of dependents only.* A dependent is described in this paragraph (a)(3) if the dependent is a dependent of an employee participating in the plan, the dependent is eligible, but not enrolled, for coverage under the terms of the plan, and, when enrollment was previously offered under the plan and was declined, the dependent was covered under another group health plan or had other health insurance coverage.

(4) *Special enrollment of both employee and dependent.* An employee and any dependent of the employee are described in this paragraph (a)(4) if they are eligible, but not enrolled, for coverage under the terms of the plan and, when enrollment was previously offered to the employee or dependent under the plan and was declined, the employee or dependent was covered under another group health plan or had other health insurance coverage.

(5) *Conditions for special enrollment.* An employee or dependent is eligible to enroll during a special enrollment period if each of the following applicable conditions is met:

(i) When the employee declined enrollment for the employee or the dependent, the employee stated in writing that coverage under another group health plan or other health insurance coverage was the reason for declining enrollment. This paragraph (a)(5)(i) applies only if—

(A) The plan required such a statement when the employee declined enrollment; and

(B) The employee is provided with notice of the requirement to provide the statement in paragraph (a)(5)(i) (and the consequences of the employee's failure to provide the statement) at the time the employee declined enrollment.

(ii) (A) When the employee declined enrollment for the employee or dependent under the plan, the employee or dependent had COBRA continuation coverage under another plan and COBRA continuation coverage under that other plan has since been exhausted; or

(B) If the other coverage that applied to the employee or dependent when enrollment was declined was not under a COBRA continuation provision, either the other coverage has been terminated as a result of loss of eligibility for the coverage or employer contributions towards the other coverage have been terminated. For this purpose, loss of eligibility for coverage includes a loss of coverage as a result of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing. Thus, for example, if an employee's coverage ceases following a termination of employment and the employee is eligible for but fails to elect COBRA continuation coverage, this is treated as a loss of eligibility under this paragraph (a)(5)(ii)(B). However, loss of eligibility does not include a loss due to failure of the individual or the participant to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). In addition, for purposes of this paragraph (a)(5)(ii)(B), employer contributions include contributions by any current or former employer (of the individual or another person) that was contributing to coverage for the individual.

(6) *Length of special enrollment period.* The employee is required to request enrollment (for the employee or the employee's dependent, as described in this section in paragraph (a)(2), paragraph (a)(3), or paragraph (a)(4)) not later than 30 days after the exhaustion of the other coverage described in paragraph (a)(5)(ii)(A) or termination of the other coverage as a result of the loss of eligibility for the other coverage for items described in paragraph (a)(5)(ii)(B) or following the termination of employer contributions toward that other coverage. The plan may impose the same requirements that apply to employees who are otherwise eligible under the plan to immediately request enrollment for coverage (for example, that the request be made in writing).

(7) *Effective date of enrollment.* Enrollment is effective not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *General.* A group health plan that makes coverage available with respect to dependents of a participant is required to provide a special enrollment period to permit individuals described in this section in paragraph (b)(2), (b)(3), (b)(4), (b)(5), or (b)(6) to be enrolled for coverage under the terms of the plan if the enrollment is requested within the time period described in paragraph (b)(7). The enrollment is effective at the time described in paragraph (b)(8). The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Special enrollment of an employee who is eligible but not enrolled.* An individual is described in this paragraph (b)(2) if the individual is an employee who is eligible, but not

enrolled, in the plan, the individual would be a participant but for a prior election by the individual not to enroll in the plan during a previous enrollment period, and a person becomes a dependent of the individual through marriage, birth, or adoption or placement for adoption.

(3) *Special enrollment of a spouse of a participant.* An individual is described in this paragraph (b)(3) if either—

(i) The individual becomes the spouse of a participant; or

(ii) The individual is a spouse of the participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(4) *Special enrollment of an employee who is eligible but not enrolled and the spouse of such employee.* An employee who is eligible, but not enrolled, in the plan, and an individual who is a dependent of such employee, are described in this paragraph (b)(4) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and either—

(i) The employee and the individual become married; or

(ii) The employee and individual are married and a child becomes a dependent of the employee through birth, adoption or placement for adoption.

(5) *Special enrollment of a dependent of a participant.* An individual is described in this paragraph (b)(5) if the individual is a dependent of a participant and the individual becomes a dependent of such participant through marriage, birth, or adoption or placement for adoption.

(6) *Special enrollment of an employee who is eligible but not enrolled and a new dependent.* An employee who is eligible, but not enrolled, in the plan, and an individual who is a dependent of the employee, are described in this paragraph (b)(6) if the employee would be a participant but for a prior election by the employee not to enroll in the plan during a previous enrollment period, and the dependent becomes a dependent of the employee through marriage, birth, or adoption or placement for adoption.

(7) *Length of special enrollment period.* The special enrollment period under paragraph (b)(1) of this section is a period of not less than 30 days and begins on the date of the marriage, birth, or adoption or placement for adoption (except that such period does not begin earlier than the date the plan makes dependent coverage generally available).

(8) *Effective date of enrollment.* Enrollment is effective—

(i) In the case of marriage, not later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan;

(ii) In the case of a dependent's birth, the date of such birth; and

(iii) In the case of a dependent's adoption or placement for adoption, the date of such adoption or placement for adoption.

(9) *Example.* The following example illustrates the requirements of this paragraph (b):

Example. (i) Employee *A* is hired on September 3, 1998 by Employer *X*, which has a group health plan in which *A* can elect to enroll either for employee-only coverage, for employee-plus-spouse coverage, or for family coverage, effective on the first day of any calendar quarter thereafter. *A* is married and has no children. *A* does not elect to join Employer *X*'s plan (for employee-only coverage, employee-plus-spouse coverage, or family coverage) on October 1, 1998 or January 1, 1999. On February 15, 1999, a child is placed for adoption with *A* and *A*'s spouse.

(ii) In this *Example*, the conditions for special enrollment of an employee with a new dependent under paragraph (b)(2) are satisfied, the conditions for special enrollment of an employee and a spouse with a new dependent under paragraph (b)(4) are satisfied, and the conditions for special enrollment of an employee and a new dependent under paragraph (b)(6) are satisfied. Accordingly, Employer *X*'s plan will satisfy this paragraph (b) if and only if it allows *A* to elect, by filing the required forms by March 16, 1999, to enroll in Employer *X*'s plan either with employee-only coverage, with employee-plus-spouse coverage, or with family coverage, effective as of February 15, 1999.

(c) *Notice of enrollment rights.* On or before the time an employee is offered the opportunity to enroll in a group health plan, the plan is required to provide the employee with a description of the plan's special enrollment rules under this section. For this purpose, the plan may use the following model description of the special enrollment rules under this section:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(d) *Special enrollment date definition.* (1) *General rule.* A special enrollment date for an individual means any date in paragraph (a)(7) or paragraph (b)(8) of this section on which the individual has a right to have enrollment in a group health plan become effective under this section.

(2) *Examples.* The following examples illustrate the requirements of this paragraph (d):

Example 1: (i) Employer *Y* maintains a group health plan that allows employees to enroll in the plan either (a) effective on the first day of employment by an election filed within three days thereafter, (b) effective on any subsequent January 1 by an election made during the preceding months of November or December, or (c) effective as of any special enrollment date described in this section. Employee *B* is hired by Employer *Y* on March 15, 1998 and does not elect to enroll in Employer *Y*'s plan until January 31, 1999 when *B* loses coverage under another plan. *B* elects to enroll in Employer *Y*'s plan effective on February 1, 1999 by filing the completed request form by January 31, 1999, in accordance with the special rule set forth in paragraph (a).

(ii) In this *Example*, *B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7).

Example 2: (i) Same facts as *Example 1,* except that *B*'s loss of coverage under the other plan occurs on December 31, 1998 and *B* elects to enroll in Employer *Y*'s plan effective on January 1, 1999 by filing the completed request form by December 31, 1998, in accordance with the special rule set forth in paragraph (a).

(ii) In this *Example, B* has enrolled on a special enrollment date because the enrollment is effective at a date described in paragraph (a)(7) (even though this date is also a regular enrollment date under the plan).

§ 146.119 HMO affiliation period as alternative to preexisting condition exclusion.

(a) *General.* A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the requirements in paragraph (b) of this section is satisfied.

(b) *Requirements for affiliation period.* (1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is applied uniformly without regard to any health status-related factors.

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

(c) *Alternatives to affiliation period.* An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. Nothing in this section requires a State to receive proposals for or approve alternatives to affiliation periods.

§ 146.121 Prohibiting discrimination against participants and beneficiaries based on a health status-related factor.

(a) *In eligibility to enroll*—(1) *General.* Subject to paragraph (a)(2) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage in connection with a group health plan, may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on any of the following health status-related factors in relation to the individual or a dependent of the individual:

(i) Health status.

(ii) Medical condition (including both physical and mental illnesses), as defined in § 146.102.

(iii) Claims experience.

(iv) Receipt of health care.

(v) Medical history.

(vi) Genetic information, as defined in § 146.102.

(vii) Evidence of insurability (including conditions arising out of acts of domestic violence).

(viii) Disability.

(2) *No application to benefits or exclusions.* To the extent consistent with section 2701 of the Act and § 146.111, paragraph (a)(1) of this section shall not be construed—

(i) To require a group health plan, or a health insurance issuer offering group health insurance coverage, to provide particular benefits other than those provided under the terms of such plan or coverage; or

(ii) To prevent such a plan or issuer from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

(3) *Construction.* For purposes of paragraph (a)(1) of this section, rules for eligibility to enroll include rules defining any applicable waiting (or affiliation) periods for such enrollment and rules relating to late and special enrollment.

4. *Example.* The following example illustrates the requirements of this paragraph (a):

Example. (i) An employer sponsors a group health plan that is available to all employees who enroll within the first 30 days of their employment. However, individuals who do not enroll in the first 30 days cannot enroll later unless they pass a physical examination.

(ii) In this *Example,* the plan discriminates on the basis of one or more health status-related factors.

(b) *In premiums or contributions*—(1) *General.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, may not require an individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan based on any health status-related factor, in relation to the individual or a dependent of the individual.

(2) *Construction.* Nothing in paragraph (b)(1) of this section can be construed—

(i) To restrict the amount that an employer may be charged by an issuer for coverage under a group health plan; or

(ii) To prevent a group health plan, and a health insurance issuer offering group health insurance coverage, from establishing premium discounts or rebates or modifying otherwise applicable copayments or deductibles in return for adherence to a bona fide wellness program. For purposes of this section, a bona fide wellness program is a program of health promotion and disease prevention.

(3) *Example.* The following example illustrates the requirements of this paragraph (b):

Example. (i) Plan *X* offers a premium discount to participants who adhere to a cholesterol-reduction wellness program. Enrollees are expected to keep a diary of their food intake over 6 weeks. They periodically submit the diary to the plan physician who responds with suggested diet modifications. Enrollees are to modify their diets in accordance with the physician's recommendations. At the end of the 6 weeks, enrollees are given a cholesterol test and those who achieve a count under 200 receive a premium discount.

(ii) In this *Example,* because enrollees who otherwise comply with the program may be unable to achieve a cholesterol count under 200 due to a health status-related factor, this is not a bona fide wellness program and such discounts would discriminate impermissibly based on one or more health status-related factors. However, if, instead, individuals covered by the plan were entitled to receive the discount for complying with the diary and dietary requirements and were not required to pass a cholesterol test, the program would be a bona fide wellness program.

§ 146.125 Effective dates.

(a) *General effective dates*—(1) *Non-collectively-bargained plans.* Except as otherwise provided in this section, part A of title XXVII of the PHS Act and this part applies with respect to group health plans, including health insurance issuers offering health insurance coverage in connection with group health plans, for plan years beginning after June 30, 1997.

(2) *Collectively bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1)), in the case of a group health plan maintained under one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, part A of title XXVII of the PHS Act and this part does not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). For these purposes, any plan amendment made under a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such part, is not treated as a termination of the collective bargaining agreement.

(3) *Preexisting condition exclusion periods for current employees.* (i) *General rule.* Any preexisting condition exclusion period permitted under § 146.111 is measured from the individual's enrollment date in the plan. This exclusion period, as limited under § 146.111, may be completed before the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject to part A of title XXVII of the PHS Act, no preexisting condition exclusion may be imposed with respect to an individual beyond the limitation in § 146.111. For an individual who has not completed the permitted exclusion period under HIPAA, upon the effective date for his or her plan, the individual may use credible coverage that the person had as of the enrollment date to reduce the remaining preexisting condition exclusion period applicable to the individual.

(ii) *Examples.* The following examples illustrate the requirements of this paragraph (a)(3):

Example 1: (i) Individual *A* has been working for Employer *X* and has been covered under Employer *X*'s plan since March 1, 1997. Under Employer *X*'s plan, as in effect before January 1, 1998, there is no coverage for any preexisting condition. Employer *X*'s plan year begins on January 1, 1998. *A*'s enrollment date in the plan is March 1, 1997, and *A* has no credible coverage before this date.

(ii) In this *Example,* Employer *X* may continue to impose the preexisting conditions exclusion under the plan through February 28, 1998 (the end of the 12-month period using anniversary dates).

Example 2: (i) Same facts as in *Example 1*, except that *A*'s enrollment date was August 1, 1996, instead of March 1, 1997.

(ii) In this *Example*, on January 1, 1998, Employer *X*'s plan may no longer exclude treatment for any preexisting condition that *A* may have, however, because Employer *X*'s plan is not subject to HIPAA until January 1, 1998, *A* is not entitled to claim reimbursement for expenses under the plan for treatments for any preexisting condition received before January 1, 1998.

(b) *Effective date for certification requirement*—(1) *General.* Subject to the transitional rule in § 146.115(a)(5)(iii), the certification rules of § 146.115 apply to events occurring on or after July 1, 1996.

(2) *Period covered by certificate.* A certificate is not required to reflect coverage before July 1, 1996.

(3) *No certificate before June 1, 1997.* Notwithstanding any other provision of this part, in no case is a certificate required to be provided before June 1, 1997.

(c) *Limitation on actions.* No enforcement action is taken, under, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by part A of title XXVII of the PHS Act before January 1, 1998, if the plan or issuer has sought to comply in good faith with such requirements. Compliance with this part is deemed to be good faith compliance with the requirements of part A of title XXVII of the PHS Act.

(d) *Transition rules for counting creditable coverage.* An individual who seeks to establish creditable coverage for periods before July 1, 1996 is entitled to establish such coverage through the presentation of documents or other means in accordance with the provisions of § 146.115(c). For coverage relating to an event occurring before July 1, 1996, a group health plan and a health insurance issuer is not subject to any penalty or enforcement action with respect to the plan's or issuer's counting (or not counting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under § 146.115(c).

(e) *Transition rules for certification of creditable coverage*—(1) *Certificates only upon request.* For events occurring on or after July 1, 1996 but before October 1, 1996, a certificate is required to be provided only upon a written request by or on behalf of the individual to whom the certificate applies.

(2) *Certificates before June 1, 1997.* For events occurring on or after October 1, 1996 and before June 1, 1997, a certificate must be furnished no later than June 1, 1997, or any later date permitted under § 146.115(a)(2) (ii) and (iii).

(3) *Optional notice*—(i) *General.* This paragraph (e)(3) applies with respect to events described in § 146.115(a)(5)(ii), that occur on or after October 1, 1996 but before June 1, 1997. A group health plan or health insurance issuer offering group health coverage is deemed to satisfy §§ 146.115 (a)(2) and (a)(3) if a notice is provided in accordance with the provisions of paragraphs (e)(3)(i) through (e)(3)(iv) of this section.

(ii) *Time of notice.* The notice must be provided no later than June 1, 1997.

(iii) *Form and content of notice.* A notice provided under this paragraph (e)(3) must be in writing and must include information substantially similar to the information included in a model notice authorized by HCFA. Copies of the model notice are available at the following website—www.hcfa.gov (or call (410) 786–1565).

(iv) *Providing certificate after request.* If an individual requests a certificate following receipt of the notice, the certificate must be provided at the time of the request as set forth in § 146.115(a)(5)(iii).

(v) *Other certification rules apply.* The rules set forth in § 146.115(a)(4)(i) (method of delivery) and (a)(1) (entities required to provide a certificate) apply with respect to the provision of the notice.

Subpart C—[Reserved]

Subpart D—Preemption and Special Rules

§ 146.143 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part A of title XXVII of the PHS Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of part A of title XXVII of the PHS Act.

(b) *Continued preemption with respect to group health plans.* Nothing in part A of title XXVII of the PHS Act affects or modifies the provisions of section 514 of ERISA with respect to group health plans.

(c) *Special rules*—(1) *General.* Subject to paragraph (c)(2) of this section, the provisions of part A of title XXVII of the PHS Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 2701 of the PHS Act, which differs from the standards or requirements specified in such section.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the ''6-month period'' described in section 2701(a)(1) of the PHS Act and § 146.111(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the ''12 months'' and ''18 months'' described in section 2701(a)(2) of the PHS Act and § 146.111(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the ''63-day period'' described in sections 2701 (c)(2)(A) and (d)(4)(A) of the PHS Act and §§ 146.111(a)(1)(iii) and 146.113 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the ''30-day period'' described in sections 2701 (b)(2) and (d)(1) of the PHS Act and § 146.111(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) of the PHS Act or expands the exceptions described in that section;

(vi) Requires special enrollment periods in addition to those required under section 2701(f) of the PHS Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B).

(d) *Definitions*—(1) *State law.* For purposes of this section the term ''State law'' includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State.* For purposes of this section the term ''State'' includes a State, the Northern Mariana Islands, any political subdivisions of a State or such Islands, or any agency or instrumentality of either.

§ 146.145 Special rules relating to group health plans.

(a) *General exception for certain small group health plans.* The requirements of this part do not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year if, on the first day of the plan year, the plan has fewer than 2 participants who are current employees.

(b) *Excepted benefits*—(1) *General.* The requirements of subpart B of this part do not apply to any group health plan (or any group health insurance coverage offered in connection with a group health plan) in relation to its provision of the benefits described in paragraph (b)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances:

(i) Coverage only for accident (including accidental death and dismemberment).

(ii) Disability income insurance.

(iii) Liability insurance, including general liability insurance and automobile liability insurance.

(iv) Coverage issued as a supplement to liability insurance.

(v) Workers' compensation or similar insurance.

(vi) Automobile medical payment insurance.

(vii) Credit-only insurance (for example, mortgage insurance).

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(1) *General.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan, as defined in paragraph (b)(3)(ii) of this section.

(ii) *Integral.* For purposes of paragraph (b)(3)(i) of this section, benefits are deemed to be an integral part of a plan unless a participant has the right to elect not to receive coverage for the benefits and, if the participant elects to receive coverage for the benefits, the participant pays an additional premium or contribution for that coverage.

(iii) *Limited scope.* Limited scope dental or vision benefits are dental or vision benefits that are sold under a separate policy or rider and that are limited in scope to a narrow range or type of benefits that are generally excluded from hospital/medical/surgical benefits packages.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care insurance services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed dollar indemnity insurance (for example, $100/day) is expected only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section.

(ii) *Conditions.* Benefits are described in paragraph (b)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(5) *Supplemental benefits.* The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance:

(i) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance),

(ii) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as CHAMPUS supplemental programs), and

(iii) Similar supplemental coverage provided to coverage under a group health plan.

Subpart E—Provisions Applicable to Only Health Insurance Issuers

§ 146.150 Guaranteed availability of coverage for employers in the small group market.

(a) *Issuance of coverage in the small group market.* Subject to paragraphs (c) through (f) of this section, each health insurance issuer that offers health insurance coverage in the small group market in a State must—

(1) Offer, to any small employer in the State, all products that are approved for sale in the small group market and that the issuer is actively marketing, and must accept any employer that applies for any of those products; and

(2) Accept for enrollment under the coverage every eligible individual (as defined in paragraph (b) of this section) who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan, or during a special enrollment period, and may not impose any restriction on an eligible individual, which is inconsistent with the nondiscrimination provisions of § 146.121 on an eligible individual being a participant or beneficiary.

(b) *Eligible individual defined.* For purposes of this section, the term ''eligible individual'' means an individual who is eligible—

(1) To enroll in group health insurance coverage offered to a group health plan maintained by a small employer, in accordance with the terms of the group health plan;

(2) For coverage under the rules of the health insurance issuer which are uniformly applicable in the State to small employers in the small group market, and

(3) For coverage in accordance with all applicable State laws governing the issuer and the small group market.

(c) *Special rules for network plans.* (1) In the case of a health insurance issuer that offers health insurance coverage in the small group market through a network plan, the issuer may—

(i) Limit the employers that may apply for the coverage to those with eligible individuals who live, work, or reside in the service area for the network plan; and

(ii) Within the service area of the plan, deny coverage to employers if the issuer has demonstrated to the applicable State authority (if required by the State authority) that—

(A) It will not have the capacity to deliver services adequately to enrollees of any additional groups because of its obligations to existing group contract holders and enrollees; and

(B) It is applying this paragraph (c)(1) uniformly to all employers without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to those employees and dependents.

(2) An issuer that denies health insurance coverage to an employer in any service area in accordance with paragraph (c)(1)(ii) of this section, may not offer coverage in the small group market within the service area to any employer for a period of 180 days after the date the coverage is denied. This paragraph (c)(2) does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

(3) Coverage offered within a service area after the 180-day period specified in paragraph (c)(2) of this section is subject to the requirements of this section.

(d) *Application of financial capacity limits.* (1) A health insurance issuer may deny health insurance coverage in the small group market if the issuer has demonstrated to the applicable State authority (if required by the State authority) that it—

(i) Does not have the financial reserves necessary to underwrite additional coverage; and

(ii) Is applying this paragraph (d)(1) uniformly to all employers in the small group market in the State consistent with applicable State law and without regard to the claims experience of those employers and their employees (and their dependents) or any health status-related factor relating to those employees and dependents.

(2) An issuer that denies group health insurance coverage to any small employer in a State in accordance with paragraph (d)(1) of this section may not offer coverage in connection with group health plans in the small group market in the State for a period of 180 days after the later of the date—

(i) The coverage is denied; or

(ii) The issuer demonstrates to the applicable State authority, if required under applicable State law, that the issuer has sufficient financial reserves to under write additional coverage.

(3) Paragraph (d)(2) of this section does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.

(4) Coverage offered after the 180-day period specified in paragraph (d)(2) of this section, is subject to the requirements of this section.

(5) An applicable State authority may provide for the application of this paragraph (d) of this section on a service-area-specific basis.

(e) *Exception to requirement for failure to meet certain minimum participation or contribution rules.*

(1) Paragraph (a) of this section does not preclude a health insurance issuer from establishing employer contribution rules or group participation rules for the offering of health insurance coverage in connection with a group health plan in the small group market, as allowed under applicable State law.

(2) For purposes of paragraph (e)(1) of this section—

(i) The term ''employer contribution rule'' means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries; and

(ii) The term ''group participation rule'' means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(f) *Exception for coverage offered only to bona fide association members.* Paragraph (a) of this section does not apply to health insurance coverage offered by a health insurance issuer if that coverage is made available in the small group market only through one or more bona fide associations (as defined in 45 CFR 144.103).

§ 146.152 Guaranteed renewability of coverage for employers in the group market.

(a) *General rule.* Subject to paragraphs (b) through (d) of this section, a health insurance issuer offering health insurance coverage in the small or large group market is required to renew or continue in force the coverage at the option of the plan sponsor.

(b) *Exceptions.* An issuer may nonrenew or discontinue group health insurance coverage offered in the small or large group market based only on one or more of the following:

(1) *Nonpayment of premiums.* The plan sponsor as failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

(2) *Fraud.* The plan sponsor has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.

(3) *Violation of participation or contribution rules.* The plan sponsor has failed to comply with a material plan provision relating to any employer contribution or group participation rules permitted under § 146.150(e) in the case of the small group market or under applicable State law in the case of the large group market.

(4) *Termination of plan.* The issuer is ceasing to offer coverage in the market in accordance with paragraphs (c) and (d) of this section and applicable State law.

(5) *Enrollees' movement outside service area.* For network plans, there is no longer any enrollee under the group health plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business); and in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment in the plan under § 146.150(c).

(6) *Association membership ceases.* For coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(c) *Discontinuing a particular product.* In any case in which an issuer decides to discontinue offering a particular product offered in the small or large group market, that product may be discontinued by the issuer in accordance with applicable State law in the particular market only if—

(1) The issuer provides notice in writing to each plan sponsor provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 days before the date the coverage will be discontinued;

(2) The issuer offers to each plan sponsor provided that particular product the option, on a guaranteed issue basis, to purchase all (or, in the case of the large group market, any) other health insurance coverage currently being offered by the issuer to a group health plan in that market; and

(3) In exercising the option to discontinue that product and in offering the option of coverage under paragraph (c)(2) of this section, the issuer acts uniformly without regard to the claims experience of those sponsors or any health status-related factor relating to any participants or beneficiaries covered or new participants or beneficiaries who may become eligible for such coverage.

(d) *Discontinuing all coverage.* An issuer may elect to discontinue offering all health insurance coverage in the small or large group market or both markets in a State in accordance with applicable State law only if—

(1) The issuer provides notice in writing to the applicable State authority and to each plan sponsor (and all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 days prior to the date the coverage will be discontinued; and

(2) All health insurance policies issued or delivered for issuance in the State in the market (or markets) are discontinued and not renewed.

(e) *Prohibition on market reentry.* An issuer who elects to discontinue offering all health insurance coverage in a market (or markets) in a State as described in paragraph (d) of this section may not issue coverage in the market (or markets) and State involved during the 5-year period beginning on the date of discontinuation of the last coverage not renewed.

(f) *Exception for uniform modification of coverage.* Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan in the—

(1) Large group market; and

(2) Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with State law and is effective uniformly among group health plans with that product.

(g) *Application to coverage offered only through associations.* In the case of health insurance coverage that is made available by a health insurance issuer in the small or large group market to employers only through one or more associations, the reference to ''plan sponsor'' is deemed, with respect to coverage provided to an employer member of the association, to include a reference to such employer.

§ 146.160 Disclosure of information.

(a) *General rule.* In connection with the offering of any health insurance coverage to a small employer, a health insurance issuer is required to—

(1) Make a reasonable disclosure to the employer, as part of its solicitation and sales materials, of the availability of information described in paragraph (b) of this section; and

(2) Upon request of the employer, provide that information to the employer.

(b) *Information described.* Subject to paragraph (d) of this section, information that must be provided under paragraph (a)(2) of this section is information concerning the following:

(1) Provisions of coverage relating to the following:

(i) The issuer's right to change premium rates and the factors that may affect changes in premium rates.

(ii) Renewability of coverage.

(iii) Any preexisting condition exclusion, including use of the alternative method of counting creditable coverage.

(iv) Any affiliation periods applied by HMOs.

(v) The geographic areas served by HMOs.

(2) The benefits and premiums available under all health insurance coverage for which the employer is qualified, under applicable State law. See § 146.150(b) through (f) for allowable limitations on product availability.

(c) *Form of information.* The information must be described in language that is understandable by the average small employer, with a level of detail that is sufficient to reasonably inform small employers of their rights and obligations under the health insurance coverage. This requirement is satisfied if the issuer provides each of the following with respect to each product offered:

(1) An outline of coverage. For purposes of this section, outline of coverage means a description of benefits in summary form.

(2) The rate or rating schedule that applies to the product (with and without the preexisting condition exclusion or affiliation period).

(3) The minimum employer contribution and group participation rules that apply to any particular type of coverage.

(4) In the case of a network plan, a map or listing of counties served.

(5) Any other information required by the State.

(d) *Exception.* An issuer is not required to disclose any information that is proprietary and trade secret information under applicable law.

Subpart F—Exclusion of Plans and Enforcement

§ 146.180 Treatment on non-Federal governmental plans.

The plan sponsor of a non-Federal governmental plan may elect to be exempted from any or all of the requirements identified in paragraph (a) of this section with respect to any portion of its plan that is not provided through health insurance coverage, if the election complies with the requirements of paragraphs (b) and (c) of this section. The election remains in effect for the period described in paragraph (d) of this section.

(a) *Exemption from requirements.* The election described in this paragraph (a) exempts a non-Federal governmental plan from the following requirements:

(1) Limitations on preexisting condition exclusion periods (§ 146.111).

(2) Special enrollment periods for individuals (and dependents) losing other coverage (§ 146.117).

(3) Prohibitions against discriminating against individual participants and beneficiaries based on health status (§ 146.121).

(4) Standards relating to benefits for mothers and newborns (section 2704 of the PHS Act).

(5) Parity in the application of certain limits to mental health benefits (section 2705 of the PHS Act).

(b) *Form and manner of election.* (1) The election must be in writing.

(2) The election document must include as an attachment a copy of the notice described in paragraphs (f) and (g) of this section.

(3) The election document must state the name of the plan and the name and address of the plan administrator.

(4) The election document must either state that the plan does not include health insurance coverage, or identify which portion of the plan is not funded through insurance.

(5) The election must be made in conformity with all the plan sponsor's rules, including any public hearing, if required, and the election document must certify that the person signing the election document, including if applicable a third party plan administrator, is legally authorized to do so by the plan sponsor.

(6) The election document must be signed by the person described in paragraph (b)(5) of this section.

(c) *Timing of election.* (1) For plans not subject to collective bargaining agreements, the election must be received by HCFA by the day preceding the beginning date of the plan year.

(2) For plans provided under a collective bargaining agreement, the election must be received by HCFA no later than 30 days after—

(i) The date of the agreement between the governmental entity and union officials; or

(ii) If applicable, ratification of the agreement.

(3) HCFA may extend the deadlines specified under paragraphs (c)(1) and (c)(2) of this section for good cause.

(4) If the plan sponsor fails to file a timely election in accordance with paragraphs (c)(1) through (c)(3) of this section, the plan is subject to the

requirements described in paragraph (a) for the entire plan year, or, in the case of a plan provided under a collective bargaining agreement, for the term of the agreement.

(d) *Period of election.* An election under paragraph (a) of this section applies—

(1) For a single specified plan year; or

(2) In the case of a plan provided under a collective bargaining agreement, for the term of the agreement. (For purposes of this section, if a collective bargaining agreement expires during the bargaining process for a new agreement, and the parties agree that the prior bargaining agreement continues in effect until the new agreement takes effect, the ''term of the agreement'' is deemed to continue until the new agreement takes effect.)

(e) *Subsequent elections.* An election under this section may be extended through subsequent elections.

(f) *Notice to participants.* (1) A plan that makes the election described in this section notifies the participant of the election, and explains the consequences of the election. This notice must be provided—

(i) to each participant at the time of enrollment under the plan; and

(ii) To all participants on an annual basis.

(2) The notice shall be in writing, and must include the information specified in paragraph (g) of this section.

(3) The notice shall be provided to each participant individually.

(4) Subject to paragraph (g) of this section, the requirements of paragraphs (f)(1) through (f)(3) of this section are considered to have been met if the notice is prominently printed in the summary plan document, or equivalent document, and each participant receives a copy of that document at the time of enrollment and annually thereafter.

(g) *Notice content.* The notice must contain at least the following information:

(1) A statement that, in general, Federal law imposes upon group health plans the requirements described in paragraph (a) of this section (which must be individually described in the notice).

(2) A statement that Federal law gives the plan sponsor of a non-Federal governmental plan the right to exempt the plan in whole or in part from the requirements described in paragraph (a) of this section, and that the plan sponsor has elected to do so.

(3) A statement identifying which parts of the plan are subject to the election, and each of the requirements of paragraph (a) of this section from which the plan sponsor has elected to be exempted.

(4) If the plan chooses to provide any of the protections of paragraph (a) of this section voluntarily, or is required to under State law, a statement identifying which protections apply.

(h) *Certification and disclosure of creditable coverage.* Notwithstanding an election under this section, a non-Federal governmental plan must provide for certification and disclosure of creditable coverage under the plan with respect to participants and their dependents in accordance with § 146.115.

(i) *Effect of failure to comply with election requirements.* (1) Subject to paragraph (i)(2) of this section, a plan's failure to comply with the requirements of paragraphs (f) through (h) of this section invalidates an election made under this section.

(2) Upon a finding by HCFA that a non-Federal governmental plan has failed to comply with the requirements of paragraphs (f) through (h), and has failed to correct the noncompliance within 30 days (as provided in § 146.184(d) (7)(iii)(B)), HCFA notifies the plan that its election has been invalidated and that it is subject to the requirements of this part.

(3) A non-Federal governmental plan described in paragraph (i)(2) of this section that fails to comply with the requirements of this part is subject to Federal enforcement by HCFA under § 146.184, including appropriate civil money penalties.

§ 146.184 Enforcement.

(a) *Enforcement with respect to group health plans*—(1) *Scope.* In general, the requirements of the Health Insurance Portability and Accountability Act that apply to group health plans are contained in part 7 of subtitle B of title I of ERISA, and in subtitle K of the Internal Revenue Code. They are enforced by the Secretary of Labor under part 5 of subtitle B of title I of ERISA, and the Secretary of the Treasury under 26 U.S.C. 4980D. However, the provisions that apply to group health plans that are non-Federal governmental plans are contained in title XXVII of the PHS Act, and enforced by HCFA. The provisions of title XXVII that apply to health insurance issuers that offer coverage in connection with any group health plan are enforced in the first instance by the States. If HCFA determines under paragraph (b) of this section that a State is not substantially enforcing the provisions, HCFA enforces them under paragraph (d) of this section.

(2) *Non-Federal governmental plans.* Requirements of this part that apply to group health plans that are non-Federal governmental plans (sponsored by a State or local governmental entity) are enforced by HCFA, as provided in paragraph (d) of this section.

(b) *Enforcement with respect to health insurance issuers*—(1) *General rule—enforcement by State.* Except as provided in paragraph (b)(2) of this section, each State enforces the requirements of this part with respect to health insurance issuers that issue, sell, renew or offer health insurance coverage in the small or large group markets in the State.

(2) *Enforcement by HCFA.* HCFA enforces the provisions of this part with respect to health insurance issuers, using the procedures described in paragraph (d) of this section, only in the following circumstances:

(i) *State election.* If the State chooses not to enforce the Federal requirements.

(ii) *State failure to enforce.* If HCFA makes a determination under paragraph (c) of this section that a State has failed to substantially enforce one or more provisions of this part.

(c) *Determination by Administrator.* if HCFA receives information, through a complaint or any other means, that raises a question whether a State is substantially enforcing one or more provisions of this part, HCFA follows the procedures set forth in this section.

(1) *Verification of exhaustion.* HCFA makes a threshold determination of whether the individuals affected by the alleged failure to enforce have made a reasonable effort to exhaust any State remedies. This may involve informal contact with State officials about the questions raised.

(2) *Notice to the State.* If HCFA is satisfied that there is a reasonable question whether there has been a failure to substantially enforce, HCFA provides notice as specified in paragraph (c)(3) of this section, to the following State officials:

(i) The Governor or chief executive officer of the State.

(ii) The insurance commissioner or chief insurance regulatory official.

(iii) The official responsible for regulating HMOs, if different than paragraph (c)(2)(ii) of this section, but only if the alleged failure involves HMOs.

(3) *Form and content of notice.* The notice described in paragraph (c)(2) is in writing, and does the following:

(i) Identifies the provision or provisions of the statute and regulations that have allegedly been violated;

(ii) Describes the facts of the specific violations.

(iii) Explains that the consequence of a failure to substantially enforce any provisions(s) is that HCFA enforces the provision(s) in accordance with paragraph (d) of this section.

(iv) Advises the State that it has 45 days to respond to the notice, unless the time is extended as described in paragraph (c)(3) of this section, and that the response should include any information that the State wishes HCFA to consider in making the preliminary determination described in paragraph (c)(5) of this section.

(4) *Good cause.* The time for responding can be extended for good cause. Examples of good cause include an agreement between HCFA and the State that there should be a public hearing on the State's enforcement, or evidence that the State is undertaking expedited enforcement activities.

(5) *Preliminary determination.* If at the end of the 45-day period, and any extension, the State has not established to HCFA's satisfaction that it is substantially enforcing the provision or provisions described in the notice, HCFA takes the following actions:

(i) Consults with the officials described in paragraph (c)(1) of this section.

(ii) Notifies the State of HCFA's preliminary determination that the State has failed to enforce the provisions, and that the failure is continuing.

(iii) Permits the State a reasonable opportunity to show evidence of substantial enforcement.

(6) *Final determination.* If, after providing notice and the opportunity to enforce under paragraph (c)(5) of this section, HCFA finds that the failure to enforce has not been corrected, HCFA sends the State a written notice of that final determination. The notice—

(i) Identifies the provisions with respect to which HCFA is taking over enforcement;

(ii) States the effective date of HCFA's enforcement;

(iii) Informs the State of the mechanism for establishing in the future that it has corrected the failure, and has begun enforcement. This mechanism will include transition procedures for ending HCFA's enforcement.

(d) *Civil money penalties*—(1) *General rule.* If any health insurance issuer that is subject to HCFA's enforcement authority under paragraph (b)(2) of this section, or any non-Federal governmental plan (or employer that sponsors a non-Federal governmental plan) that is subject to HCFA's enforcement authority under paragraph (a)(2) of this section, fails to comply with any applicable requirement of this part, if may be subject to a civil money penalty as described in this paragraph (d).

(2) *Complaint.* Any person who is entitled to any right under this part, and who believes that the right is being denied as a result of any failure described in paragraph (d)(1) of this section, may file a complaint with HCFA. Based on the complaint, HCFA identifies which entities are potentially responsible for the violation, in accordance with paragraph (d)(3) of this section.

(3) *Determination of responsible entity.* If a failure to comply is established under this section, the responsible entity, as determined under this paragraph, is liable for the penalty. If the violation is due to a failure by—

(i) A health insurance issuer, the issuer is the responsible entity;

(ii) A group health plan that is a non-Federal governmental plan sponsored by a single employer, the employer is the responsible entity;

(iii) A group health plan that is a non-Federal governmental plan sponsored by two or more employers, the plan is the responsible entity.

(4) *Notice to responsible entities.* HCFA provides notice to the appropriate entity or entities identified under paragraph (d)(3) of this section that a complaint or other information has been received alleging a violation of this part. The notice—

(i) Describes the substance of any complaint or other allegation;

(ii) Provides 30 days for the responsible entity or entities to respond with additional information. This can include—

(A) Information refuting that there has been a violation;

(B) Evidence that the entity did not know, and exercising due diligence could not have known, of the violation;

(C) Evidence of a previous record of compliance.

(5) *Notice to other regulators.* HCFA notifies the State if the alleged violation involves a health insurance issuer under its jurisdiction.

(6) *Notice of assessment.* If, based on the information provided in the complaint, as well as any information submitted by the entity or any other parties, HCFA proposes to assess a civil money penalty, HCFA sends written notice of assessment to the responsible entity or entities by certified mail, return receipt requested. The notice contains the following information:

(i) A reference to the provision that was violated.

(ii) The name or names of the individuals with respect to whom a violation occurred, with relevant identification numbers.

(iii) The facts that support the finding of a violation, and the initial date of the violation.

(iv) The amount of the proposed penalty as of the date of the notice.

(v) The basis for calculating the penalty, including consideration of prior compliance.

(vi) Instructions for responding to the notice, including—

(A) A specific statement of the respondent's right to a hearing; and

(B) A statement that failure to request a hearing within 30 days permits the imposition of the proposed penalty, without right of appeal.

(7) *Amount of penalty*—(i) *Maximum daily penalty.* The penalty cannot exceed $100 for each day, for each responsible entity, for each individual with respect to whom such a failure occurs.

(ii) *Standard for calculating daily penalty.* In calculating the amount of the penalty HCFA takes into account the responsible entity's previous record of compliance and the gravity of the violation.

(iii) *Limitations on penalties.* No civil money penalty is imposed:

(A) With respect to a period during which a failure existed, but none of the responsible entities knew, or exercising reasonable diligence would have known, that the failure existed.

(B) With respect to the period occurring immediately after the period described in paragraph (d)(7)(iii)(A) of this section, if the failure—

(*1*) Was due to reasonable cause and was not due to willful neglect; and

(*2*) Was corrected within 30 days of the first day that any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that the failure existed.

(C) The burden is on the responsible entity or entities to establish to the satisfaction of HCFA that none of the entities knew, or exercising reasonable diligence could have known that the failure existed.

(8) *Hearings*—(i) *Right to a hearing.* Any entity against which a penalty is assessed may request a hearing by HCFA. The request must be in writing, and must be postmarked within 30 days after the date the notice of assessment is issued.

(ii) *Failure to request a hearing.* If no hearing is requested under this paragraph, the notice of assessment constitutes a final order that is not subject to appeal.

(iii) *Parties to the hearing.* Parties to the hearing include any responsible entities, as well as the party who filed the complaint. An informational notice

is also sent to the State, or to the Secretaries of Labor and the Treasury, as appropriate.

(iv) *Initial agency decision.* The initial agency decision is made by an administrative law judge. The decision is made on the record according to section 554 of title 5, United States Code. The decision becomes a final, appealable order after 30 days, unless it is modified in accordance with paragraph (d)(8)(v) of this section.

(v) *Review by HCFA.* HCFA may modify or vacate the initial agency decision. Notice of intent to modify or vacate the decision is issued to the parties within 30 days after the date of the decision of the administrative law judge.

(9) *Judicial review*—(i) *Filing of action for review.* Any entity against whom a final order imposing a civil money penalty is entered in accordance with paragraph (d)(8) of this section may obtain review in the United States District Court for any district in which the entity is located or the United States District Court for the District of Columbia by—

(A) Filing a notice of appeal in that court within 30 days from the date of a final order; and

(B) Simultaneously sending a copy of the notice of appeal by registered mail to HCFA.

(ii) *Certification of administrative record.* HCFA will promptly certify and file with the court the record upon which the penalty was imposed.

(iii) *Standard of review.* The findings of HCFA may not be set aside unless they are found to be unsupported by substantial evidence, as provided by Section 706(2) (E) of title 5, United States Code.

(iv) *Appeal.* Any final decision, order or judgement of the district court concerning the Administrator's review is subject to appeal as provided in Chapter 83 of Title 28, United States Code.

(10) *Failure to pay assessment, maintenance of action*—(i) *Failure to pay assessment.* If any entity fails to pay an assessment after it becomes a final order under paragraphs (d)(7)(i)(A) or (d)(7)(iii) of this section, or after the court has entered final judgment in favor of HCFA, HCFA refers the matter to the Attorney General, who brings an action in the appropriate United States district court to recover the amount assessed.

(ii) *Final order not subject to review.* In an action brought under paragraph (d)(10)(i) of this section, the validity and appropriateness of the final order described in paragraphs (d)(7)(i)(A) or (d)(7)(iii) of this section is not subject to review.

(11) *Use of penalty funds.* (i) Any funds collected under this section will be paid to HCFA or other office imposing the penalty.

(ii) The funds will be available without appropriation and until expended.

(iii) The funds may only be used for the purpose of enforcing the provisions with respect to which the penalty was imposed.

PARTS 147—199 [RESERVED]

Authority: Secs. 2701 through 2723, 2791, and 2792 of the PHS Act, 42 U.S.C. 300gg–41 through 300gg–63, 300gg–91, and 300gg–92.

Dated: March 25, 1997.

Bruce C. Vladeck,

Administrator, Health Care Financing Administration.

Dated: March 25, 1997.

Donna E. Shalala,

Secretary.

[FR Doc. 97–8275 Filed 4–1–97; 12:42 pm]

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Parts 54 and 602

[TD 9166]

RIN 1545–AX84

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210–AA54

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

45 CFR Parts 144 and 146

RIN 0938–AL43

Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers Under HIPAA Titles I & IV

AGENCIES: 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 regulation.

SUMMARY: This document contains final regulations governing portability requirements for group health plans and issuers of health insurance coverage offered in connection with a group health plan. The rules contained in this document implement changes made to the Internal Revenue Code, the Employee Retirement Income Security Act, and the Public Health Service Act enacted as part of the Health Insurance Portability and Accountability Act of 1996.

DATES: *Effective date.* These final regulations are effective February 28, 2005.

Applicability date. These final regulations apply for plan years beginning on or after July 1, 2005.

FOR FURTHER INFORMATION CONTACT: Dave Mlawsky, Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services, at 1–877–267–2323 ext. 61565; Amy Turner, Employee Benefits Security Administration, Department of Labor, at (202) 693–8335; or Russ Weinheimer, Internal Revenue Service, Department of the Treasury, at (202) 622–6080.

SUPPLEMENTARY INFORMATION:

Customer Service Information

To assist consumers and the regulated community, the Departments have issued questions and answers concerning HIPAA. Individuals interested in obtaining copies of Department of Labor publications concerning changes in health care law may call a toll free number, 1–866–444–EBSA (3272), or access the publications on-line at *www.dol.gov/ebsa,* the Department of Labor's Web site. These regulations as well as other information on the new health care laws are also available on the Department of Labor's interactive web pages, Health *E*laws. In addition, CMS's publication entitled ''Protecting Your Health Insurance Coverage'' is available by calling 1–800–633–4227 or on the Department of Health and Human Services' Web site (*www.cms.hhs.gov/hipaa1*), which includes the interactive webpages, HIPAA Online. Copies of the HIPAA regulations, as well as notices and press releases related to HIPAA and other health care laws, are also available at the above-referenced Web sites.

A. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191, was enacted on August 21, 1996. HIPAA amended the Internal Revenue Code of 1986 (Code), the Employee Retirement Income Security Act of 1974 (ERISA), and the Public Health Service Act (PHS Act) to provide for, among other things, improved portability and continuity of health coverage. Interim final regulations implementing the HIPAA provisions were first made available to the public on April 1, 1997 (published in the **Federal Register** on April 8, 1997, 62 FR 16894) (April 1997 interim rules). On December 29, 1997, the Departments published in the **Federal Register** (62 FR 67688) a clarification of the April 1997 interim rules as they relate to excepted benefits. On October 25, 1999, the Departments published a notice in the **Federal Register** (64 FR 57520) soliciting additional comments on the portability requirements based on the experience of plans and issuers operating under the April 1997 interim rules.

After consideration of all the comments received on the portability provisions, the Departments are publishing these final regulations. These final regulations do not significantly modify the framework established in the April 1997 interim rules. Instead, these final regulations implement changes to improve the portability of health coverage while seeking to minimize burdens on group health plans and group health insurance issuers. These final regulations become applicable to plans and issuers on the first day of the plan year beginning on or after July 1, 2005. Each plan or issuer must continue to comply with the April 1997 interim rules until these final regulations become applicable to that plan or issuer. In addition, the Departments are publishing proposed regulations elsewhere in this issue of the **Federal Register** to address additional and discrete issues.

B. Overview of the Final Regulations

1. Definitions—26 CFR 54.9801–2, 29 CFR 2590–701–2, 45 CFR 144.103

This section of the final regulations provides most of the definitions used in the regulations implementing HIPAA. In addition to some minor restructuring of the April 1997 interim rules (*i.e.*, some definitions have been moved into other sections of the regulations), some additional terms have been added. Among the new terms is the definition of the term *dependent. Dependent* is defined as any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant. This is intended to clarify that for purposes of HIPAA the terms of the group health plan determine which individuals are eligible for coverage as a dependent under the plan. Thus, for example, the plan terms control the age (if any) at which and conditions under which a child of a participant ceases to be eligible for coverage as a dependent. Moreover, whether an individual is eligible for special enrollment as a dependent is determined in part based on the plan's definition of dependent.

2. Limitations on Preexisting Condition Exclusions—26 CFR 54.9801–3, 29 CFR 2590.701–3, 45 CFR 146.111

This section of the final regulations addresses HIPAA's limitations on a plan's or issuer's ability to impose a preexisting condition exclusion. Comments addressing this topic generally approved of the approach taken in the Departments' April 1997 interim rules. Accordingly, these final regulations do not modify significantly the April 1997 interim rules but instead add several clarifications to the general framework already established. Also, some comments reflect a misunderstanding of the notice requirements for plans and issuers that impose a preexisting condition exclusion. Thus, these final regulations are restructured to clarify these notice

obligations. In addition, an example in the regulations contains language that plans and issuers can use to satisfy the notice requirements.

Definition of a Preexisting Condition Exclusion

In these final regulations, a preexisting condition exclusion continues to be defined broadly. A preexisting condition exclusion is any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. This definition has been moved to this section on limitations on preexisting condition exclusions to emphasize the difference between the broadness of the definition and the narrowness of permissible preexisting condition exclusions. The definition has also been modified slightly from the previous definition and clarifications of its application have been added.

If a plan exclusion satisfies the definition of a preexisting condition exclusion, it is subject to the rules of this section for preexisting condition exclusions. Under the April 1997 interim rules, whether an exclusion is a preexisting condition exclusion is determined by whether the plan provision restricts benefits for a condition because it was present before the ''first day of coverage.'' These final regulations have replaced the term *first day of coverage* with *effective date of coverage under a group health plan or health insurance coverage.* In the case of a plan that changes health insurance issuers, ''first day of coverage'' can be read to mean only the first day of coverage under the plan and not the first day of coverage under the new issuer's policy or contract (because ''first day of coverage'' is thus defined for purposes of determining the enrollment date). This reading would mean that an exclusion of benefits based on the fact that a condition existed before the effective date of coverage in the health insurance of the succeeding issuer would not be a preexisting condition (because it would not apply based on the fact that a condition existed before the first day of coverage under the plan). The phrase ''effective date of coverage under a group health plan or health insurance coverage'' under the final regulations thus applies to coverage either under a plan or health insurance coverage. Therefore, a provision used by a succeeding issuer to deny benefits for a condition because it arose before the effective date of coverage under the new policy would also fit the definition of a preexisting condition exclusion.

Since the April 1997 interim rules were published, several situations have repeatedly arisen in which a plan exclusion is not designated as a preexisting condition exclusion but nevertheless satisfies the definition of a preexisting condition exclusion. Examples have been added to illustrate some of these common plan provisions. These situations include a plan provision that provides coverage for accidental injury only if the injury occurred while covered under the plan, a plan provision that counts against a lifetime limit benefits received under prior health coverage, and a plan provision that denies benefits for pregnancy until 12 months after an individual generally becomes eligible for benefits under the plan.[1] The regulations also include a series of examples relating to exclusions for congenital conditions. These examples illustrate that a plan that generally provides benefits for a condition cannot exclude benefits for the condition in instances where it arises congenitally without complying with these limitations on preexisting condition exclusions. However, these limitations would not apply if a plan excludes benefits for all instances of a condition, even if all instances are likely to be congenital. Plans and policies that contain these types of preexisting condition exclusions that are not designated as such should be modified to comply with HIPAA's requirements for preexisting condition exclusions, or the exclusions should be deleted. In addition, because a preexisting condition exclusion discriminates against individuals based on one or more health factors, unless a preexisting condition exclusion complies with HIPAA's limitations on preexisting condition exclusions, the plan provision will also violate the HIPAA nondiscrimination provisions.[2]

General Rules Governing Preexisting Condition Exclusions

In addition to modifying the definition of a preexisting condition exclusion, these final regulations set forth HIPAA's limitations on preexisting condition exclusions, as follows:

Six-Month Look-Back Rule

The final regulations retain the 6-month look-back rule set forth in the April 1997 interim rules. In addition, these regulations clarify that a plan or issuer can use a period shorter than 6 months for purposes of applying the 6-month look-back rule. Examples in these final regulations also clarify that if a doctor's recommendation for treatment occurs before the 6-month look-back period, an individual can be subject to a preexisting condition exclusion only if the individual receives the recommended treatment within the 6-month look-back period.

Maximum Length of Preexisting Condition Exclusion

The final regulations retain the rule set forth in the April 1997 interim rules that a preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date.

Reducing a Preexisting Condition Exclusion Period by Creditable Coverage

The final regulations retain the rule set forth in the April 1997 interim rules. Accordingly, under these final regulations, the period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage[3] the individual has as of the enrollment date (not including any days before a significant break in coverage). Some comments asked how this rule applies to individuals who currently have coverage under another plan (that is, the coverage has not yet ended). An example clarifies that a plan or issuer must count all days of creditable coverage prior to an individual's enrollment date, even if that coverage is still in effect.

Other Standards

The final regulations retain the statement that other legal standards may apply to group health coverage preexisting condition exclusions. In this connection, the Department of Labor's Veterans' Employment and Training Service (VETS) has commented that the Uniformed Services Employment and Reemployment Rights Act (USERRA) provides reemployment rights for persons who leave civilian employment to perform service in the uniformed

[1] Several comments (including those of several State insurance commissioner's offices) have asked the Departments to clarify that a preexisting condition exclusion would also include any waiting period or other temporary benefit exclusion (other than a waiting period on all benefits). The Departments are publishing separately in this issue of the **Federal Register** a Request for Information, which invites further comments on this issue of benefit-specific waiting periods.

[2] See 26 CFR 54.9802–1T(b)(3), 29 CFR 2590.702(b)(3), and 45 CFR 146.121(b)(3), published on January 8, 2001 at 66 FR 1378.

[3] For purposes of these regulations, the phrase ''days of creditable coverage'' has the same meaning as the phrase ''aggregate of the periods of creditable coverage'' as such phrase is used in the statute.

services and prohibits employer discrimination against any person on the basis of the person's military service, obligations, intent to join or certain other protected activities. In general, USERRA reemployment rights apply to persons who leave civilian employment to serve a single enlistment period in the active military or to employees who are members of the National Guard or Reserve and are required to perform intermittent military service or training. USERRA provides rights regarding both continuation of group health plan coverage by an employee who is absent to perform service in the uniformed services and reinstatement of group health plan coverage upon reemployment if the coverage was interrupted by the service. In response to this comment, the final regulations include a statement that USERRA can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service. For more information, a VETS directory and additional USERRA information is available at *www.dol.gov/vets.*

Enrollment Definitions

Both the 6-month look-back period and the maximum length of preexisting condition exclusion are measured with respect to an individual's enrollment date. The final regulations generally retain the enrollment definitions that were set forth in the April 1997 interim rules (including definitions of enrollment date, waiting period, and late enrollee). Under HIPAA, the April 1997 interim rules, and these final regulations, the enrollment date is the first day of coverage under the plan or, if there is a waiting period, the first day of the waiting period. These final regulations clarify that if an individual receiving benefits under a group health plan changes benefit package options, or if the plan changes group health insurance issuers, the individual's enrollment date remains the same.

The Departments received several comments reflecting confusion about the relationship between the preexisting condition exclusion rules and the definitions of enrollment date and waiting period. Accordingly, guidance concerning waiting periods previously located in the definitions section has been moved to this section of the regulations and expanded. In addition, the definition of waiting period has been modified with respect to individuals seeking individual market coverage. Specifically, these final rules clarify that if an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on either the date coverage begins (if the application results in coverage), or the date on which the application is denied by the issuer or the date on which the offer of coverage lapses (if the application does not result in coverage). Under the statute, the April 1997 interim rules, and these final regulations, the effect of considering this period a waiting period is that the period is not counted when determining the length of any break in coverage. This rule modifies the rule contained in the April 1997 interim rules (which provided a waiting period only if the individual actually obtained coverage). The modification addresses situations where some individuals have been denied individual market policies or individuals declined coverage because, for example, the policies had an exorbitant premium.

Additional examples illustrate the interaction between a waiting period and the 6-month look-back period, the application of the 6-month look-back and maximum preexisting condition exclusion period rules to plans with more than one benefit package option at open season, and the interaction between these rules and other eligibility criteria under the plan.

Individuals and Conditions That Cannot Be Subject to a Preexisting Condition Exclusion

Under HIPAA, the April 1997 interim rules, and these final rules, a preexisting condition exclusion cannot be applied to pregnancy. Nor can a preexisting condition exclusion be applied to a newborn, adopted child, or child placed for adoption if the child is covered under a group health plan (or other creditable coverage) within 30 days after birth, adoption, or placement for adoption.

One comment noted that the rule for newborns in the April 1997 interim rules is expressed inconsistently. Some of those expressions are inconsistent with the rule for adopted children. Specifically, the rule for adopted children and one expression of the rule for newborns refers to eligibility being conditioned on being covered under any creditable coverage as of the last day of the 30-day period after birth, adoption, or placement for adoption. However, in other expressions of the rule for newborns, a reference is made to being covered under creditable coverage within 30 days after birth. These final regulations use one term consistently, referring to coverage within 30 days after birth, adoption, or placement for adoption. This accords with the conference report. H.R. Conf. Rep. No. 736, 104th Cong. 2d Session 184–185 (1996). Consequently, if, for example, a child is covered within 30 days of birth, the child cannot be subject to a preexisting condition exclusion even if the child is no longer covered under the plan on the 30th day after birth (unless the child has a significant break in coverage).

Several comments noted that State laws applicable to health insurance issuers sometimes require that a mother's health coverage must provide benefits for health care expenses incurred for the child for a specified period following birth and cannot be recouped even if the child never enrolls in the plan under which the mother is covered. A new example clarifies that, in this situation, the child has creditable coverage within 30 days after birth and, therefore, no preexisting condition exclusion may be imposed on the child unless the child has a subsequent significant break in coverage.

Finally, HIPAA, the April 1997 interim rules, and these final regulations provide that a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. Comments expressed concern that the definition of genetic information in the April 1997 interim rules was too broad and would prevent the application of a preexisting condition exclusion to conditions that would be otherwise permitted independent of any genetic information. Although these regulations have not changed the definition of genetic information, the regulations clarify that if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section. This rule was located in the definition of medical condition in the April 1997 interim rules. Some comments indicated this rule was difficult to locate. Thus, it has been moved to this section, and an example illustrating the rule has been added.

First Notice of Preexisting Condition Exclusion—General Notice

Under these final regulations, as with the April 1997 interim rules, a group health plan imposing a preexisting condition exclusion, and a health insurance issuer offering group health insurance coverage under a plan imposing a preexisting condition

exclusion, must provide a written general notice of preexisting condition exclusion before it can impose a preexisting condition exclusion.

After publication of the April 1997 interim rules, the Departments received questions about the operation of this requirement. The April 1997 interim rules provided that a plan or issuer could not impose a preexisting condition exclusion with respect to a participant or dependent before providing the general notice to the participant. Several comments asked whether plans and issuers could delay providing the general notice until a large claim was filed and then pend the claim until the general notice was sent. Other comments expressed concern that if plans do not notify individuals upon enrollment about the benefit exclusions that apply to their coverage, individuals will not be able to make informed decisions about their health care choices.

The Departments had contemplated under the April 1997 interim rules that individuals should be provided the information required in the general notice before they incurred claims that could be denied under a preexisting condition exclusion. These final regulations clarify the procedural requirements for the general notice of preexisting condition exclusion. Specifically, under the final regulations, the general notice of preexisting condition exclusion must be provided as part of any written application materials distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice. Moreover, regarding the content of this general notice, the final regulations clarify precisely what is required when disclosing the existence and terms of the plan's preexisting condition exclusion. In addition, these final regulations require the notice to include the person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion. An example in these final regulations sets forth sample language that plans and issuers can use when developing the general notice for their coverages.

Issuers that sell different policies to different plans should also be aware that when describing the existence and terms of the maximum preexisting condition exclusion period, the issuer must describe to individuals the actual maximum exclusion period under their policy. Therefore, if an issuer sells two policies, one with a 6-month and one with a 12-month maximum preexisting condition exclusion, the issuer could not send one notice to individuals under both policies indicating that the maximum preexisting condition exclusion is 12 months. Instead, the issuer is required to send one notice to participants under the policy with the 6-month preexisting condition exclusion (indicating that the maximum exclusion period is 6 months) and a different notice to participants under the policy with the 12-month preexisting condition exclusion (indicating that the maximum exclusion period is 12 months).

Determination of Creditable Coverage

These final regulations require a plan or issuer that imposes a preexisting condition exclusion to make a determination of creditable coverage within a reasonable time after receiving information regarding prior health coverage. This rule was included in the section of the April 1997 interim rules addressing certification and disclosure of previous coverage, and it has been moved to this section on preexisting condition exclusions unchanged. These final regulations clarify that a plan or issuer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.[4]

Second Notice of Preexisting Condition Exclusion—Individual Notice

These final regulations retain the requirement to provide an individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. These final regulations clarify that this individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. Also, a plan or issuer is not required to provide this notice if the plan or issuer does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage. These final regulations add a new example that illustrates how the notice works and includes sample language that may be helpful to plans and issuers in developing this type of notice with respect to their coverage.

[4] Of course, after a claim has been denied under a preexisting condition exclusion, other laws, such as section 503 of ERISA, may set forth timing rules for an individual to appeal a denied claim.

Reconsideration

Consistent with the April 1997 interim rules, these final regulations do not prevent a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage and if certain procedural requirements are met. The final regulations have been slightly reorganized and modified to make clearer that a plan or issuer is permitted to modify its initial determination if a notice of the new determination (that meets the requirements of the second, individual notice of preexisting condition exclusion, described above) is provided and, until the notice of the new determination is provided, the plan or issuer acts in a manner consistent with the initial determination for purposes of approving access to medical services (such as pre-surgery authorization).

3. Rules Relating to Creditable Coverage—26 CFR 54.9801–4, 29 CFR 2590.701–4, 45 CFR 146.113

This section of the final regulations describes the varieties of health coverage that constitute creditable coverage and sets forth rules for how to count creditable coverage for purposes of the rule requiring plans and issuers to offset the maximum length of a preexisting condition exclusion by prior creditable coverage.

Creditable Coverage

The rules in the final regulations describing the varieties of health coverage that constitute creditable coverage generally follow the April 1997 interim rules, with two modifications. The April 1997 interim rules contain ten categories of creditable coverage. After publication of the April 1997 interim rules, Congress created the State Children's Health Insurance Program (S–CHIP), which allows states to provide health coverage to eligible children through Medicaid expansion or private market mechanisms. This coverage meets the definition of creditable coverage as either Medicaid coverage, group health plan coverage, or health insurance coverage. In addition, Congress specifically provides [5] that S–CHIP coverage is creditable coverage under HIPAA. Therefore, these final regulations have added coverage under S–CHIP as an eleventh category of creditable coverage.

The second modification is to the definition of public health plan. This

[5] Section 2109 of the Social Security Act, enacted by section 4901 of the Balanced Budget Act of 1997, Pub. L. 105–33, 111 Stat. 567.

definition has been changed in two ways. The first change relates to the type of health coverage provided by a public health plan. The statute does not define the term. The April 1997 interim rules limit the definition of public health plans to certain plans provided through health *insurance* coverage. Some comments suggested it was unnecessary to restrict the definition to insured coverage and argued that the term public health plan should be expanded. These final regulations delete the word ''insurance'' from that requirement so that any health coverage provided by a governmental entity, regardless of whether it has the risk-shifting or risk-distributing effects of insurance, is a public health plan.

The second change to the definition of public health plan relates to the type of governmental entity that can establish or maintain a public health plan. Under the April 1997 interim rules, only health coverage provided under a plan established or maintained by a State, a county, or another political subdivision of a State can be a public health plan. This definition does not include a plan established or maintained by a foreign government or the U.S. government. The preamble to the April 1997 interim rules specifically solicited comments on whether public health systems of foreign countries should be considered public health plans.

Many comments addressed this issue, arguing both for and against including public health systems of foreign governments in the definition of public health plan. The comments in favor of inclusion argued that generally the health coverage provided through public health systems in foreign countries is more comprehensive than that received in this country. Some comments argued that the exclusion of foreign public health systems from the definition of public health plan arbitrarily penalizes individuals who maintain continuous health coverage through a foreign public health system. The comments against inclusion focused on the difficulty for a plan or issuer to verify whether someone had the coverage they claimed under a foreign public health system.

Under these final regulations, the definition of a public health plan includes health coverage provided under a plan established or maintained by a foreign country or a political subdivision. While this result can inconvenience plans and issuers, verifying this type of coverage may be no more inconvenient than verifying certain other types of coverage, such as group health coverage provided through foreign employers. In addition, this result is much less inequitable than denying an individual coverage for a preexisting condition in a case in which the individual can provide reliable evidence of having coverage under the public health system of a foreign government. Under the rules for establishing creditable coverage in the absence of a certificate of creditable coverage, an individual is required to present at a minimum some corroborating evidence of the claimed creditable coverage and is required to cooperate with a plan's or issuer's efforts to verify coverage. Thus, in the case of an individual claiming coverage under the public health system of a foreign country, a plan or issuer could require some evidence of residency in the foreign country (or evidence that some other eligibility standard had been met) and the individual would have to cooperate with the plan's or issuer's efforts to verify that the individual had coverage under that country's health system.

Under the revised definition in these final regulations, health coverage provided under a plan established or maintained by the U.S. Government is also a public health plan.

Counting Creditable Coverage

The rules in the final regulations for how to count creditable coverage are adopted with stylistic and conforming changes from the April 1997 interim rules. In addition, a technical modification was added, as required by a statutory change made by the Trade Act of 2002 (''the Trade Act'', Public Law 107–210, enacted on August 6, 2002). Under the Trade Act, workers whose employment is adversely affected by international trade may become entitled to receive trade adjustment assistance (TAA) and a 65% health coverage tax credit (HCTC). The Trade Act also amended COBRA continuation coverage provisions in ERISA, the Public Health Service Act, and the Internal Revenue Code, to provide a second opportunity to elect COBRA for individuals who are eventually determined to qualify for TAA, but who did not elect COBRA after their original loss of health coverage. Because this could result in a ''significant break in coverage'' for purposes of HIPAA, the Trade Act specifies that the period beginning with the loss of coverage, and ending on the first day of the second election period, for individuals who elect COBRA during this second election period, should be disregarded for purposes of the HIPAA pre-existing condition provisions. Accordingly, as required by the Trade Act, under these final rules the days between the date an individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred. For more information on TAA, contact the Department of Labor's Employment and Training Administration at 877–US2–JOBS or at *www.doleta.gov/tradeact.* For more information on the HCTC, contact the IRS toll-free at 866–628–4282.

The existing examples relating to the tolling of the period for determining a significant break in coverage in the case of individuals seeking coverage in the individual market have also been modified to conform to the change in the definition of waiting period, which under these final regulations includes the period beginning when an individual submits a substantially complete application for coverage in the individual market and ends when the application is denied or when the offer of coverage lapses. In addition, here, as throughout these final regulations, references in the April 1997 interim rules to ''plan or policy'' have been revised so that the reference includes health insurance coverage not offered through a policy of insurance, such as health insurance coverage offered through a contract of a health maintenance organization.

Published elsewhere in this issue of the **Federal Register** is a proposed rule that provides that the period that determines whether a significant break in coverage has occurred (generally 63 days) is tolled in cases in which a certificate of creditable coverage is not provided on or before the day coverage ceases. In those cases, the significant-break-in-coverage period would be tolled until a certificate is provided or, if earlier, until 44 days after the coverage ceases.

These final regulations retain the methods in the April 1997 interim rules for counting creditable coverage, that is, the standard method and the alternative method. Comments requested that the alternative method be expanded so that a plan or issuer could elect to have it apply to categories in addition to the five categories prescribed in the April 1997 interim rules (mental health; substance abuse treatment; prescription drugs; dental care; and vision care). The types of categories described in the comments were significant differences in deductibles, cost-sharing, or out-of-pocket maximums between plans. One comment suggested that any comparison between plans on the basis of difference in deductibles or cost sharing was unworkable.

It is the view of the Departments that a comparison between plans, and allowing one plan not to count creditable coverage (in whole or in part) under another plan, based solely on differences in deductibles or in some other cost-sharing mechanism or in all cost-sharing mechanisms, is an insufficient basis for determining the comparative value of benefits under the plans. A plan with a low deductible or low co-payments might also have an annual or per-incident limit on benefits so low as to make the plan with the higher deductible or higher cost sharing actually more valuable. Similarly, a plan with a higher deductible or coinsurance might also have a higher table of usual, customary, and reasonable costs, might be much more liberal in covering treatments considered experimental, and might provide a much broader base of benefits than the plan with the lower deductible or coinsurance. Because of the numerous ways that plans or issuers can limit the amount of benefits available under the plan, it is very complicated to compare the value of one plan or coverage with another. Singling out one or several of these features is insufficient for making a true comparison of the value of the benefits.

4. Evidence of Creditable Coverage—26 CFR 54.9801–5, 29 CFR 2590.701–5, 45 CFR 146.115

This section of the final regulations sets forth guidance regarding the certification requirements and other requirements for disclosure of information relating to prior creditable coverage. The provision of a certificate and certain other disclosures of information provided for in the statute, the April 1997 interim rules, and these final regulations are intended to enable an individual to establish prior creditable coverage for purposes of reducing or eliminating any preexisting condition exclusion imposed on the individual by any subsequent group health plan coverage. The Departments received generally favorable comments on the April 1997 interim rules from interested parties who submitted comments with regard to the certification requirements. For example, several comments praised the Departments' promulgation of a model certificate in the April 1997 interim rules as a vehicle that helped reduce compliance burdens associated with the statutory requirements under HIPAA.

Form of Certificate

These final regulations retain the requirement that the certificate must generally be provided in writing. The April 1997 interim rules clarified that for this purpose a writing included any form approved by the Secretaries as a writing. These final regulations modify that standard to include any other medium approved by the Secretary. As with the April 1997 interim rules, these final regulations provide that where an individual requests that the certificate be sent to another plan or issuer instead of the individual, and the other plan or issuer agrees, the certification information may be provided by other means, such as by telephone.

Information in Certificate

The information required to be provided in a certificate under these final regulations is the same as required under the April 1997 interim rules with one addition. In response to recommendations made by the U.S. General Accounting Office (GAO) [6] and several comments, the Departments have modified the April 1997 interim rules to require that an educational statement be provided as part of a certificate of creditable coverage in order to inform consumers of their HIPAA rights. Some comments stated that such educational language was not necessary, but indicated that if the Departments adopted such an approach they should provide language for compliance purposes. In response to the GAO recommendation, the Departments have amended the requirements for the certificate of creditable coverage in the final regulations to include the provision of an educational statement regarding certain HIPAA protections. Model educational language is provided in the model certificate (set forth below). This eliminates the burden on plans and issuers of developing language to satisfy this requirement.

Model Certificate

The first model certificate below has been authorized by the Secretary of each of the Departments. The model educational statement is set forth under the heading ''Statement of HIPAA Portability Rights.'' Use of the model certificate by group health plans and group health insurance issuers will satisfy the requirements of paragraph (a)(3)(ii) of the regulations. The second model certificate below has been authorized by the Secretary of Health and Human Services. State Medicaid programs may use this version. Once these final regulations are applicable, use of the previously-published model certificate (published in the preamble to the April 1997 interim rules) will no longer satisfy paragraph (a)(3)(ii) of the regulations.

In addition to these model certificates, the Departments are publishing a different model certificate for group health plans and group health insurance issuers in the preamble to the proposed rules published elsewhere in this issue of the **Federal Register**. That model certificate includes in its educational statement an additional paragraph regarding coordination with rules under the Family and Medical Leave Act (FMLA). The Secretaries of the Departments authorize plans and issuers to use either model certificate in fulfillment of their obligations under paragraph (a)(3)(ii) of this section in the final regulations. State Medicaid programs may use either the model certificate below that is designated for Medicaid programs, or the model certificate in the proposed rules that is so designated and includes an additional paragraph on FMLA.

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[6] In the report entitled ''PRIVATE HEALTH INSURANCE: Progress and Challenges in Implementing 1996 Federal Standards'' (GAO/HEHS–99–100, May 12, 1999) the GAO recommended that the Departments revise the model certificate of creditable health plan coverage to more explicitly inform consumers of their new rights under HIPAA. At a minimum, the GAO recommended that the certificate of creditable coverage should inform consumers about appropriate contacts for additional information about HIPAA and highlight key provisions and restrictions, including (1) the limits on preexisting condition exclusion periods and the guaranteed renewability of all health coverage; (2) the reduction or elimination of preexisting condition exclusion periods for employees changing jobs; (3) the prohibition against excluding an individual from an employer health plan on the basis of health status; and (4) the guarantee of access to insurance products for certain individuals losing group health coverage and the restrictions placed on that guarantee.

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

1. Date of this certificate: _____
2. Name of group health plan: _____
   _____
3. Name of participant: _____
4. Identification number of participant: _____
5. Name of individuals to whom this certificate applies: _____
   _____
6. Name, address, and telephone number of plan administrator or issuer responsible for providing this certificate: _____
   _____
7. For further information, call: _____
8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip lines 9 and 10: ___
9. Date waiting period or affiliation period (if any) began:
   _____
10. Date coverage began: _____
11. Date coverage ended (or if coverage has not ended, enter "continuing"): _____

[Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.]

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

➔ Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

➔ Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

➔ Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa, the DOL's interactive web pages - Health *E*laws, or http://www.cms.hhs.gov/hipaa1.

CERTIFICATE OF MEDICAID COVERAGE

1. Date of this certificate: _____
2. Name of state Medicaid program: _____
3. Name of recipient: _____
4. Identification number of recipient: _____
5. Name of individuals to whom this certificate applies: _____ _____
6. Name, address, and telephone number of state Medicaid agency responsible for providing this certificate: _____ _____
7. For further information call: _____
8. If the individual(s) identified in line 5 has (have) at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here and skip line 9. ____
9. Date coverage began: _____
10. Date coverage ended (or if coverage has not ended, enter "continuing"): _____

[Note: separate certificates will be furnished if information is not identical for the recipient and each dependent.]

Statement of HIPAA Portability Rights

IMPORTANT — KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this state Medicaid program. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under a group health plan, to help you get special enrollment in a group health plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as "preexisting condition exclusions." A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your "enrollment date." Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

➔ Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in a group health plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

➔ Therefore, once your coverage in a group health plan ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an "eligible individual," you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan;
- Your group coverage was not terminated because of fraud or nonpayment of premiums;
- You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
- You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

➔ Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for "Protecting Your Health Insurance Coverage"). These publications and other useful information are also available on the Internet at: http://www.dol.gov/ebsa or http://www.cms.hhs.gov/hipaa1.

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Procedure for Requesting Certificates

The April 1997 interim rules require plans and health insurance issuers to establish a procedure for individuals to request and receive certificates of creditable coverage. The Departments have received requests to clarify whether such procedures need to be in writing. These final regulations clarify that the procedures need to be in writing, helping to ensure that individuals are aware of their right to request a certificate and how to make the request.

In addition, the Departments have become aware that some plans and issuers believe they are not required to provide a certificate to individuals who request one while their coverage is still in effect. This requirement exists under the April 1997 interim rules. However, due to these questions being raised, the final regulations more explicitly state this requirement.

Dependent Coverage Information

Under HIPAA, plans and health insurance issuers are required to issue certificates of creditable coverage (automatically, and upon request) to dependents who are or were covered under a group health plan. In response to comments, and in order to allow entities responsible for issuing certificates adequate time to modify their data collection systems, the Departments established a transitional rule in the April 1997 interim rules for providing dependent coverage information. Under this transitional rule, a group health plan or health insurance issuer that, after having made reasonable efforts, could not provide a certificate of creditable coverage for a dependent could satisfy the requirements for providing a certificate to the dependent by providing the name of the participant covered by the group health plan or health insurance issuer and specifying that the type of coverage described in the certificate was for dependent coverage (for example, family coverage or employee-plus-spouse coverage). This transitional rule was effective through June 30, 1998.

Under these final regulations, the transitional rule is no longer in effect and dependents are entitled to receive individualized certificates of creditable coverage under the same circumstances as other individuals. As with the April 1997 interim rules, these final regulations permit a single certificate of creditable coverage to be provided with respect to both a participant and the participant's dependents if the information is identical for each individual. In addition, these final regulations retain the provisions of the April 1997 interim rules permitting the combining of information for families. As a result, in situations where coverage information is not identical for a participant and the participant's dependents, these final regulations allow certificates for all individuals to be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

Special Rules for Certain Entities

Section 2791(a)(3) of the PHS Act provides that certain entities not otherwise subject to HIPAA's requirements are to comply with the statutory certification of coverage requirements that apply to group health plans, with respect to providing certificates of creditable coverage for Medicare, Medicaid, TRICARE, and medical care programs provided through the Indian Health Service or a tribal organization. These rules further establish that such entities are required to comply with the general statutory requirement to provide certificates. However, the Departments recognize that these programs operate in a different manner than do private employment-based group health plans, nonfederal governmental group health plans, and health insurance issuers. In addition, the populations served by these programs are unique. Therefore, it may be appropriate to allow these programs to implement the certification process in a manner that addresses these unique characteristics and better serves the individuals covered by these programs, including requiring different information elements (for example, see the above model certificate of creditable coverage for use by State Medicaid programs). HHS will coordinate with the appropriate entities responsible for issuing these certificates and will issue separate guidance to these entities on how they must comply with the certification requirements.

5. Special Enrollment Periods—26 CFR 54.9801–6, 29 CFR 2590.701–6, 45 CFR 146.117

Under HIPAA, the April 1997 interim rules, and these final regulations, a group health plan and a health insurance issuer offering group health insurance coverage are required to provide for special enrollment periods during which certain individuals are allowed to enroll (without having to wait until a late enrollment opportunity and regardless of whether the plan offers late enrollment). A special enrollment right can arise if a person with other health coverage loses eligibility for that coverage or employer contributions toward the other coverage cease, or if a person becomes a dependent through marriage, birth, adoption, or placement for adoption.

In order to qualify for special enrollment, an individual must be otherwise eligible for coverage under the plan. Being otherwise eligible for coverage means having met the plan's substantive eligibility requirements (such as satisfying any waiting period, being in an eligible job classification, or working full time), regardless of whether the individual previously satisfied the plan's procedural requirements for becoming enrolled (such as completing written application materials or providing them to the plan within a specified time frame) during any enrollment opportunity prior to special enrollment.

The special enrollment rules have been reorganized and clarified. As discussed below, the special enrollment rules have also been modified in response to comments.

Loss of Eligibility for Other Coverage

A special enrollment right resulting from loss of eligibility for other coverage is available to employees and their dependents who meet certain requirements. As under the April 1997 interim rules, the employee or dependent must otherwise be eligible for coverage under the terms of the plan. When coverage was previously declined, the employee or dependent must have been covered under another group health plan or must have had other health insurance coverage. The plan can require that, when coverage in the plan was previously declined, the employee must have declared in writing that the reason was other coverage, in which case the plan must at that time have provided notice of this requirement and the consequences of the employee's failure to provide the statement.

These regulations include an example that clarifies that the initial opportunity for enrollment (generally provided when employment begins) is not the only time when an individual with other health coverage may decline coverage for purposes of satisfying the prerequisites to special enrollment upon loss of other coverage. (Other examples discussed below also illustrate this principle.) An individual who initially did not enroll for coverage without having other health coverage might later be eligible for special enrollment. This could occur if, after subsequently enrolling in other coverage, the individual had an opportunity for late

enrollment or special enrollment under the plan, but again chose not to enroll.

These final regulations, like the April 1997 interim rules, contain a list of situations when an individual loses eligibility for other coverage. While the list is not exhaustive, it has nonetheless been expanded in these final regulations to address situations that have prompted frequent questions. Thus, these regulations clarify that a loss of eligibility for coverage occurs, in the case of individual coverage provided through an HMO, when an individual no longer resides, lives, or works in the service area of the HMO (whether or not within the choice of the individual) and the HMO does not provide coverage for that reason. In the case of group coverage provided through an HMO, the same rule applies, provided that there is no other coverage under the plan available to the individual. For purposes of this rule, the HMO service area is typically defined by State law. In addition, the regulations clarify that a loss of eligibility for coverage occurs due to the cessation of dependent status. For example, a child who ''ages out'' of dependent coverage—who attains an age in excess of the maximum age for coverage of a dependent child—incurs a loss of eligibility for coverage for purposes of special enrollment.

The regulations also clarify that a loss of eligibility for coverage occurs when a plan no longer offers any benefits to a class of similarly situated individuals. Thus, if a plan terminated health coverage for all part-time workers, the part-time workers incur a loss of eligibility for coverage, even if the plan continues to provide coverage to other employees. An example in the final regulations also illustrates how the loss of eligibility rule applies to a plan that terminates a benefit package option. Similarly, if an issuer providing one of the options ceases to operate in the group market, thus terminating one of the options offered by the plan, the individuals formerly in the terminated option would incur a loss of eligibility for coverage for purposes of special enrollment, unless the plan otherwise provided a current right to enroll in alternative health coverage. In addition, the final regulations clarify that an employee who is already enrolled in a benefit package may enroll in another benefit package under the plan if a dependent of that employee has a special enrollment right in the plan because the dependent lost eligibility for other coverage.

These regulations clarify that a loss of eligibility for coverage is still considered to exist even if there are subsequent coverage opportunities. As under the April 1997 interim rules, an individual does not have to elect COBRA continuation coverage or exercise similar continuation rights in order to preserve the right to special enrollment. Moreover, a special enrollment right exists even if an individual who lost coverage elects COBRA continuation coverage. In that case, if an individual declines special enrollment, and instead elects and exhausts COBRA continuation coverage, the individual has a second special enrollment right upon exhausting the COBRA continuation coverage.

In addition, as under the statute and the April 1997 interim rules, even if there is no loss of eligibility for coverage, a special enrollment right can result when employer contributions towards other coverage terminate. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer.

Lifetime Benefit Limits

Comments asked how the special enrollment rules apply when an individual reaches a lifetime limit on all benefits under a plan. The regulations clarify that where an individual has a claim denied due to the operation of a lifetime limit on all benefits, there is a loss of eligibility for coverage for special enrollment purposes. In this regard, an individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until 30 days after the earliest date that a claim is denied due to the operation of the lifetime limit. Accordingly, because individuals who are keeping track of claims in relation to a lifetime limit can request enrollment immediately (after the claim is incurred, but before it is denied by the plan), the period for requesting special enrollment can be longer than 30 days. (Timeframes for providing certificates of creditable coverage and determining when COBRA is exhausted for individuals who have reached a lifetime limit on all benefits are set forth elsewhere in these final regulations, under the certificate and the definition provisions, respectively.)

Tolling of the Special Enrollment Period

Proposed rules, published elsewhere in this issue of the **Federal Register**, would toll the beginning of the 30-day period for requesting special enrollment until a certificate of creditable coverage is provided to the person losing coverage, up to a maximum of 44 days of tolling. This tolling rule would be in the paragraph reserved for special enrollment procedures in these final regulations.

Dependent Special Enrollment

Comments asked for clarification of the interaction of coverage for children under a State Children's Health Insurance Program (S–CHIP) and special enrollment. In particular, it was asked whether a child would have a right to special enrollment in a group health plan if the child becomes eligible for benefits under S–CHIP and the child is otherwise eligible for dependent coverage under the plan. This situation would arise if a State creates a children's health program that provides payments to a parent to cover the increased cost of enrolling a dependent child in the parent's employer's group health. However, without a special enrollment right, the parent might not be able to take advantage of the program until the next late enrollment opportunity, if the plan allows late enrollment at all. The statutory language of HIPAA, however, only provides special enrollment if there is loss of eligibility for other coverage, loss of employer contributions, or addition of a new dependent to the employee's family. Becoming eligible under a health program such as S–CHIP does not fall under any of these categories.[7]

Under these final regulations, as under the April 1997 interim rules, the special enrollment of dependents is subject to the plan's general eligibility requirements. For example, a plan may require an employee to remain enrolled, or to special enroll, in order to special enroll the employee's dependent. However, a plan's general eligibility requirements cannot prevent the application of a special enrollment right. For example, a plan may not deny special enrollment to an otherwise eligible dependent merely because the individual became a dependent of the participant after the participant's first day of coverage under the plan.

Modification of Special Enrollment Procedures

Under proposed rules, published elsewhere in this issue of the **Federal Register**, more detailed procedures are described for how plans and issuers would have to enroll individuals requesting special enrollment.

[7] Nonetheless, in addition to the dependent special enrollment rights under HIPAA, for plans subject to ERISA, section 609 of ERISA imposes additional requirements on group health plans to provide benefits to certain children, including in cases where a qualified medical child support order applies, as well as in cases of adoption. HIPAA does not prevent States from imposing similar requirements on nonfederal governmental plans.

When Coverage Begins Under Special Enrollment

Where the special enrollment right results from marriage or a loss of eligibility, coverage generally begins no later than the first day of the first calendar month after the date the plan or issuer receives the request for special enrollment. Where the special enrollment right results from a birth, coverage must begin on the date of birth. In the case of adoption or placement for adoption, coverage must begin no later than the date of such adoption or placement for adoption.

Clarification of Special Enrollment During a Late Enrollment Opportunity

The April 1997 interim rules provided a definition of the term *special enrollment date.* The purpose of the definition and accompanying examples was to illustrate that if an individual who qualified for special enrollment enrolled during a coinciding late enrollment opportunity, the individual could not be treated as a late enrollee. The final regulations eliminate the term *special enrollment date* and clarify this issue by providing that if an individual requests enrollment while the individual is entitled to special enrollment, the individual is a special enrollee, even if the request coincides with a late enrollment opportunity under the plan. Thus, the individual cannot be treated as a late enrollee.

Notice of Special Enrollment

The preamble to the April 1997 interim rules stated that a plan must provide a description of the special enrollment rights to anyone who declines coverage. However, the text of the April 1997 interim rules required the notice to be provided to all eligible employees. Even employees who enroll may need to avail themselves of their special enrollment rights in the future, either for a spouse or other dependent, or if they lose the present coverage. Thus, these regulations reiterate the requirement in the April 1997 interim rules that a plan must provide all employees (those who enroll as well as those who decline enrollment) with a notice of special enrollment at or before the time the employee is initially offered the opportunity to enroll in the plan. The regulation also provides model language that plans can use to satisfy this requirement.

Treatment of Special Enrollees

HIPAA provides that a late enrollee does not include an individual who enrolls when first eligible or who enrolls during a special enrollment period. These regulations further clarify that individuals who enroll during a special enrollment period must generally be treated the same as individuals who enroll when first eligible. That is, relative to similarly situated individuals who enroll when first eligible, special enrollees must be offered all the same benefit packages, cannot be required to pay more for coverage, and cannot be subject to a longer preexisting condition exclusion.

6. HMO Affiliation Period as an Alternative to a Preexisting Condition Exclusion—29 CFR 2590.701–7, 45 CFR 146.119

Under HIPAA, the April 1997 interim rules, and these final regulations, a group health plan that offers health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period under certain conditions. An affiliation period is a period of time that must expire before health insurance coverage provided by an HMO becomes effective and during which time the HMO is not required to provide benefits. Under these final regulations an affiliation period can be imposed if each of the following requirements is satisfied:

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is imposed consistent with the requirements of the HIPAA nondiscrimination provisions.

(4) The affiliation period does not exceed 2 months (or 3 months for a late enrollee).

(5) The affiliation period begins on the enrollment date (or, in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage, but for the affiliation period).

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

The requirements related to HMO affiliation periods contained in these final regulations clarify that a group health plan offering health insurance through an HMO or an HMO that offers health insurance coverage in connection with a group health plan may impose different affiliation periods, so long as the affiliation period complies with the requirements of the HIPAA nondiscrimination provisions. To illustrate this clarification, these final regulations contain an example where a group health plan that provides benefits through an HMO imposes an affiliation period with respect to salaried employees but does not impose an affiliation period with respect to hourly employees. This example illustrates that it is permissible to impose an affiliation period on salaried employees but not hourly employees, so long as treating these two groups differently complies with the requirements of the HIPAA nondiscrimination provisions.

The April 1997 interim rules and these final regulations specify that the affiliation period begins on the enrollment date (which is the first day of coverage under the plan, or if there is a waiting period for coverage under the plan, the first day of the waiting period), not when coverage under a particular benefit package option begins. Accordingly, an example in these final regulations illustrates that if a group health plan offers multiple benefit package options simultaneously, the HMO cannot impose an affiliation period on a plan participant who later switches to the HMO benefit package option, assuming the period of time that has elapsed since the enrollment date (during which the participant was covered under the first benefit package option) exceeds the duration of the HMO affiliation period. Moreover, these regulations clarify that, in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage, but for the affiliation period.

The April 1997 interim rules and these final regulations allow an HMO to use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. Because an affiliation period may be imposed only if no preexisting condition exclusion is imposed, an alternative to an affiliation period may not encompass an arrangement that is in the nature of a preexisting condition exclusion.

7. Interaction With the Family and Medical Leave Act—26 CFR 54.9801–7, 29 CFR 701–8, 45 CFR 146.120

This section has been reserved. For proposed rules on the interaction with the Family and Medical Leave Act, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**.

8. Special Rules; Excepted Plans and Excepted Benefits—26 CFR 54.9831–1, 29 2590.732, 45 CFR 146.145

This section of the final regulations contains special rules that apply for

Chapter 100 of the Code, Part 7 of Subtitle B of Title I of ERISA (Part 7 of ERISA), and Title XXVII of the PHS Act. For ease in applying these rules, the definition of *group health plan* has been moved from the definitions section to this section (and the reference to employees in that definition has been modified to clarify that the term includes both current and former employees). New rules have been added for defining limited scope dental and vision benefits and for determining the extent to which benefits provided under a health flexible spending arrangement are excepted benefits. Special rules for partnerships have also been clarified.

Determination of the Number of Plans

A paragraph has been reserved in the final regulation for determining the number of plans an employer or employee organization maintains. For proposed rules on this topic, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**.

Coverage Provided by an Employer Through Two or More Individual Policies

If an employer provides coverage to its employees through two or more individual policies, the coverage may be considered coverage offered in connection with a group health plan and, therefore, subject to the group market provisions under HIPAA. A determination of whether there is a group health plan depends on the particular facts and circumstances surrounding the extent of the employer's involvement. For example, one significant factor in establishing whether there is a group health plan is the extent to which the employer makes contributions to health insurance premiums. The fact that health insurance coverage is provided through a contract regulated under State law as individual health insurance coverage does not necessarily prevent the coverage from being treated for HIPAA purposes as coverage sold in the group market. Similarly, the policy that provides the coverage does not have to be considered a ''group'' policy under State law in order for the group market requirements to apply. Further, the mere fact that an employer forwards employee payroll deductions to a health insurance issuer will not, alone, cause the coverage to become group health plan coverage. However, the employer need not be a party to the insurance policy, or arrange or pay for it directly, in order for its coverage to be considered group health plan coverage. For example, if an employer's actions appear to endorse one or more policies offered by a health insurance issuer (or issuers), the coverage might be considered group health plan coverage.

General Exception for Certain Small Group Health Plans

Under HIPAA, the April 1997 interim rules, and these final regulations, the group market requirements do not apply to a group health plan or to group health insurance coverage offered in connection with a group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees. As noted in the preamble to the April 1997 interim rules, a State may apply some or all of the group market provisions in the PHS Act to health insurance issuers in connection with group health plans with fewer than two participants who are current employees on the first day of the plan year. In this case, to the extent the State applies its group market provisions to such insurance, the insurance would not be subject to the individual market requirements.

In the event a group health plan has two or more participants who are current employees on the first day of the plan year but the number of participants who are current employees drops below two during the plan year, under these final regulations the group market requirements continue to apply to the group health plan for the duration of the plan year.

To the extent a health insurance issuer offers group health insurance that is subject to HIPAA's group health insurance requirements, HIPAA generally prohibits the issuer from terminating or failing to offer to renew the insurance (*see* 45 CFR 146.152). With respect to very small employers, whether group health insurance is subject to the requirements of 45 CFR 146.152 is generally determined by whether the group health plan has two or more participants who are current employees on the first day of the plan year. If so, the issuer generally must provide such coverage throughout the plan year, and is prohibited from terminating coverage in the midst of that plan year merely because the number of current-employee participants drops below two.[8] However, an issuer is permitted to terminate an employer's coverage in the midst of a plan year if the employer fails to satisfy any valid plan participation requirements in the midst of that plan year (*see* 45 CFR 146.152(a)(3)), including instances where such failure causes the number of current-employee participants to drop below two.

Excepted Benefits

Under HIPAA, the April 1997 interim rules, and these final regulations, certain benefits are excepted from HIPAA in all circumstances, including coverage only for accident (including accidental death and dismemberment); disability income coverage; liability insurance, including general liability insurance and automotive liability insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar coverage; automobile medical payment insurance; credit-only insurance (for example, mortgage insurance); and coverage for on-site medical clinics.

Limited Excepted Benefits

Under HIPAA, the April 1997 interim rules, and these final regulations, limited scope dental benefits, limited scope vision benefits, and long-term care benefits[9] are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan that is subject to these regulations. Benefits are not an integral part of such a plan if participants have the right not to elect coverage for the benefits, and if participants who elect such coverage must pay an additional premium or contribution for it. These regulations clarify that whether limited scope dental benefits, limited scope vision benefits, or long-term care benefits are provided through a plan that is subject to these regulations, or through a separate plan, is irrelevant to determining whether such benefits are an integral part of a plan that is subject to these regulations. Thus, if participants can decline coverage for the limited-scope benefits, and those electing such coverage must pay an additional premium or contribution, the limited scope benefits could be considered not to be an integral part of a plan that is subject to these regulations, even if such benefits are not provided through that plan.

Limited Scope Vision and Dental Benefits

These regulations define *limited scope dental benefits* as benefits

[8] See CMS Program Memorandum No. 99–03, *Group Size Issues Under Title XXVII of the Public Health Service Act,* September 1999.

[9] Long term care benefits are defined as benefits that are either subject to State long-term care insurance laws; that meet the qualifications of section 7702B(c)(1) or 7702B0(b) of the Internal Revenue Code; or are based on cognitive impairment or loss of functional capacity that is expected to be chronic.

substantially all of which are for treatment of the mouth (including any organ or structure within the mouth). These regulations also define *limited scope vision benefits* as benefits substantially all of which are for treatment of the eye. Thus, if benefits meet the definition of limited scope dental benefits or limited scope vision benefits, they will be excepted benefits if they satisfy the requirements set forth in these regulations.

These definitions were added in response to questions raised in comments about the prior guidance. The April 1997 interim rules did not define these terms. The preamble to the April 1997 interim rules suggested that the term *limited scope dental benefits* typically does not include medical services, such as those procedures associated with oral cancer or with a mouth injury that results in broken, displaced, or lost teeth. Similarly, the preamble to the April 1997 interim rules suggested that the term *limited scope vision benefits* does not include benefits for such ophthalmological services as treatment of an eye disease (such as glaucoma or a bacterial eye infection) or an eye injury. Comments indicated that typically most independent dental and vision coverages include benefits for these types of medical services. Accordingly, these regulations include definitions of limited scope dental benefits and limited scope vision benefits that reflect this market reality.

Health FSAs

Some comments asked about the extent to which health flexible spending arrangements (FSAs) are subject to these regulations. A health FSA generally is a benefit program that provides employees with coverage under which specified, incurred expenses may be reimbursed (subject to reimbursement maximums and any other reasonable conditions) and under which the maximum amount of reimbursement that is reasonably available to a participant for a period of coverage is not substantially in excess of the total premium (including both employee-paid and employer-paid portions of the premium) for the participant's coverage. Coverage and reimbursements provided to an individual under a group health plan that is a health FSA and that conforms to the generally applicable rules for accident or health plans qualify for the same tax-favored treatment that generally is extended to coverage and reimbursements under employer-provided accident or health plans. Health FSA reimbursements typically provide coverage for medical care expenses not otherwise covered by the employer's primary group health plan. A health FSA is permitted to operate under a cafeteria plan described in section 125 of the Code. Pursuant to the rules of section 125, an employee can elect to reduce the employee's salary in order to pay for health FSA coverage without the employee having to include that portion of the salary in gross income. Commonly, the maximum benefit payable under a health FSA for any year is equal to the amount of the employee's salary reduction election for the year, plus any additional employer contribution for the year.

The April 1997 interim rules did not address the extent to which health FSAs qualify as excepted benefits. On December 29, 1997, a clarification to the April 1997 interim rules was published that specified the circumstances under which a health FSA qualifies as excepted benefits. (62 FR 67688) That clarification stated that benefits under a health FSA are treated as excepted benefits if the FSA meets certain requirements. Specifically, FSA benefits are treated as excepted benefits if the maximum benefit payable for the employee under the FSA for the year does not exceed two times the employee's salary reduction election under the FSA for the year (or, if greater, the amount of the employee's salary reduction election under the FSA for the year, plus $500). In addition, the employee must have other coverage available under a group health plan of the employer for the year, and that other coverage cannot be limited to benefits that are excepted benefits.

Based on section 9832(c)(2)(C) of the Code, section 733(c)(2)(C) of ERISA, and section 2791(c)(2)(C) of the PHS Act, these regulations adopt the December 29, 1997 guidance with some additional clarifications. Specifically, these regulations clarify that to be considered excepted benefits, a health FSA must meet the definition of a health FSA in section 106(c)(2) of the Code. Also, these regulations clarify that other group health plan coverage not limited to excepted benefits must be made available for the year to the class of participants by reason of their employment. Similarly, the maximum amount payable to any participant in the class for the year is the amount to consider when determining whether the maximum amount payable under the FSA for the year complies with the limit specified in the previous paragraph. Additionally, these regulations clarify that an employer credit under a health FSA that an employee can elect to receive as taxable income is considered an employee salary reduction election. However, if the employee cannot receive the employer credit as taxable income (that is, the credit is lost unless the employee uses the amount for nontaxable benefits under a cafeteria plan), then the amount is not considered an employee salary reduction election.

Application to HSAs and HDHPs

Section 1201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108–173, added section 223 to the Internal Revenue Code to permit individuals to establish Health Savings Accounts (HSAs). HSAs are established to receive tax-favored contributions and amounts in an HSA may be used to pay or reimburse qualified medical expenses. Questions have arisen concerning the application of HIPAA to HSAs.

In order to establish and contribute to an HSA, an individual must be covered by a High Deductible Health Plan (HDHP). An HDHP is a health plan that satisfies certain requirements with respect to deductibles and out-of-pocket expenses. An HDHP may be a group health plan sponsored by an employer or individual health insurance coverage purchased in the individual market. There is no provision in the HIPAA rules that excludes an HDHP, by virtue of qualifying as an HDHP, from the respective HIPAA requirements for group health plans or individual health insurance coverage. Generally, employer-sponsored HDHPs are employee welfare benefit plans. See Department of Labor Field Assistance Bulletin 2004–01 (FAB 2004–01), issued on April 7, 2004. Because an employer-sponsored HDHP provides medical care, it is generally subject to the portability requirements of HIPAA and the applicable regulations.

FAB 2004–01 concluded that HSAs, in contrast to HDHPs, generally will not constitute employee welfare benefit plans. See Department of Labor Field Assistance Bulletin 2004–01 (FAB 2004–01), issued on April 7, 2004. Because HSAs are generally not employee welfare benefit plans, the HIPAA portability requirements under ERISA or the PHS Act generally will not apply.

Moreover, the HIPAA portability requirements generally are not relevant for purposes of HSAs. Due to the rules imposed by the Internal Revenue Code with respect to HSAs, employers or HSA trustees do not have discretion with respect to the coverage provided by an HSA, both with respect to what expenses qualify for reimbursement as well as which individuals' expenses are eligible. For example, expenses reimbursable by an HSA cannot

generally be restricted by the employer or HSA trustee. Under the statute and administrative guidance, any expense incurred after an HSA is established is eligible for reimbursement, without restriction by an employer contributing to the HSA or trustee of the HSA. Thus, as a practical matter, whether or not an expense relates to a preexisting condition cannot determine the reimbursement. As such HSAs by design cannot impose a preexisting condition exclusion. Similarly, due to comparability rules requiring uniform contributions to HSAs by employers, employers and trustees generally cannot use differing amounts of contributions to impose a preexisting condition exclusion.

The eligibility for tax-free reimbursement from an HSA is also determined by statute; namely, the qualified medical expenses of the HSA owner and the HSA owner's dependents incurred after the HSA is established may be reimbursed on a tax-free basis by the HSA. Special enrollment rules for dependent children or spouses are not relevant because once an HSA is established they are eligible for tax-free reimbursements immediately. With respect to special enrollment upon loss of coverage, the rules for employer contributions generally require that all employees who are eligible for HSA contributions and participating in the employer's HDHP receive comparable HSA contributions. Thus, the combination of the comparability rules and the application of the special enrollment rules to the HDHP will generally ensure compliance with respect to employer HSA contributions because once an employee is enrolled in an employer-provided HDHP due to the special enrollment rules, the employer must make comparable contributions to the employee's HSA.

Indemnity Insurance

Under HIPAA, the April 1997 interim rules, and these final regulations, hospital indemnity and other fixed-dollar indemnity insurance are excepted benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; if there is no coordination of benefits between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and if the benefits are paid with respect to an event regardless of whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor. These regulations clarify that, for hospital indemnity or other fixed-dollar indemnity insurance to qualify as excepted benefits, such insurance must pay a fixed dollar amount per day (or other period), regardless of the amount of expenses incurred. An example clarifies that if a policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum amount per day, the benefits are not excepted benefits. This is the result even if, in practice, the policy pays the maximum for every day of hospitalization.

Supplemental Insurance

Under HIPAA, the April 1997 interim rules, and these final regulations, Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act); coverage supplemental to TRICARE; and similar coverage that is supplemental to a group health plan are excepted benefits if they are provided under a separate policy, certificate, or contract of insurance. These regulations clarify that, for coverage supplemental to a group health plan to qualify as excepted benefits, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Coverage that becomes secondary or supplemental only under a coordination-of-benefits provision in the insurance contract or plan documents does not qualify as excepted supplemental benefits.

Treatment of Partnerships

Any plan, fund, or program that is established or maintained by a partnership and that provides medical care to present or former partners or their dependents, and that otherwise would not be an employee welfare benefit plan, is considered an employee welfare benefit plan that is a group health plan under Part 7 of ERISA and Title XXVII of the PHS Act.[10] As such, the partnership is considered the employer with respect to any partner. Participants in the plan include individuals who are partners of the partnership. Additionally, with respect to group health plans maintained by self-employed individuals (under which one or more employees are participants), the self-employed individual is considered a participant if this individual is or may become eligible to receive a benefit under the plan or if the individual's beneficiaries may be so eligible. These regulations clarify that, for purposes of Part 7 of ERISA and Title XXVII of PHS Act, a partner must be a bona fide partner in order to be considered an employee, and the partnership is considered the employer of a partner only if the partner is a bona fide partner. These final regulations also clarify that whether an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

Counting the Average Number of Employees

A paragraph has been reserved in the final rules for determining the average number of employees employed by an employer for a year. For proposed rules on this topic, see the Departments' notice of proposed rulemaking, published elsewhere in this issue of the **Federal Register**.

C. Economic Impact and Paperwork Burden

Summary—Department of Labor and Department of Health and Human Services

HIPAA's group market portability provisions, which include limitations on the scope and application of preexisting condition exclusions, and special enrollment rights, provide a minimum standard of protection designed to increase access to health coverage. The Departments crafted these final regulations to secure these protections, consistent with the intent of Congress, and to do so in a manner that is economically efficient.

The primary economic effects of HIPAA's portability provisions ensue directly from the statute. These regulations, by clarifying and securing HIPAA's statutory protections, will delineate and possibly expand HIPAA's effects at the margin.

Effects of the Statute

HIPAA's statutory group market portability provisions extend coverage to certain individuals and preexisting conditions not otherwise covered. This extension of coverage entails both benefits and costs. Individuals enjoying expanded coverage will realize benefits. In some instances these individuals will gain coverage for services they otherwise would have purchased out-of-pocket. In other instances the extension of coverage will induce individuals to consume more (or different) health care services, which in some cases may improve health outcomes. The dollar value of the extended coverage is estimated to be $515 million annually. Potential additional benefits from improved health outcomes are difficult

[10] Such a plan, fund, or program is also considered a group health plan under section 5000(b)(1) and Chapter 100 of the Code.

to quantify (and the Departments have not attempted to do so), but may be large in aggregate, and will be large for at least some individuals whose health outcomes may be substantially improved. Another indirect benefit of HIPAA's portability provisions is a reduction in so-called ''job lock''—a phenomenon in which individuals keep jobs they would prefer to leave to avoid losing coverage for preexisting conditions. If workers move into more productive jobs, the overall economy will benefit.

It should be noted that the benefits of HIPAA's portability provisions in any given year will be concentrated in a relatively small population that gains coverage under HIPAA for needed care that would otherwise not be covered. The number that might so benefit has been estimated at 100,000 individuals.

The direct costs of HIPAA's portability provisions generally include the cost of extending coverage to additional services, as well as certain attendant administrative costs. The cost of extended coverage is estimated at $515 million annually. The major administrative costs include the cost of providing certificates of creditable coverage, and possibly the cost of carrying out special enrollments and offsets of preexisting condition exclusion periods. The Departments did not attempt to fully estimate the administrative costs of the HIPAA statute but in crafting this regulation did attempt to constrain these costs.

The Departments believe that the cost of HIPAA is borne by covered workers. Cost can be shifted to workers through increases in employee premium shares or reductions (or smaller increases) in pay or other components of compensation, or by increases in deductibles or other cost sharing or other reductions in the richness of health benefits. Whereas the benefits of HIPAA are concentrated in a relatively small population, the costs are distributed broadly across plans and enrollees.

The Departments have considered whether the costs imposed by HIPAA's statutory portability provisions have had any major indirect negative effects, and concluded that such effects are possible but probably small.

Any mandate to increase the richness or availability of health insurance adds to the cost of insurance. It is possible that some small number of employers and employees already at the brink of affordability would drop coverage in response to the implementation of HIPAA. The Departments also note that the estimated $515 million cost associated with extensions of coverage under HIPAA amounts to a small fraction of one percent of total expenditures by private group health plans. This suggests that the cost of HIPAA is a small, possibly negligible, factor in most employers' decisions to offer health coverage and workers' decisions to enroll. The Departments believe that the benefits of HIPAA's statutory group market portability provisions justify their cost. The Departments' full assessment of the costs and benefits of HIPAA's statutory provisions and their basis for that assessment is detailed later in the preamble.

Effects of the Final Regulations

By clarifying and securing HIPAA's statutory portability protections, these regulations will help ensure that HIPAA rights are fully realized. The result is likely to be a small increase at the margin in the direct and indirect economic effects of HIPAA's statutory portability provisions. The Departments believe that the regulation's benefits will justify its costs.

Additional economic benefits derive from the regulations' clarifications of HIPAA's portability requirements. By clarifying employees' rights and plan sponsors' obligations under HIPAA's portability provisions, the regulations will reduce uncertainty over health benefits, thereby fostering labor market efficiency and the establishment and continuation of group health plans by employers.

Many provisions of the final regulations closely resemble provisions included in the interim final regulations that the final regulations supplant. This regulatory action, however, adds or amends both certain provisions directed at the scope of HIPAA's portability protections and certain provisions establishing administrative requirements intended to safeguard those protections.

Scope of Protections

These final regulations are intended to secure and implement HIPAA's group market portability provisions under certain special circumstances. The final regulations therefore contain a number of provisions intended to clearly delimit the scope of HIPAA's portability protections. Most of these provisions closely resemble and will have the same effect as provisions of the interim final regulations. Others, however, clarify or expand at the margin the range of situations to which HIPAA's portability protections apply or in which a loss of eligibility may trigger special enrollment rights. These include the requirement that health coverage under foreign government programs be treated as creditable coverage for purposes of limiting the application of preexisting condition exclusions; the extension of special enrollment rights to individuals who lose eligibility for coverage in connection with the application of lifetime benefit limits, movement out of an HMO's service area, or the termination of a health coverage option previously offered under a group health plan; and the establishment of a special enrollment right for a participant to change among available coverage options under a group health plan when adding one or more dependents in connection with marriage, adoption, or placement for adoption. Each of these provisions is expected to result in a small increase in the economic effects of HIPAA's statutory portability protections. The Departments have no basis to quantify these small increases. The potential size of affected sub populations is explored later in the preamble.

Administrative Requirements

In order to secure and implement HIPAA's group market special enrollment and portability provisions, both the HIPAA statute and these final regulations establish certain administrative requirements.

As noted above, the HIPAA statute generally requires plans and issuers to provide certifications of prior coverage to individuals leaving coverage. These regulations additionally require plans and issuers to notify individuals of their special enrollments rights, any preexisting condition exclusion provisions, and the applicability of such exclusions where individuals provide evidence of prior coverage that is of insufficient duration to fully offset exclusion periods. Plans will incur cost to comply with these administrative requirements. The Departments estimate the administrative cost to prepare and distribute certifications and notices to be $97 million per year. Nearly all of this, or $96 million, is attributable to the preparation and distribution of certifications as required under HIPAA's statutory provisions. These final regulations include numerous special provisions that serve to reduce plans' cost of providing certifications. A more strict interpretation of the statute would require plans to send an individual certificate to each affected enrollee. Such strict interpretation would result in plans sending 80.1 million certificates annually at cost of $157.6 million, which is $61.6 million more than the burden imposed by the final regulations.

Generally all of the major administrative requirements included in the final regulations were also included in the interim final regulations. The final regulations make minor additions to two requirements, however. They require plans to include educational statements in certificates of creditable coverage and to maintain in writing their procedures for requesting certificates. The cost of these additional requirements is expected to be small, and was not estimated separately from the overall cost of providing certificates.

Other changes included in these final regulations are likely to slightly reduce plans' cost to provide certain HIPAA-required notices. Included with the final regulation is new sample language for general and specific notices of preexisting condition exclusions, which may serve to reduce some plans' costs of providing these notices, and revised sample language for special enrollment rights notices. The final regulations also clarify the narrow scope of the requirement to notify certain affected participants of the specific application of preexisting condition exclusions. The Departments did not estimate the impact of these provisions separately from the overall cost of providing general and specific notices of preexisting condition exclusions and notices of special enrollment rights.

The Departments' full assessment of the costs and benefits of this regulation and their basis for that assessment is detailed later in this preamble.

Executive Order 12866—Department of Labor and Department of Health and Human Services

Under Executive Order 12866 (58 FR 551735, Oct. 4, 1993), the Departments must determine whether a regulatory action is ''significant'' and therefore subject to the requirements of the Executive Order and subject to review by the Office of Management and Budget (OMB). Under section 3(f), the order 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, 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 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.

Pursuant to the terms of the Executive Order, this action is ''economically significant'' and subject to OMB review under Section 3(f) of the Executive Order. Consistent with the Executive Order, the Departments have assessed the costs and benefits of this action. The Departments' assessment, and the analysis underlying that assessment, is detailed below. The Departments performed a comprehensive, unified analysis to estimate the costs and benefits attributable to the regulations for purposes of compliance with Executive Order 12866, the Regulatory Flexibility Act, and the Paperwork Reduction Act.

Statement of Need for Action

These final regulations are needed to clarify and interpret the HIPAA portability provisions (increased portability through limitation on preexisting condition exclusions) under Section 701 of the Employee Retirement Income Security Act of 1974 (ERISA), Section 2701 of the Public Health Service Act, and Section 9801 of the Internal Revenue Code of 1986. The provisions are needed to improve the availability and portability of health coverage by limiting preexisting condition exclusions and their use, and requiring that group health plans and group health insurance issuers allow individuals to enroll under certain circumstances (special enrollment). Additional guidance was required to clarify certain definitions, such as the definition of creditable coverage; to clarify the method of determining the proper length of a preexisting condition exclusion period for an individual; to describe the circumstances under which an individual must be allowed a special enrollment opportunity; and to describe notices that group health plans and group health insurance issuers must provide to individuals.

Economic Effects

The Departments believe that this regulation's benefits will justify its costs. This belief is grounded in the assessment of costs and benefit that is summarized earlier in the preamble and detailed below.

Regulatory Flexibility Act—Department of Labor and Department of Health and Human Services

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.*) that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a rule will not have a significant economic impact on a substantial number of small entities, section 604 of the RFA requires the agency to present a final regulatory flexibility analysis at the time of the publication of the notice of final rulemaking describing the impact of the rule on small entities. Small entities include small businesses, organizations, and governmental jurisdictions.

Because these final rules are being issued without prior notices of proposed rulemaking, the RFA does not apply, and the Departments are not required to either certify that the rule will not have a significant impact on a substantial number of small entities or conduct a regulatory flexibility analysis. The Departments nonetheless crafted these regulations in careful consideration of their effects on small entities.

For purposes of this discussion, the Departments consider a small entity to be an employee benefit plan with fewer than 100 participants. The basis for this definition is found in section 104(a)(2) of ERISA, which permits the Secretary of Labor to prescribe simplified annual reports for pension plans which cover fewer than 100 participants. Under section 104(a)(3), the Secretary may also provide for simplified annual reporting and disclosure if the statutory requirements of part 1 of Title I of ERISA would otherwise be inappropriate for welfare benefit plans. Pursuant to the authority of section 104(a)(3), the Department of Labor has previously issued at 29 CFR 2520.104–20, 2520.104–21, 2520.104–41, 2520.104–46 and 2520.104b–10, certain simplified reporting provisions and limited exemptions from reporting and disclosure requirements for small plans, including unfunded or insured welfare plans covering fewer than 100 participants and which satisfy certain other requirements.

Further, while some small plans are maintained by large employers, most are maintained by small employers. Both small and large plans may enlist small third party service providers to perform administrative functions, but it is generally understood that third party service providers transfer their costs to their plan clients in the form of fees. Thus, the Departments believe that assessing the impact of this rule on small plans is an appropriate substitute for evaluating the effect on small entities. The definition of small entity

considered appropriate for this purpose differs, however, from a definition of small business based on size standards promulgated by the Small Business Administration (SBA) (13 CFR 121.201) pursuant to the Small Business Act (5 U.S.C. 631 *et seq.*). The Department of Labor solicited comments on the use of this standard for evaluating the effects of the interim final on small entities. No comments were received with respect to the standard.

The Departments believe that the benefits of this regulation will justify its costs. This belief is grounded in the assessment of costs and benefit that is summarized earlier in the preamble and detailed below in the ''Basis for Assessment of Economic Impact'' section. The direct financial value of coverage extensions pursuant to HIPAA's portability provisions are estimated to be approximately $180 million for small plans, or a small fraction of one percent of total small plan expenditures.[11]

In order to secure and implement HIPAA's portability provisions, the HIPAA statute and interim final regulations established certain administrative requirements, including requirements to provide certifications of creditable coverage and notices of special enrollment rights and preexisting condition exclusions. The Departments estimate the cost for small plans to prepare and distribute certifications and notices to be $13 million per year.[12] These costs will initially be borne by issuers who supply small group insurance products and by third-party administrators who provide services to small insured plans. These two types of entities will spread the costs across a much larger pool of small plans who will in turn transfer cost broadly to plan enrollees.

Special Analyses—Department of the Treasury

Notwithstanding the determinations of the Departments of Labor and of Health and Human Services, for purposes of the Department of the Treasury it has been determined that this Treasury decision is not a significant regulatory action. Pursuant to sections 603(a) and 605(b) of the Regulatory Flexibility Act, it is hereby certified that the collections of information referenced in this Treasury decision (*see* §§ 54.9801–3, 54.9801–4, 54.9801–5, and 54.9801–6) will not have a significant economic impact on a substantial number of small entities. Although a substantial number of small entities will be subject to the collection of information requirements in these regulations, the requirements will not have a significant economic impact on these entities. The average time required to complete a certification required under these regulations is estimated to be 4 to 5 minutes for all employers. This average is based on the assumption that most employers will automate the certification process. The paperwork requirements other than certifications that are contained in the regulations are estimated to impose less than 2% of the burden imposed by the certifications. Many small employers that maintain group health plans have their plans administered by an insurance company or third party administrators (TPAs). Most insurers and TPAs are expected to automate the certification process and therefore their average time to produce a certificate should be similar to the 4 to 5 minute average estimated for all employers. However, even for small employers that do not automate the certification process, the collection of information requirements in the regulation will not have a significant impact. Even if it is conservatively assumed that their average time to produce a certificate is 3 times as long as the highest estimate for all employers (*i.e.*, 15 minutes per certificate) and that all of their employees are covered by their group health plan and that half of the employees receive a certificate each year, the average burden per employee is less than 8 minutes per year. This can be rounded up to 8 minutes to more than account for the additional burden imposed by the other paperwork requirements of the final regulations. Thus, for example, for an employer with 10 employees, the annual burden would be not more than 1 hour and 20 minutes per year. At an estimated cost of $18 per hour, this would result in a cost of not more than $24 per year for the employer, which is not a significant economic impact. Because the collection of information requirements of this Treasury decision will not have a significant economic impact on a substantial number of small entities, a Regulatory Flexibility Analysis under the Regulatory Flexibility Act (5 U.S.C. chapter 6) is not required. Pursuant to section 7805(f) of the Code, the notice of proposed rulemaking preceding these regulations was submitted to the Small Business Administration for comment on its impact on small business.

Paperwork Reduction Act

Department of Labor

These final regulations include three separate collections of information as that term is defined in the Paperwork Reduction Act of 1995 (PRA 95), 44 U.S.C. 3502(3): the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by the Office of Management and Budget (OMB) through October 31, 2006 in accordance with PRA 95 under control numbers 1210–0101, 1210–0102, and 1210–0103.

Department of the Treasury

These final regulations include a collection of information as that term is defined in PRA 95: the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by OMB under control number 1545–1537.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid control number assigned by the Office of Management and Budget.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Department of Health and Human Services

These final regulations include three separate collections of information as that term is defined in PRA 95: the Notice of Enrollment Rights, Notice of Preexisting Condition Exclusion, and Certificate of Creditable Coverage. Each of these disclosures is currently approved by OMB through June 30, 2006 in accordance with PRA 95 under control number 0938–0702.

[11] Computer runs using Medical Expenditure Survey Household Component (MEPS–HC) and the Robert Wood Johnson Employer Healthy Benefits Survey determined that the share of covered private-sector job leavers at small firms average 35 percent of all covered private sector job leavers. From this, we inferred that the financial burden borne by small plans is approximately 35 percent of the total expenditures by private-sector group health plans.

[12] As noted above, the total cost for certificates and notices is estimated to be $97 million. We estimate that 13 percent of individuals receiving certificates and notices receive them from small group health plans, and on that basis estimates that 13% of the total cost falls on such plans. As noted below, we estimate that out of a total of 54 million individuals who leave coverage under group health plans, individual health insurance policies or public programs, 20 million, or 44 percent, are leaving private-sector group plans. Assuming that the proportion of these that are leaving small plans is equal to the proportion of covered, private-sector job leavers who leave small firms (estimated to be 35 percent, as noted above), 13 percent of those leaving any type of coverage are leaving coverage under small group plans.

Small Business Regulatory Enforcement Fairness Act

This final rule is subject to the provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and is being transmitted to Congress and the Comptroller General for review. The final rule, is a ''major rule,'' as that term is defined in 5 U.S.C. 804, because it may result in (1) an annual effect on the economy of $100 million or more; (2) a major increase in costs or prices for consumers, individual industries, or federal, State or local government agencies, or geographic regions; or (3) significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. These final regulations have no such mandated consequential effect on State, local, or tribal governments, or on the private sector.

Federalism Statement Under Executive Order 13132—Department of Labor and Department of Health and Human Services

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 regulation.

In the Departments' view, these final regulations have federalism implications because they may 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. However, in the Departments' view, the federalism implications of these final regulations are substantially mitigated because, with respect to health insurance issuers, the vast majority of States have enacted laws which meet or exceed the federal HIPAA portability standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking or securities. While ERISA prohibits States from regulating a plan as an insurance or investment company or bank, HIPAA added a new section to ERISA (as well as to the PHS Act) narrowly preempting State requirements for issuers of group health insurance coverage. Specifically, with respect to seven provisions of the HIPAA portability rules, States may impose stricter obligations on health insurance issuers.[13] Moreover, with respect to other requirements for health insurance issuers, States may continue to apply State law requirements except to the extent that such requirements prevent the application of HIPAA's portability, access, and renewability provisions.

In enacting these new preemption provisions, Congress intended to preempt State insurance requirements only to the extent that they prevent the application of the basic protections set forth in HIPAA. HIPAA's conference report States that the conferees intended the narrowest preemption of State laws with regard to health insurance issuers. H.R. Conf. Rep. No. 736, 104th Cong. 2d Session 205 (1996). State insurance laws that are more stringent than the federal requirements are unlikely to ''prevent the application of'' the HIPAA portability provisions, and be preempted. Accordingly, States have significant latitude to impose requirements on health insurance insurers that are more restrictive than the federal law.

Guidance conveying this interpretation of HIPAA's preemption provisions was published in the **Federal Register** on April 8, 1997. 62 FR 16904.

[13] States may shorten the six-month look-back period prior to the enrollment date; shorten the 12-month and 18-month maximum preexisting condition exclusion periods; increase the 63-day significant break in coverage period; increase the 30-day period for newborns, adopted children, and children placed for adoption to enroll in the plan with no preexisting condition exclusion; further limit the circumstances in which a preexisting condition exclusion may be applied (beyond the federal exceptions for certain newborns, adopted children, children placed for adoption, pregnancy, and genetic information in the absence of a diagnosis; require additional special enrollment periods; and reduced the HMO affiliation period to less than 2 months (3 months for late enrollees).

These final regulations clarify and implement the statute's minimum standards and do not significantly reduce the discretion given the States by the statute. Moreover, the Departments understand that the vast majority of States have requirements that meet or exceed the minimum requirements of the HIPAA portability provisions.

HIPAA provides that the States may enforce the provisions of HIPAA as they pertain to issuers, but that the Secretary of Health and Human Services must enforce any provisions that a State fails to substantially enforce. Currently, HHS enforces the HIPAA portability provisions in only one State in accordance with that State's specific request to do so. When exercising its responsibility to enforce the provisions of HIPAA, HHS works cooperatively with the State for the purpose of addressing the State's concerns and avoiding conflicts with the exercise of State authority. HHS has developed procedures to implement its enforcement responsibilities, and to afford the States the maximum opportunity to enforce HIPAA's requirements in the first instance. HHS's procedures address the handling of reports that States may not be substantially enforcing HIPAA's requirements, and the mechanism for allocating responsibility between the States and HHS. In compliance with Executive Order 13132's requirement that agencies examine closely any policies that may have federalism implications or limit the policymaking discretion of the States, DOL and HHS have engaged in numerous efforts to consult and work cooperatively with affected State and local officials.

For example, the Departments sought and received input from State insurance regulators and the National Association of Insurance Commissioners (NAIC). The NAIC is a non-profit corporation established by the insurance commissioners of the 50 States, the District of Columbia, and the four U.S. territories. In most States the Insurance Commissioner is appointed by the Governor, in approximately 14 States, the insurance commissioner is an elected official. Among other activities, it provides a forum for the development of uniform policy when uniformity is appropriate. Its members meet, discuss and offer solutions to mutual problems. The NAIC sponsors quarterly meetings to provide a forum for the exchange of ideas and in-depth consideration of insurance issues by regulators, industry representatives and consumers. CMS and the Department of Labor staff have consistently attended these quarterly meetings to listen to the concerns of the

State Insurance Departments regarding HIPAA portability issues. In addition to the general discussions, committee meetings, and task groups, the NAIC sponsors the standing CMS/DOL meeting on HIPAA issues for members during the quarterly conferences. This meeting provides CMS and the Department of Labor with the opportunity to provide updates on regulations, bulletins, enforcement actions, and outreach efforts regarding HIPAA.

The Departments received written comments on the interim regulation from the NAIC and from ten States. In general, these comments raised technical issues that the Departments considered in conjunction with similar issues raised by other commenters. In a letter sent before issuance of the interim regulation, the NAIC expressed concerns that the Departments interpret the new preemption provisions of HIPAA narrowly so as to give the States flexibility to impose more stringent requirements. As discussed above, the Departments address this concern in the preamble to the interim regulation.

In addition, the Departments specifically consulted with the NAIC in developing these final regulations. Through the NAIC, the Departments sought and received the input of State insurance departments regarding certain insurance industry definitions, enrollment procedures and standard coverage terms. This input is generally reflected in the discussion of comments received and changes made in Section B—Overview of the Regulations of the preamble to these regulations.

The Departments have also cooperated with the States in several ongoing outreach initiatives, through which information on HIPAA is shared among federal regulators, State regulators and the regulated community. In particular, the Department of Labor has established a Health Benefits Education Campaign with more than 70 partners, including CMS, NAIC and many business and consumer groups. CMS has sponsored conferences with the States—the Consumer Outreach and Advocacy conferences in March 1999 and June 2000, and the Implementation and Enforcement of HIPAA National State-Federal Conferences in August 1999, 2000, 2001, 2002, and 2003. Furthermore, both the Department of Labor and CMS Web sites offer links to important State Web sites and other resources, facilitating coordination between the State and federal regulators and the regulated community.

Throughout the process of developing these regulations, to the extent feasible within the specific preemption provisions of HIPAA, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and the Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in Section 8(a) of Executive Order 13132, and by the signatures affixed to these final regulations, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached final regulation, Final Regulations for Health Coverage Portability for Group Health Plans and Group Health Insurance Issuers (RIN 1210–AA54 and RIN 0938–AL43), in a meaningful and timely manner.

Basis for Assessment of Economic Impact—Department of Labor and Department of Health and Human Services

As noted above, the primary economic effects of HIPAA's portability provisions ensue directly from the statute. These regulations, by clarifying and securing HIPAA's statutory protections, will delineate and possibly expand HIPAA's effects at the margin.

Effects of the Statute

In order to determine how many workers could benefit from crediting prior coverage against a new health plan's preexisting condition exclusion period, we examined the 18 million individuals who changed jobs in 2002. Of these, approximately 1 in 3 had health care coverage at those jobs and an additional 8 million dependents also received employer-sponsored health care coverage through these job changers. By allowing prior creditable coverage, 4 million job changers, who had at least 12 months of prior creditable coverage, were able to change jobs without the risk of a preexisting condition exclusions for them or their 5 million dependents. An additional 2 million workers who changed jobs and had some smaller amount of prior coverage, faced reduced waiting periods before receiving full coverage for them and their 3 million dependents.[14]

The most direct effect of HIPAA's statutory group market portability provisions is the extension of coverage to individuals and preexisting conditions not otherwise covered. This extension of coverage entails both benefits and costs. Individuals enjoying expanded coverage will realize benefits. In some instances these individuals will gain coverage for services they otherwise would have purchased out-of-pocket, thereby reaping a simple and direct financial benefit In other instances the extension of coverage will induce individuals to consume more (or different) health care services, reaping a benefit which has financial value, and which in some cases will produce additional indirect benefits both to the individual (improved health) and possibly to the economy at large (increased productivity).[15] The simple financial value of the direct benefits (essentially the dollar value of the extended coverage) is estimated to be $515 million.[16] The indirect benefits are

[14] We calculated these estimates using internal runs off the MEPS–HC. These runs gave the number of total job changers, total job changers that had employer-sponsored insurance (ESI), and whether this coverage had been for less than 12 months or not. Estimates for dependents were based off the ratio of policy-holders to total dependents from the March 2003 Current Population Survey (March CPS). This approach to the question of how many people are impacted by increased portability parallels that of the September 1995 U.S. General Accounting Office (GAO), Report HEHS–95–257, ''Health Insurance Portability: Reform Could Ensure Continued Coverage for up to 25 Million Americans,'' September 1995.

[15] For more detailed information, see Ellen O'Brien's article ''Employer' Benefits from Workers' Health Insurance'' Milbank Quarterly, Vol. 1 No. 1, 2003. She provides an extensive analysis of the literature on benefits accruing to employers from offering health benefits. She reports that researchers are beginning to calculate the costs to employers of unhealthy employees. Her work provides information on studies that have demonstrated that poor health may be related to lower productivity. For example, she discusses studies that have examined the effects on workplace productivity of specific health conditions and show that poor health reduces workers' productivity at work, and that effective health care treatments can reduce productivity losses and may even pay for themselves in terms of increased productivity.

[16] The estimate of $515 million is the 1999 projection published in the August 1, 1996 Congressional Budget Office (CBO) report, ''Estimate of Costs of Private Sector Mandates;'' Bill Number H.R. 3103, indexed. The index is derived from the average annual percent change from 1999 to 2004 in aggregate private health insurance expenditures, as reported in Table 3 of the ''National Health Care Projections Tables'' by the Centers for Medicare & Medicaid Services, Office of the Actuary. CBO estimated the direct cost to the private sector would total about $300 million in 1999. The specific items included in the estimate are: (1) Limiting the length of time employer-sponsored and group insurance plans could withhold coverage for pre-existing conditions, and (2) requiring that periods of continuous prior health plan coverage be credited against pre-existing condition exclusions of a new plan.

According to CBO, two-thirds of the cost reflects the provision to limit exclusions for pre-existing conditions. The key components of this estimate are: (1) The number of people who would have more of their medical expenses covered by insurance if exclusions were limited to one year or less, and (2) the average cost to insurers of that newly insured medical care. The provision

difficult to quantify (and the Departments have not attempted to do so), but may be large in aggregate, and will be large for at least some individuals whose health outcomes may be substantially improved.

Another indirect (though intended) benefit of HIPAA's portability provisions is a reduction in so-called ''job lock.'' Job lock occurs when an individual stays in a job with health insurance that he or she would prefer to leave out of concern that he or she would lose coverage for care of his or her own or a covered dependent's preexisting condition[17].

No attempt is made here to quantify increases in labor force mobility attributable to reduced job lock under HIPAA. However, it is noted that at least two indirect economic effects are likely to follow such increased mobility. First, the cost of coverage for some preexisting conditions will be transferred from one plan or issuer to another.[18] Second, if, as is likely, a result is movement of workers into more productive jobs, the overall economy will benefit.

It should be noted that the benefits of HIPAA's portability provisions in any given year will be concentrated in a relatively small population—generally, individuals who because of some combination of family health status and use of health services, job mobility, and plan provisions related to preexisting condition exclusions or enrollment opportunities, gain coverage under HIPAA for needed care that would otherwise not be covered.

According to CBO, any point in time, about 100,000 individuals would have a preexisting condition exclusion reduced for prior creditable coverage. An additional 45,000 would gain added coverage in the individual market.[19]

The direct costs of HIPAA's portability provisions generally include the cost of extending coverage to additional services, as well as certain attendant administrative costs. The cost of extended coverage is estimated at $515 million annually. The major administrative costs include the cost of providing certificates of creditable coverage, and possibly the cost of carrying out special enrollments and offsets of preexisting condition exclusion periods. The Departments did not attempt to fully estimate the administrative costs of the HIPAA statute but did, in crafting this regulation, attempt to constrain these costs, where possible. without compromising HIPAA's intent, as discussed below.

The Departments considered the probable incidence of these costs. The Departments believe that by and large the cost of HIPAA, like all of the cost of group health benefits, are borne by covered workers.[20] The most direct ways this cost can be shifted to workers is through increases in employee premium shares or reductions (or smaller increases) in pay or other components of compensation. Other paths for shifting of HIPAA's cost to workers might include increases in deductibles or other cost sharing, or other reductions in the richness of health benefits.

Whereas the benefits of HIPAA are concentrated in a relatively small population, the costs are distributed broadly across plans and enrollees. The cost for affected large, self-insured or experience rated group plans is spread across all enrollees in the plan. The cost for small insured plans typically is spread across large populations of small plans and their enrollees, partly as a result of State laws that compress small group premium rates.

The Departments have considered whether the costs imposed by HIPAA's statutory portability provisions have had any major indirect negative effects, and concluded that such effects are possible but probably small.

Any mandate to increase the richness or availability of health insurance adds to the cost of insurance. It is possible that some small number of employers already at the brink of affordability would drop coverage in response to the implementation of HIPAA. The number of employers so affected is probably limited in part because as noted above, employers can shift HIPAA's cost to workers in various ways, including through increases in employee premium shares or cost sharing—though such increases might prompt some workers at the margin to decline coverage. Economic literature provides some estimates of the responsiveness of employers and workers to increases in the price of insurance.[21]

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crediting prior coverage against current exclusions will account for a third of the cost. This estimate is based on two components: (1) The number of people who would receive some added coverage, and (2) the additional full-year cost of coverage, adjusted to reflect the estimated number of months of that coverage.

[17] Findings on the effect of health insurance coverage on job mobility have been mixed. A thorough assessment of the job lock literature in the past 10 years concluded that the most convincing evidence suggests that health insurance plays an important role in job mobility decisions, but is unclear as to its implications (*see* Gruber, Jonathan and Brigitte C. Madrian, 2002, Health Insurance, Labor Supply and Job Mobility: A Critical Review of the Literature, NBER Working Paper Series, No. 8817). A major concern in this literature has been to find an identification strategy able to overcome the potential correlation between the holding of employer-sponsored health insurance and other factors affecting job mobility independent from health insurance (*see* Anna Sanz de Galdeano, 2004. Health Insurance and Job Mobility: Evidence from Clinton's Second Mandate, Center for Studies in Economics and Finance Working Paper, No. 122). This is illustrated by the 2004 Health Confidence Survey which finds that 27 percent of the non-aged population reported that they or an immediate family member had experienced some form of job lock, but only 15 percent of those attributed the job-lock to a preexisting condition (*see* Ruth Helman & Paul Frostin, ''Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey.'' Employee Benefits Research Institute, Issue Brief no. 275 (EBRI, November 2004)).

[18] This transfer generally implies offsetting costs and benefits. It is possible, however, that in some instances individuals' mobility will allow them to exploit opportunities for adverse selection by moving into a richer health plan (*see* Cutler, D. and Reber, S., 1998. Paying for health insurance: the tradeoff between competition and adverse selection. Quarterly Journal of Economics 113, 433–466, and Cutler, D. and Zeckhauser, R. 2000. The anatomy of health insurance, in Culyer, A., Newhouse, J.P. (Eds.), Handbook of Health Economics, Vol. 1A. Elsevier, Amsterdam, pp. 564–629. For a contrasting study see, Pauly, M.V., Mitchell, O. and Zeng, Y. 2004 ''Death Spiral Or Euthanasia? The Demise Of Generous Group Health Insurance Coverage'' NBER Working Paper No. 10464, for a discussion). Such movements would constitute extensions of coverage with costs and benefits resembling those of direct extensions of coverage under HIPAA.

[19] Congressional Budget Office, ''Estimate of Costs of Private Sector Mandates; Bill Number H.R. 3103, August 1, 1996.

[20] The voluntary nature of the employment-based health benefit system in conjunction with the open and dynamic character of labor markets make explicit as well as implicit negotiations on compensation a key determinant of the prevalence of employee benefits coverage. It is likely that 80% to 100% of the cost of employee benefits is borne by workers through reduced wages (*see* for example Jonathan Gruber and Alan B. Krueger, ''The Incidence of Mandated Employer-Provided Insurance: Lessons from Workers Compensation Insurance,'' *Tax Policy and Economy* (1991); Jonathan Gruber, ''The Incidence of Mandated Maternity Benefits,'' *American Economic Review,* Vol. 84 (June 1994), pp. 622–641; Lawrence H. Summers, ''Some Simple Economics of Mandated Benefits,'' *American Economic Review,* Vol. 79, No. 2 (May 1989); Louise Sheiner, ''Health Care Costs, Wages, and Aging,'' Federal Reserve Board of Governors working paper, April 1999; and Edward Montgomery, Kathryn Shaw, and Mary Ellen Benedict, ''Pensions and Wages: An Hedonic Price Theory Approach,'' *International Economic Review,* Vol. 33 No. 1, Feb. 1992). The prevalence of benefits is therefore largely dependent on the efficacy of this exchange. If workers perceive that there is the potential for inappropriate denial of benefits they will discount their value to adjust for this risk. This discount drives a wedge in the compensation negotiation, limiting its efficiency. With workers unwilling to bear the full cost of the benefit, fewer benefits will be provided. To the extent which workers perceive a federal regulation supported by enforcement authority to improve the security and quality of benefits, the differential between the employers' costs and workers' willingness to accept wage offsets is minimized.

[21] Research shows that while the share of employers offering insurance is generally stable and eligibility rates have only declined slightly over time, the overall increase in uninsured workers is due to the decline in worker take-up rates, which workers primarily attribute to cost. Research on

Continued

The Departments note, however, that cost increases attributable to HIPAA are not price increases per se but reflect the cost to enrich benefits, implying that negative responses should be smaller than would be expected in connection with pure price increases. The Departments also note that the estimated $515 million cost associated with extensions of coverage under HIPAA amounts to a small fraction of one percent of total expenditures by private group health plans.[22] This compares with average annual group premium growth of 9.4 percent for family coverage between 1996 and 2002.[23] To the extent that such increases are small, they are likely to have a negligible effect on employers' decisions to provide health insurance and in workers' decisions to enroll.

Various other studies to date suggest that any negative indirect effects of HIPAA are relatively minor. In one study,[24] large employers and health benefit consultants reported few ongoing problems in adopting HIPAA's portability provisions. Many issuers interviewed for the report said that their plans tended to require few changes to comply with HIPAA. This is probably because many large employer plans had already incorporated portability protections, similar to those of HIPAA. A second study indicates that while the share of small firms (those with fewer than 200 workers) offering health insurance has increased slightly from 1996 to 2004, the share has drifted downward from its high of 68 percent in the economic boom year of 2000.[25] In addition, in aggregate, employers covered a larger proportion of health care costs for family plans in 2002 than in 1996, with a slight decrease in the share of single plans over the same time period.[26]

The data above suggest that the HIPAA changes may have been less significant in the decision about health insurance coverage than overall economic conditions and labor market forces. In fact, there is no evidence that any indirect economic effect, positive or negative, can be readily attributed to the statute. Therefore, it appears that HIPAA has not placed an unreasonable burden on health plans.

There has been a significant decrease in the prevalence of preexisting condition exclusion clauses among large plans. A major employee benefits survey[27] reported that in 1996, 59 percent of the employees in small firms (less than 200 employees) were subject to pre-existing condition limitations. In 2002, the figure had dropped to 33 percent. If preexisting condition limitation exists for new employees, the average number of months to wait before coverage declined from 10.7 months in 1996 to 10.0 months in 2002. A discussion of results from a 1998 version of the same survey noted that, overall, 42 percent of employers reported making changes to their plans' preexisting condition clauses due to HIPAA. The Departments are not aware of any surveys that have consistently tracked the prevalence of preexisting condition exclusions in smaller plans (less than 200 employees) since 1996.

Another significant trend involves the use of waiting periods. According to a survey of employers with 200 or more employees, the average number of days that new enrollees must wait before health coverage takes effect increased from 40 days in 1996 to 58 days in 1998. Some attribute this increase indirectly to HIPAA, suggesting that some plans may be replacing the preexisting condition exclusion period with a longer waiting period.

Effects of the Final Regulations

By clarifying and securing HIPAA's statutory portability protections, these regulations will help ensure that HIPAA rights are fully realized. The result is likely to be a small increase at the margin in the direct and indirect economic effects of HIPAA's statutory portability provisions.

Additional economic benefits derive from the regulations' clarifications of HIPAA's portability requirements. The regulations provide clarity through both their provisions and their examples of how those provisions apply in various circumstances. By clarifying employees' rights and plan sponsors' obligations under HIPAA's portability provisions, the regulations will reduce uncertainty and costly disputes over these rights and obligations. They will promote employers' and employees' common understanding of the value of group health plan benefits and confidence in the security and predictability of those benefits, thereby improving labor market efficiency and fostering the establishment and continuation of group health plans by employers.

Many provisions of the final regulations closely resemble provisions included in the interim final regulations that the final regulations supplant. The economic impact of this regulatory action therefore generally will be limited to the impact of provisions that were not so included. These include both provisions directed at the scope of HIPAA's portability protections and provisions establishing administrative requirements intended to safeguard those protections.

Scope of Protections

These final regulations are intended to secure and implement HIPAA's group market portability provisions under certain special circumstances. The final regulations therefore contain a number of provisions intended to clearly delimit the scope of HIPAA's portability protections. Most of these provisions closely resemble and will have the same effect as provisions of the interim final regulations. Others, however, clarify or expand at the margin the range of situations to which HIPAA's portability protections explicitly apply. These include the requirement that health coverage under foreign government programs be treated as creditable coverage for purposes of limiting the application of preexisting condition exclusions; the extension of special enrollment rights to individuals who lose eligibility for coverage in connection with the application of lifetime benefit limits, movement out of an HMO's service area, or the termination of a health coverage option previously offered under a group health plan; and the establishment of a special enrollment right for a participant to change among available coverage options under a group health plan when

elasticity of coverage, however, has focused on getting uninsured workers to adopt coverage (which appears to require large subsidies) rather than covered workers opting out of coverage. This makes it difficult to ascertain the loss in coverage that would result from a marginal increase in costs. (*See,* for example, David M. Cutler ''Employee Costs and the Decline in Health Insurance Coverage'' NBER Working Paper #9036. July 2002; Gruber, Jonathon and Ebonya Washington. ''Subsidies to Employee Health Insurance Premiums and the Health Insurance Market'' NBER Working Paper #9567. March 2003; and Cooper, PF and J. Vistnes. ''Workers' Decisions to Take-up Offered Insurance Coverage: Assessing the Importance of Out-of-Pocket Costs'' Med Care 2003, 41(7 Suppl): III35–43.) Finally, economic discussions on elasticity of insurance tend to view coverage as a discrete concept and does not consider that the value of coverage may have also changed.

[22] While these costs are expected in aggregate to be less than one percent of total expenditures by group health plans, the statute may disproportionately affect particular plans.

[23] This is the average annual rate of increase in total family premiums as reported in the Medical Expenditure Panel Survey, Insurance Component (MEPS–IC) public tables, 1996–2002.

[24] U.S. General Accounting Office, Report HEH–99–100, ''Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards,'' pp. 6–7, May 1999.

[25] Gabel, Jon R. *et al.* ''Health Benefits in 2004: Four Years of Double Digit Premium Increases Take Their Toll on Coverage'' Health Affairs, Volume 23, Number 5, September/October 2004.

[26] As reported in the MEPS–IC 1996–2002 public tables.

[27] Employee Health Benefits 2002 Study, Kaiser Family Foundation.

adding one or more dependents in connection with marriage, adoption, or placement for adoption. Each of these provisions is expected to result in a small increase in the economic effects of HIPAA's statutory portability protections.

The Departments lack any firm basis for quantifying the number of individuals likely to be affected by these provisions, and therefore were unable to quantify the resultant increase in transfers. However, given the special and narrow circumstances to which these provisions apply, the number of affected individuals, and therefore the increase in transfers under these regulations, is expected to be small. In reaching this conclusion, the Departments considered the following.

In 2002, an estimated 359,000 employer sponsored insurance enrollees had moved from abroad in the previous year.[28] It is not known what fraction of these had been covered under foreign government programs, or of those, what fraction joined group health plans that included preexisting condition exclusions while suffering from and requiring additional care for preexisting conditions. Comparing GAO's estimate of the number of individuals who could potentially benefit from HIPAA's portability protections (20 million or more individuals with prior creditable coverage who join new health plans in a given year) with CBO estimates of the number who might actually have added coverage for needed care (145,000) produces a ratio of about 1 percent. If this proportion holds for group health plan enrollees who moved to the U.S. from abroad, and if all such enrollees were previously covered under a foreign government program (an upper bound), then about 4,000 individuals annually might gain coverage for needed care under the final regulation's provision treating coverage under such programs as creditable coverage.[29]

The provision that clarifies the special enrollment rights of individuals who lose eligibility for coverage in connection with the movement out of an HMO's service area is expected mainly to benefit certain individuals with COBRA continuation coverage. The number of individuals affected in any given year is expected to be small. It is estimated that in 2002, fewer than 10,000 COBRA enrollees were covered by HMOs, moved across State or county lines, and were potentially eligible for coverage under another family member's group plan.[30]

Lifetime benefit limits (LBL) are fairly common in-group health plans and are typically set at $1 million or more.[31] Based on tabulations made by an actuarial consulting firm,[32] in plans with LBLs of $1 million, annually about 27 per one million enrollees will exceed the benefit limits. In plans with a $500,000 LBL, the comparable figure is 181 per million enrollees; and in plans with a $2 million LBL, 5 per million enrollees. Combining these proportions with a distribution of LBLs by plan enrollment reported by a national employer survey, yields about 8,700 plan enrollees who will annually reach their plan's LBL. The Departments recognize that those individuals who do encounter such limits by definition have very high expenses, a large portion of which would be transferred to the group health plans into which they special enroll. It is possible, however, that a large share of such transfers would have occurred even without the provisions of these final regulations establishing a right to special enroll upon encountering lifetime limits. For example, the same individuals might have enrolled in these plans during open enrollment opportunities, either before or after encountering the limits. Alternatively, participants who have met their LBL might have left their jobs in order to create a special enrollment opportunity.

The Departments estimate that annually about 1 million families will be eligible for special enrollments due to marriage, 2 million due to births. About one-half of employees offered coverage at work have a choice of plan options.[33] Taken together, this suggests that the number of individuals gaining special enrollment rights to switch among options within group health plans when adding dependents may be large. However, it is unclear how many will elect to switch, or how many who do would have been so permitted even absent the applicable requirement of these final regulations. More important, it is unclear whether merely switching among options will increase or decrease the transfer from the affected health plans to the affected individuals. In any event, individuals exercising this special enrollment right to switch options are not gaining coverage under any particular group health plan but are merely modifying that coverage.

Administrative Requirements

In order to secure and implement HIPAA's group market special enrollment and portability provisions, both the HIPAA statute and these final regulations establish certain administrative requirements. As noted above, the HIPAA statute generally requires plans and issuers to provide certifications of prior coverage to individuals leaving coverage. These regulations additionally require plans and issuers to notify individuals of their special enrollments rights, any preexisting condition exclusion provisions, and the applicability of such exclusions where individuals provide evidence of prior coverage that is of insufficient duration to fully offset exclusion periods. Plans will incur cost to comply with these administrative requirements. The Departments estimate the administrative cost to prepare and distribute certifications and notices to be $97 million per year.[34]

Nearly all of this, or $96 million, is attributable to the preparation and distribution of certifications as required under HIPAA's statutory provisions. These final regulations include numerous special provisions that serve to reduce plans' cost of providing certifications. These provisions serve to streamline and standardize certifications' content and format, minimize the number of duplicative certifications issued, and encourage the use of telephone calls and other modes of communication when they will suffice in lieu of written certifications. The provisions are designed to minimize certifications' cost while ensuring that individuals and plans (respectively) can efficiently and effectively demonstrate and verify prior coverage. Demonstration and verification of prior coverage enable individuals to secure and plans to

[28] Calculation from the 2003 March CPS.

[29] This number is 1 percent of the number of ESI holders in 2002 who moved from abroad the previous year.

[30] Estimates using the March 2003 CPS. It should be noted that CPS is a weighted survey and that the number of actual observations of individuals that were COBRA enrollees with HMO coverage, moved across counties and/or States and were eligible for coverage under another family member's group plan was extremely small. As a result, this estimate is extremely noisy.

[31] See, for example, U.S. Bureau of Labor Statistics, *Employee Benefits in Medium and Large Establishments, 2000* (Washington, DC: U.S. Government Printing Office, 2003).

[32] Milliman USA memorandum dated December 6, 2001.

[33] Sally Trude, ''Who Has A Choice of Health Plans?'' Center for Studying Health Systems Change, *Issue Brief: Findings from HSC,* No. 27, Feb. 2000.

[34] The Departments assumed that a clerical-level employee at a total labor cost (wages, fringe benefits, and overhead) of $17.24 per-hour would generate the certificates. The Departments further assumed that the average time required to complete a certification is 4 to 5 minutes for all employers. This average is based on the assumption that most employers will automate the certification process. The cost of printing/copying, an envelope and postage is assumed to be $0.53 per employee.

appropriately honor individuals' portability rights under HIPAA.

First, an intermediate issuer will not have to issue a certificate of creditable coverage when an individual changes options under the same health plan. In lieu of the certificate, the issuer could simply transmit to the plan information regarding individuals' effective date of coverage and the last date of coverage. An individual would retain the right to get a certificate automatically and upon request if he/she leaves the plan.

Second, telephonic certification will fulfill the requirement to send a certificate if the receiving plan, prior plan, and the participant mutually agree to that arrangement. The individual can get a written certificate upon request.

Third, in situations where the issuer and the plan contract for the issuer to complete the certificates, the plan would not remain liable even if the issuer failed to send the certificates.

Fourth, the period of coverage listed on automatic certificates will be only the last continuous period of coverage without any break. This is the most efficient and simplest method of record keeping for plans and issuers.

Fifth, the period of coverage contained in the on-request certification will be all periods of coverage ending within 24 months before the date of the request. Essentially, a plan may simply look back two years and send copies of any automatic certificates issued during that period.

Sixth, a single certificate of creditable coverage can be provided with respect to both a participant and the participant's dependent if the information is identical for each individual. In addition, certificates may contain combined information for families.

Seventh, plans and issuers are not required to furnish an individual an automatic certificate with respect to a dependent until they know or should know of the dependent's cessation of coverage under the plan.

The above reductions in burdens on plans and issuers may cause more frequent circumstances in which participants are required to demonstrate creditable coverage. In order to help offset some of the additional burdens that will be shifted to the participants, the regulations provide the following protections:

First, if an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of dependent status, and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

Second, if the accuracy of a certificate is contested or a certificate is unavailable when needed, individuals have the right to demonstrate creditable coverage through the presentation of relevant corroborating evidence of creditable coverage during the relevant time period and by cooperating with the plan's efforts to verify the individual's coverage.

Third, plans and issuers that impose preexisting condition exclusion periods must notify participants of this fact. They must also explain that prior creditable coverage can reduce the length of a preexisting condition exclusion period, and that the plan or issuer will assist in obtaining a certificate of creditable coverage from any prior plan or issuer, if necessary. An exclusion may not be imposed until this notice is given. This is beneficial to participants insofar as it forewarns them of potential claim denials and enables them to more easily exercise their right to protection from such denials under HIPAA's portability provisions.

Fourth, after an individual has presented evidence of creditable coverage, the plan or issuer must give the individual a written notice of the length of any preexisting condition exclusion that remains after offsetting for creditable coverage.

Fifth, certificates of creditable coverage now contain educational language that more explicitly informs consumers of their HIPAA rights.

As noted earlier in this preamble, GAO and others recommended that educational statements be added to certifications. The Departments have provided a suitable statement for use by plans, thereby eliminating any need for plans to develop their own. The cost of providing such statements is therefore expected to be minimal.

The administrative cost associated with provision of certifications under the HIPAA statute and these final regulations was estimated as follows.

The ongoing burden associated with the issuance of automatic certifications by group plans is estimated as a function of (1) the number of events that trigger such issuances; (2) the statutory and regulatory specifications for the content of the certificates; and (3) the assumed burden associated with the preparation and distribution of each certificate.

Certifications must be issued when an event, defined as the loss of health coverage by a participant or by a dependent, occurs. Survey tabulations indicate that there were 54.3 million events in 2002.[35] Additionally, results from the March 1999 CPS indicate that about 3 percent of the events involve a dependent who lives at a different address than the participant. In such cases the plan is required to send out at least 2 separate certificates.

The model certificate illustrates how plans may incur a lesser burden when it is certified that prior periods of coverage were of at least 18 months duration; that is, in lieu of a specific date that coverage began and waiting/affiliation period information, such certifications may simply indicate that the prior period of coverage lasted at least 18 months. In contrast, certifications of shorter periods of prior coverage must contain the specific dates when coverage—and waiting/affiliation periods, if applicable—began.

Combining the options for the addresses with the time periods results in four categories of certifications: (1) One address and less than 18 months of prior creditable coverage (12 million annual events); (2) one address and 18 months or more of prior creditable coverage (42.3 million); (3) more than one address and prior creditable coverage of less than 18 months (.4 million); and (4) more than one address and 18 months or more of prior creditable coverage (1.3 million).

Consistent with the interim regulations, we assume that the per-certificate preparation effort requires 5 minutes for prior creditable coverage of less than 18 months and 4 minutes for creditable coverage that is greater than or equal to 18 months. The additional cost involved in sending certificates to multiple addresses for a given participant is assumed to be 50 percent of the cost of sending a certificate to one address.

The Departments assumed that the certificates would be generated by a clerical-level employee who costs the plans $17.24 per-hour in wages, benefits, and overhead [36]. The cost of printing/copying, envelope and postage is assumed to be $0.53 per envelope.

[35] This total is based on internal estimates. The ESI total (24.0 million or 20.4 private-sector and 3.6 public sector) was the sum of policy-holders who left jobs, according to the 2002 MEPS–HC, and their dependents, which were derived by multiplying this number by the CPS ratio of dependents to policy holders. Based on counts of the number of people with partial year coverage off the March 2003 CPS, we estimated the SCHIP and Medicaid total to be 14.9 million and the private individual market to be 15.4 million.

[36] The total labor cost is derived from wage and compensation data from the Bureau of Labor Statistics and includes an overhead componenet, which is a multiple of compensation based on the Government Cost Estimate.

The resulting annual burden is $96 million.

A more strict interpretation of the statute would require plans to send an individual certificate to each affected enrollee. Obviously, this requirement would significantly increase the administrative burden. Such strict interpretation would result in plans sending 80.1 million certificates annually at cost of $157.6 million, which is $61.6 million more than the burden imposed by the final regulations.

The final regulations require that plans, in response to requests made by or on behalf of individuals, provide certificates at any time while the individual is covered under the plan and for up to 24 months after coverage ceases. Such requests are most likely to be made by an individual who is unable to locate the certificate of creditable coverage from his/her prior health plan and is seeking to enroll in a group health plan that imposes preexisting condition exclusions or is seeking to reduce or eliminate any preexisting condition exclusions that may otherwise be applied by a source of individual coverage.

The Departments believe that the requested certificate burden is negligible for several reasons. First, as reported by a major health benefits survey [37] the proportion of enrollees that are in plans with preexisting condition exclusion has not changed from the 2000 share of 30 percent, which is down from the pre-HIPAA level of 60 percent. In addition, the educational statement contained within the certificate serves to highlight the importance of the document, thus encouraging its retention. Furthermore, the final rules permit individuals to establish and verify creditable coverage through other means. Finally, evidence of creditable coverage may be transmitted through means other than documentation, such as by a telephone call from the plan to a third party.

Apart from the provision of certifications of prior creditable coverage, the remaining $1 million in administrative expenses is attributable to notices of special enrollment rights and of the existence and application of preexisting condition exclusions, which are required under these final regulations. The Departments believe that these notices are necessary to ensure that individuals understand and can effectively exercise their special enrollment and portability rights under HIPAA, and that the benefits of ensuring this outweigh the associated administrative cost.

The regulations provide that a plan must provide all employees with a notice describing special enrollment rights at or before the time the employee is initially offered the opportunity to enroll in the plan. The final regulations provide model language that can be used to satisfy the special enrollment notice requirement.

The Departments believe that the vast majority of plans have incorporated special enrollment language into their plan enrollment materials. Thus, the cost of the special enrollment notice is assumed to be a minor component of the overall cost of providing plan enrollment materials.

The number of employees who are hired annually by firms that offer health coverage and who are eligible for such coverage was developed by using the proportion of workers with less than one year of tenure as reported by the 2002 MEPS–HC. We find that 10.8 million employees will be newly hired and eligible for health coverage on an annual basis. We assume that the special enrollment notice is a component of plan enrollment materials and requires one-third of a sheet of paper. Using a printing/copying cost of $0.05 per page, we assume that the per-notice cost is $0.0167. The resulting burden is estimated to be $180,687.

The final regulations provide that every plan with a preexisting condition exclusion must provide in writing a general notice of such provisions to individuals eligible for enrollment under the plan. The regulations specify what is required of the plan when it discusses the amount and terms of its preexisting condition exclusion, including the person to contact for further information regarding the exclusions. In addition, the regulations clarify that issuers must describe the actual maximum exclusion period that is applicable to a specific plan. A regulatory example provides sample language that the plans can use to develop the general notice.

Based on results from the 2000 Kaiser/HRET Employer survey, we assume that 35 percent of plans with fewer than 100 participants, and 28 percent of plans with 100 or more participants, apply preexisting condition exclusions to new enrollees. If we apply these proportions to the number of new employees hired each year by employers that offer health coverage, we find that 3.1 million employees will annually receive the general notice.

As with the special enrollment notice, we assume that the general notice of preexisting condition exclusions is a component of standard plan enrollment materials and also requires one-third of a sheet of paper. Assuming a printing/copying cost of $0.05 per page, the per-notice cost is $0.0167. The annual cost to distribute the notices is therefore estimated to be $51,852.

The regulations provide sample notice language, thus relieving the plans of the burden of developing their own forms.

Plans that impose preexisting condition exclusions must, in writing, notify participants who have failed to demonstrate sufficient prior coverage that the exclusions will affect them and indicate what the length of the preexisting condition exclusion period is, with respect to each individual. This notice is required only in situations in which the individual presents evidence of prior creditable coverage and its duration is less than the maximum length of the preexisting condition exclusion period. These final regulations clarify that the notice does not have to identify any medical conditions that are specific to the individual and subject to the exclusion.

Tabulations from the 2002 MEPS–HC indicate that, of those individuals in the private sector who changed jobs and hold insurance, 16 percent have prior creditable coverage of between 1 day and 12 months, which is the statutory preexisting condition exclusion maximum for individuals who enroll when first eligible. The comparable proportion for State and local governmental plans is 18 percent. Applying these proportion to the number of general preexisting exclusion notices required, yields 478,569 notices that will be prepared annually.

Because the notice must be customized to reflect each individual's applicable preexisting condition exclusion period, the per-notice time burden will be greater than that for the general notice of preexisting condition exclusions. Consistent with the interim final regulations, the Departments assume that the preparation of each notice will take two minutes of a clerical-level employee's time, plus $0.47 for printing, envelope, and postage, yielding a per-notice cost of $1.05. The resulting annual burden is estimated to be $582,497.

The estimated burden represents only the cost of producing and distributing the notices and does not include the expense involved in determining the adequacy of a participant's prior coverage, since such expense is considered to be part of the regular business practices necessary to comply with HIPAA's statutory portability protections.

[37] *Kaiser Family Foundation and Health Research and Educational Trust, Employer Health Benefits 2002 Annual Survey.*

Generally all of the major administrative requirements included in the final regulations were also included in the interim final regulations. The final regulations make minor additions to two requirements, however. They require plans to include educational statements in certificates of creditable coverage and to maintain in writing their procedures for requesting certificates. The cost of these additional requirements is expected to be small, and was not estimated separately from the overall cost of providing certificates.

The requirement that certification request procedures be in writing is essentially a clarification of the interim final regulations' requirement that plans have such procedures. The Departments believe it is likely that most plans already maintain written procedures, and therefore expect the cost of this requirement to be small. The Departments did not estimate the cost of this requirement separately from the cost of providing certifications on request.

Other changes included in these final regulations are likely to slightly reduce plans' cost to provide certain HIPAA-required notices. Included with the final regulation is new sample language for general and specific notices of preexisting condition exclusions, which may serve to reduce some plans' costs of providing these notices, and revised sample language for special enrollment rights notices. The final regulations also clarify the narrow scope of the requirement to notify certain affected participants of the specific application of preexisting condition exclusions, thereby potentially relieving some plans of the burden associated with a more expansive interpretation of that requirement. The Departments did not estimate the impact of these provisions separately from the overall cost of providing general and specific notices of preexisting condition exclusions and notices of special enrollment rights.

Statutory Authority

The Department of the Treasury final rule is adopted pursuant to the authority contained in sections 7805 and 9833 of the Code (26 U.S.C. 7805, 9833).

The Department of Labor final rule is adopted pursuant to the authority contained in 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), Public Law 104–191, 101 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); Secretary of Labor's Order 1–2003, 68 FR 5374 (Feb. 3, 2003).

The Department of HHS final rule is adopted pursuant to the authority contained in sections 2701 through 2763, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as added by HIPAA (Public Law 104–191, 110 Stat. 1936), and amended by MHPA and NMHPA (Public Law 104–204, 110 Stat. 2935), and WHCRA (Public Law 105–277, 112 Stat. 2681–436).

List of Subjects

26 CFR Part 54

Excise taxes, Health care, Health insurance, Pensions, Reporting and recordkeeping requirements.

26 CFR Part 602

Reporting and recordkeeping requirements.

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, and State regulation of health insurance.

Adoption of Amendments to the Regulations

Internal Revenue Service

26 CFR Chapter I

■ Accordingly, 26 CFR parts 54 and 602 are amended as follows:

PART 54—PENSION EXCISE TAXES

■ **Paragraph 1.** The authority citation for part 54 is amended by:

■ 1. Removing the citations for 54.9801–1T, 54.9801–2T, 54.9801–3T, 54.9801–4T, 54.9801–5T, 54.9801–6T, 54.9831–1T, and 54.9833–1T.

■ 2. Adding entries in numerical order for 54.9801–1, 54.9801–2, 54.9801–3, 54.9801–4, 54.9801–5, 54.9801–6, 54.9802–1, 54.9831–1, and 54.9833–1.

The additions read as follows:

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

Section 54.9801–1 also issued under 26 U.S.C. 9833.

Section 54.9801–2 also issued under 26 U.S.C. 9833.

Section 54.9801–3 also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9833.

Section 54.9801–4 also issued under 26 U.S.C. 9801(c)(1)(I) and 9833.

Section 54.9801–5 also issued under 26 U.S.C. 9801(c)(4), 9801(e)(3), and 9833.

Section 54.9801–6 also issued under 26 U.S.C. 9833.

Section 54.9802–1 also issued under 26 U.S.C. 9833. * * *

Section 54.9831–1 also issued under 26 U.S.C. 9833.

Section 54.9833–1 also issued under 26 U.S.C. 9833.

■ **Par. 2.** Sections 54.9801–1T, 54.9801–2T, 54.9801–3T, 54.9801–4T, 54.9801–5T, 54.9801–6T, 54.9831–1T, and 54.9833–1T are removed.

■ **Par. 3.** Sections 54.9801–1, 54.9801–2, 54.9801–3, 54.9801–4, 54.9801–5, 54.9801–6, 54.9831–1, and 54.9833–1 are added to read as follows:

§ 54.9801–1 Basis and scope.

(a) *Statutory basis.* Sections 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–1T, 54.9811–1T, 54.9812–1T, 54.9831–1, and 54.9833–1 (portability sections) implement Chapter 100 of Subtitle K of the Internal Revenue Code of 1986.

(b) *Scope.* A group health plan may provide greater rights to participants and beneficiaries than those set forth in these portability sections. These portability sections set forth minimum requirements for group health plans concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to creditable coverage.

(4) Special enrollment periods.

(5) Prohibition against discrimination on the basis of health factors.

(c) *Similar requirements under the Employee Retirement Income Security Act and the Public Health Service Act.* Sections 701, 702, 703, 711, 712, 732, and 733 of the Employee Retirement Income Security Act of 1974 and sections 2701, 2702, 2704, 2705, 2721, and 2791 of the Public Health Service Act impose requirements similar to those imposed under Chapter 100 of Subtitle K with respect to health insurance issuers offering group health insurance coverage. See 29 CFR part 2590 and 45 CFR parts 144, 146, and 148. See also part B of Title XXVII of the Public Health Service Act and 45 CFR part 148 for other rules applicable to health insurance offered in the individual market (defined in § 54.9801–2).

§ 54.9801–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–1T, 54.9811–1T, 54.9812–1T, 54.9831–1, and 54.9833–1.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means section 4980B (other than paragraph (f)(1) of section 4980B insofar as it relates to pediatric vaccines), sections 601–608 of ERISA, or Title XXII of the PHS Act.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

Condition means a *medical condition.*

Creditable coverage means *creditable coverage* within the meaning of § 54.9801–4(a).

Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Employee Retirement Income Security Act of 1974 (ERISA) means the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (*enrollment date, first day of coverage,* and *waiting period*) are set forth in § 54.9801–3(a)(3)(i), (ii), and (iii).

Excepted benefits means the benefits described as excepted in § 54.9831(c).

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan or *plan* means a *group health plan* within the meaning of § 54.9831(a).

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the *individual market,* rather than the group market; see the definition of individual market in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance. However, benefits described in § 54.9831(c)(2) are not treated as benefits consisting of medical care.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Issuer means a *health insurance issuer.*

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in § 54.9801–3(a)(3)(v) and (vi) .

Medical care has the meaning given such term by section 213(d), determined without regard to section 213(d)(1)(C) and so much of section 213(d)(1)(D) as relates to qualified long-term care insurance.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Participant means *participant* within the meaning of section 3(7) of ERISA.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means *preexisting condition exclusion* within the meaning of § 54.9801–3(a)(1).

Public health plan means *public health plan* within the meaning of § 54.9801–4(a)(1)(ix).

Public Health Service Act (PHS Act) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Short-term, limited-duration insurance means 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.

Significant break in coverage means a *significant break in coverage* within the meaning of § 54.9801–4(b)(2)(iii).

Special enrollment means enrollment in a group health plan under the rights described in § 54.9801–6 or in group health insurance coverage under the rights described in 29 CFR 2590.701–6 or 45 CFR 146.117.

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 54.9801–4(a)(1)(vii).

Waiting period means *waiting period* within the meaning of § 54.9801–3(a)(3)(iii).

§ 54.9801–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *Defined*—(i) A *preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

(ii) *Examples.* The rules of this paragraph (a)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer *S*. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. (Therefore, the exclusion of benefits is required to comply with the limitations on preexisting condition exclusions in this section. For an example illustrating the application of these limitations to a succeeding insurance policy, see *Example 3* of paragraph (a)(3)(iv) of this section.)

Example 2. (i) *Facts.* A group health plan provides coverage for cosmetic surgery in cases of accidental injury, but only if the injury occurred while the individual was covered under the plan.

(ii) *Conclusion.* In this *Example 2*, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 3. (i) *Facts.* A group health plan provides coverage for the treatment of diabetes, generally not subject to any lifetime dollar limit. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a lifetime limit of $10,000.

(ii) *Conclusion.* In this *Example 3*, the $10,000 lifetime limit is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 4. (i) *Facts.* A group health plan provides coverage for the treatment of acne, subject to a lifetime limit of $2,000. The plan counts against this $2,000 lifetime limit on acne treatment benefits provided under prior health coverage.

(ii) *Conclusion.* In this *Example 4*, counting benefits for a specific condition provided under prior health coverage against a lifetime limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 5. (i) *Facts.* When an individual's coverage begins under a group health plan, the individual generally becomes eligible for all benefits. However, benefits for pregnancy are not available until the individual has been covered under the plan for 12 months.

(ii) *Conclusion.* In this *Example 5*, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. Because a plan is prohibited under paragraph (b)(5) of this section from imposing any preexisting condition exclusion on pregnancy, the plan provision is prohibited. However, if the plan provision included an exception for women who were pregnant before the effective date of coverage under the plan (so that the provision applied only to women who became pregnant on or after the effective date of coverage) the plan provision would not be a preexisting condition exclusion (and would not be prohibited by paragraph (b)(5) of this section).

Example 6. (i) *Facts.* A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion.* In this *Example 6*, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 7. (i) *Facts.* A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion.* In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not subject to the limitations on preexisting condition exclusions in this section.

Example 8. (i) *Facts.* A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) *Conclusion.* In this *Example 8*, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

(2) *General rules.* Subject to paragraph (b) of this section (prohibiting the imposition of a preexisting condition exclusion with respect to certain individuals and conditions), a group health plan may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a)(2) are satisfied. (*See* section 701 of ERISA

and section 2701 of the PHS Act, under which these requirements are also imposed on a health insurance issuer offering group health insurance coverage.)

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or such shorter period as applies under the plan) ending on the enrollment date.

(A) For purposes of this paragraph (a)(2)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(2)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* is diagnosed with a medical condition 8 months before *A*'s enrollment date in Employer *R*'s group health plan. *A*'s doctor recommends that *A* take a prescription drug for 3 months, and *A* follows the recommendation.

(ii) *Conclusion.* In this *Example 1*, Employer *R*'s plan may impose a preexisting condition exclusion with respect to *A*'s condition because *A* received treatment during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan by taking the prescription medication during that period. However, if *A* did not take the prescription drug during the 6-month period, Employer *R*'s plan would not be able to impose a preexisting condition exclusion with respect to that condition.

Example 2. (i) *Facts.* Individual *B* is treated for a medical condition 7 months before the enrollment date in Employer *S*'s group health plan. As part of such treatment, *B*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *B* does not receive a follow-up examination, and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *B* or received by *B* during the 6-month period ending on *B*'s enrollment date in Employer *S*'s plan.

(ii) *Conclusion.* In this *Example 2*, Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date.

Example 3. (i) *Facts.* Same facts as *Example 2*, except that Employer *S*'s plan learns of the condition and attaches a rider to *B*'s certificate of coverage excluding coverage for the condition. Three months after enrollment, *B*'s condition recurs, and Employer *S*'s plan denies payment under the rider.

(ii) *Conclusion.* In this *Example 3*, the rider is a preexisting condition exclusion and Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date. (In addition, such a rider would violate the provisions of § 54.9802–1, even if *B* had received treatment for the condition within the 6-month period ending on the enrollment date.)

Example 4. (i) *Facts.* Individual *C* has asthma and is treated for that condition several times during the 6-month period before *C*'s enrollment date in Employer *T*'s plan. Three months after the enrollment date, *C* begins coverage under Employer *T*'s plan. Two months later, *C* is hospitalized for asthma.

(ii) *Conclusion.* In this *Example 4*, Employer *T*'s plan may impose a preexisting condition exclusion with respect to *C*'s asthma because care relating to *C*'s asthma was received during the 6-month period ending on *C*'s enrollment date (which, under the rules of paragraph (a)(3)(i) of this section, is the first day of the waiting period).

Example 5. (i) *Facts.* Individual *D*, who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as retinal degeneration, a foot condition, and poor circulation (all of which are conditions that may be directly attributed to diabetes). *D* receives treatment for these conditions during the 6-month period ending on *D*'s enrollment date in Employer *U*'s plan. After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) *Conclusion.* In this *Example 5*, the leg fracture is not a condition related to *D*'s diabetes, retinal degeneration, foot condition, or poor circulation, even though they may have contributed to the accident. Therefore, benefits to treat the leg fracture cannot be subject to a preexisting condition exclusion. However, any additional medical services that may be needed because of *D*'s preexisting diabetes, poor circulation, or retinal degeneration that would not be needed by another patient with a broken leg who does not have these conditions may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion.* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999; the 18-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through January 31, 2000.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage*—(A) The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 54.9801–4. Creditable coverage may be evidenced through a certificate of creditable coverage (required under § 54.9801–5(a)), or through other means in accordance with the rules of § 54.9801–5(c).

(B) The rules of this paragraph (a)(2)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* works for Employer *X* and has been covered continuously under *X*'s group health plan. *D*'s spouse works for Employer *Y*. *Y* maintains a group health plan that imposes a 12-month preexisting condition exclusion (reduced by creditable coverage) on all new enrollees. *D* enrolls in *Y*'s plan, but also stays covered under *X*'s plan. *D* presents *Y*'s plan with evidence of creditable coverage under *X*'s plan.

(ii) *Conclusion.* In this *Example*, *Y*'s plan must reduce the preexisting condition exclusion period that applies to *D* by the number of days of coverage that *D* had under *X*'s plan as of *D*'s enrollment date in *Y*'s plan (even though *D*'s coverage under *X*'s plan was continuing as of that date).

(iv) *Other standards.* See § 54.9802–1 for other standards that may apply with respect to certain benefit limitations or restrictions under a group health plan. Other laws may also apply, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service.

(3) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage (as described in paragraph (a)(3)(ii) of this section) or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

(ii) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

(iii) *Waiting period* means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on —

(A) If the application results in coverage, the date coverage begins;

(B) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

(iv) The rules of paragraphs (a)(3)(i), (ii), and (iii) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998, and on October 14, 1998 *E* completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) *Conclusion.* In this *Example 1*, *E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E*, the permissible 6-month period in paragraph (a)(2)(i) is the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan can apply a preexisting condition exclusion under paragraph (a)(2)(ii) is the period from October 13, 1998 through October 12, 1999, and this period must be reduced under paragraph (a)(2)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

Example 2. (i) *Facts.* A group health plan has two benefit package options, Option 1 and Option 2. Under each option a 12-month preexisting condition exclusion is imposed. Individual *B* is enrolled in Option 1 on the first day of employment with the employer maintaining the plan, remains enrolled in Option 1 for more than one year, and then decides to switch to Option 2 at open season.

(ii) *Conclusion.* In this *Example 2*, *B* cannot be subject to any preexisting condition exclusion under Option 2 because any preexisting condition exclusion period would have to begin on *B*'s enrollment date, which is *B*'s first day of coverage, rather than the date that *B* enrolled in Option 2. Therefore, the preexisting condition exclusion period expired before *B* switched to Option 2.

Example 3. (i) *Facts.* On May 13, 1997, Individual *E* is hired by an employer and enrolls in the employer's group health plan. The plan provides benefits solely through an insurance policy offered by Issuer *S*. On December 27, 1998, *E*'s leg is injured in an accident and the leg is amputated. On January 1, 1999, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 3*, *E*'s enrollment date is May 13, 1997, *E*'s first day of coverage. Therefore, the permissible 6-month look-back period for the preexisting condition exclusion imposed under Issuer *T*'s policy begins on November 13, 1996 and ends on May 12, 1997. In addition, the 12-month maximum permissible preexisting condition exclusion period begins on May 13, 1997 and ends on May 12, 1998. Accordingly, because no medical advice, diagnosis, care, or treatment was recommended to or received by *E* for the leg during the 6-month look-back period (even though medical care was provided within the 6-month period preceding the effective date of *E*'s coverage under Issuer *T*'s policy), the plan may not impose any preexisting condition exclusion with respect to *E*. Moreover, even if *E* had received treatment during the 6-month look-back period, the plan still would not be permitted to impose a preexisting condition exclusion because the 12-month maximum permissible preexisting condition exclusion period expired on May 12, 1998 (before the effective date of *E*'s coverage under Issuer *T*'s policy). See 29 CFR 2590.701–3(a)(3)(iv) *Example 3* and 45 CFR 146.111(a)(3)(iv) *Example 3* for a conclusion that Issuer *T* is similarly prohibited from imposing a preexisting condition exclusion with respect to *E*.

Example 4. (i) *Facts.* A group health plan limits eligibility for coverage to full-time employees of Employer *Y*. Coverage becomes effective on the first day of the month following the date the employee becomes eligible. Employee *C* begins working full-time for Employer *Y* on April 11. Prior to this date, *C* worked part-time for *Y*. *C* enrolls in the plan and coverage is effective May 1.

(ii) *Conclusion.* In this *Example 4*, *C*'s enrollment date is April 11 and the period from April 11 through April 30 is a waiting period. The period while *C* was working part-time, and therefore not in an eligible class of employees, is not part of the waiting period.

Example 5. (i) *Facts.* To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the previous quarter. If the hours requirement is satisfied, coverage becomes effective on the first day of the current calendar quarter. Employee *D* begins work on January 28 and does not work 250 hours in covered employment during the first quarter (ending March 31). *D* works at least 250 hours in the second quarter (ending June 30) and is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).

(ii) *Conclusion.* In this *Example 5*, *D*'s enrollment date is the first day of the quarter during which *D* satisfies the hours requirement, which is April 1. The period from April 1 through June 30 is a waiting period.

(v) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(vi) (A) *Late enrollment* means enrollment of an individual under a group health plan other than—

(*1*) On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(*2*) Through special enrollment. (For rules relating to special enrollment, see § 54.9801–6.)

(B) If an individual ceases to be eligible for coverage under the plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(vii) *Examples.* The rules of paragraphs (a)(3)(v) and (vi) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999 but elects not to enroll in the plan until a later annual open enrollment period, with coverage effective January 1, 2001. *F* has no special enrollment right at that time.

(ii) *Conclusion.* In this *Example 1*, *F* is a late enrollee with respect to *F*'s coverage that became effective under the plan on January 1, 2001.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that *F* terminates employment with Employer *W* on July 1, 1999 without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) *Conclusion.* In this *Example 2*, *F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—(i) *In general.* Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion on a child who, within 30 days after birth, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 54.9801–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child.

(ii) *Examples.* The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *E*, who has no prior creditable coverage, begins working for Employer *W* and has accumulated 210 days of creditable coverage under Employer *W*'s group health plan on the date *E* gives birth to a child. Within 30 days after the birth, the child is enrolled in the plan. Ninety days after the birth, both *E* and the child terminate coverage under the plan. Both *E* and the child then experience a break in coverage of 45 days before *E* is hired by Employer *X* and the two are enrolled in Employer *X*'s group health plan.

(ii) *Conclusion.* In this *Example 1*, because *E*'s child is enrolled in Employer *W*'s plan within 30 days after birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Likewise, Employer *X*'s plan may not impose any preexisting condition exclusion on *E*'s child because the child was covered under creditable coverage within 30 days after birth and had no significant break in coverage before enrolling in Employer *X*'s plan. On the other hand, because *E* had only 300 days of creditable coverage prior to *E*'s enrollment date in Employer *X*'s plan, Employer *X*'s plan may impose a preexisting condition exclusion on *E* for up to 65 days (66 days if the 12-month period after *E*'s enrollment date in *X*'s plan includes February 29).

Example 2. (i) *Facts.* Individual *F* is enrolled in a group health plan in which coverage is provided through a health insurance issuer. *F* gives birth. Under State law applicable to the health insurance issuer, health care expenses incurred for the child during the 30 days following birth are covered as part of *F*'s coverage. Although *F* may obtain coverage for the child beyond 30 days by timely requesting special enrollment and paying an additional premium, the issuer is prohibited under State law from recouping the cost of any expenses incurred for the child within the 30-day period if the child is not later enrolled.

(ii) *Conclusion.* In this *Example 2*, the child is covered under creditable coverage within 30 days after birth, regardless of whether the child enrolls as a special enrollee under the plan. Therefore, no preexisting condition exclusion may be imposed on the child unless the child has a significant break in coverage.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan may not impose any preexisting condition exclusion on a child who is adopted or placed for adoption before attaining 18 years of age and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 54.9801–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Significant break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage. (*See* § 54.9801–4(b)(2)(iii) for rules relating to the determination of a significant break in coverage.)

(4) *Special enrollment.* For special enrollment rules relating to new dependents, see § 54.9801–6(b).

(5) *Pregnancy.* A group health plan may not impose a preexisting condition exclusion relating to pregnancy.

(6) *Genetic information*—(i) A group health plan may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. However, if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section.

(ii) The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *A* enrolls in a group health plan that imposes a 12-month maximum preexisting condition exclusion. Three months before *A*'s enrollment, *A*'s doctor told *A* that, based on genetic information, *A* has a predisposition towards breast cancer. *A* was not diagnosed with breast cancer at any time prior to *A*'s enrollment date in the plan. Nine months after *A*'s enrollment date in the plan, *A* is diagnosed with breast cancer.

(ii) *Conclusion.* In this *Example*, the plan may not impose a preexisting condition exclusion with respect to *A*'s breast cancer because, prior to *A*'s enrollment date, *A* was not diagnosed with breast cancer.

(c) *General notice of preexisting condition exclusion.* A group health plan imposing a preexisting condition exclusion must provide a written general notice of preexisting condition exclusion to participants under the plan and cannot impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until such a notice is provided. (See 29 CFR 2590.701–3(c) and 45 CFR 146.111(c), which also impose this requirement on a health insurance issuer offering group health insurance coverage subject to a preexisting condition exclusion.)

(1) *Manner and timing.* A plan must provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the plan for enrollment. If the plan does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* The general notice of preexisting condition exclusion must notify participants of the following:

(i) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period (which is not to exceed 6 months under paragraph (a)(2)(i) of this section); the maximum preexisting condition exclusion period under the plan (which cannot exceed 12 months (or 18 months for late enrollees) under paragraph (a)(2)(ii) of this section); and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage (described in paragraph (a)(2)(iii) of this section).

(ii) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage (as required by § 54.9801–5(a)) or through other means (as described in § 54.9801–5(c)). This must include a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(iii) A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (c) is provided to an individual by another party, the plan's obligation to provide a general notice of preexisting condition exclusion with respect to that individual is satisfied. (See 29 CFR 2590.701–3(c)(3) and 45 CFR 146.111(c)(3), which provide that

the issuer's obligation is similarly satisfied.)

(4) *Example with sample language.* The rules of this paragraph (c) are illustrated by the following example, which includes sample language that plans can use as a basis for preparing their own notices to satisfy the requirements of this paragraph (c):

Example. (i) *Facts.* A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month look-back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior ''creditable coverage.'' Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual *B* at Address *M* or Telephone Number *N*.

(ii) *Conclusion.* In this *Example*, the plan satisfies the general notice requirement of this paragraph (c).

(d) *Determination of creditable coverage*—(1) *Determination within reasonable time.* If a group health plan receives creditable coverage information under § 54.9801–5, the plan is required, within a reasonable time following receipt of the information, to make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care. (See 29 CFR 2590.701–3(d) and 45 CFR 146.111(d), which also impose this requirement on a health insurance issuer offering group health insurance coverage.)

(2) *No time limit on presenting evidence of creditable coverage.* A plan may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(3) *Example.* The rules of this paragraph (d) are illustrated by the following example:

Example. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *H* develops an urgent health condition before receiving a certificate of creditable coverage from *H*'s prior group health plan. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf in accordance with the rules of § 54.9801–5.

(ii) *Conclusion.* In this *Example*, the plan must review the evidence presented by *H* and make a determination of creditable coverage within a reasonable time that is consistent with the urgency of *H*'s health condition. (This determination may be modified as permitted under paragraph (f) of this section.)

(e) *Individual notice of period of preexisting condition exclusion.* After an individual has presented evidence of creditable coverage and after the plan has made a determination of creditable coverage under paragraph (d) of this section, the plan must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan is not required to provide this notice if the plan does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage. (See 29 CFR 2590.701–3(e) and 45 CFR 146.111(e), which also impose this requirement on a health insurance issuer offering group health insurance coverage.)

(1) *Manner and timing.* The individual notice must be provided by the earliest date following a determination that the plan, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* A plan must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (e) is provided to an individual by another party, the plan's obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is satisfied. (See 29 CFR 2590.701–3(e)(3) and 45 CFR 146.111(e)(3), which provide that the issuer's obligation is similarly satisfied.)

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *G* presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that *G* is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies *G* that, based on the certificate *G* submitted, *G* is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of *G*'s medical conditions that could be subject to the exclusion.

(ii) *Conclusion.* In this *Example 1*, the plan satisfies the requirements of this paragraph (e).

Example 2. (i) *Facts.* Same facts as in *Example 1*, except that the plan determines that *G* has 430 days of creditable coverage based on *G*'s certificate indicating 430 days of creditable coverage under *G*'s prior plan.

(ii) *Conclusion.* In this *Example 2*, the plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

(f) *Reconsideration.* Nothing in this section prevents a plan from modifying

an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

§ 54.9801–4 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 54.9831–1(a).

(ii) Health insurance coverage as defined in § 54.9801–2 (whether or not the entity offering the coverage is subject to Chapter 100 of Subtitle K, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26);

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition —

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a public health plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage.* Creditable coverage does not include coverage of solely excepted benefits (described in § 54.9831–1).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 54.9801–3(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section or may provide that a health insurance issuer offering health insurance coverage under the plan may use the alternative method of counting creditable coverage.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, the amount of creditable coverage is determined without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage. Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage. (*See* section 731(b)(2)(iii) of ERISA and section 2723(b)(2)(iii) of the PHS Act, which exclude from preemption State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(v) *Examples.* The rules of this paragraph (b)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* has creditable coverage under Employer *P*'s plan for 18 months before coverage ceases. *A* is provided a certificate of creditable coverage on *A*'s last day of coverage. Sixty-four days after the last date of coverage under *P*'s plan, a is hired by Employer *Q* and enrolls in *Q*'s group health plan. *Q*'s plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 1, A* has a break in coverage of 63 days. Because *A*'s break in coverage is a significant break in coverage, *Q*'s plan may disregard *A*'s prior coverage and a may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that *A* is hired by *Q* and enrolls in *Q*'s plan on the 63rd day after the last date of coverage under *P*'s plan.

(ii) *Conclusion.* In this *Example 2, A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to *A.*

Example 3. (i) *Facts.* Same facts as *Example 1,* except that *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) *Conclusion.* In this *Example 3,* under State law, the issuer that provides group health insurance coverage to *Q*'s plan must count *A*'s period of creditable coverage prior

to the 63-day break. (However, if *Q*'s plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and *A*'s previous health coverage could be disregarded.)

Example 4. [Reserved]

Example 5. (i) *Facts.* Individual *C* has creditable coverage under Employer *S*'s plan for 200 days before coverage ceases. *C* is provided a certificate of creditable coverage on *C*'s last day of coverage. *C* then does not have any creditable coverage for 51 days before being hired by Employer *T*. *T*'s plan has a 3-month waiting period. *C* works for *T* for 2 months and then terminates employment. Eleven days after terminating employment with *T*, *C* begins working for Employer *U*. *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 5, C* does not have a significant break in coverage because, after disregarding the waiting period under *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). accordingly, *C* has 200 days of creditable coverage, and *U*'s plan may not apply its 6-month preexisting condition exclusion with respect to *C*.

Example 6. [Reserved]

Example 7. (i) *Facts.* Individual *E* has creditable coverage under Employer *X*'s plan. *E* is provided a certificate of creditable coverage on *E*'s last day of coverage. On the 63rd day without coverage, *E* submits a substantially complete application for a health insurance policy in the individual market. *E*'s application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion.*

In this *Example 7*, because *E* applied for the policy before the end of the 63rd day, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 73 days.

Example 8. (i) *Facts.* Same facts as *Example 7*, except that *E*'s application for a policy in the individual market is denied.

(ii) *Conclusion.* In this *Example 8,* even though *E* did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied *E* would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *Other permissible counting methods*—(a) *Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 54.9801–5), a group health plan may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(vi) is illustrated by the following example:

Example. (i) *Facts.* Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by Group Health Plan *Z*. *F's* enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraphs (b)(2)(i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered.* Under the alternative method, a group health plan determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan may use the alternative method for any or all of the categories. The plan may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan. A plan that provides benefits (in part or in whole) through one or more policies or contracts of insurance will not fail the uniform application requirement of this paragraph (c)(2) if the alternative method is used (or not used) separately with respect to participants and beneficiaries under any policy or contact, provided that the alternative method is applied uniformly with respect to all coverage under that policy or contract. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(iv) Dental care; or

(v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and State this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Disclosure of information on previous benefits.* See § 54.9801–5(b) for special rules concerning disclosure of coverage to a plan (or issuer) using the alternative method of counting creditable coverage under this paragraph (c).

(6) *Counting creditable coverage*—(i) *In general.* Under the alternative method, the group health plan counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2)), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) *Conclusion.* In this *Example,* Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

§ 54.9801–5 Evidence of creditable coverage.

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *In general.* A group health plan is required to furnish certificates of creditable coverage in accordance with this paragraph (a). (See section 701(e) of ERISA and section 2701(e) of the PHS Act, under which this obligation is also imposed on each health insurance issuer offering group health insurance coverage under the plan.)

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a) with respect to an individual satisfies that requirement if another party provides the certificate, but only to the extent that the certificate contains the information required in paragraph (a)(3) of this section. For example, a group health plan is deemed to have satisfied the certification requirement with respect to a participant or beneficiary if any other entity actually provides a certificate that includes the information required under paragraph (a)(3) of this section with respect to the participant or beneficiary.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan satisfies the certification requirements under this paragraph (a) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and an employer sponsoring a plan under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the plan does not violate the certification requirements of this paragraph (a) (though the issuer would have violated the certification requirements pursuant to section 701(e) of ERISA and section 2701(e) of the PHS Act).

(iv) *Special rules relating to issuers providing coverage under a plan*—(A)(*1*) *Responsibility of issuer for coverage period.* See 29 CFR 2590.701–5 and 45 CFR 146.115, under which an issuer is not required to provide information regarding coverage provided to an individual by another party.

(*2*) *Example.* The rule referenced by this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) *Facts.* A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example,* if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B)(*1*) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy or contract ceases before the individual's coverage under the plan ceases, the issuer is required (under section 701(e) of ERISA and section 2701(e) of the PHS Act) to provide sufficient information to the plan (or to another party designated by the plan) to enable the plan (or other party), after cessation of the individual's coverage under the plan, to provide a certificate that reflects the period of coverage under the policy or contract. By providing that information to the plan, the issuer satisfies its obligation to provide an automatic certificate for that period of creditable coverage with respect to the individual under paragraph (a)(2)(ii) of this section. The issuer, however, must still provide a certificate upon request as required under paragraph (a)(2)(iii) of this section. In addition, the issuer is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). Moreover, if the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy or contract ceases, the issuer must still provide an automatic certificate under paragraph (a)(2)(ii) of this section. If an individual's coverage under an issuer's policy or contract ceases on the effective date for changing enrollment options under the plan, the issuer may presume (absent information to the contrary) that the individual's coverage under the plan continues. Therefore, the issuer is required to provide information to the plan in accordance with this paragraph (a)(1)(iv)(B)(*1*) (and is not required to provide an automatic certificate under paragraph (a)(2)(ii) of this section).

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example:

Example. (i) *Facts.* A group health plan provides coverage under an HMO option and an indemnity option through different issuers, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example,* if an employee switches from the indemnity option to the HMO option on January 1, the indemnity issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance*—(i) *Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 4980B(g)(3)) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 4980B(f)(6) (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who

is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate must be provided at the time the individual ceases to be covered under the plan. A plan satisfies the requirement to provide an automatic certificate at the time the individual ceases to be covered if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums).

(*1*) The cessation of temporary continuation coverage (TCC) under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefit Program) is a cessation of coverage upon which an automatic certificate must be provided.

(*2*) In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time after coverage ceases under the plan.

(*3*) If an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease for purposes of this paragraph (a)(2)(ii)(B) on the earliest date that a claim is denied due to the operation of the lifetime limit.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual' s coverage under the plan ceases. A plan satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* A certificate must be provided in response to a request made by, or on behalf of, an individual at any time while the individual is covered under a plan and up to 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* terminates employment with Employer *Q. A* is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer *Q's* group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) *Conclusion.* In this *Example 1,* the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A.*

(ii) *Conclusion.* In this *Example 2,* the automatic certificate may be provided after the COBRA notice but must be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) *Facts.* Employer *R* maintains an insured group health plan. *R* has never had 20 employees and thus *R's* plan is not subject to the COBRA continuation provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R's* plan.

(ii) *Conclusion.* In this *Example 3,* the automatic certificate must be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) *Facts.* Individual *C* terminates employment with Employer *S* and receives both a notice of *C's* rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S's* group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, *S's* group health plan determines that *C's* COBRA continuation coverage has ceased due to a failure to make a timely payment for continuation coverage.

(ii) *Conclusion.* In this *Example 4,* the plan must provide an updated automatic certificate to *C* within a reasonable time after the end of the grace period.

Example 5. (i) *Facts.* Individual *D* is currently covered under the group health plan of Employer *T. D* requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for *T's* plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) *Conclusion.* In this *Example 5,* the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate*—(i) *Written certificate*—(A) *In general.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (including any form approved by the Secretary as a writing).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraph (a)(2)(ii) or (iii) of this section, if —

(*1*) An individual who is entitled to receive the certificate requests that the certificate be sent to another plan or issuer instead of to the individual;

(*2*) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (such as by telephone); and

(*3*) The receiving plan or issuer receives the information from the sending plan or issuer through such means within the time required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following—

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(*1*) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(*2*) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began;

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and

(H) An educational statement regarding HIPAA, which explains:

(*1*) The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage);

(*2*) Special enrollment rights;

(*3*) The prohibitions against discrimination based on any health factor;

(*4*) The right to individual health coverage;

(*5*) The fact that State law may require issuers to provide additional protections to individuals in that State; and

(*6*) Where to get more information.

(iii) *Periods of coverage under the certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, the certificate provided must include each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 54.9831–1(c). In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 54.9801–4(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a written procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address).

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated individual or entity. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated individual or entity.

(5) *Special rules concerning dependent coverage*—(i)(A) *Reasonable efforts.* A plan is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5)(i) are illustrated by the following example:

Example. (i) *Facts.* A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) *Conclusion.* In this *Example,* the plan has satisfied the standard in this paragraph (a)(5)(i) of this section that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent covered by the certificate, the procedures described in paragraph (c)(5) of this section may be used to demonstrate dependent status. In addition, these procedures may be used to demonstrate that a child was covered under any creditable coverage within 30 days after birth, adoption, or placement for adoption. See also § 54.9801–3(b), under which such a child cannot be subject to a preexisting condition exclusion.

(6) *Special certification rules for entities not subject to Chapter 100 of Subtitle K*—(i) *Issuers.* For rules requiring that issuers in the group and individual markets provide certificates consistent with the rules in this section, see section 701(e) of ERISA and sections 2701(e), 2721(b)(1)(B), and 2743 of the PHS Act.

(ii) *Other entities.* For special rules requiring that certain other entities not subject to Chapter 100 of Subtitle K provide certificates consistent with the rules in this section, see section 2791(a)(3) of the PHS Act applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of the PHS Act (relating to Medicare, Medicaid, TRICARE, and Indian Health Service), section 2721(b)(1)(A) of the PHS Act applicable to nonfederal governmental plans generally, and section 2721(b)(2)(C)(ii) of the PHS Act applicable to nonfederal governmental plans that elect to be excluded from the requirements of Subparts 1 through 3 of Part A of Title XXVII of the PHS Act.

(b) *Disclosure of coverage to a plan or issuer using the alternative method of counting creditable coverage*—(1) *In general.* After an individual provides a certificate of creditable coverage to a plan (or issuer) using the alternative method under § 54.9801–4(c), that plan (or issuer) (requesting entity) must request that the entity that issued the certificate (prior entity) disclose the

information set forth in paragraph (b)(2) of this section. The prior entity is required to disclose this information promptly.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category.

(3) *Charge for providing information.* The prior entity may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information*—(1) *Purpose.* The rules in this paragraph (c) implement section 9801(c)(4), which permits individuals to demonstrate the duration of creditable coverage through means other than certificates, and section 9801(e)(3), which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual.

(2) *In general.* If the accuracy of a certificate is contested or a certificate is unavailable when needed by an individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time;

(ii) The individual has creditable coverage provided by an entity that is not required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(iv) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(3) *Evidence of creditable coverage*—(i) *Consideration of evidence*—(A) A plan is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage. A plan shall treat the individual as having furnished a certificate under paragraph (a) of this section if—

(*1*) The individual attests to the period of creditable coverage;

(*2*) The individual also presents relevant corroborating evidence of some creditable coverage during the period; and

(*3*) The individual cooperates with the plan's efforts to verify the individual's coverage.

(B) For purposes of this paragraph (c)(3)(i), cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that corroborate creditable coverage (and waiting or affiliation periods) include explanations of benefits (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting or affiliation periods) may also be corroborated through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(3) are illustrated by the following example:

Example. (i) *Facts.* Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, *W*, and requests a certificate. However, *F* (and *X*'s plan, on *F*'s behalf and with *F*'s cooperation) is unable to obtain a certificate from *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) *Conclusion.* In this *Example,* based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(4) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine the duration of an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(5) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

§ 54.9801–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In general.* A group health plan is required to permit current employees and dependents (as defined in § 54.9801–2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (See section 701(f)(1) of ERISA and section 2701(f)(1) of the PHS Act, under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Individuals eligible for special enrollment*—(i) *When employee loses coverage.* A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;

(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(ii) *When dependent loses coverage*—(A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(*1*) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(*2*) When coverage under the plan was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(*3*) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* works for Employer *X*. *A*,*A*'s spouse, and *A*'s dependent children are eligible but not enrolled for coverage under X's group health plan. *A*'s spouse works for Employer *Y* and at the time coverage was offered under X's plan, *A* was enrolled in coverage under *Y*'s plan. Then, *A* loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 1,* because *A* satisfies the conditions for special enrollment under paragraph (a)(2)(i) of this section, *A*, *A*'s spouse, and *A*'s dependent children are eligible for special enrollment under *X*'s plan.

Example 2. (i) *Facts.* Individual *A* and *A*'s spouse are eligible but not enrolled for coverage under Group Health Plan *P* maintained by *A*'s employer. When *A* was first presented with an opportunity to enroll *A* and *A*'s spouse, they did not have other coverage. Later, *A* and *A*'s spouse enroll in Group Health Plan *Q* maintained by the employer of *A*'s spouse. During a subsequent open enrollment period in *P*, *A* and *A*'s spouse did not enroll because of their coverage under *Q*. They then lose eligibility for coverage under *Q*.

(ii) *Conclusion.* In this *Example 2,* because *A* and *A*'s spouse were covered under *Q* when they did not enroll in *P* during open enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, *A* and *A*'s spouse are eligible for special enrollment under *P*.

Example 3. (i) *Facts.* Individual *B* works for Employer *X*. *B* and *B*'s spouse are eligible but not enrolled for coverage under *X*'s group health plan. *B*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *B*'s spouse was enrolled in self-only coverage under *Y*'s group health plan. Then, *B*'s spouse loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 3,* because *B*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *B* and *B*'s spouse are eligible for special enrollment under *X*'s plan.

Example 4. (i) *Facts.* Individual *A* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *A* enrolls for self-only coverage in the HMO option. *A*'s spouse works for Employer *Y* and was enrolled for self-only coverage under *Y*'s plan at the time coverage was offered under *X*'s plan. Then, *A*'s spouse loses coverage under *Y*'s plan. *A* requests special enrollment for *A* and *A*'s spouse under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 4*, because *A*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *A* and *A*'s spouse can enroll in either benefit package under *X*'s plan. Therefore, if *A* requests enrollment in accordance with the requirements of this section, the plan must allow *A* and *A*'s spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment*—(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802–1(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 54.9801–2.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to State in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the

employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *D* enrolls in a group health plan maintained by Employer *Y*. At the time *D* enrolls, *Y* pays 70 percent of the cost of employee coverage and *D* pays the rest. *Y* announces that beginning January 1, *Y* will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1,* employer contributions towards *D*'s coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether *D* elects to pay the total cost and continue coverage under *Y*'s plan).

Example 2. (i) *Facts.* A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee *A* is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2, A* has experienced a loss of eligibility for coverage that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if *A* satisfies the other conditions of this paragraph (a), the plan must permit *A* to enroll in Option 2 as a special enrollee. (*A* may also be eligible to enroll in another group health plan, such as a plan maintained by the employer of *A*'s spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to *A*.

Example 3. (i) *Facts.* Individual *C* is covered under a group health plan maintained by Employer *X*. While covered under *X*'s plan, *C* was eligible for but did not enroll in a plan maintained by Employer *Z*, the employer of *C*'s spouse. *C* terminates employment with *X* and loses eligibility for coverage under *X*'s plan. *C* has a special enrollment right to enroll in *Z*'s plan, but *C* instead elects COBRA continuation coverage under *X*'s plan. *C* exhausts COBRA continuation coverage under *X*'s plan and requests special enrollment in *Z*'s plan.

(ii) *Conclusion.* In this *Example 3, C* has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that *C* had into *Z*'s plan immediately after the loss of eligibility for coverage under *X*'s plan was an offer of coverage under *Z*'s plan. When *C* later exhausts COBRA coverage under *X*'s plan, *C* has a second special enrollment right in *Z*'s plan.

(4) *Applying for special enrollment and effective date of coverage*—(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (other than an event described in paragraph (a)(3)(i)(D)) to request enrollment (for the employee or the employee's dependent). In the case of an event described in paragraph (a)(3)(i)(D) of this section (relating to loss of eligibility for coverage due to the operation of a lifetime limit on all benefits), a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(ii) Coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) In general. A group health plan that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan. (*See* 29 CFR 2590.701–6(b) and 45 CFR 146.117(b), under which this obligation is also imposed on a health insurance issuer offering group health insurance coverage.)

(2) *Individuals eligible for special enrollment.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph (b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either—

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in § 54.9801–2) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph (b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage*—(i) *Request.* A plan must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin*—(A) *Marriage.* In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan (or any issuer offering health insurance

coverage under the plan) receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee *A* is hired on September 3. *A* is married to *B*, and they have no children. On March 15 in the following year a child *C* is born to *A* and *B*. Before that date, *A* and *B* have not been enrolled in the plan.

(ii) *Conclusion.* In this *Example 1,* the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If *A* satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows *A* to enroll either with employee-only coverage, with employee-plus-spouse coverage (for *A* and *B*), or with family coverage (for *A, B,* and *C*). The plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 2. (i) *Facts.* Individual *D* works for Employer *X. X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, *E,* is placed for adoption with *D.* Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 2, D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required.* The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees*—(1) If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible. For rules prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 54.9801–3(b).

(3) The rules of this section are illustrated by the following example:

Example 2. (i) *Facts.* Employer *Y* maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual *B* loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. *B* submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example, B* is a special enrollee. Therefore, even though *B*'s request for enrollment coincides with an open enrollment period, *B*'s coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

§ 54.9831–1 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Defined.* A group health plan means a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* The requirements of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–1T, 54.9811–1T, 54.9812–1T, and 54.9833–1 do not apply to any group health plan for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits*—(1) *In general.* The requirements of §§ 54.9801–1 through 54.9801–6, 54.9802–1, 54.9802–1T, 54.9811–1T, 54.9812–1T, and 54.9833–1 do not apply to any group health plan in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially of which are for treatment of the eye.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1), or provided under a qualified long-term care insurance contract, as defined in section 7702B(b); or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2)) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example,* the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* (*See* 29 CFR 2590.732(d)(1) and 45 CFR 146.145(d)(1), under which a plan providing medical care, maintained by a partnership, and usually not treated as an employee welfare benefit plan under ERISA is treated as a group health plan for purposes of Part 7 of Subtitle B of Title I of ERISA and Title XXVII of the PHS Act.)

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term *participant* also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

§ 54.9833–1 Effective dates.

Sections 54.9801–1 through 54.9801–6, 54.9831–1, and this section are applicable for plan years beginning on or after July 1, 2005.

PART 602—OMB CONTROL NUMBERS UNDER THE PAPERWORK REDUCTION ACT

■ **Par. 4.** The authority citation for part 602 continues to read as follows:

Authority: 26 U.S.C. 7805.

■ **Par. 5.** In § 602.101, paragraph (b) is amended by:

■ a. Removing the entries in the table for §§ 54.9801–3T, 54.9801–4T, 54.9801–5T, and 54.9801–6T.

■ b. Adding the following entries in numerical order to the table:

§ 602.101 OMB Control numbers.

* * * * *

(b) * * *

CFR part or section where identified and described	Current OMB control No.
* * * * *	
54.9801–3	1545–1537
54.9801–4	1545–1537
54.9801–5	1545–1537
54.9801–6	1545–1537
* * * * *	

Mark E. Matthews,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: July 14, 2004.

Gregory F. Jenner,

Acting Assistant Secretary of the Treasury.

Employee Benefits Security Administration

29 CFR Chapter XXV

■ For the reasons set forth above, Chapter XXV of Title 29 of the Code of Federal Regulations is amended as set forth below:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 1. The authority citation for Part 2590 is revised 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), Public Law 104–191, 101 Stat. 1936; sec. 401(b), Public Law 105–200, 112 Stat. 645 (42 U.S.C. 651 note); Secretary of Labor's Order 1–2003, 68 FR 5374 (Feb. 3, 2003).

■ 2. The heading for Subpart B is revised to read as follows:

Subpart B—Health Coverage Portability, Nondiscrimination, and Renewability

■ 3. Sections 2590.701–1, 2590.701–2, 2590.701–3, 2590.701–4, 2590.701–5, 2590.701–6, and 2590.701–7 are revised to read as follows:

§ 2590.701–1 Basis and scope.

(a) *Statutory basis.* This Subpart B implements Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (hereinafter ERISA or the Act).

(b) *Scope.* A group health plan or health insurance issuer offering group health insurance coverage may provide greater rights to participants and beneficiaries than those set forth in this Subpart B. This Subpart B sets forth minimum requirements for group health plans and health insurance issuers offering group health insurance coverage concerning:

(1) Limitations on a preexisting condition exclusion period.

(2) Certificates and disclosure of previous coverage.

(3) Rules relating to counting creditable coverage.

(4) Special enrollment periods.

(5) Prohibition against discrimination on the basis of health factors.

(6) Use of an affiliation period by an HMO as an alternative to a preexisting condition exclusion.

§ 2590.701–2 Definitions.

Unless otherwise provided, the definitions in this section govern in applying the provisions of §§ 2590.701 through 2590.734.

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

COBRA definitions:

(1) *COBRA* means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601–608 of the Act, section 4980B of the Internal Revenue Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), or Title XXII of the PHS Act.

(4) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

Condition means a *medical condition.*

Creditable coverage means *creditable coverage* within the meaning of § 2590.701–4(a).

Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (*enrollment date, first day of coverage,*

and *waiting period*) are set forth in § 2590.701–3(a)(3)(i), (ii), and (iii).

Excepted benefits means the benefits described as excepted in § 2590.732(c).

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan or *plan* means a *group health plan* within the meaning of § 2590.732(a).

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of *individual market* in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of the Act). Such term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Internal Revenue Code means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

Issuer means a *health insurance issuer.*

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in § 2590.701–3(a)(3)(v) and (vi).

Medical care means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Participant means *participant* within the meaning of section 3(7) of the Act.

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion means *preexisting condition exclusion* within the meaning of § 2590.701–3(a)(1).

Public health plan means *public health plan* within the meaning of § 2590.701–4(a)(1)(ix).

Public Health Service Act (PHS Act) means the Public Health Service Act (42 U.S.C. 201, *et seq.*).

Short-term, limited-duration insurance means 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.

Significant break in coverage means a *significant break in coverage* within the meaning of § 2590.701–4(b)(2)(iii).

Special enrollment means enrollment in a group health plan or group health insurance coverage under the rights described in § 2590.701–6.

State means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State health benefits risk pool means a *State health benefits risk pool* within the meaning of § 2590.701–4(a)(1)(vii).

Waiting period means *waiting period* within the meaning of § 2590.701–3(a)(3)(iii).

§ 2590.701–3 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *Defined*—(i) A *preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

(ii) *Examples.* The rules of this paragraph (a)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer *S*. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. (Therefore, the exclusion of benefits is required to comply with the limitations on preexisting condition exclusions in this section. For an example illustrating the application of these limitations to a succeeding insurance policy, see *Example 3* of paragraph (a)(3)(iv) of this section.)

Example 2. (i) *Facts.* A group health plan provides coverage for cosmetic surgery in cases of accidental injury, but only if the injury occurred while the individual was covered under the plan.

(ii) *Conclusion.* In this *Example 2,* the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 3. (i) *Facts.* A group health plan provides coverage for the treatment of diabetes, generally not subject to any lifetime dollar limit. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a lifetime limit of $10,000.

(ii) *Conclusion.* In this *Example 3,* the $10,000 lifetime limit is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 4. (i) *Facts.* A group health plan provides coverage for the treatment of acne, subject to a lifetime limit of $2,000. The plan counts against this $2,000 lifetime limit acne treatment benefits provided under prior health coverage.

(ii) *Conclusion.* In this *Example 4,* counting benefits for a specific condition provided under prior health coverage against a lifetime limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 5. (i) *Facts.* When an individual's coverage begins under a group health plan, the individual generally becomes eligible for all benefits. However, benefits for pregnancy are not available until the individual has been covered under the plan for 12 months.

(ii) *Conclusion.* In this *Example 5,* the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. Because a plan is prohibited under paragraph (b)(5) of this section from imposing any preexisting condition exclusion on pregnancy, the plan provision is prohibited. However, if the plan provision included an exception for women who were pregnant before the effective date of coverage under the plan (so that the provision applied only to women who became pregnant on or after the effective date of coverage) the plan provision would not be a preexisting condition exclusion (and would not be prohibited by paragraph (b)(5) of this section).

Example 6. (i) *Facts.* A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion.* In this *Example 6,* the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 7. (i) *Facts.* A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion.* In this *Example 7,* the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not subject to the limitations on preexisting condition exclusions in this section.

Example 8. (i) *Facts.* A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) *Conclusion.* In this *Example 8,* the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

(2) *General rules.* Subject to paragraph (b) of this section (prohibiting the imposition of a preexisting condition exclusion with respect to certain individuals and conditions), a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a)(2) are satisfied.

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or such shorter period as applies under the plan) ending on the enrollment date.

(A) For purposes of this paragraph (a)(2)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(2)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* is diagnosed with a medical condition 8 months before *A*'s enrollment date in Employer *R*'s group health plan. *A*'s doctor recommends that *A* take a prescription drug for 3 months, and *A* follows the recommendation.

(ii) *Conclusion.* In this *Example 1,* Employer *R*'s plan may impose a preexisting condition exclusion with respect to *A*'s condition because *A* received treatment during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan by taking the prescription medication during that period. However, if *A* did not take the prescription drug during the 6-month period, Employer *R*'s plan would not be able to impose a preexisting condition exclusion with respect to that condition.

Example 2. (i) *Facts.* Individual *B* is treated for a medical condition 7 months before the enrollment date in Employer *S*'s group health plan. As part of such treatment, *B*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *B* does not receive a

follow-up examination, and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *B* or received by *B* during the 6-month period ending on *B*'s enrollment date in Employer *S*'s plan.

(ii) *Conclusion.* In this *Example 2,* Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date.

Example 3. (i) *Facts.* Same facts as Example 2, except that Employer *S*'s plan learns of the condition and attaches a rider to *B*'s certificate of coverage excluding coverage for the condition. Three months after enrollment, *B*'s condition recurs, and Employer *S*'s plan denies payment under the rider.

(ii) *Conclusion.* In this *Example 3,* the rider is a preexisting condition exclusion and Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date. (In addition, such a rider would violate the provisions of § 2590.702, even if *B* had received treatment for the condition within the 6-month period ending on the enrollment date.)

Example 4. (i) *Facts.* Individual *C* has asthma and is treated for that condition several times during the 6-month period before *C*'s enrollment date in Employer *T*'s plan. Three months after the enrollment date, *C* begins coverage under Employer T's plan. Two months later, *C* is hospitalized for asthma.

(ii) *Conclusion.* In this *Example 4,* Employer *T*'s plan may impose a preexisting condition exclusion with respect to *C*'s asthma because care relating to *C*'s asthma was received during the 6-month period ending on *C*'s enrollment date (which, under the rules of paragraph (a)(3)(i) of this section, is the first day of the waiting period).

Example 5. (i) *Facts.* Individual *D*, who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as retinal degeneration, a foot condition, and poor circulation (all of which are conditions that may be directly attributed to diabetes). *D* receives treatment for these conditions during the 6-month period ending on *D*'s enrollment date in Employer *U*'s plan. After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) *Conclusion.* In this *Example 5*, the leg fracture is not a condition related to *D*'s diabetes, retinal degeneration, foot condition, or poor circulation, even though they may have contributed to the accident. Therefore, benefits to treat the leg fracture cannot be subject to a preexisting condition exclusion. However, any additional medical services that may be needed because of *D*'s preexisting diabetes, poor circulation, or retinal degeneration that would not be needed by another patient with a broken leg who does not have these conditions may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion.* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999; the 18-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through January 31, 2000.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage*—(A) The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 2590.701–4. Creditable coverage may be evidenced through a certificate of creditable coverage (required under § 2590.701–5(a)), or through other means in accordance with the rules of § 2590.701–5(c).

(B) The rules of this paragraph (a)(2)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* works for Employer *X* and has been covered continuously under *X*'s group health plan. *D*'s spouse works for Employer *Y*. *Y* maintains a group health plan that imposes a 12-month preexisting condition exclusion (reduced by creditable coverage) on all new enrollees. *D* enrolls in *Y*'s plan, but also stays covered under *X*'s plan. *D* presents *Y*'s plan with evidence of creditable coverage under *X*'s plan.

(ii) *Conclusion.* In this *Example, Y*'s plan must reduce the preexisting condition exclusion period that applies to *D* by the number of days of coverage that *D* had under *X*'s plan as of *D*'s enrollment date in *Y*'s plan (even though *D*'s coverage under *X*'s plan was continuing as of that date).

(iv) *Other standards.* See § 2590.702 for other standards in this Subpart B that may apply with respect to certain benefit limitations or restrictions under a group health plan. Other laws may also apply, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service.

(3) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage (as described in paragraph (a)(3)(ii) of this section) or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

(ii) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

(iii) *Waiting period* means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on—

(A) If the application results in coverage, the date coverage begins;

(B) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

(iv) The rules of paragraphs (a)(3)(i), (ii), and (iii) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and on October 14, 1998 *E* completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) *Conclusion.* In this *Example 1, E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E*, the permissible 6-month period in paragraph (a)(2)(i) is the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan can apply a preexisting condition exclusion under paragraph (a)(2)(ii) is the period from October 13, 1998 through October 12, 1999, and this period must be reduced under paragraph (a)(2)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

Example 2. (i) *Facts.* A group health plan has two benefit package options, Option 1 and Option 2. Under each option a 12-month

preexisting condition exclusion is imposed. Individual *B* is enrolled in Option 1 on the first day of employment with the employer maintaining the plan, remains enrolled in Option 1 for more than one year, and then decides to switch to Option 2 at open season.

(ii) *Conclusion.* In this *Example 2, B* cannot be subject to any preexisting condition exclusion under Option 2 because any preexisting condition exclusion period would have to begin on *B*'s enrollment date, which is *B*'s first day of coverage, rather than the date that *B* enrolled in Option 2. Therefore, the preexisting condition exclusion period expired before *B* switched to Option 2.

Example 3. (i) *Facts.* On May 13, 1997, Individual *E* is hired by an employer and enrolls in the employer's group health plan. The plan provides benefits solely through an insurance policy offered by Issuer *S*. On December 27, 1998, *E*'s leg is injured in an accident and the leg is amputated. On January 1, 1999, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 3, E*'s enrollment date is May 13, 1997, *E*'s first day of coverage. Therefore, the permissible 6-month look-back period for the preexisting condition exclusion imposed under Issuer *T*'s policy begins on November 13, 1996 and ends on May 12, 1997. In addition, the 12-month maximum permissible preexisting condition exclusion period begins on May 13, 1997 and ends on May 12, 1998. Accordingly, because no medical advice, diagnosis, care, or treatment was recommended to or received by *E* for the leg during the 6-month look-back period (even though medical care was provided within the 6-month period preceding the effective date of *E*'s coverage under Issuer *T*'s policy), Issuer *T* may not impose any preexisting condition exclusion with respect to *E*. Moreover, even if *E* had received treatment during the 6-month look-back period, Issuer *T* still would not be permitted to impose a preexisting condition exclusion because the 12-month maximum permissible preexisting condition exclusion period expired on May 12, 1998 (before the effective date of *E*'s coverage under Issuer *T*'s policy).

Example 4. (i) *Facts.* A group health plan limits eligibility for coverage to full-time employees of Employer *Y*. Coverage becomes effective on the first day of the month following the date the employee becomes eligible. Employee *C* begins working full-time for Employer *Y* on April 11. Prior to this date, *C* worked part-time for *Y*. *C* enrolls in the plan and coverage is effective May 1.

(ii) *Conclusion.* In this *Example 4, C*'s enrollment date is April 11 and the period from April 11 through April 30 is a waiting period. The period while *C* was working part-time, and therefore not in an eligible class of employees, is not part of the waiting period.

Example 5. (i) *Facts.* To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the previous quarter. If the hours requirement is satisfied, coverage becomes effective on the first day of the current calendar quarter. Employee *D* begins work on January 28 and does not work 250 hours in covered employment during the first quarter (ending March 31). *D* works at least 250 hours in the second quarter (ending June 30) and is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).

(ii) *Conclusion.* In this *Example 5, D*'s enrollment date is the first day of the quarter during which *D* satisfies the hours requirement, which is April 1. The period from April 1 through June 30 is a waiting period.

(v) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(vi) (A) *Late enrollment* means enrollment of an individual under a group health plan other than—

(*1*) On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(*2*) Through special enrollment. (For rules relating to special enrollment, see § 2590.701–6.)

(B) If an individual ceases to be eligible for coverage under the plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(vii) *Examples.* The rules of paragraphs (a)(3)(v) and (vi) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999 but elects not to enroll in the plan until a later annual open enrollment period, with coverage effective January 1, 2001. *F* has no special enrollment right at that time.

(ii) *Conclusion.* In this *Example 1, F* is a late enrollee with respect to *F*'s coverage that became effective under the plan on January 1, 2001.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that *F* terminates employment with Employer *W* on July 1, 1999 without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) *Conclusion.* In this *Example 2, F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—(i) *In general.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who, within 30 days after birth, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 2590.701–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child.

(ii) *Examples.* The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *E*, who has no prior creditable coverage, begins working for Employer *W* and has accumulated 210 days of creditable coverage under Employer *W*'s group health plan on the date *E* gives birth to a child. Within 30 days after the birth, the child is enrolled in the plan. Ninety days after the birth, both *E* and the child terminate coverage under the plan. Both *E* and the child then experience a break in coverage of 45 days before *E* is hired by Employer *X* and the two are enrolled in Employer *X*'s group health plan.

(ii) *Conclusion.* In this *Example 1,* because *E*'s child is enrolled in Employer *W*'s plan within 30 days after birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Likewise, Employer *X*'s plan may not impose any preexisting condition exclusion on *E*'s child because the child was covered under creditable coverage within 30 days after birth and had no significant break in coverage before enrolling in Employer *X*'s plan. On the other hand, because *E* had only 300 days of creditable coverage prior to *E*'s enrollment date in Employer *X*'s plan, Employer *X*'s plan may impose a preexisting condition exclusion on *E* for up to 65 days (66 days if the 12-month period after *E*'s enrollment date in *X*'s plan includes February 29).

Example 2. (i) *Facts.* Individual *F* is enrolled in a group health plan in which coverage is provided through a health insurance issuer. *F* gives birth. Under State law applicable to the health insurance issuer, health care expenses incurred for the child during the 30 days following birth are covered as part of *F*'s coverage. Although *F* may obtain coverage for the child beyond 30 days by timely requesting special enrollment and paying an additional premium, the issuer is prohibited under State law from recouping the cost of any expenses incurred for the child within the 30-day period if the child is not later enrolled.

(ii) *Conclusion.* In this *Example 2,* the child is covered under creditable coverage within 30 days after birth, regardless of whether the child enrolls as a special enrollee under the plan. Therefore, no preexisting condition exclusion may be imposed on the child unless the child has a significant break in coverage.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who is adopted or placed for adoption before attaining 18 years of age and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 2590.701–4(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Significant break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage. (*See* § 2590.701–4(b)(2)(iii) for rules relating to the determination of a significant break in coverage.)

(4) *Special enrollment.* For special enrollment rules relating to new dependents, see § 2590.701–6(b).

(5) *Pregnancy.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to pregnancy.

(6) *Genetic information*—(i) A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. However, if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section.

(ii) The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *A* enrolls in a group health plan that imposes a 12-month maximum preexisting condition exclusion. Three months before *A*'s enrollment, *A*'s doctor told *A* that, based on genetic information, *A* has a predisposition towards breast cancer. *A* was not diagnosed with breast cancer at any time prior to *A*'s enrollment date in the plan. Nine months after *A*'s enrollment date in the plan, *A* is diagnosed with breast cancer.

(ii) *Conclusion.* In this *Example,* the plan may not impose a preexisting condition exclusion with respect to *A*'s breast cancer because, prior to *A*'s enrollment date, *A* was not diagnosed with breast cancer.

(c) *General notice of preexisting condition exclusion.* A group health plan imposing a preexisting condition exclusion, and a health insurance issuer offering group health insurance coverage subject to a preexisting condition exclusion, must provide a written general notice of preexisting condition exclusion to participants under the plan and cannot impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until such a notice is provided.

(1) *Manner and timing.* A plan or issuer must provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* The general notice of preexisting condition exclusion must notify participants of the following:

(i) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period (which is not to exceed 6 months under paragraph (a)(2)(i) of this section); the maximum preexisting condition exclusion period under the plan (which cannot exceed 12 months (or 18-months for late enrollees) under paragraph (a)(2)(ii) of this section); and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage (described in paragraph (a)(2)(iii) of this section).

(ii) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage (as required by § 2590.701–5(a)) or through other means (as described in § 2590.701–5(c)). This must include a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(iii) A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (c) is provided to an individual, the obligation to provide a general notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Example with sample language.* The rules of this paragraph (c) are illustrated by the following example, which includes sample language that plans and issuers can use as a basis for preparing their own notices to satisfy the requirements of this paragraph (c):

Example. (i) *Facts.* A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month look-back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior ''creditable coverage.'' Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual *B* at Address *M* or Telephone Number *N.*

(ii) Conclusion. In this Example, the plan satisfies the general notice requirement of this paragraph (c), and thus also satisfies this requirement for any issuer providing the coverage.

(d) *Determination of creditable coverage*—(1) *Determination within reasonable time.* If a group health plan or health insurance issuer offering group health insurance coverage receives

creditable coverage information under § 2590.701–5, the plan or issuer is required, within a reasonable time following receipt of the information, to make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care.

(2) *No time limit on presenting evidence of creditable coverage.* A plan or issuer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(3) *Example.* The rules of this paragraph (d) are illustrated by the following example:

Example. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *H* develops an urgent health condition before receiving a certificate of creditable coverage from *H*'s prior group health plan. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf in accordance with the rules of § 2590.701–5.

(ii) *Conclusion.* In this *Example,* the plan must review the evidence presented by *H* and make a determination of creditable coverage within a reasonable time that is consistent with the urgency of *H*'s health condition. (This determination may be modified as permitted under paragraph (f) of this section.)

(e) *Individual notice of period of preexisting condition exclusion.* After an individual has presented evidence of creditable coverage and after the plan or issuer has made a determination of creditable coverage under paragraph (d) of this section, the plan or issuer must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan or issuer is not required to provide this notice if the plan or issuer does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage.

(1) *Manner and timing.* The individual notice must be provided by the earliest date following a determination that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* A plan or issuer must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan or issuer relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan or issuer.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (e) is provided to an individual, the obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *G* presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that *G* is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies *G* that, based on the certificate *G* submitted, *G* is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of *G*'s medical conditions that could be subject to the exclusion.

(ii) *Conclusion.* In this *Example 1,* the plan satisfies the requirements of this paragraph (e).

Example 2. (i) *Facts.* Same facts as in *Example 1,* except that the plan determines that *G* has 430 days of creditable coverage based on *G*'s certificate indicating 430 days of creditable coverage under *G*'s prior plan.

(ii) *Conclusion.* In this *Example 2,* the plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

(f) *Reconsideration.* Nothing in this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that—

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

§ 2590.701–4 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 2590.732(a).

(ii) Health insurance coverage as defined in § 2590.701–2 (whether or not the entity offering the coverage is subject to Part 7 of Subtitle B of Title I of the Act, and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26) of the Internal Revenue Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a *public health plan* means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage.* Creditable coverage does not include coverage of solely excepted benefits (described in § 2590.732).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 2590.701–3(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan or issuer may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, the amount of creditable coverage is determined without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage. Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage. (*See also* § 2590.731(c)(2)(iii) regarding the applicability to issuers of State insurance laws that require a break of more than 63 days before an individual has a significant break in coverage for purposes of State insurance law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(v) *Examples.* The rules of this paragraph (b)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* has creditable coverage under Employer *P*'s plan for 18 months before coverage ceases. *A* is provided a certificate of creditable coverage on *A*'s last day of coverage. Sixty-four days after the last date of coverage under *P*'s plan, *A* is hired by Employer *Q* and enrolls in *Q*'s group health plan. *Q*'s plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 1, A* has a break in coverage of 63 days. Because *A*'s break in coverage is a significant break in coverage, *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that *A* is hired by *Q* and enrolls in *Q*'s plan on the 63rd day after the last date of coverage under *P*'s plan.

(ii) *Conclusion.* In this *Example 2, A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to *A.*

Example 3. (i) *Facts.* Same facts as *Example 1,* except that *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) *Conclusion.* In this *Example 3,* under State law, the issuer that provides group health insurance coverage to *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break. (However, if *Q*'s plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and *A*'s previous health coverage could be disregarded.)

Example 4. —[Reserved]

Example 5. (i) *Facts.* Individual *C* has creditable coverage under Employer *S*'s plan for 200 days before coverage ceases. *C* is provided a certificate of creditable coverage on *C*'s last day of coverage. *C* then does not have any creditable coverage for 51 days before being hired by Employer *T. T*'s plan has a 3-month waiting period. *C* works for *T* for 2 months and then terminates employment. Eleven days after terminating employment with *T, C* begins working for Employer *U. U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 5, C* does not have a significant break in coverage because, after disregarding the waiting period under *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). Accordingly, *C* has 200 days of creditable coverage, and *U*'s plan may not apply its 6-month preexisting condition exclusion with respect to *C.*

Example 6. —[Reserved]

Example 7. (i) *Facts.* Individual *E* has creditable coverage under Employer *X*'s plan. *E* is provided a certificate of creditable coverage on *E*'s last day of coverage. On the 63rd day without coverage, *E* submits a substantially complete application for a health insurance policy in the individual market. *E*'s application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion.* In this *Example 7,* because *E* applied for the policy before the end of the 63rd day, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 73 days.

Example 8. (i) *Facts.* Same facts as *Example 7,* except that *E*'s application for a policy in the individual market is denied.

(ii) *Conclusion.* In this *Example 8,* even though *E* did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied *E* would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *Other permissible counting methods*—(A) *Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 2590.701–5), a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(vi) is illustrated by the following example:

Example. (i) *Facts.* Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F*

then becomes covered by Group Health Plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example*, Plan *Z* may determine, in accordance with the rules prescribed in paragraphs (b)(2)(i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered.* Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan or issuer may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or health insurance coverage. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(iv) Dental care; or

(v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and State this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the alternative method, including an identification of the categories used.

(5) *Disclosure of information on previous benefits.* See § 2590.701–5(b) for special rules concerning disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage under this paragraph (c).

(6) *Counting creditable coverage*—(i) *In general.* Under the alternative method, the group health plan or issuer counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan or issuer counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) *Conclusion.* In this *Example,* Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

§ 2590.701–5 Evidence of creditable coverage.

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *In general.* A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to furnish certificates of creditable coverage in accordance with this paragraph (a).

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a) with respect to an individual satisfies that requirement if another party provides the certificate, but only to the extent that the certificate contains the information required in paragraph (a)(3) of this section. For example, in the case of a group health plan funded through an insurance policy, the issuer satisfies the certification requirement with respect to an individual if the plan actually provides a certificate that includes all the information required under paragraph (a)(3) of this section with respect to the individual.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan satisfies the certification requirements under this paragraph (a) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and a plan sponsor under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the issuer, but not the plan, violates the certification requirements of this paragraph (a).

(iv) *Special rules for issuers*—(A)(*1*) *Responsibility of issuer for coverage period.* An issuer is not required to provide information regarding coverage provided to an individual by another party.

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) *Facts.* A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with

the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example,* if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B)(*1*) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy or contract ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan (or to another party designated by the plan) to enable the plan (or other party), after cessation of the individual's coverage under the plan, to provide a certificate that reflects the period of coverage under the policy or contract. By providing that information to the plan, the issuer satisfies its obligation to provide an automatic certificate for that period of creditable coverage with respect to the individual under paragraph (a)(2)(ii) of this section. The issuer, however, must still provide a certificate upon request as required under paragraph (a)(2)(iii) of this section. In addition, the issuer is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). Moreover, if the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy or contract ceases, the issuer must still provide an automatic certificate under paragraph (a)(2)(ii) of this section. If an individual's coverage under an issuer's policy or contract ceases on the effective date for changing enrollment options under the plan, the issuer may presume (absent information to the contrary) that the individual's coverage under the plan continues. Therefore, the issuer is required to provide information to the plan in accordance with this paragraph (a)(1)(iv)(B)(*1*) (and is not required to provide an automatic certificate under paragraph (a)(2)(ii) of this section).

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example:

Example. (i) *Facts.* A group health plan provides coverage under an HMO option and an indemnity option through different issuers, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example,* if an employee switches from the indemnity option to the HMO option on January 1, the indemnity issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance*—(i) *Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 607(3) of the Act) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan or issuer satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 606 of the Act (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate must be provided at the time the individual ceases to be covered under the plan. A plan or issuer satisfies the requirement to provide an automatic certificate at the time the individual ceases to be covered if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums).

(*1*) The cessation of temporary continuation coverage (TCC) under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefit Program) is a cessation of coverage upon which an automatic certificate must be provided.

(*2*) In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time after coverage ceases under the plan.

(*3*) If an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease for purposes of this paragraph (a)(2)(ii)(B) on the earliest date that a claim is denied due to the operation of the lifetime limit.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual' s coverage under the plan ceases. A plan, or issuer, satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* A certificate must be provided in response to a request made by, or on behalf of, an individual at any time while the individual is covered under a plan and up to 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* terminates employment with Employer *Q. A* is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer *Q*'s group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) *Conclusion.* In this *Example 1*, the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A*.

(ii) *Conclusion.* In this *Example 2*, the automatic certificate may be provided after the COBRA notice but must be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) *Facts.* Employer *R* maintains an insured group health plan. *R* has never had 20 employees and thus *R*'s plan is not subject to the COBRA continuation provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R*'s plan.

(ii) *Conclusion.* In this *Example 3*, the automatic certificate must be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) *Facts.* Individual *C* terminates employment with Employer *S* and receives both a notice of *C*'s rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S*'s group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, *S*'s group health plan determines that *C*'s COBRA continuation coverage has ceased due to a failure to make a timely payment for continuation coverage.

(ii) *Conclusion.* In this *Example 4*, the plan must provide an updated automatic certificate to *C* within a reasonable time after the end of the grace period.

Example 5. (i) *Facts.* Individual *D* is currently covered under the group health plan of Employer *T*. *D* requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for *T*'s plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) *Conclusion.* In this *Example 5*, the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate*—(i) *Written certificate*—(A) *In general.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (or any other medium approved by the Secretary).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraph (a)(2)(ii) or (iii) of this section, if—

(*1*) An individual who is entitled to receive the certificate requests that the certificate be sent to another plan or issuer instead of to the individual;

(*2*) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (such as by telephone); and

(*3*) The receiving plan or issuer receives the information from the sending plan or issuer through such means within the time required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following—

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(*1*) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(*2*) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began;

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and

(H) An educational statement regarding HIPAA, which explains:

(*1*) The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage);

(*2*) Special enrollment rights;

(*3*) The prohibitions against discrimination based on any health factor;

(*4*) The right to individual health coverage;

(*5*) The fact that state law may require issuers to provide additional protections to individuals in that State; and

(*6*) Where to get more information.

(iii) *Periods of coverage under the certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, the certificate provided must include each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately States the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan or issuer provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 2590.732(c). In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 2590.701–4(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. (*See also* § 2520.104b–1, which permits plans to make disclosures under the Act—including the furnishing of certificates—through electronic means if certain standards are met.) If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the

dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a written procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address).

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated individual or entity. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated individual or entity.

(5) *Special rules concerning dependent coverage*—(i)(A) *Reasonable efforts.* A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan or issuer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5)(i) are illustrated by the following example:

Example. (i) *Facts.* A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or on which a person ceases to be a dependent of the employee.

(ii) *Conclusion.* In this *Example*, the plan has satisfied the standard in this paragraph (a)(5)(i) of this section that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent covered by the certificate, the procedures described in paragraph (c)(5) of this section may be used to demonstrate dependent status. In addition, these procedures may be used to demonstrate that a child was covered under any creditable coverage within 30 days after birth, adoption, or placement for adoption. *See also* § 2590.701–3(b), under which such a child cannot be subject to a preexisting condition exclusion.

(6) *Special certification rules for entities not subject to Part 7 of Subtitle B of Title I of the Act*—(i) *Issuers.* For special rules requiring that issuers not subject to Part 7 of Subtitle B of Title I of the Act provide certificates consistent with the rules in this section, including issuers offering coverage with respect to creditable coverage described in sections 701(c)(1)(G), (I), and (J) of the Act (coverage under a State health benefits risk pool, a public health plan, and a health benefit plan under section 5(e) of the Peace Corps Act), see sections 2743 and 2721(b)(1)(B) of the PHS Act (requiring certificates by issuers in the individual market, and issuers offering health insurance coverage in connection with a group health plan, including a church plan or a governmental plan (such as the Federal Employees Health Benefits Program (FEHBP)). (However, this section does not require a certificate to be provided with respect to short-term, limited-duration insurance, as described in the definition of *individual health insurance coverage* in § 2590.701–2, that is not provided by a group health plan or issuer offering health insurance coverage in connection with a group health plan.)

(ii) *Other entities.* For special rules requiring that certain other entities not subject to Part 7 of Subtitle B of Title I of the Act provide certificates consistent with the rules in this section, see section 2791(a)(3) of the PHS Act applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of the PHS Act (relating to Medicare, Medicaid, TRICARE, and Indian Health Service), section 2721(b)(1)(A) of the PHS Act applicable to nonfederal governmental plans generally, section 2721(b)(2)(C)(ii) of the PHS Act applicable to nonfederal governmental plans that elect to be excluded from the requirements of Subparts 1 through 3 of Part A of Title XXVII of the PHS Act, and section 9832(a) of the Internal Revenue Code applicable to group health plans, which includes church plans (as defined in section 414(e) of the Internal Revenue Code).

(b) *Disclosure of coverage to a plan or issuer using the alternative method of counting creditable coverage*—(1) *In general.* After an individual provides a certificate of creditable coverage to a plan or issuer using the alternative method under § 2590.701–4(c), that plan or issuer (requesting entity) must request that the entity that issued the certificate (prior entity) disclose the information set forth in paragraph (b)(2) of this section. The prior entity is required to disclose this information promptly.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category.

(3) *Charge for providing information.* The prior entity may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information*—(1) *Purpose.* The rules in this paragraph (c) implement section 701(c)(4) of the Act, which permits individuals to demonstrate the duration of creditable coverage through means other than certificates, and section 701(e)(3) of the Act, which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual.

(2) *In general.* If the accuracy of a certificate is contested or a certificate is unavailable when needed by an individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time;

(ii) The individual has creditable coverage provided by an entity that is not required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(iv) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(3) *Evidence of creditable coverage*—(i) *Consideration of evidence*—(A) A plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage. A plan or issuer shall treat the individual as having furnished a certificate under paragraph (a) of this section if—

(*1*) The individual attests to the period of creditable coverage;

(*2*) The individual also presents relevant corroborating evidence of some creditable coverage during the period; and

(*3*) The individual cooperates with the plan's or issuer's efforts to verify the individual's coverage.

(B) For purposes of this paragraph (c)(3)(i), cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that corroborate creditable coverage (and waiting or affiliation periods) include explanations of benefits (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting or affiliation periods) may also be corroborated through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(3) are illustrated by the following example:

Example. (i) *Facts.* Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, *W*, and requests a certificate. However, *F* (and *X*'s plan, on *F*'s behalf and with *F*'s cooperation) is unable to obtain a certificate from *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) *Conclusion.* In this *Example*, based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(4) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine the duration of an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(5) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

§ 2590.701–6 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In general.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as defined in § 2590.701–2) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Individuals eligible for special enrollment*—(i) *When employee loses coverage.* A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;

(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(ii) *When dependent loses coverage*—(A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(*1*) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(*2*) When coverage under the plan was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(*3*) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan or issuer is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* works for Employer *X*. *A*, *A*'s spouse, and *A*'s dependent children are eligible but not enrolled for coverage under *X*'s group health plan. *A*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *A* was enrolled in coverage under *Y*'s plan. Then, *A* loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 1,* because *A* satisfies the conditions for special enrollment under paragraph (a)(2)(i) of this section, *A*, *A*'s spouse, and *A*'s dependent children are eligible for special enrollment under *X*'s plan.

Example 2. (i) *Facts.* Individual *A* and *A*'s spouse are eligible but not enrolled for coverage under Group Health Plan *P* maintained by *A*'s employer. When *A* was first presented with an opportunity to enroll *A* and *A*'s spouse, they did not have other coverage. Later, *A* and *A*'s spouse enroll in Group Health Plan *Q* maintained by the employer of *A*'s spouse. During a subsequent open enrollment period in *P*, *A* and *A*'s spouse did not enroll because of their coverage under *Q*. They then lose eligibility for coverage under *Q*.

(ii) *Conclusion.* In this *Example 2*, because *A* and *A*'s spouse were covered under *Q* when they did not enroll in *P* during open

enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, *A* and *A*'s spouse are eligible for special enrollment under *P*.

Example 3. (i) *Facts.* Individual *B* works for Employer *X*. *B* and *B*'s spouse are eligible but not enrolled for coverage under *X*'s group health plan. *B*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *B*'s spouse was enrolled in self-only coverage under *Y*'s group health plan. Then, *B*'s spouse loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 3*, because *B*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *B* and *B*'s spouse are eligible for special enrollment under *X*'s plan.

Example 4. (i) *Facts.* Individual *A* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *A* enrolls for self-only coverage in the HMO option. *A*'s spouse works for Employer *Y* and was enrolled for self-only coverage under *Y*'s plan at the time coverage was offered under *X*'s plan. Then, *A*'s spouse loses coverage under *Y*'s plan. *A* requests special enrollment for *A* and *A*'s spouse under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 4,* because *A*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *A* and *A*'s spouse can enroll in either benefit package under *X*'s plan. Therefore, if *A* requests enrollment in accordance with the requirements of this section, the plan must allow *A* and *A*'s spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment*—(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 2590.702(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 2590.701–2.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to State in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *D* enrolls in a group health plan maintained by Employer *Y*. At the time *D* enrolls, *Y* pays 70 percent of the cost of employee coverage and *D* pays the rest. *Y* announces that beginning January 1, *Y* will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1,* employer contributions towards *D*'s coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether *D* elects to pay the total cost and continue coverage under *Y*'s plan).

Example 2. (i) *Facts.* A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee *A* is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2, A* has experienced a loss of eligibility for coverage that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if *A* satisfies the other conditions of this paragraph (a), the plan must permit *A* to enroll in Option 2 as a special enrollee. (*A* may also be eligible to enroll in another group health plan, such as a plan maintained by the employer of *A*'s spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to *A*.

Example 3. (i) *Facts.* Individual *C* is covered under a group health plan maintained by Employer *X*. While covered under *X*'s plan, *C* was eligible for but did not enroll in a plan maintained by Employer *Z*, the employer of *C*'s spouse. *C* terminates employment with *X* and loses eligibility for coverage under *X*'s plan. *C* has a special

enrollment right to enroll in *Z*'s plan, but *C* instead elects COBRA continuation coverage under *X*'s plan. *C* exhausts COBRA continuation coverage under *X*'s plan and requests special enrollment in *Z*'s plan.

(ii) *Conclusion.* In this *Example 3, C* has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that *C* had into *Z*'s plan immediately after the loss of eligibility for coverage under *X*'s plan was an offer of coverage under *Z*'s plan. When *C* later exhausts COBRA coverage under *X*'s plan, *C* has a second special enrollment right in *Z*'s plan.

(4) *Applying for special enrollment and effective date of coverage*—(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (other than an event described in paragraph (a)(3)(i)(D)) to request enrollment (for the employee or the employee's dependent). In the case of an event described in paragraph (a)(3)(i)(D) of this section (relating to loss of eligibility for coverage due to the operation of a lifetime limit on all benefits), a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(ii) Coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *In general.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Individuals eligible for special enrollment.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph (b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either —

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in § 2590.701–2) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph (b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage*—(i) *Request.* A plan or issuer must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin*—(A) *Marriage.* In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee *A* is hired on September 3. *A* is married to *B*, and they have no children. On March 15 in the following year a child *C* is born to *A* and *B*. Before that date, *A* and *B* have not been enrolled in the plan.

(ii) *Conclusion.* In this *Example 1,* the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If *A* satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows *A* to enroll either with employee-only coverage, with employee-plus-spouse coverage (for *A* and *B*), or with family coverage (for *A, B,* and *C*). The plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 2. (i) *Facts.* Individual *D* works for Employer X. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, E, is placed for adoption with *D*. Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 2, D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required.* The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees*—(1) If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible. For rules prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 2590.701–3(b).

(3) The rules of this section are illustrated by the following example:

Example. (i) *Facts.* Employer *Y* maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual *B* loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. *B* submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example, B* is a special enrollee. Therefore, even though *B*'s request for enrollment coincides with an open enrollment period, *B*'s coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

§ 2590.701–7 HMO affiliation period as an alternative to a preexisting condition exclusion.

(a) *In general.* A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the following requirements is satisfied—

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is imposed consistent with the requirements of § 2590.702 (prohibiting discrimination based on a health factor).

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date, or in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage but for the affiliation period.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

(b) *Examples.* The rules of paragraph (a) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan. Benefits under the plan are provided through an HMO, which imposes a two-month affiliation period. In order to be eligible under the plan, employees must have worked for the employer for six months. Individual *A* begins working for the employer on February 1.

(ii) *Conclusion.* In this *Example 1*, Individual *A*'s enrollment date is February 1 (see § 2590.701–3(a)(2)), and both the waiting period and the affiliation period begin on this date and run concurrently. Therefore, the affiliation period ends on March 31, the waiting period ends on July 31, and *A* is eligible to have coverage begin on August 1.

Example 2. (i) *Facts.* A group health plan has two benefit package options, a fee-for-service option and an HMO option. The HMO imposes a 1-month affiliation period. Individual *B* is enrolled in the fee-for-service option for more than one month and then decides to switch to the HMO option at open season.

(ii) *Conclusion.* In this *Example 2,* the HMO may not impose the affiliation period with respect to *B* because any affiliation period would have to begin on *B*'s enrollment date in the plan rather than the date that *B* enrolled in the HMO option. Therefore, the affiliation period would have expired before *B* switched to the HMO option.

Example 3. (i) *Facts.* An employer sponsors a group health plan that provides benefits through an HMO. The plan imposes a two-month affiliation period with respect to salaried employees, but it does not impose an affiliation period with respect to hourly employees.

(ii) *Conclusion.* In this *Example 3,* the plan may impose the affiliation period with respect to salaried employees without imposing any affiliation period with respect to hourly employees (unless, under the circumstances, treating salaried and hourly employees differently does not comply with the requirements of § 2590.702).

(c) *Alternatives to affiliation period.* An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. However, an arrangement that is in the nature of a preexisting condition exclusion cannot be an alternative to an affiliation period. Nothing in this part requires a State to receive proposals for or approve alternatives to affiliation periods.

■ 4. Section 2590.701–8 is added and reserved to read as follows:

§ 2590.701–8 Interaction with the Family and Medical Leave Act. [Reserved]

■ 5. Revise the heading of subpart D to read as follows:

Subpart D—General Provisions Related to Subparts B and C

■ 6. Sections 2590.731, 2590.732 and 2590.736 are revised to read as follows:

§ 2590.731 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this

section and except as provided in paragraph (c) of this section, part 7 of subtitle B of Title I of the Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part 7 of subtitle B of Title I of the Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules*—(1) *In general.* Subject to paragraph (c)(2) of this section, the provisions of part 7 of subtitle B of Title I of the Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 701 which differs from the standards or requirements specified in such section.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the ''6-month period'' described in section 701(a)(1) of the Act and § 2590.701–3(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the ''12 months'' and ''18 months'' described in section 701(a)(2) of the Act and § 2590.701–3(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the ''63-day period'' described in sections 701(c)(2)(A) and (d)(4)(A) of the Act and §§ 2590.701–3(a)(1)(iii) and 2590.701–4 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the ''30-day period'' described in sections 701(b)(2) and (d)(1) of the Act and § 2590.701–3(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 701(d) of the Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 701(f) of the Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 701(g)(1)(B) of the Act.

(d) *Definitions*—(1) *State law.* For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. *A* law of the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State.* For purposes of this section the term *State* includes a State (as defined in § 2590.701–2), any political subdivisions of a State, or any agency or instrumentality of either.

§ 2590.732 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Defined.* A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* The requirements of this part, other than § 2590.711, do not apply to any group health plan (and group health insurance coverage) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits*—(1) *In general.* The requirements of this Part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially all of which are for treatment of the eye.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year

cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example,* the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* Any plan, fund, or program that would not be (but for this paragraph (d)) an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, is treated (subject to paragraph (d)(2)) as an employee welfare benefit plan that is a group health plan.

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term participant also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

§ 2590.736 Applicability dates.

Sections 2590.701–1 through 2590.701–8 and 2590.731 through 2590.736 are applicable for plan years beginning on or after July 1, 2005. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2004.

Signed at Washington, DC, this 1st day of December, 2004.

Ann L. Combs,

Assistant Secretary, Employee Benefits Security Administration, U.S. Department of Labor.

Department of Health and Human Services

45 CFR Subtitle A

■ For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR Part 144 and Part 146 as follows:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ A. Part 144 is amended as set forth below:

■ 1. The authority citation for Part 144 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg-63, 300gg-91, 30gg-92 as amended by HIPAA (Public Law 104–191, 110 Stat. 1936), MHPA (Public Law 104–204, 110 Stat. 2944, as amended by Public Law 107–116, 115 Stat. 2177), NMHPA (Public Law 104–204, 110 Stat. 2935), WHCRA (Public Law 105–277, 112 Stat. 2681–436), and section 103(c)(4) of HIPAA.

■ 2. Section 144.103 is revised to read as follows:

§ 144.103 Definitions.

For purposes of parts 146 (group market), 148 (individual market), and 150 (enforcement) of this subchapter, the following definitions apply unless otherwise provided:

Affiliation period means a period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide benefits.

Applicable State authority means, with respect to a health insurance issuer in a State, the State insurance commissioner or official or officials designated by the State to enforce the requirements of 45 CFR parts 146 and 148 for the State involved with respect to the issuer.

Beneficiary has the meaning given the term under section 3(8) of the Employee Retirement Income Security Act of 1974 (ERISA), which States, ''a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit'' under the plan.

Bona fide association means, with respect to health insurance coverage offered in a State, an association that meets the following conditions:

(1) Has been actively in existence for at least 5 years.

(2) Has been formed and maintained in good faith for purposes other than obtaining insurance.

(3) Does not condition membership in the association on any health status-related factor relating to an individual (including an employee of an employer or a dependent of any employee).

(4) Makes health insurance coverage offered through the association available to all members regardless of any health status-related factor relating to the members (or individuals eligible for coverage through a member).

(5) Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

(6) Meets any additional requirements that may be imposed under State law.

Church plan means a Church plan within the meaning of section 3(33) of ERISA.

COBRA definitions:

(1) *COBRA* means Title *X* of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(2) *COBRA continuation coverage* means coverage, under a group health plan, that satisfies an applicable COBRA continuation provision.

(3) *COBRA continuation provision* means sections 601–608 of the Employee Retirement Income Security Act, section 4980B of the Internal Revenue Code of 1986 (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), or Title XXII of the PHS Act.

(4) *Continuation coverage* means coverage under a COBRA continuation provision or a similar State program. Coverage provided by a plan that is subject to a COBRA continuation provision or similar State program, but that does not satisfy all the requirements of that provision or program, will be deemed to be continuation coverage if it allows an individual to elect to continue coverage for a period of at least 18 months. Continuation coverage does not include coverage under a conversion policy required to be offered to an individual upon exhaustion of continuation coverage, nor does it include continuation coverage under the Federal Employees Health Benefits Program.

(5) *Exhaustion of COBRA continuation coverage* means that an individual's COBRA continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted COBRA continuation coverage if such coverage ceases—

(i) Due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives, or works in the service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other COBRA continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.

(6) *Exhaustion of continuation coverage* means that an individual's continuation coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis, or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). An individual is considered to have exhausted continuation coverage if—

(i) Coverage ceases due to the failure of the employer or other responsible entity to remit premiums on a timely basis;

(ii) When the individual no longer resides, lives or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no other continuation coverage available to the individual; or

(iii) When the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other continuation coverage available to the individual.

Condition means a *medical condition.*

Creditable coverage has the meaning given the term in 45 CFR 146.113(a).

Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Eligible individual, for purposes of—

(1) The group market provisions in 45 CFR part 146, subpart E, is defined in 45 CFR 146.150(b); and

(2) The individual market provisions in 45 CFR part 148, is defined in 45 CFR 148.103.

Employee has the meaning given the term under section 3(6) of ERISA, which States, ''any individual employed by an employer.''

Employer has the meaning given the term under section 3(5) of ERISA, which States, ''any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.''

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective), without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Enrollment date definitions (*enrollment date, first day of coverage,* and *waiting period*) are set forth in 45 CFR 146.111(a)(3)(i) through (iii).

ERISA stands for the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*).

Excepted benefits, consistent for purposes of the—

(1) Group market provisions in 45 CFR part 146 subpart D, is defined in 45 CFR 146.145(c); and

(2) Individual market provisions in 45 CFR part 148, is defined in 45 CFR 148.220.

Federal governmental plan means a governmental plan established or maintained for its employees by the Government of the United States or by any agency or instrumentality of such Government.

Genetic information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

Governmental plan means a governmental plan within the meaning of section 3(32) of ERISA.

Group health insurance coverage means health insurance coverage offered in connection with a group health plan.

Group health plan or *plan* means a group health plan within the meaning of 45 CFR 146.145(a).

Group market means the market for health insurance coverage offered in connection with a group health plan. (However, certain very small plans may be treated as being in the individual market, rather than the group market; see the definition of *individual market* in this section.)

Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance.

Health insurance issuer or *issuer* means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance (within the meaning of section 514(b)(2) of ERISA). This term does not include a group health plan.

Health maintenance organization or *HMO* means—

(1) A Federally qualified health maintenance organization (as defined in section 1301(a) of the PHS Act);

(2) An organization recognized under State law as a health maintenance organization; or

(3) A similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

Health status-related factor is any factor identified as a health factor in 45 CFR 146.121(a).

Individual health insurance coverage means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. Individual health insurance coverage can include dependent coverage.

Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan. Unless a State elects otherwise in accordance with section 2791(e)(1)(B)(ii) of the PHS Act, such term also includes coverage offered in connection with a group health plan that has fewer than two participants who are current employees on the first day of the plan year.

Internal Revenue Code means the Internal Revenue Code of 1986, as amended (Title 26, United States Code).

Issuer means a *health insurance issuer.*

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

Large group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a large employer, unless otherwise provided under State law.

Late enrollment definitions (*late enrollee* and *late enrollment*) are set forth in 45 CFR 146.111(a)(3)(v) and (vi).

Medical care means amounts paid for—

(1) The diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1) of this definition; and

(3) Insurance covering medical care referred to in paragraphs (1) and (2) of this definition.

Medical condition or *condition* means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Network plan means health insurance coverage of a health insurance issuer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of providers under contract with the issuer.

Non-Federal governmental plan means a governmental plan that is not a Federal governmental plan.

Participant has the meaning given the term under section 3(7) of ERISA, which States, ''any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.''

PHS Act stands for the Public Health Service Act (42 U.S.C. 201 *et seq.*).

Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation.

Plan sponsor has the meaning given the term under section 3(16)(B) of ERISA, which states, ''(i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.''

Plan year means the year that is designated as the plan year in the plan document of a group health plan, except that if the plan document does not designate a plan year or if there is no plan document, the plan year is—

(1) The deductible or limit year used under the plan;

(2) If the plan does not impose deductibles or limits on a yearly basis, then the plan year is the policy year;

(3) If the plan does not impose deductibles or limits on a yearly basis, and either the plan is not insured or the

insurance policy is not renewed on an annual basis, then the plan year is the employer's taxable year; or

(4) In any other case, the plan year is the calendar year.

Preexisting condition exclusion has the meaning given the term in 45 CFR 146.111(a)(1), with respect to group health plans and group health insurance coverage. With respect to individual market health insurance issuers or other entities providing coverage to federally eligible individuals pursuant to 45 CFR part 148, preexisting condition exclusion means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the first day of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information that is obtained relating to an individual's health status before the individual's first day of coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

Public health plan has the meaning given the term in 45 CFR 146.113(a)(1)(ix).

Short-term, limited-duration insurance means 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.

Significant break in coverage has the meaning given the term in 45 CFR 146.113(b)(2)(iii).

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year, unless otherwise provided under State law.

Small group market means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer.

Special enrollment means enrollment in a group health plan or group health insurance coverage under the rights described in 45 CFR 146.117.

State means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

State health benefits risk pool has the meaning given the term in 45 CFR § 146.113(a)(1)(vii).

Waiting period has the meaning given the term in 45 CFR 146.111(a)(3)(iii).

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ B. Part 146 is amended as set forth below:

■ 1. The authority citation for Part 146 is revised to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, 30gg–92 as amended by HIPAA (Public Law 104–191, 110 Stat. 1936), MHPA (Public Law 104–204, 110 Stat. 2944, as amended by Public Law 107–116, 115 Stat. 2177), NMHPA (Public Law 104–204, 110 Stat. 2935), WHCRA (Public Law 105–277, 112 Stat. 2681–436), and section 103(c)(4) of HIPAA.

■ 2. Revise § 146.111 to read as follows:

§ 146.111 Limitations on preexisting condition exclusion period.

(a) *Preexisting condition exclusion*—(1) *Defined.*—(i) A *preexisting condition exclusion* means a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage under a group health plan or group health insurance coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that day. A preexisting condition exclusion includes any exclusion applicable to an individual as a result of information relating to an individual's health status before the individual's effective date of coverage under a group health plan or group health insurance coverage, such as a condition identified as a result of a pre-enrollment questionnaire or physical examination given to the individual, or review of medical records relating to the pre-enrollment period.

(ii) *Examples.* The rules of this paragraph (a)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan provides benefits solely through an insurance policy offered by Issuer *S*. At the expiration of the policy, the plan switches coverage to a policy offered by Issuer *T*. Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 1*, the exclusion of benefits for any prosthesis if the body part was lost before the effective date of coverage is a preexisting condition exclusion because it operates to exclude benefits for a condition based on the fact that the condition was present before the effective date of coverage under the policy. (Therefore, the exclusion of benefits is required to comply with the limitations on preexisting condition exclusions in this section. For an example illustrating the application of these limitations to a succeeding insurance policy, see *Example 3* of paragraph (a)(3)(iv) of this section.)

Example 2. (i) *Facts.* A group health plan provides coverage for cosmetic surgery in cases of accidental injury, but only if the injury occurred while the individual was covered under the plan.

(ii) *Conclusion.* In this *Example 2*, the plan provision excluding cosmetic surgery benefits for individuals injured before enrolling in the plan is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 3. (i) *Facts.* A group health plan provides coverage for the treatment of diabetes, generally not subject to any lifetime dollar limit. However, if an individual was diagnosed with diabetes before the effective date of coverage under the plan, diabetes coverage is subject to a lifetime limit of $10,000.

(ii) *Conclusion.* In this *Example 3*, the $10,000 lifetime limit is a preexisting condition exclusion because it limits benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 4. (i) *Facts.* A group health plan provides coverage for the treatment of acne, subject to a lifetime limit of $2,000. The plan counts against this $2,000 lifetime limit acne treatment benefits provided under prior health coverage.

(ii) *Conclusion.* In this *Example 4*, counting benefits for a specific condition provided under prior health coverage against a lifetime limit for that condition is a preexisting condition exclusion because it operates to limit benefits for a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 5. (i) *Facts.* When an individual's coverage begins under a group health plan, the individual generally becomes eligible for all benefits. However, benefits for pregnancy are not available until the individual has been covered under the plan for 12 months.

(ii) *Conclusion.* In this *Example 5*, the requirement to be covered under the plan for 12 months to be eligible for pregnancy benefits is a subterfuge for a preexisting condition exclusion because it is designed to

exclude benefits for a condition (pregnancy) that arose before the effective date of coverage. Because a plan is prohibited under paragraph (b)(5) of this section from imposing any preexisting condition exclusion on pregnancy, the plan provision is prohibited. However, if the plan provision included an exception for women who were pregnant before the effective date of coverage under the plan (so that the provision applied only to women who became pregnant on or after the effective date of coverage) the plan provision would not be a preexisting condition exclusion (and would not be prohibited by paragraph (b)(5) of this section).

Example 6. (i) *Facts.* A group health plan provides coverage for medically necessary items and services, generally including treatment of heart conditions. However, the plan does not cover those same items and services when used for treatment of congenital heart conditions.

(ii) *Conclusion.* In this *Example 6*, the exclusion of coverage for treatment of congenital heart conditions is a preexisting condition exclusion because it operates to exclude benefits relating to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

Example 7. (i) *Facts.* A group health plan generally provides coverage for medically necessary items and services. However, the plan excludes coverage for the treatment of cleft palate.

(ii) *Conclusion.* In this *Example 7*, the exclusion of coverage for treatment of cleft palate is not a preexisting condition exclusion because the exclusion applies regardless of when the condition arose relative to the effective date of coverage. The plan provision, therefore, is not subject to the limitations on preexisting condition exclusions in this section.

Example 8. (i) *Facts.* A group health plan provides coverage for treatment of cleft palate, but only if the individual being treated has been continuously covered under the plan from the date of birth.

(ii) *Conclusion.* In this *Example 8*, the exclusion of coverage for treatment of cleft palate for individuals who have not been covered under the plan from the date of birth operates to exclude benefits in relation to a condition based on the fact that the condition was present before the effective date of coverage. The plan provision, therefore, is subject to the limitations on preexisting condition exclusions in this section.

(2) *General rules.* Subject to paragraph (b) of this section (prohibiting the imposition of a preexisting condition exclusion with respect to certain individuals and conditions), a group health plan, and a health insurance issuer offering group health insurance coverage, may impose, with respect to a participant or beneficiary, a preexisting condition exclusion only if the requirements of this paragraph (a)(2) are satisfied.

(i) *6-month look-back rule.* A preexisting condition exclusion must relate to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period (or such shorter period as applies under the plan) ending on the enrollment date.

(A) For purposes of this paragraph (a)(2)(i), medical advice, diagnosis, care, or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law.

(B) For purposes of this paragraph (a)(2)(i), the 6-month period ending on the enrollment date begins on the 6-month anniversary date preceding the enrollment date. For example, for an enrollment date of August 1, 1998, the 6-month period preceding the enrollment date is the period commencing on February 1, 1998 and continuing through July 31, 1998. As another example, for an enrollment date of August 30, 1998, the 6-month period preceding the enrollment date is the period commencing on February 28, 1998 and continuing through August 29, 1998.

(C) The rules of this paragraph (a)(2)(i) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* is diagnosed with a medical condition 8 months before *A*'s enrollment date in Employer *R*'s group health plan. *A*'s doctor recommends that *A* take a prescription drug for 3 months, and *A* follows the recommendation.

(ii) *Conclusion.* In this *Example 1,* Employer *R*'s plan may impose a preexisting condition exclusion with respect to *A*'s condition because A received treatment during the 6-month period ending on *A*'s enrollment date in Employer *R*'s plan by taking the prescription medication during that period. However, if *A* did not take the prescription drug during the 6-month period, Employer *R*'s plan would not be able to impose a preexisting condition exclusion with respect to that condition.

Example 2. (i) *Facts.* Individual *B* is treated for a medical condition 7 months before the enrollment date in Employer *S*'s group health plan. As part of such treatment, *B*'s physician recommends that a follow-up examination be given 2 months later. Despite this recommendation, *B* does not receive a follow-up examination, and no other medical advice, diagnosis, care, or treatment for that condition is recommended to *B* or received by *B* during the 6-month period ending on *B*'s enrollment date in Employer *S*'s plan.

(ii) *Conclusion.* In this *Example 2,* Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date.

Example 3. (i) *Facts.* Same facts as *Example 2,* except that Employer *S*'s plan learns of the condition and attaches a rider to *B*'s certificate of coverage excluding coverage for the condition. Three months after enrollment, *B*'s condition recurs, and Employer *S*'s plan denies payment under the rider.

(ii) *Conclusion.* In this *Example 3,* the rider is a preexisting condition exclusion and Employer *S*'s plan may not impose a preexisting condition exclusion with respect to the condition for which *B* received treatment 7 months prior to the enrollment date. (In addition, such a rider would violate the provisions of § 146.121, even if *B* had received treatment for the condition within the 6-month period ending on the enrollment date.)

Example 4. (i) *Facts.* Individual *C* has asthma and is treated for that condition several times during the 6-month period before *C*'s enrollment date in Employer *T*'s plan. Three months after the enrollment date, *C* begins coverage under Employer *T*'s plan. Two months later, *C* is hospitalized for asthma.

(ii) *Conclusion.* In this *Example 4,* Employer *T*'s plan may impose a preexisting condition exclusion with respect to *C*'s asthma because care relating to *C*'s asthma was received during the 6-month period ending on *C*'s enrollment date (which, under the rules of paragraph (a)(3)(i) of this section, is the first day of the waiting period).

Example 5. (i) *Facts.* Individual *D,* who is subject to a preexisting condition exclusion imposed by Employer *U*'s plan, has diabetes, as well as retinal degeneration, a foot condition, and poor circulation (all of which are conditions that may be directly attributed to diabetes). *D* receives treatment for these conditions during the 6-month period ending on *D*'s enrollment date in Employer *U*'s plan. After enrolling in the plan, *D* stumbles and breaks a leg.

(ii) *Conclusion.* In this *Example 5,* the leg fracture is not a condition related to D's diabetes, retinal degeneration, foot condition, or poor circulation, even though they may have contributed to the accident. Therefore, benefits to treat the leg fracture cannot be subject to a preexisting condition exclusion. However, any additional medical services that may be needed because of *D*'s preexisting diabetes, poor circulation, or retinal degeneration that would not be needed by another patient with a broken leg who does not have these conditions may be subject to the preexisting condition exclusion imposed under Employer *U*'s plan.

(ii) *Maximum length of preexisting condition exclusion.* A preexisting condition exclusion is not permitted to extend for more than 12 months (18 months in the case of a late enrollee) after the enrollment date. For example, for an enrollment date of August 1, 1998, the 12-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through July 31, 1999; the

18-month period after the enrollment date is the period commencing on August 1, 1998 and continuing through January 31, 2000.

(iii) *Reducing a preexisting condition exclusion period by creditable coverage*—(A) The period of any preexisting condition exclusion that would otherwise apply to an individual under a group health plan is reduced by the number of days of creditable coverage the individual has as of the enrollment date, as counted under § 146.113. Creditable coverage may be evidenced through a certificate of creditable coverage (required under § 146.115(a)), or through other means in accordance with the rules of § 146.115(c).

(B) The rules of this paragraph (a)(2)(iii) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* works for Employer *X* and has been covered continuously under *X*'s group health plan. *D*'s spouse works for Employer *Y. Y* maintains a group health plan that imposes a 12-month preexisting condition exclusion (reduced by creditable coverage) on all new enrollees. *D* enrolls in *Y*'s plan, but also stays covered under *X*'s plan. *D* presents *Y*'s plan with evidence of creditable coverage under *X*'s plan.

(ii) *Conclusion.* In this *Example, Y*'s plan must reduce the preexisting condition exclusion period that applies to *D* by the number of days of coverage that *D* had under *X*'s plan as of *D*'s enrollment date in *Y*'s plan (even though *D*'s coverage under *X*'s plan was continuing as of that date).

(iv) *Other standards.* See § 146.121 for other standards in this Subpart A that may apply with respect to certain benefit limitations or restrictions under a group health plan. Other laws may also apply, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of a preexisting condition exclusion to certain individuals who are reinstated in a group health plan following active military service.

(3) *Enrollment definitions*—(i) *Enrollment date* means the first day of coverage (as described in paragraph (a)(3)(ii) of this section) or, if there is a waiting period, the first day of the waiting period. If an individual receiving benefits under a group health plan changes benefit packages, or if the plan changes group health insurance issuers, the individual's enrollment date does not change.

(ii) *First day of coverage* means, in the case of an individual covered for benefits under a group health plan, the first day of coverage under the plan and, in the case of an individual covered by health insurance coverage in the individual market, the first day of coverage under the policy or contract.

(iii) *Waiting period* means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of a group health plan can become effective. If an employee or dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a waiting period. If an individual seeks coverage in the individual market, a waiting period begins on the date the individual submits a substantially complete application for coverage and ends on—

(A) If the application results in coverage, the date coverage begins;

(B) If the application does not result in coverage, the date on which the application is denied by the issuer or the date on which the offer of coverage lapses.

(iv) The rules of paragraphs (a)(3)(i), (ii), and (iii) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employer *V*'s group health plan provides for coverage to begin on the first day of the first payroll period following the date an employee is hired and completes the applicable enrollment forms, or on any subsequent January 1 after completion of the applicable enrollment forms. Employer *V*'s plan imposes a preexisting condition exclusion for 12 months (reduced by the individual's creditable coverage) following an individual's enrollment date. Employee *E* is hired by Employer *V* on October 13, 1998 and on October 14, 1998 *E* completes and files all the forms necessary to enroll in the plan. *E*'s coverage under the plan becomes effective on October 25, 1998 (which is the beginning of the first payroll period after *E*'s date of hire).

(ii) *Conclusion.* In this *Example 1, E*'s enrollment date is October 13, 1998 (which is the first day of the waiting period for *E*'s enrollment and is also *E*'s date of hire). Accordingly, with respect to *E,* the permissible 6-month period in paragraph (a)(2)(i) is the period from April 13, 1998 through October 12, 1998, the maximum permissible period during which Employer *V*'s plan can apply a preexisting condition exclusion under paragraph (a)(2)(ii) is the period from October 13, 1998 through October 12, 1999, and this period must be reduced under paragraph (a)(2)(iii) by *E*'s days of creditable coverage as of October 13, 1998.

Example 2. (i) *Facts.* A group health plan has two benefit package options, Option 1 and Option 2. Under each option a 12-month preexisting condition exclusion is imposed. Individual *B* is enrolled in Option 1 on the first day of employment with the employer maintaining the plan, remains enrolled in Option 1 for more than one year, and then decides to switch to Option 2 at open season.

(ii) *Conclusion.* In this *Example 2, B* cannot be subject to any preexisting condition exclusion under Option 2 because any preexisting condition exclusion period would have to begin on *B*'s enrollment date, which is *B*'s first day of coverage, rather than the date that *B* enrolled in Option 2. Therefore, the preexisting condition exclusion period expired before B switched to Option 2.

Example 3. (i) *Facts.* On May 13, 1997, Individual *E* is hired by an employer and enrolls in the employer's group health plan. The plan provides benefits solely through an insurance policy offered by Issuer *S.* On December 27, 1998, *E*'s leg is injured in an accident and the leg is amputated. On January 1, 1999, the plan switches coverage to a policy offered by Issuer *T.* Issuer *T*'s policy excludes benefits for any prosthesis if the body part was lost before the effective date of coverage under the policy.

(ii) *Conclusion.* In this *Example 3, E*'s enrollment date is May 13, 1997, *E*'s first day of coverage. Therefore, the permissible 6-month look-back period for the preexisting condition exclusion imposed under Issuer *T*'s policy begins on November 13, 1996 and ends on May 12, 1997. In addition, the 12-month maximum permissible preexisting condition exclusion period begins on May 13, 1997 and ends on May 12, 1998. Accordingly, because no medical advice, diagnosis, care, or treatment was recommended to or received by *E* for the leg during the 6-month look-back period (even though medical care was provided within the 6-month period preceding the effective date of *E*'s coverage under Issuer *T*'s policy), Issuer *T* may not impose any preexisting condition exclusion with respect to *E.* Moreover, even if *E* had received treatment during the 6-month look-back period, Issuer *T* still would not be permitted to impose a preexisting condition exclusion because the 12-month maximum permissible preexisting condition exclusion period expired on May 12, 1998 (before the effective date of *E*'s coverage under Issuer *T*'s policy).

Example 4. (i) *Facts.* A group health plan limits eligibility for coverage to full-time employees of Employer *Y.* Coverage becomes effective on the first day of the month following the date the employee becomes eligible. Employee *C* begins working full-time for Employer *Y* on April 11. Prior to this date, *C* worked part-time for *Y. C* enrolls in the plan and coverage is effective May 1.

(ii) *Conclusion.* In this *Example 4*, *C*'s enrollment date is April 11 and the period from April 11 through April 30 is a waiting period. The period while *C* was working part-time, and therefore not in an eligible class of employees, is not part of the waiting period.

Example 5. (i) *Facts.* To be eligible for coverage under a multiemployer group health plan in the current calendar quarter, the plan requires an individual to have worked 250 hours in covered employment during the previous quarter. If the hours requirement is satisfied, coverage becomes effective on the first day of the current calendar quarter. Employee *D* begins work on January 28 and does not work 250 hours in covered employment during the first quarter (ending March 31). *D* works at least 250 hours in the second quarter (ending June 30) and is enrolled in the plan with coverage effective July 1 (the first day of the third quarter).

(ii) *Conclusion.* In this *Example 5*, *D*'s enrollment date is the first day of the quarter during which *D* satisfies the hours requirement, which is April 1. The period from April 1 through June 30 is a waiting period.

(v) *Late enrollee* means an individual whose enrollment in a plan is a late enrollment.

(vi) (A) *Late enrollment* means enrollment of an individual under a group health plan other than—

(*1*) On the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(*2*) Through special enrollment. (For rules relating to special enrollment, see § 146.117.)

(B) If an individual ceases to be eligible for coverage under the plan, and then subsequently becomes eligible for coverage under the plan, only the individual's most recent period of eligibility is taken into account in determining whether the individual is a late enrollee under the plan with respect to the most recent period of coverage. Similar rules apply if an individual again becomes eligible for coverage following a suspension of coverage that applied generally under the plan.

(vii) *Examples.* The rules of paragraphs (a)(3)(v) and (vi) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* Employee *F* first becomes eligible to be covered by Employer *W*'s group health plan on January 1, 1999 but elects not to enroll in the plan until a later annual open enrollment period, with coverage effective January 1, 2001. *F* has no special enrollment right at that time.

(ii) *Conclusion.* In this *Example 1*, *F* is a late enrollee with respect to *F*'s coverage that became effective under the plan on January 1, 2001.

Example 2. (i) *Facts.* Same facts as *Example 1*, except that *F* terminates employment with Employer *W* on July 1, 1999 without having had any health insurance coverage under the plan. *F* is rehired by Employer *W* on January 1, 2000 and is eligible for and elects coverage under Employer *W*'s plan effective on January 1, 2000.

(ii) *Conclusion.* In this *Example 2*, *F* would not be a late enrollee with respect to *F*'s coverage that became effective on January 1, 2000.

(b) *Exceptions pertaining to preexisting condition exclusions*—(1) *Newborns*—(i) *In general.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who, within 30 days after birth, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after birth and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 146.113(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child.

(ii) *Examples.* The rules of this paragraph (b)(1) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *E,* who has no prior creditable coverage, begins working for Employer *W* and has accumulated 210 days of creditable coverage under Employer *W*'s group health plan on the date *E* gives birth to a child. Within 30 days after the birth, the child is enrolled in the plan. Ninety days after the birth, both *E* and the child terminate coverage under the plan. Both *E* and the child then experience a break in coverage of 45 days before *E* is hired by Employer *X* and the two are enrolled in Employer *X*'s group health plan.

(ii) *Conclusion.* In this *Example 1,* because *E*'s child is enrolled in Employer *W*'s plan within 30 days after birth, no preexisting condition exclusion may be imposed with respect to the child under Employer *W*'s plan. Likewise, Employer *X*'s plan may not impose any preexisting condition exclusion on *E*'s child because the child was covered under creditable coverage within 30 days after birth and had no significant break in coverage before enrolling in Employer *X*'s plan. On the other hand, because *E* had only 300 days of creditable coverage prior to *E*'s enrollment date in Employer *X*'s plan, Employer *X*'s plan may impose a preexisting condition exclusion on *E* for up to 65 days (66 days if the 12-month period after *E*'s enrollment date in *X*'s plan includes February 29).

Example 2. (i) *Facts.* Individual *F* is enrolled in a group health plan in which coverage is provided through a health insurance issuer. *F* gives birth. Under State law applicable to the health insurance issuer, health care expenses incurred for the child during the 30 days following birth are covered as part of *F*'s coverage. Although *F* may obtain coverage for the child beyond 30 days by timely requesting special enrollment and paying an additional premium, the issuer is prohibited under State law from recouping the cost of any expenses incurred for the child within the 30-day period if the child is not later enrolled.

(ii) *Conclusion.* In this *Example 2,* the child is covered under creditable coverage within 30 days after birth, regardless of whether the child enrolls as a special enrollee under the plan. Therefore, no preexisting condition exclusion may be imposed on the child unless the child has a significant break in coverage.

(2) *Adopted children.* Subject to paragraph (b)(3) of this section, a group health plan, and a health insurance issuer offering group health insurance coverage, may not impose any preexisting condition exclusion on a child who is adopted or placed for adoption before attaining 18 years of age and who, within 30 days after the adoption or placement for adoption, is covered under any creditable coverage. Accordingly, if a child is enrolled in a group health plan (or other creditable coverage) within 30 days after adoption or placement for adoption and subsequently enrolls in another group health plan without a significant break in coverage (as described in § 146.113(b)(2)(iii)), the other plan may not impose any preexisting condition exclusion on the child. This rule does not apply to coverage before the date of such adoption or placement for adoption.

(3) *Significant break in coverage.* Paragraphs (b)(1) and (2) of this section no longer apply to a child after a significant break in coverage. (*See* § 146.113(b)(2)(iii) for rules relating to the determination of a significant break in coverage.)

(4) *Special enrollment.* For special enrollment rules relating to new dependents, see § 146.117(b).

(5) *Pregnancy.* A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to pregnancy.

(6) *Genetic information*—(i) A group health plan, and a health insurance issuer offering group health insurance coverage, may not impose a preexisting condition exclusion relating to a condition based solely on genetic information. However, if an individual is diagnosed with a condition, even if the condition relates to genetic information, the plan may impose a preexisting condition exclusion with respect to the condition, subject to the other limitations of this section.

(ii) The rules of this paragraph (b)(6) are illustrated by the following example:

Example. (i) *Facts.* Individual *A* enrolls in a group health plan that imposes a 12-month maximum preexisting condition exclusion. Three months before *A*'s enrollment, *A*'s doctor told *A* that, based on genetic information, *A* has a predisposition towards breast cancer. *A* was not diagnosed with breast cancer at any time prior to *A*'s enrollment date in the plan. Nine months after *A*'s enrollment date in the plan, *A* is diagnosed with breast cancer.

(ii) *Conclusion.* In this *Example,* the plan may not impose a preexisting condition exclusion with respect to *A*'s breast cancer because, prior to *A*'s enrollment date, *A* was not diagnosed with breast cancer.

(c) *General notice of preexisting condition exclusion.* A group health plan imposing a preexisting condition exclusion, and a health insurance issuer offering group health insurance

coverage subject to a preexisting condition exclusion, must provide a written general notice of preexisting condition exclusion to participants under the plan and cannot impose a preexisting condition exclusion with respect to a participant or a dependent of the participant until such a notice is provided.

(1) *Manner and timing.* A plan or issuer must provide the general notice of preexisting condition exclusion as part of any written application materials distributed by the plan or issuer for enrollment. If the plan or issuer does not distribute such materials, the notice must be provided by the earliest date following a request for enrollment that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* The general notice of preexisting condition exclusion must notify participants of the following:

(i) The existence and terms of any preexisting condition exclusion under the plan. This description includes the length of the plan's look-back period (which is not to exceed 6 months under paragraph (a)(2)(i) of this section); the maximum preexisting condition exclusion period under the plan (which cannot exceed 12 months (or 18-months for late enrollees) under paragraph (a)(2)(ii) of this section); and how the plan will reduce the maximum preexisting condition exclusion period by creditable coverage (described in paragraph (a)(2)(iii) of this section).

(ii) A description of the rights of individuals to demonstrate creditable coverage, and any applicable waiting periods, through a certificate of creditable coverage (as required by § 146.115(a)) or through other means (as described in § 146.115(c)). This must include a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(iii) A person to contact (including an address or telephone number) for obtaining additional information or assistance regarding the preexisting condition exclusion.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (c) is provided to an individual, the obligation to provide a general notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Example with sample language.* The rules of this paragraph (c) are illustrated by the following example, which includes sample language that plans and issuers can use as a basis for preparing their own notices to satisfy the requirements of this paragraph (c):

Example. (i) *Facts.* A group health plan makes coverage effective on the first day of the first calendar month after hire and on each January 1 following an open season. The plan imposes a 12-month maximum preexisting condition exclusion (18 months for late enrollees) and uses a 6-month look-back period. As part of the enrollment application materials, the plan provides the following statement:

This plan imposes a preexisting condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the six-month period ends on the day before the waiting period begins. The preexisting condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 30 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months (18 months if you are a late enrollee) from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior ''creditable coverage.'' Most prior health coverage is creditable coverage and can be used to reduce the preexisting condition exclusion if you have not experienced a break in coverage of at least 63 days. To reduce the 12-month (or 18-month) exclusion period by your creditable coverage, you should give us a copy of any certificates of creditable coverage you have. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan or issuer. There are also other ways that you can show you have creditable coverage. Please contact us if you need help demonstrating creditable coverage.

All questions about the preexisting condition exclusion and creditable coverage should be directed to Individual *B* at Address *M* or Telephone Number *N*.

(ii) *Conclusion.* In this *Example,* the plan satisfies the general notice requirement of this paragraph (c), and thus also satisfies this requirement for any issuer providing the coverage.

(d) *Determination of creditable coverage*—(1) *Determination within reasonable time.* If a group health plan or health insurance issuer offering group health insurance coverage receives creditable coverage information under § 146.115, the plan or issuer is required, within a reasonable time following receipt of the information, to make a determination regarding the amount of the individual's creditable coverage and the length of any exclusion that remains. Whether this determination is made within a reasonable time depends on the relevant facts and circumstances. Relevant facts and circumstances include whether a plan's application of a preexisting condition exclusion would prevent an individual from having access to urgent medical care.

(2) *No time limit on presenting evidence of creditable coverage.* A plan or issuer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.

(3) *Example.* The rules of this paragraph (d) are illustrated by the following example:

Example. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *H* develops an urgent health condition before receiving a certificate of creditable coverage from *H*'s prior group health plan. *H* attests to the period of prior coverage, presents corroborating documentation of the coverage period, and authorizes the plan to request a certificate on *H*'s behalf in accordance with the rules of § 146.115.

(ii) *Conclusion.* In this *Example,* the plan must review the evidence presented by *H* and make a determination of creditable coverage within a reasonable time that is consistent with the urgency of *H*'s health condition. (This determination may be modified as permitted under paragraph (f) of this section.)

(e) *Individual notice of period of preexisting condition exclusion.* After an individual has presented evidence of creditable coverage and after the plan or issuer has made a determination of creditable coverage under paragraph (d) of this section, the plan or issuer must provide the individual a written notice of the length of preexisting condition exclusion that remains after offsetting for prior creditable coverage. This individual notice is not required to identify any medical conditions specific to the individual that could be subject to the exclusion. A plan or issuer is not required to provide this notice if the plan or issuer does not impose any preexisting condition exclusion on the individual or if the plan's preexisting condition exclusion is completely offset by the individual's prior creditable coverage.

(1) *Manner and timing.* The individual notice must be provided by the earliest date following a determination that the plan or issuer, acting in a reasonable and prompt fashion, can provide the notice.

(2) *Content.* A plan or issuer must disclose—

(i) Its determination of any preexisting condition exclusion period that applies to the individual (including the last day on which the preexisting condition exclusion applies);

(ii) The basis for such determination, including the source and substance of any information on which the plan or issuer relied;

(iii) An explanation of the individual's right to submit additional evidence of creditable coverage; and

(iv) A description of any applicable appeal procedures established by the plan or issuer.

(3) *Duplicate notices not required.* If a notice satisfying the requirements of this paragraph (e) is provided to an individual, the obligation to provide this individual notice of preexisting condition exclusion with respect to that individual is satisfied for both the plan and the issuer.

(4) *Examples.* The rules of this paragraph (e) are illustrated by the following examples:

Example 1. (i) *Facts.* A group health plan imposes a preexisting condition exclusion period of 12 months. After receiving the general notice of preexisting condition exclusion, Individual *G* presents a certificate of creditable coverage indicating 240 days of creditable coverage. Within seven days of receipt of the certificate, the plan determines that *G* is subject to a preexisting condition exclusion of 125 days, the last day of which is March 5. Five days later, the plan notifies *G* that, based on the certificate *G* submitted, *G* is subject to a preexisting condition exclusion period of 125 days, ending on March 5. The notice also explains the opportunity to submit additional evidence of creditable coverage and the plan's appeal procedures. The notice does not identify any of *G*'s medical conditions that could be subject to the exclusion.

(ii) *Conclusion.* In this *Example 1,* the plan satisfies the requirements of this paragraph (e).

Example 2. (i) *Facts.* Same facts as in *Example 1*, except that the plan determines that *G* has 430 days of creditable coverage based on *G*'s certificate indicating 430 days of creditable coverage under *G*'s prior plan.

(ii) *Conclusion.* In this *Example 2,* the plan is not required to notify *G* that *G* will not be subject to a preexisting condition exclusion.

(f) *Reconsideration.* Nothing in this section prevents a plan or issuer from modifying an initial determination of creditable coverage if it determines that the individual did not have the claimed creditable coverage, provided that —

(1) A notice of the new determination (consistent with the requirements of paragraph (e) of this section) is provided to the individual; and

(2) Until the notice of the new determination is provided, the plan or issuer, for purposes of approving access to medical services (such as a pre-surgery authorization), acts in a manner consistent with the initial determination.

■ 3. Revise § 146.113 to read as follows:

§ 146.113 Rules relating to creditable coverage.

(a) *General rules*—(1) *Creditable coverage.* For purposes of this section, except as provided in paragraph (a)(2) of this section, the term *creditable coverage* means coverage of an individual under any of the following:

(i) A group health plan as defined in § 146.145(a).

(ii) Health insurance coverage as defined in § 144.103 of this chapter (whether or not the entity offering the coverage is subject to the requirements of this part and 45 CFR part 148 and without regard to whether the coverage is offered in the group market, the individual market, or otherwise).

(iii) Part A or B of Title XVIII of the Social Security Act (Medicare).

(iv) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

(v) Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, *uniformed services* means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service).

(vi) A medical care program of the Indian Health Service or of a tribal organization.

(vii) A State health benefits risk pool. For purposes of this section, a *State health benefits risk pool* means—

(A) An organization qualifying under section 501(c)(26) of the Internal Revenue Code;

(B) A qualified high risk pool described in section 2744(c)(2) of the PHS Act; or

(C) Any other arrangement sponsored by a State, the membership composition of which is specified by the State and which is established and maintained primarily to provide health coverage for individuals who are residents of such State and who, by reason of the existence or history of a medical condition—

(*1*) Are unable to acquire medical care coverage for such condition through insurance or from an HMO, or

(*2*) Are able to acquire such coverage only at a rate which is substantially in excess of the rate for such coverage through the membership organization.

(viii) A health plan offered under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefits Program).

(ix) A public health plan. For purposes of this section, a *public health plan* means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

(x) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

(xi) Title XXI of the Social Security Act (State Children's Health Insurance Program).

(2) *Excluded coverage.* Creditable coverage does not include coverage of solely excepted benefits (described in § 146.145).

(3) *Methods of counting creditable coverage.* For purposes of reducing any preexisting condition exclusion period, as provided under § 146.111(a)(2)(iii), the amount of an individual's creditable coverage generally is determined by using the standard method described in paragraph (b) of this section. A plan or issuer may use the alternative method under paragraph (c) of this section with respect to any or all of the categories of benefits described under paragraph (c)(3) of this section.

(b) *Standard method*—(1) *Specific benefits not considered.* Under the standard method, the amount of creditable coverage is determined without regard to the specific benefits included in the coverage.

(2) *Counting creditable coverage*—(i) *Based on days.* For purposes of reducing the preexisting condition exclusion period that applies to an individual, the amount of creditable coverage is determined by counting all the days on which the individual has one or more types of creditable coverage. Accordingly, if on a particular day an individual has creditable coverage from more than one source, all the creditable coverage on that day is counted as one day. Any days in a waiting period for coverage are not creditable coverage.

(ii) *Days not counted before significant break in coverage.* Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(iii) *Significant break in coverage defined*—A significant break in coverage means a period of 63 consecutive days during each of which an individual does not have any creditable coverage. (See also § 146.143(c)(2)(iii) regarding the applicability to issuers of State insurance laws that require a break of more than 63 days before an individual

has a significant break in coverage for purposes of State insurance law.)

(iv) *Periods that toll a significant break.* Days in a waiting period and days in an affiliation period are not taken into account in determining whether a significant break in coverage has occurred. In addition, for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(v) *Examples.* The rules of this paragraph (b)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* has creditable coverage under Employer *P*'s plan for 18 months before coverage ceases. *A* is provided a certificate of creditable coverage on *A*'s last day of coverage. Sixty-four days after the last date of coverage under *P*'s plan, *A* is hired by Employer *Q* and enrolls in *Q*'s group health plan. *Q*'s plan has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 1, A* has a break in coverage of 63 days. Because *A*'s break in coverage is a significant break in coverage, *Q*'s plan may disregard *A*'s prior coverage and *A* may be subject to a 12-month preexisting condition exclusion.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that *A* is hired by *Q* and enrolls in *Q*'s plan on the 63rd day after the last date of coverage under *P*'s plan.

(ii) *Conclusion.* In this *Example 2, A* has a break in coverage of 62 days. Because *A*'s break in coverage is not a significant break in coverage, *Q*'s plan must count *A*'s prior creditable coverage for purposes of reducing the plan's preexisting condition exclusion period that applies to *A*.

Example 3. (i) *Facts.* Same facts as *Example 1,* except that *Q*'s plan provides benefits through an insurance policy that, as required by applicable State insurance laws, defines a significant break in coverage as 90 days.

(ii) *Conclusion.* In this *Example 3,* under State law, the issuer that provides group health insurance coverage to *Q*'s plan must count *A*'s period of creditable coverage prior to the 63-day break. (However, if *Q*'s plan was a self-insured plan, the coverage would not be subject to State law. Therefore, the health coverage would not be governed by the longer break rules and *A*'s previous health coverage could be disregarded.)

Example 4. —[Reserved]

Example 5. (i) *Facts.* Individual *C* has creditable coverage under Employer *S*'s plan for 200 days before coverage ceases. *C* is provided a certificate of creditable coverage on *C*'s last day of coverage. *C* then does not have any creditable coverage for 51 days before being hired by Employer *T*. *T*'s plan has a 3-month waiting period. *C* works for *T* for 2 months and then terminates employment. Eleven days after terminating employment with *T, C* begins working for Employer *U*. *U*'s plan has no waiting period, but has a 6-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example 5, C* does not have a significant break in coverage because, after disregarding the waiting period under *T*'s plan, *C* had only a 62-day break in coverage (51 days plus 11 days). Accordingly, *C* has 200 days of creditable coverage, and *U*'s plan may not apply its 6-month preexisting condition exclusion with respect to *C*.

Example 6. —[Reserved]

Example 7. (i) *Facts.* Individual *E* has creditable coverage under Employer *X*'s plan. *E* is provided a certificate of creditable coverage on *E*'s last day of coverage. On the 63rd day without coverage, *E* submits a substantially complete application for a health insurance policy in the individual market. *E*'s application is accepted and coverage is made effective 10 days later.

(ii) *Conclusion.* In this *Example 7,* because *E* applied for the policy before the end of the 63rd day, the period between the date of application and the first day of coverage is a waiting period and no significant break in coverage occurred even though the actual period without coverage was 73 days.

Example 8. (i) *Facts.* Same facts as *Example 7,* except that *E*'s application for a policy in the individual market is denied.

(ii) *Conclusion.* In this *Example 8,* even though *E* did not obtain coverage following application, the period between the date of application and the date the coverage was denied is a waiting period. However, to avoid a significant break in coverage, no later than the day after the application for the policy is denied *E* would need to do one of the following: submit a substantially complete application for a different individual market policy; obtain coverage in the group market; or be in a waiting period for coverage in the group market.

(vi) *Other permissible counting methods*—(A) *Rule.* Notwithstanding any other provisions of this paragraph (b)(2), for purposes of reducing a preexisting condition exclusion period (but not for purposes of issuing a certificate under § 146.115), a group health plan, and a health insurance issuer offering group health insurance coverage, may determine the amount of creditable coverage in any other manner that is at least as favorable to the individual as the method set forth in this paragraph (b)(2), subject to the requirements of other applicable law.

(B) *Example.* The rule of this paragraph (b)(2)(vi) is illustrated by the following example:

Example. (i) *Facts.* Individual *F* has coverage under Group Health Plan *Y* from January 3, 1997 through March 25, 1997. *F* then becomes covered by Group Health Plan *Z*. *F*'s enrollment date in Plan *Z* is May 1, 1997. Plan *Z* has a 12-month preexisting condition exclusion.

(ii) *Conclusion.* In this *Example,* Plan *Z* may determine, in accordance with the rules prescribed in paragraphs (b)(2)(i), (ii), and (iii) of this section, that *F* has 82 days of creditable coverage (29 days in January, 28 days in February, and 25 days in March). Thus, the preexisting condition exclusion will no longer apply to *F* on February 8, 1998 (82 days before the 12-month anniversary of *F*'s enrollment (May 1)). For administrative convenience, however, Plan *Z* may consider that the preexisting condition exclusion will no longer apply to *F* on the first day of the month (February 1).

(c) *Alternative method*—(1) *Specific benefits considered.* Under the alternative method, a group health plan, or a health insurance issuer offering group health insurance coverage, determines the amount of creditable coverage based on coverage within any category of benefits described in paragraph (c)(3) of this section and not based on coverage for any other benefits. The plan or issuer may use the alternative method for any or all of the categories. The plan or issuer may apply a different preexisting condition exclusion period with respect to each category (and may apply a different preexisting condition exclusion period for benefits that are not within any category). The creditable coverage determined for a category of benefits applies only for purposes of reducing the preexisting condition exclusion period with respect to that category. An individual's creditable coverage for benefits that are not within any category for which the alternative method is being used is determined under the standard method of paragraph (b) of this section.

(2) *Uniform application.* A plan or issuer using the alternative method is required to apply it uniformly to all participants and beneficiaries under the plan or health insurance coverage. The use of the alternative method is required to be set forth in the plan.

(3) *Categories of benefits.* The alternative method for counting creditable coverage may be used for coverage for the following categories of benefits—

(i) Mental health;

(ii) Substance abuse treatment;

(iii) Prescription drugs;

(iv) Dental care; or

(v) Vision care.

(4) *Plan notice.* If the alternative method is used, the plan is required to—

(i) State prominently that the plan is using the alternative method of counting creditable coverage in disclosure statements concerning the plan, and state this to each enrollee at the time of enrollment under the plan; and

(ii) Include in these statements a description of the effect of using the

alternative method, including an identification of the categories used.

(5) *Issuer notice.* With respect to health insurance coverage offered by an issuer in the small or large group market, if the insurance coverage uses the alternative method, the issuer states prominently in any disclosure statement concerning the coverage, that the issuer is using the alternative method, and includes in such statements a description of the effect of using the alternative method. This applies separately to each type of coverage offered by the health insurance issuer.

(6) *Disclosure of information on previous benefits.* See § 146.115(b) for special rules concerning disclosure of coverage to a plan, or issuer, using the alternative method of counting creditable coverage under this paragraph (c).

(7) *Counting creditable coverage*—(i) *In general.* Under the alternative method, the group health plan or issuer counts creditable coverage within a category if any level of benefits is provided within the category. Coverage under a reimbursement account or arrangement, such as a flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code), does not constitute coverage within any category.

(ii) *Special rules.* In counting an individual's creditable coverage under the alternative method, the group health plan, or issuer, first determines the amount of the individual's creditable coverage that may be counted under paragraph (b) of this section, up to a total of 365 days of the most recent creditable coverage (546 days for a late enrollee). The period over which this creditable coverage is determined is referred to as the determination period. Then, for the category specified under the alternative method, the plan or issuer counts within the category all days of coverage that occurred during the determination period (whether or not a significant break in coverage for that category occurs), and reduces the individual's preexisting condition exclusion period for that category by that number of days. The plan or issuer may determine the amount of creditable coverage in any other reasonable manner, uniformly applied, that is at least as favorable to the individual.

(iii) *Example.* The rules of this paragraph (c)(7) are illustrated by the following example:

Example. (i) *Facts.* Individual *D* enrolls in Employer *V*'s plan on January 1, 2001. Coverage under the plan includes prescription drug benefits. On April 1, 2001, the plan ceases providing prescription drug benefits. *D*'s employment with Employer *V* ends on January 1, 2002, after *D* was covered under Employer *V*'s group health plan for 365 days. *D* enrolls in Employer *Y*'s plan on February 1, 2002 (*D*'s enrollment date). Employer *Y*'s plan uses the alternative method of counting creditable coverage and imposes a 12-month preexisting condition exclusion on prescription drug benefits.

(ii) *Conclusion.* In this *Example*, Employer *Y*'s plan may impose a 275-day preexisting condition exclusion with respect to *D* for prescription drug benefits because *D* had 90 days of creditable coverage relating to prescription drug benefits within *D*'s determination period.

■ 4. Revise § 146.115 to read as follows:

§ 146.115 Certification and disclosure of previous coverage.

(a) *Certificate of creditable coverage*—(1) *Entities required to provide certificate*—(i) *In General.* A group health plan, and each health insurance issuer offering group health insurance coverage under a group health plan, is required to furnish certificates of creditable coverage in accordance with this paragraph (a).

(ii) *Duplicate certificates not required.* An entity required to provide a certificate under this paragraph (a) with respect to an individual satisfies that requirement if another party provides the certificate, but only to the extent that the certificate contains the information required in paragraph (a)(3) of this section. For example, in the case of a group health plan funded through an insurance policy, the issuer satisfies the certification requirement with respect to an individual if the plan actually provides a certificate that includes all the information required under paragraph (a)(3) of this section with respect to the individual.

(iii) *Special rule for group health plans.* To the extent coverage under a plan consists of group health insurance coverage, the plan satisfies the certification requirements under this paragraph (a) if any issuer offering the coverage is required to provide the certificates pursuant to an agreement between the plan and the issuer. For example, if there is an agreement between an issuer and a plan sponsor under which the issuer agrees to provide certificates for individuals covered under the plan, and the issuer fails to provide a certificate to an individual when the plan would have been required to provide one under this paragraph (a), then the issuer, but not the plan, violates the certification requirements of this paragraph (a).

(iv) *Special rules for issuers*—(A)(*1*) *Responsibility of issuer for coverage period.* An issuer is not required to provide information regarding coverage provided to an individual by another party.

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(A) is illustrated by the following example:

Example. (i) *Facts.* A plan offers coverage with an HMO option from one issuer and an indemnity option from a different issuer. The HMO has not entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example,* if an employee switches from the indemnity option to the HMO option and later ceases to be covered under the plan, any certificate provided by the HMO is not required to provide information regarding the employee's coverage under the indemnity option.

(B)(*1*) *Cessation of issuer coverage prior to cessation of coverage under a plan.* If an individual's coverage under an issuer's policy or contract ceases before the individual's coverage under the plan ceases, the issuer is required to provide sufficient information to the plan (or to another party designated by the plan) to enable the plan (or other party), after cessation of the individual's coverage under the plan, to provide a certificate that reflects the period of coverage under the policy or contract. By providing that information to the plan, the issuer satisfies its obligation to provide an automatic certificate for that period of creditable coverage with respect to the individual under paragraph (a)(2)(ii) of this section. The issuer, however, must still provide a certificate upon request as required under paragraph (a)(2)(iii) of this section. In addition, the issuer is required to cooperate with the plan in responding to any request made under paragraph (b)(2) of this section (relating to the alternative method of counting creditable coverage). Moreover, if the individual's coverage under the plan ceases at the time the individual's coverage under the issuer's policy or contract ceases, the issuer must still provide an automatic certificate under paragraph (a)(2)(ii) of this section. If an individual's coverage under an issuer's policy or contract ceases on the effective date for changing enrollment options under the plan, the issuer may presume (absent information to the contrary) that the individual's coverage under the plan continues. Therefore, the issuer is required to provide information to the plan in accordance with this paragraph (a)(1)(iv)(B)(*1*) (and is not required to provide an automatic certificate under paragraph (a)(2)(ii) of this section).

(*2*) *Example.* The rule of this paragraph (a)(1)(iv)(B) is illustrated by the following example:

Example. (i) *Facts.* A group health plan provides coverage under an HMO option and an indemnity option through different issuers, and only allows employees to switch on each January 1. Neither the HMO nor the indemnity issuer has entered into an agreement with the plan to provide certificates as permitted under paragraph (a)(1)(iii) of this section.

(ii) *Conclusion.* In this *Example,* if an employee switches from the indemnity option to the HMO option on January 1, the indemnity issuer must provide the plan (or a person designated by the plan) with appropriate information with respect to the individual's coverage with the indemnity issuer. However, if the individual's coverage with the indemnity issuer ceases at a date other than January 1, the issuer is instead required to provide the individual with an automatic certificate.

(2) *Individuals for whom certificate must be provided; timing of issuance*—(i) *Individuals.* A certificate must be provided, without charge, for participants or dependents who are or were covered under a group health plan upon the occurrence of any of the events described in paragraph (a)(2)(ii) or (iii) of this section.

(ii) *Issuance of automatic certificates.* The certificates described in this paragraph (a)(2)(ii) are referred to as automatic certificates.

(A) *Qualified beneficiaries upon a qualifying event.* In the case of an individual who is a qualified beneficiary (as defined in section 607(3) of ERISA, section 4980(B)(g)(1) of the Internal Revenue Code, or section 2208 of the PHS Act) entitled to elect COBRA continuation coverage, an automatic certificate is required to be provided at the time the individual would lose coverage under the plan in the absence of COBRA continuation coverage or alternative coverage elected instead of COBRA continuation coverage. A plan or issuer satisfies this requirement if it provides the automatic certificate no later than the time a notice is required to be furnished for a qualifying event under section 606 of ERISA, section 4980(B)(f)(6) of the Internal Revenue Code, and section 2206 of the PHS Act (relating to notices required under COBRA).

(B) *Other individuals when coverage ceases.* In the case of an individual who is not a qualified beneficiary entitled to elect COBRA continuation coverage, an automatic certificate must be provided at the time the individual ceases to be covered under the plan. A plan or issuer satisfies the requirement to provide an automatic certificate at the time the individual ceases to be covered if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums).

(*1*) The cessation of temporary continuation coverage (TCC) under Title 5 U.S.C. Chapter 89 (the Federal Employees Health Benefit Program) is a cessation of coverage upon which an automatic certificate must be provided.

(*2*) In the case of an individual who is entitled to elect to continue coverage under a State program similar to COBRA and who receives the automatic certificate not later than the time a notice is required to be furnished under the State program, the certificate is deemed to be provided within a reasonable time after coverage ceases under the plan.

(*3*) If an individual's coverage ceases due to the operation of a lifetime limit on all benefits, coverage is considered to cease for purposes of this paragraph (a)(2)(ii)(B) on the earliest date that a claim is denied due to the operation of the lifetime limit.

(C) *Qualified beneficiaries when COBRA ceases.* In the case of an individual who is a qualified beneficiary and has elected COBRA continuation coverage (or whose coverage has continued after the individual became entitled to elect COBRA continuation coverage), an automatic certificate is to be provided at the time the individual' s coverage under the plan ceases. A plan, or issuer, satisfies this requirement if it provides the automatic certificate within a reasonable time after coverage ceases (or after the expiration of any grace period for nonpayment of premiums). An automatic certificate is required to be provided to such an individual regardless of whether the individual has previously received an automatic certificate under paragraph (a)(2)(ii)(A) of this section.

(iii) *Any individual upon request.* A certificate must be provided in response to a request made by, or on behalf of, an individual at any time while the individual is covered under a plan and up to 24 months after coverage ceases. Thus, for example, a plan in which an individual enrolls may, if authorized by the individual, request a certificate of the individual's creditable coverage on behalf of the individual from a plan in which the individual was formerly enrolled. After the request is received, a plan or issuer is required to provide the certificate by the earliest date that the plan or issuer, acting in a reasonable and prompt fashion, can provide the certificate. A certificate is required to be provided under this paragraph (a)(2)(iii) even if the individual has previously received a certificate under this paragraph (a)(2)(iii) or an automatic certificate under paragraph (a)(2)(ii) of this section.

(iv) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* terminates employment with Employer *Q. A* is a qualified beneficiary entitled to elect COBRA continuation coverage under Employer *Q*'s group health plan. A notice of the rights provided under COBRA is typically furnished to qualified beneficiaries under the plan within 10 days after a covered employee terminates employment.

(ii) *Conclusion.* In this *Example 1,* the automatic certificate may be provided at the same time that *A* is provided the COBRA notice.

Example 2. (i) *Facts.* Same facts as *Example 1,* except that the automatic certificate for *A* is not completed by the time the COBRA notice is furnished to *A.*

(ii) *Conclusion.* In this *Example 2,* the automatic certificate may be provided after the COBRA notice but must be provided within the period permitted by law for the delivery of notices under COBRA.

Example 3. (i) *Facts.* Employer *R* maintains an insured group health plan. *R* has never had 20 employees and thus *R*'s plan is not subject to the COBRA continuation provisions. However, *R* is in a State that has a State program similar to COBRA. *B* terminates employment with *R* and loses coverage under *R*'s plan.

(ii) *Conclusion.* In this *Example 3,* the automatic certificate must be provided not later than the time a notice is required to be furnished under the State program.

Example 4. (i) *Facts.* Individual *C* terminates employment with Employer *S* and receives both a notice of *C*'s rights under COBRA and an automatic certificate. *C* elects COBRA continuation coverage under Employer *S*'s group health plan. After four months of COBRA continuation coverage and the expiration of a 30-day grace period, *S*'s group health plan determines that *C*'s COBRA continuation coverage has ceased due to a failure to make a timely payment for continuation coverage.

(ii) *Conclusion.* In this *Example 4,* the plan must provide an updated automatic certificate to *C* within a reasonable time after the end of the grace period.

Example 5. (i) *Facts.* Individual *D* is currently covered under the group health plan of Employer *T. D* requests a certificate, as permitted under paragraph (a)(2)(iii) of this section. Under the procedure for *T*'s plan, certificates are mailed (by first class mail) 7 business days following receipt of the request. This date reflects the earliest date that the plan, acting in a reasonable and prompt fashion, can provide certificates.

(ii) *Conclusion.* In this *Example 5,* the plan's procedure satisfies paragraph (a)(2)(iii) of this section.

(3) *Form and content of certificate*—(i) *Written certificate*—(A) *In General.* Except as provided in paragraph (a)(3)(i)(B) of this section, the certificate must be provided in writing (or any

other medium approved by the Secretary).

(B) *Other permissible forms.* No written certificate is required to be provided under this paragraph (a) with respect to a particular event described in paragraph (a)(2)(ii) or (iii) of this section, if—

(*1*) An individual who is entitled to receive the certificate requests that the certificate be sent to another plan or issuer instead of to the individual;

(*2*) The plan or issuer that would otherwise receive the certificate agrees to accept the information in this paragraph (a)(3) through means other than a written certificate (such as by telephone); and

(*3*) The receiving plan or issuer receives the information from the sending plan or issuer through such means within the time required under paragraph (a)(2) of this section.

(ii) *Required information.* The certificate must include the following—

(A) The date the certificate is issued;

(B) The name of the group health plan that provided the coverage described in the certificate;

(C) The name of the participant or dependent with respect to whom the certificate applies, and any other information necessary for the plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the participant if the certificate is for (or includes) a dependent;

(D) The name, address, and telephone number of the plan administrator or issuer required to provide the certificate;

(E) The telephone number to call for further information regarding the certificate (if different from paragraph (a)(3)(ii)(D) of this section);

(F) Either—

(*1*) A statement that an individual has at least 18 months (for this purpose, 546 days is deemed to be 18 months) of creditable coverage, disregarding days of creditable coverage before a significant break in coverage, or

(*2*) The date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began;

(G) The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing as of the date of the certificate; and

(H) An educational statement regarding HIPAA, which explains:

(*1*) The restrictions on the ability of a plan or issuer to impose a preexisting condition exclusion (including an individual's ability to reduce a preexisting condition exclusion by creditable coverage);

(*2*) Special enrollment rights;

(*3*) The prohibitions against discrimination based on any health factor;

(*4*) The right to individual health coverage;

(*5*) The fact that State law may require issuers to provide additional protections to individuals in that State; and

(*6*) Where to get more information.

(iii) *Periods of coverage under the certificate.* If an automatic certificate is provided pursuant to paragraph (a)(2)(ii) of this section, the period that must be included on the certificate is the last period of continuous coverage ending on the date coverage ceased. If an individual requests a certificate pursuant to paragraph (a)(2)(iii) of this section, the certificate provided must include each period of continuous coverage ending within the 24-month period ending on the date of the request (or continuing on the date of the request). A separate certificate may be provided for each such period of continuous coverage.

(iv) *Combining information for families.* A certificate may provide information with respect to both a participant and the participant's dependents if the information is identical for each individual. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

(v) *Model certificate.* The requirements of paragraph (a)(3)(ii) of this section are satisfied if the plan or issuer provides a certificate in accordance with a model certificate authorized by the Secretary.

(vi) *Excepted benefits; categories of benefits.* No certificate is required to be furnished with respect to excepted benefits described in § 146.145(c). In addition, the information in the certificate regarding coverage is not required to specify categories of benefits described in § 146.113(c) (relating to the alternative method of counting creditable coverage). However, if excepted benefits are provided concurrently with other creditable coverage (so that the coverage does not consist solely of excepted benefits), information concerning the benefits may be required to be disclosed under paragraph (b) of this section.

(4) *Procedures*—(i) *Method of delivery.* The certificate is required to be provided to each individual described in paragraph (a)(2) of this section or an entity requesting the certificate on behalf of the individual. The certificate may be provided by first-class mail. If the certificate or certificates are provided to the participant and the participant's spouse at the participant's last known address, then the requirements of this paragraph (a)(4) are satisfied with respect to all individuals residing at that address. If a dependent's last known address is different than the participant's last known address, a separate certificate is required to be provided to the dependent at the dependent's last known address. If separate certificates are being provided by mail to individuals who reside at the same address, separate mailings of each certificate are not required.

(ii) *Procedure for requesting certificates.* A plan or issuer must establish a written procedure for individuals to request and receive certificates pursuant to paragraph (a)(2)(iii) of this section. The written procedure must include all contact information necessary to request a certificate (such as name and phone number or address).

(iii) *Designated recipients.* If an automatic certificate is required to be provided under paragraph (a)(2)(ii) of this section, and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is permitted to provide the certificate to the designated individual or entity. If a certificate is required to be provided upon request under paragraph (a)(2)(iii) of this section and the individual entitled to receive the certificate designates another individual or entity to receive the certificate, the plan or issuer responsible for providing the certificate is required to provide the certificate to the designated individual or entity.

(5) *Special rules concerning dependent coverage*—(i)(A) *Reasonable efforts.* A plan or issuer is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a dependent under paragraph (a)(2)(ii) of this section, no individual certificate is required to be furnished until the plan or issuer knows (or making reasonable efforts should know) of the dependent's cessation of coverage under the plan.

(B) *Example.* The rules of this paragraph (a)(5)(i) are illustrated by the following example:

Example. (i) *Facts.* A group health plan covers employees and their dependents. The plan annually requests all employees to provide updated information regarding dependents, including the specific date on which an employee has a new dependent or

on which a person ceases to be a dependent of the employee.

(ii) *Conclusion.* In this *Example,* the plan has satisfied the standard in this paragraph (a)(5)(i) of this section that it make reasonable efforts to determine the cessation of dependents' coverage and the related dependent coverage information.

(ii) *Special rules for demonstrating coverage.* If a certificate furnished by a plan or issuer does not provide the name of any dependent covered by the certificate, the procedures described in paragraph (c)(5) of this section may be used to demonstrate dependent status. In addition, these procedures may be used to demonstrate that a child was covered under any creditable coverage within 30 days after birth, adoption, or placement for adoption. See also § 146.111(b), under which such a child cannot be subject to a preexisting condition exclusion.

(6) *Special certification rules*—(i) *Issuers.* Issuers of group and individual health insurance are required to provide certificates of any creditable coverage they provide in the group or individual health insurance market, even if the coverage is provided in connection with an entity or program that is not itself required to provide a certificate because it is not subject to the group market provisions of this part, part 7 of subtitle B of title I of ERISA, or chapter 100 of subtitle K of the Internal Revenue Code. This would include coverage provided in connection with any of the following:

(A) Creditable coverage described in sections 2701(c)(1)(G), (I) and (J) of the PHS Act (coverage under a State health benefits risk pool, a public health plan, and a health benefit plan under section 5(e) of the Peace Corps Act).

(B) Coverage subject to section 2721(b)(1)(B) of the PHS Act (requiring certificates by issuers offering health insurance coverage in connection with any group health plan, including a church plan or a governmental plan (including the Federal Employees Health Benefits Program).

(C) Coverage subject to section 2743 of the PHS Act applicable to health insurance issuers in the individual market. (However, this section does not require a certificate to be provided with respect to short-term limited duration insurance, which is excluded from the definition of ''individual health insurance coverage'' in 45 CFR 144.103 that is not provided in connection with a group health plan, as described in paragraph (a)(6)(i)(B) of this section.)

(ii) *Other entities.* For special rules requiring that certain other entities, not subject to this part, provide certificates consistent with the rules of this section, see section 2791(a)(3) of the PHS Act applicable to entities described in sections 2701(c)(1)(C), (D), (E), and (F) of the PHS Act (relating to Medicare, Medicaid, TRICARE, and Indian Health Service), section 2721(b)(1)(A) of the PHS Act applicable to non-Federal governmental plans generally, section 2721(b)(2)(C)(ii) of the PHS Act applicable to non-Federal governmental plans that elect to be excluded from the requirements of subparts 1 through 3 of part A of title XXVII of the PHS Act, and section 9805(a) of the Internal Revenue Code applicable to group health plans, which includes church plans (as defined in section 414(e) of the Internal Revenue Code).

(b) *Disclosure of coverage to a plan or issuer using the alternative method of counting creditable coverage*—(1) *In general.* After an individual provides a certificate of creditable coverage to a plan or issuer using the alternative method under § 146.113(c), that plan or issuer (requesting entity) must request that the entity that issued the certificate (prior entity) disclose the information set forth in paragraph (b)(2) of this section. The prior entity is required to disclose this information promptly.

(2) *Information to be disclosed.* The prior entity is required to identify to the requesting entity the categories of benefits with respect to which the requesting entity is using the alternative method of counting creditable coverage, and the requesting entity may identify specific information that the requesting entity reasonably needs in order to determine the individual's creditable coverage with respect to any such category.

(3) *Charge for providing information.* The prior entity may charge the requesting entity for the reasonable cost of disclosing such information.

(c) *Ability of an individual to demonstrate creditable coverage and waiting period information*—(1) *Purpose.* The rules in this paragraph (c) implement section 2701(c)(4) of the PHS Act, which permits individuals to demonstrate the duration of creditable coverage through means other than certificates, and section 2701(e)(3) of the PHS Act, which requires the Secretary to establish rules designed to prevent an individual's subsequent coverage under a group health plan or health insurance coverage from being adversely affected by an entity's failure to provide a certificate with respect to that individual.

(2) *In general.* If the accuracy of a certificate is contested or a certificate is unavailable when needed by an individual, the individual has the right to demonstrate creditable coverage (and waiting or affiliation periods) through the presentation of documents or other means. For example, the individual may make such a demonstration when—

(i) An entity has failed to provide a certificate within the required time;

(ii) The individual has creditable coverage provided by an entity that is not required to provide a certificate of the coverage pursuant to paragraph (a) of this section;

(iii) The individual has an urgent medical condition that necessitates a determination before the individual can deliver a certificate to the plan; or

(iv) The individual lost a certificate that the individual had previously received and is unable to obtain another certificate.

(3) *Evidence of creditable coverage*—(i) *Consideration of evidence*—(A) A plan or issuer is required to take into account all information that it obtains or that is presented on behalf of an individual to make a determination, based on the relevant facts and circumstances, whether an individual has creditable coverage. A plan or issuer shall treat the individual as having furnished a certificate under paragraph (a) of this section if—

(*1*) The individual attests to the period of creditable coverage;

(*2*) The individual also presents relevant corroborating evidence of some creditable coverage during the period; and

(*3*) The individual cooperates with the plan's or issuer's efforts to verify the individual's coverage.

(B) For purposes of this paragraph (c)(3)(i), cooperation includes providing (upon the plan's or issuer's request) a written authorization for the plan or issuer to request a certificate on behalf of the individual, and cooperating in efforts to determine the validity of the corroborating evidence and the dates of creditable coverage. While a plan or issuer may refuse to credit coverage where the individual fails to cooperate with the plan's or issuer's efforts to verify coverage, the plan or issuer may not consider an individual's inability to obtain a certificate to be evidence of the absence of creditable coverage.

(ii) *Documents.* Documents that corroborate creditable coverage (and waiting or affiliation periods) include explanations of benefits (EOBs) or other correspondence from a plan or issuer indicating coverage, pay stubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant

documents that evidence periods of health coverage.

(iii) *Other evidence.* Creditable coverage (and waiting or affiliation periods) may also be corroborated through means other than documentation, such as by a telephone call from the plan or provider to a third party verifying creditable coverage.

(iv) *Example.* The rules of this paragraph (c)(3) are illustrated by the following example:

Example. (i) *Facts.* Individual *F* terminates employment with Employer *W* and, a month later, is hired by Employer *X*. *X*'s group health plan imposes a preexisting condition exclusion of 12 months on new enrollees under the plan and uses the standard method of determining creditable coverage. *F* fails to receive a certificate of prior coverage from the self-insured group health plan maintained by *F*'s prior employer, *W*, and requests a certificate. However, *F* (and *X*'s plan, on *F*'s behalf and with *F*'s cooperation) is unable to obtain a certificate from *W*'s plan. *F* attests that, to the best of *F*'s knowledge, *F* had at least 12 months of continuous coverage under *W*'s plan, and that the coverage ended no earlier than *F*'s termination of employment from *W*. In addition, *F* presents evidence of coverage, such as an explanation of benefits for a claim that was made during the relevant period.

(ii) *Conclusion.* In this *Example,* based solely on these facts, *F* has demonstrated creditable coverage for the 12 months of coverage under *W*'s plan in the same manner as if *F* had presented a written certificate of creditable coverage.

(4) *Demonstrating categories of creditable coverage.* Procedures similar to those described in this paragraph (c) apply in order to determine the duration of an individual's creditable coverage with respect to any category under paragraph (b) of this section (relating to determining creditable coverage under the alternative method).

(5) *Demonstrating dependent status.* If, in the course of providing evidence (including a certificate) of creditable coverage, an individual is required to demonstrate dependent status, the group health plan or issuer is required to treat the individual as having furnished a certificate showing the dependent status if the individual attests to such dependency and the period of such status and the individual cooperates with the plan's or issuer's efforts to verify the dependent status.

■ 5. Revise § 146.117 to read as follows:

§ 146.117 Special enrollment periods.

(a) *Special enrollment for certain individuals who lose coverage*—(1) *In General.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, is required to permit current employees and dependents (as defined in § 144.103 of this chapter) who are described in paragraph (a)(2) of this section to enroll for coverage under the terms of the plan if the conditions in paragraph (a)(3) of this section are satisfied. The special enrollment rights under this paragraph (a) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Individuals eligible for special enrollment*—(i) *When employee loses coverage.* A current employee and any dependents (including the employee's spouse) each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(A) The employee and the dependents are otherwise eligible to enroll in the benefit package;

(B) When coverage under the plan was previously offered, the employee had coverage under any group health plan or health insurance coverage; and

(C) The employee satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(ii) *When dependent loses coverage*—(A) A dependent of a current employee (including the employee's spouse) and the employee each are eligible for special enrollment in any benefit package under the plan (subject to plan eligibility rules conditioning dependent enrollment on enrollment of the employee) if—

(*1*) The dependent and the employee are otherwise eligible to enroll in the benefit package;

(*2*) When coverage under the plan was previously offered, the dependent had coverage under any group health plan or health insurance coverage; and

(*3*) The dependent satisfies the conditions of paragraph (a)(3)(i), (ii), or (iii) of this section and, if applicable, paragraph (a)(3)(iv) of this section.

(B) However, the plan or issuer is not required to enroll any other dependent unless that dependent satisfies the criteria of this paragraph (a)(2)(ii), or the employee satisfies the criteria of paragraph (a)(2)(i) of this section.

(iii) *Examples.* The rules of this paragraph (a)(2) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *A* works for Employer *X*. *A, A*'s spouse, and *A*'s dependent children are eligible but not enrolled for coverage under *X*'s group health plan. *A*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *A* was enrolled in coverage under *Y*'s plan. Then, *A* loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 1,* because *A* satisfies the conditions for special enrollment under paragraph (a)(2)(i) of this section, *A, A*'s spouse, and *A*'s dependent children are eligible for special enrollment under *X*'s plan.

Example 2. (i) *Facts.* Individual *A* and *A*'s spouse are eligible but not enrolled for coverage under Group Health Plan *P* maintained by *A*'s employer. When *A* was first presented with an opportunity to enroll *A* and *A*'s spouse, they did not have other coverage. Later, *A* and *A*'s spouse enroll in Group Health Plan *Q* maintained by the employer of *A*'s spouse. During a subsequent open enrollment period in *P, A* and *A*'s spouse did not enroll because of their coverage under *Q*. They then lose eligibility for coverage under *Q*.

(ii) *Conclusion.* In this *Example 2,* because *A* and *A*'s spouse were covered under *Q* when they did not enroll in *P* during open enrollment, they satisfy the conditions for special enrollment under paragraphs (a)(2)(i) and (ii) of this section. Consequently, *A* and *A*'s spouse are eligible for special enrollment under *P*.

Example 3. (i) *Facts.* Individual *B* works for Employer *X*. *B* and *B*'s spouse are eligible but not enrolled for coverage under *X*'s group health plan. *B*'s spouse works for Employer *Y* and at the time coverage was offered under *X*'s plan, *B*'s spouse was enrolled in self-only coverage under *Y*'s group health plan. Then, *B*'s spouse loses eligibility for coverage under *Y*'s plan.

(ii) *Conclusion.* In this *Example 3,* because *B*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *B* and *B*'s spouse are eligible for special enrollment under *X*'s plan.

Example 4. (i) *Facts.* Individual *A* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *A* enrolls for self-only coverage in the HMO option. *A*'s spouse works for Employer *Y* and was enrolled for self-only coverage under *Y*'s plan at the time coverage was offered under *X*'s plan. Then, *A*'s spouse loses coverage under *Y*'s plan. *A* requests special enrollment for *A* and *A*'s spouse under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 4,* because *A*'s spouse satisfies the conditions for special enrollment under paragraph (a)(2)(ii) of this section, both *A* and *A*'s spouse can enroll in either benefit package under *X*'s plan. Therefore, if *A* requests enrollment in accordance with the requirements of this section, the plan must allow *A* and *A*'s spouse to enroll in the indemnity option.

(3) *Conditions for special enrollment*—(i) *Loss of eligibility for coverage.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(i) are satisfied at the time the coverage is terminated as a result of loss of eligibility (regardless of whether the individual is eligible for or elects COBRA continuation coverage). Loss of eligibility under this paragraph (a)(3)(i) does not include a loss due to the failure

of the employee or dependent to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Loss of eligibility for coverage under this paragraph (a)(3)(i) includes (but is not limited to)—

(A) Loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(B) In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and

(E) A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 146.121(d)) that includes the individual.

(ii) *Termination of employer contributions.* In the case of an employee or dependent who has coverage that is not COBRA continuation coverage, the conditions of this paragraph (a)(3)(ii) are satisfied at the time employer contributions towards the employee's or dependent's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the employee or dependent.

(iii) *Exhaustion of COBRA continuation coverage.* In the case of an employee or dependent who has coverage that is COBRA continuation coverage, the conditions of this paragraph (a)(3)(iii) are satisfied at the time the COBRA continuation coverage is exhausted. For purposes of this paragraph (a)(3)(iii), an individual who satisfies the conditions for special enrollment of paragraph (a)(3)(i) of this section, does not enroll, and instead elects and exhausts COBRA continuation coverage satisfies the conditions of this paragraph (a)(3)(iii). (*Exhaustion of COBRA continuation coverage* is defined in § 144.103 of this chapter.)

(iv) *Written statement.* A plan may require an employee declining coverage (for the employee or any dependent of the employee) to state in writing whether the coverage is being declined due to other health coverage only if, at or before the time the employee declines coverage, the employee is provided with notice of the requirement to provide the statement (and the consequences of the employee's failure to provide the statement). If a plan requires such a statement, and an employee does not provide it, the plan is not required to provide special enrollment to the employee or any dependent of the employee under this paragraph (a)(3). A plan must treat an employee as having satisfied the plan requirement permitted under this paragraph (a)(3)(iv) if the employee provides a written statement that coverage was being declined because the employee or dependent had other coverage; a plan cannot require anything more for the employee to satisfy the plan's requirement to provide a written statement. (For example, the plan cannot require that the statement be notarized.)

(v) The rules of this paragraph (a)(3) are illustrated by the following examples:

Example 1. (i) *Facts.* Individual *D* enrolls in a group health plan maintained by Employer *Y*. At the time *D* enrolls, *Y* pays 70 percent of the cost of employee coverage and *D* pays the rest. *Y* announces that beginning January 1, *Y* will no longer make employer contributions towards the coverage. Employees may maintain coverage, however, if they pay the total cost of the coverage.

(ii) *Conclusion.* In this *Example 1*, employer contributions towards *D*'s coverage ceased on January 1 and the conditions of paragraph (a)(3)(ii) of this section are satisfied on this date (regardless of whether *D* elects to pay the total cost and continue coverage under *Y*'s plan).

Example 2. (i) *Facts.* A group health plan provides coverage through two options—Option 1 and Option 2. Employees can enroll in either option only within 30 days of hire or on January 1 of each year. Employee *A* is eligible for both options and enrolls in Option 1. Effective July 1 the plan terminates coverage under Option 1 and the plan does not create an immediate open enrollment opportunity into Option 2.

(ii) *Conclusion.* In this *Example 2*, A has experienced a loss of eligibility for coverage that satisfies paragraph (a)(3)(i) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. Therefore, if *A* satisfies the other conditions of this paragraph (a), the plan must permit *A* to enroll in Option 2 as a special enrollee. (*A* may also be eligible to enroll in another group health plan, such as a plan maintained by the employer of *A*'s spouse, as a special enrollee.) The outcome would be the same if Option 1 was terminated by an issuer and the plan made no other coverage available to *A*.

Example 3. (i) *Facts.* Individual *C* is covered under a group health plan maintained by Employer *X*. While covered under *X*'s plan, *C* was eligible for but did not enroll in a plan maintained by Employer Z, the employer of *C*'s spouse. *C* terminates employment with *X* and loses eligibility for coverage under *X*'s plan. *C* has a special enrollment right to enroll in *Z*'s plan, but *C* instead elects COBRA continuation coverage under *X*'s plan. *C* exhausts COBRA continuation coverage under *X*'s plan and requests special enrollment in *Z*'s plan.

(ii) *Conclusion.* In this *Example 3*, *C* has satisfied the conditions for special enrollment under paragraph (a)(3)(iii) of this section, and has satisfied the other conditions for special enrollment under paragraph (a)(2)(i) of this section. The special enrollment right that *C* had into *Z*'s plan immediately after the loss of eligibility for coverage under *X*'s plan was an offer of coverage under *Z*'s plan. When *C* later exhausts COBRA coverage under *X*'s plan, *C* has a second special enrollment right in *Z*'s plan.

(4) *Applying for special enrollment and effective date of coverage*—(i) A plan or issuer must allow an employee a period of at least 30 days after an event described in paragraph (a)(3) of this section (other than an event described in paragraph (a)(3)(i)(D)) to request enrollment (for the employee or the employee's dependent). In the case of an event described in paragraph (a)(3)(i)(D) of this section (relating to loss of eligibility for coverage due to the operation of a lifetime limit on all benefits), a plan or issuer must allow an employee a period of at least 30 days after a claim is denied due to the operation of a lifetime limit on all benefits.

(ii) Coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(b) *Special enrollment with respect to certain dependent beneficiaries*—(1) *General.* A group health plan, and a health insurance issuer offering health insurance coverage in connection with a group health plan, that makes coverage available with respect to dependents is required to permit individuals described in paragraph (b)(2) of this section to be enrolled for coverage in a benefit

package under the terms of the plan. Paragraph (b)(3) of this section describes the required special enrollment period and the date by which coverage must begin. The special enrollment rights under this paragraph (b) apply without regard to the dates on which an individual would otherwise be able to enroll under the plan.

(2) *Individuals eligible for special enrollment.* An individual is described in this paragraph (b)(2) if the individual is otherwise eligible for coverage in a benefit package under the plan and if the individual is described in paragraph (b)(2)(i), (ii), (iii), (iv), (v), or (vi) of this section.

(i) *Current employee only.* A current employee is described in this paragraph (b)(2)(i) if a person becomes a dependent of the individual through marriage, birth, adoption, or placement for adoption.

(ii) *Spouse of a participant only.* An individual is described in this paragraph (b)(2)(ii) if either—

(A) The individual becomes the spouse of a participant; or

(B) The individual is a spouse of a participant and a child becomes a dependent of the participant through birth, adoption, or placement for adoption.

(iii) *Current employee and spouse.* A current employee and an individual who is or becomes a spouse of such an employee, are described in this paragraph (b)(2)(iii) if either—

(A) The employee and the spouse become married; or

(B) The employee and spouse are married and a child becomes a dependent of the employee through birth, adoption, or placement for adoption.

(iv) *Dependent of a participant only.* An individual is described in this paragraph (b)(2)(iv) if the individual is a dependent (as defined in § 144.103 of this chapter) of a participant and the individual has become a dependent of the participant through marriage, birth, adoption, or placement for adoption.

(v) *Current employee and a new dependent.* A current employee and an individual who is a dependent of the employee, are described in this paragraph (b)(2)(v) if the individual becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(vi) *Current employee, spouse, and a new dependent.* A current employee, the employee's spouse, and the employee's dependent are described in this paragraph (b)(2)(vi) if the dependent becomes a dependent of the employee through marriage, birth, adoption, or placement for adoption.

(3) *Applying for special enrollment and effective date of coverage*—(i) *Request.* A plan or issuer must allow an individual a period of at least 30 days after the date of the marriage, birth, adoption, or placement for adoption (or, if dependent coverage is not generally made available at the time of the marriage, birth, adoption, or placement for adoption, a period of at least 30 days after the date the plan makes dependent coverage generally available) to request enrollment (for the individual or the individual's dependent).

(ii) *Reasonable procedures for special enrollment.* [Reserved]

(iii) *Date coverage must begin*—(A) *Marriage.* In the case of marriage, coverage must begin no later than the first day of the first calendar month beginning after the date the plan or issuer receives the request for special enrollment.

(B) *Birth, adoption, or placement for adoption.* Coverage must begin in the case of a dependent's birth on the date of birth and in the case of a dependent's adoption or placement for adoption no later than the date of such adoption or placement for adoption (or, if dependent coverage is not made generally available at the time of the birth, adoption, or placement for adoption, the date the plan makes dependent coverage available).

(4) *Examples.* The rules of this paragraph (b) are illustrated by the following examples:

Example 1. (i) *Facts.* An employer maintains a group health plan that offers all employees employee-only coverage, employee-plus-spouse coverage, or family coverage. Under the terms of the plan, any employee may elect to enroll when first hired (with coverage beginning on the date of hire) or during an annual open enrollment period held each December (with coverage beginning the following January 1). Employee *A* is hired on September 3. *A* is married to *B*, and they have no children. On March 15 in the following year a child *C* is born to *A* and *B*. Before that date, *A* and *B* have not been enrolled in the plan.

(ii) *Conclusion.* In this *Example 1*, the conditions for special enrollment of an employee with a spouse and new dependent under paragraph (b)(2)(vi) of this section are satisfied. If *A* satisfies the conditions of paragraph (b)(3) of this section for requesting enrollment timely, the plan will satisfy this paragraph (b) if it allows *A* to enroll either with employee-only coverage, with employee-plus-spouse coverage (for *A* and *B*), or with family coverage (for *A*, *B*, and *C*). The plan must allow whatever coverage is chosen to begin on March 15, the date of *C*'s birth.

Example 2. (i) *Facts.* Individual *D* works for Employer *X*. *X* maintains a group health plan with two benefit packages—an HMO option and an indemnity option. Self-only and family coverage are available under both options. *D* enrolls for self-only coverage in the HMO option. Then, a child, *E*, is placed for adoption with *D*. Within 30 days of the placement of *E* for adoption, *D* requests enrollment for *D* and *E* under the plan's indemnity option.

(ii) *Conclusion.* In this *Example 2*, *D* and *E* satisfy the conditions for special enrollment under paragraphs (b)(2)(v) and (b)(3) of this section. Therefore, the plan must allow *D* and *E* to enroll in the indemnity coverage, effective as of the date of the placement for adoption.

(c) *Notice of special enrollment.* At or before the time an employee is initially offered the opportunity to enroll in a group health plan, the plan must furnish the employee with a notice of special enrollment that complies with the requirements of this paragraph (c).

(1) *Description of special enrollment rights.* The notice of special enrollment must include a description of special enrollment rights. The following model language may be used to satisfy this requirement:

> If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
>
> In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within [insert ''30 days'' or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption.
>
> To request special enrollment or obtain more information, contact [insert the name, title, telephone number, and any additional contact information of the appropriate plan representative].

(2) *Additional information that may be required.* The notice of special enrollment must also include, if applicable, the notice described in paragraph (a)(3)(iv) of this section (the notice required to be furnished to an individual declining coverage if the plan requires the reason for declining coverage to be in writing).

(d) *Treatment of special enrollees*—(1) If an individual requests enrollment while the individual is entitled to special enrollment under either paragraph (a) or (b) of this section, the individual is a special enrollee, even if the request for enrollment coincides with a late enrollment opportunity under the plan. Therefore, the

individual cannot be treated as a late enrollee.

(2) Special enrollees must be offered all the benefit packages available to similarly situated individuals who enroll when first eligible. For this purpose, any difference in benefits or cost-sharing requirements for different individuals constitutes a different benefit package. In addition, a special enrollee cannot be required to pay more for coverage than a similarly situated individual who enrolls in the same coverage when first eligible. The length of any preexisting condition exclusion that may be applied to a special enrollee cannot exceed the length of any preexisting condition exclusion that is applied to similarly situated individuals who enroll when first eligible. For rules prohibiting the application of a preexisting condition exclusion to certain newborns, adopted children, and children placed for adoption, see § 146.111(b).

(3) The rules of this section are illustrated by the following example:

Example. (i) *Facts.* Employer *Y* maintains a group health plan that has an enrollment period for late enrollees every November 1 through November 30 with coverage effective the following January 1. On October 18, Individual *B* loses coverage under another group health plan and satisfies the requirements of paragraphs (a)(2), (3), and (4) of this section. *B* submits a completed application for coverage on November 2.

(ii) *Conclusion.* In this *Example*, *B* is a special enrollee. Therefore, even though *B*'s request for enrollment coincides with an open enrollment period, *B*'s coverage is required to be made effective no later than December 1 (rather than the plan's January 1 effective date for late enrollees).

■ 6. Revise § 146.119 to read as follows:

§ 146.119 HMO affiliation period as an alternative to a preexisting condition exclusion.

(a) *In general.* A group health plan offering health insurance coverage through an HMO, or an HMO that offers health insurance coverage in connection with a group health plan, may impose an affiliation period only if each of the following requirements is satisfied—

(1) No preexisting condition exclusion is imposed with respect to any coverage offered by the HMO in connection with the particular group health plan.

(2) No premium is charged to a participant or beneficiary for the affiliation period.

(3) The affiliation period for the HMO coverage is imposed consistent with the requirements of § 146.121 (prohibiting discrimination based on a health factor).

(4) The affiliation period does not exceed 2 months (or 3 months in the case of a late enrollee).

(5) The affiliation period begins on the enrollment date, or in the case of a late enrollee, the affiliation period begins on the day that would be the first day of coverage but for the affiliation period.

(6) The affiliation period for enrollment in the HMO under a plan runs concurrently with any waiting period.

(b) *Examples.* The rules of paragraph (a) of this section are illustrated by the following examples:

Example 1. (i) *Facts.* An employer sponsors a group health plan. Benefits under the plan are provided through an HMO, which imposes a two-month affiliation period. In order to be eligible under the plan, employees must have worked for the employer for six months. Individual *A* begins working for the employer on February 1.

(ii) *Conclusion.* In this *Example 1,* Individual *A*'s enrollment date is February 1 (see § 146.111(a)(2)), and both the waiting period and the affiliation period begin on this date and run concurrently. Therefore, the affiliation period ends on March 31, the waiting period ends on July 31, and *A* is eligible to have coverage begin on August 1.

Example 2. (i) *Facts.* A group health plan has two benefit package options, a fee-for-service option and an HMO option. The HMO imposes a 1-month affiliation period. Individual *B* is enrolled in the fee-for-service option for more than one month and then decides to switch to the HMO option at open season.

(ii) *Conclusion.* In this *Example 2,* the HMO may not impose the affiliation period with respect to *B* because any affiliation period would have to begin on *B*'s enrollment date in the plan rather than the date that *B* enrolled in the HMO option. Therefore, the affiliation period would have expired before *B* switched to the HMO option.

Example 3. (i) *Facts.* An employer sponsors a group health plan that provides benefits through an HMO. The plan imposes a two-month affiliation period with respect to salaried employees, but it does not impose an affiliation period with respect to hourly employees.

(ii) *Conclusion.* In this *Example 3,* the plan may impose the affiliation period with respect to salaried employees without imposing any affiliation period with respect to hourly employees (unless, under the circumstances, treating salaried and hourly employees differently does not comply with the requirements of § 146.121).

(c) *Alternatives to affiliation period.* An HMO may use alternative methods in lieu of an affiliation period to address adverse selection, as approved by the State insurance commissioner or other official designated to regulate HMOs. However, an arrangement that is in the nature of a preexisting condition exclusion cannot be an alternative to an affiliation period. Nothing in this part requires a State to receive proposals for or approve alternatives to affiliation periods.

■ 7. Add and reserve § 146.120 to read as follows:

§ 146.120 Interaction with the Family and Medical Leave Act [Reserved]

■ 8. Revise § 146.125 to read as follows:

§ 146.125 Applicability dates.

Sections 146.111 through 146.119, § 146.143, and § 146.145 are applicable for plan years beginning on or after July 1, 2005. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 45 CFR parts 144 and 146, contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2004.

■ 9. Revise § 146.143 to read as follows:

§ 146.143 Preemption; State flexibility; construction.

(a) *Continued applicability of State law with respect to health insurance issuers.* Subject to paragraph (b) of this section and except as provided in paragraph (c) of this section, part A of title XXVII of the PHS Act is not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.

(b) *Continued preemption with respect to group health plans.* Nothing in part A of title XXVII of the PHS Act affects or modifies the provisions of section 514 of the Act with respect to group health plans.

(c) *Special rules*—(1) *In general.* Subject to paragraph (c)(2) of this section, the provisions of part A of title XXVII of the PHS Act relating to health insurance coverage offered by a health insurance issuer supersede any provision of State law which establishes, implements, or continues in effect a standard or requirement applicable to imposition of a preexisting condition exclusion specifically governed by section 2701 of the PHS Act which differs from the standards or requirements specified in section 2701 of the PHS Act.

(2) *Exceptions.* Only in relation to health insurance coverage offered by a health insurance issuer, the provisions of this part do not supersede any provision of State law to the extent that such provision—

(i) Shortens the period of time from the ''6-month period'' described in section 2701(a)(1) of the PHS Act and

§ 146.111(a)(1)(i) (for purposes of identifying a preexisting condition);

(ii) Shortens the period of time from the ''12 months'' and ''18 months'' described in section 2701(a)(2) of the PHS Act and § 146.111(a)(1)(ii) (for purposes of applying a preexisting condition exclusion period);

(iii) Provides for a greater number of days than the ''63-day period'' described in sections 2701(c)(2)(A) and (d)(4)(A) of the PHS Act and §§ 146.111(a)(1)(iii) and 146.113 (for purposes of applying the break in coverage rules);

(iv) Provides for a greater number of days than the ''30-day period'' described in sections 2701(b)(2) and (d)(1) of the PHS Act and § 146.111(b) (for purposes of the enrollment period and preexisting condition exclusion periods for certain newborns and children that are adopted or placed for adoption);

(v) Prohibits the imposition of any preexisting condition exclusion in cases not described in section 2701(d) of the PHS Act or expands the exceptions described therein;

(vi) Requires special enrollment periods in addition to those required under section 2701(f) of the PHS Act; or

(vii) Reduces the maximum period permitted in an affiliation period under section 2701(g)(1)(B) of the PHS Act.

(d) *Definitions*—(1) *State law.* For purposes of this section the term *State law* includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia is treated as a State law rather than a law of the United States.

(2) *State.* For purposes of this section the term *State* includes a State (as defined in § 144.103), any political subdivisions of a State, or any agency or instrumentality of either.

■ 10. Revise § 146.145 to read as follows:

§ 146.145 Special rules relating to group health plans.

(a) *Group health plan*—(1) *Definition.* A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

(2) *Determination of number of plans.* [Reserved]

(b) *General exception for certain small group health plans.* The requirements of this part, other than § 146.130, do not apply to any group health plan (and group health insurance coverage) for any plan year if, on the first day of the plan year, the plan has fewer than two participants who are current employees.

(c) *Excepted benefits*—(1) *In general.* The requirements of subparts B and C of this part do not apply to any group health plan (or any group health insurance coverage) in relation to its provision of the benefits described in paragraph (c)(2), (3), (4), or (5) of this section (or any combination of these benefits).

(2) *Benefits excepted in all circumstances.* The following benefits are excepted in all circumstances—

(i) Coverage only for accident (including accidental death and dismemberment);

(ii) Disability income coverage;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Coverage issued as a supplement to liability insurance;

(v) Workers' compensation or similar coverage;

(vi) Automobile medical payment insurance;

(vii) Credit-only insurance (for example, mortgage insurance); and

(viii) Coverage for on-site medical clinics.

(3) *Limited excepted benefits*—(i) *In general.* Limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan as described in paragraph (c)(3)(ii) of this section. In addition, benefits provided under a health flexible spending arrangement are excepted benefits if they satisfy the requirements of paragraph (c)(3)(v) of this section.

(ii) *Not an integral part of a group health plan.* For purposes of this paragraph (c)(3), benefits are not an integral part of a group health plan (whether the benefits are provided through the same plan or a separate plan) only if the following two requirements are satisfied—

(A) Participants must have the right to elect not to receive coverage for the benefits; and

(B) If a participant elects to receive coverage for the benefits, the participant must pay an additional premium or contribution for that coverage.

(iii) *Limited scope*—(A) *Dental benefits.* Limited scope dental benefits are benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth).

(B) *Vision benefits.* Limited scope vision benefits are benefits substantially all of which are for treatment of the eye.

(iv) *Long-term care.* Long-term care benefits are benefits that are either—

(A) Subject to State long-term care insurance laws;

(B) For qualified long-term care services, as defined in section 7702B(c)(1) of the Internal Revenue Code, or provided under a qualified long-term care insurance contract, as defined in section 7702B(b) of the Internal Revenue Code; or

(C) Based on cognitive impairment or a loss of functional capacity that is expected to be chronic.

(v) *Health flexible spending arrangements.* Benefits provided under a health flexible spending arrangement (as defined in section 106(c)(2) of the Internal Revenue Code) are excepted for a class of participants only if they satisfy the following two requirements—

(A) Other group health plan coverage, not limited to excepted benefits, is made available for the year to the class of participants by reason of their employment; and

(B) The arrangement is structured so that the maximum benefit payable to any participant in the class for a year cannot exceed two times the participant's salary reduction election under the arrangement for the year (or, if greater, cannot exceed $500 plus the amount of the participant's salary reduction election). For this purpose, any amount that an employee can elect to receive as taxable income but elects to apply to the health flexible spending arrangement is considered a salary reduction election (regardless of whether the amount is characterized as salary or as a credit under the arrangement).

(4) *Noncoordinated benefits*—(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (c)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) *Conditions.* Benefits are described in paragraph (c)(4)(i) of this section only if—

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group

health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) *Example.* The rules of this paragraph (c)(4) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) *Conclusion.* In this *Example,* even though the benefits under the policy satisfy the conditions in paragraph (c)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

(5) *Supplemental benefits.* (i) The following benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance—

(A) Medicare supplemental health insurance (as defined under section 1882(g)(1) of the Social Security Act; also known as Medigap or MedSupp insurance);

(B) Coverage supplemental to the coverage provided under Chapter 55, Title 10 of the United States Code (also known as TRICARE supplemental programs); and

(C) Similar supplemental coverage provided to coverage under a group health plan. To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

(ii) The rules of this paragraph (c)(5) are illustrated by the following example:

Example. (i) *Facts.* An employer sponsors a group health plan that provides coverage for both active employees and retirees. The coverage for retirees supplements benefits provided by Medicare, but does not meet the requirements for a supplemental policy under section 1882(g)(1) of the Social Security Act.

(ii) *Conclusion.* In this *Example,* the coverage provided to retirees does not meet the definition of supplemental excepted benefits under this paragraph (c)(5) because the coverage is not Medicare supplemental insurance as defined under section 1882(g)(1) of the Social Security Act, is not a TRICARE supplemental program, and is not supplemental to coverage provided under a group health plan.

(d) *Treatment of partnerships.* For purposes of this part:

(1) *Treatment as a group health plan.* Any plan, fund, or program that would not be (but for this paragraph (d)) an employee welfare benefit plan and that is established or maintained by a partnership, to the extent that the plan, fund, or program provides medical care (including items and services paid for as medical care) to present or former partners in the partnership or to their dependents (as defined under the terms of the plan, fund, or program), directly or through insurance, reimbursement, or otherwise, is treated (subject to paragraph (d)(2) of this section) as an employee welfare benefit plan that is a group health plan.

(2) *Employment relationship.* In the case of a group health plan, the term *employer* also includes the partnership in relation to any bona fide partner. In addition, the term *employee* also includes any bona fide partner. Whether or not an individual is a bona fide partner is determined based on all the relevant facts and circumstances, including whether the individual performs services on behalf of the partnership.

(3) *Participants of group health plans.* In the case of a group health plan, the term *participant* also includes any individual described in paragraph (d)(3)(i) or (ii) of this section if the individual is, or may become, eligible to receive a benefit under the plan or the individual's beneficiaries may be eligible to receive any such benefit.

(i) In connection with a group health plan maintained by a partnership, the individual is a partner in relation to the partnership.

(ii) In connection with a group health plan maintained by a self-employed individual (under which one or more employees are participants), the individual is the self-employed individual.

(e) *Determining the average number of employees.* [Reserved]

Dated: November 24, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: December 2, 2004.

Tommy G. Thompson,

Secretary, Department of Health and Human Services.

[FR Doc. 04–28112 Filed 12–29–04; 8:45 am]

BILLING CODE 4830–01–P; 4510–29–P; 4120–01–P

Consistency With Safety and Soundness

The Agencies also have determined that the exceptions are consistent with safety and soundness, provided that the depository institution determines and maintains appropriate documentation of the following: (1) The transaction involves real property located in the Major Disaster Area; (2) there is a binding commitment to fund the transaction that was entered into on or after August 14, 2016, but no later than December 31, 2017; and (3) the value of the real property supports the institution's decision to enter into the transaction. In addition, the transaction must continue to be subject to review by management and by the Agencies in the course of examinations of the institution.

Expiration Date

Exceptions made under section 1123 of FIRREA may be provided for no more than three years after the President determines that a major disaster exists in the area.[4] The Agencies have determined that the exceptions provided for by this order shall expire on December 31, 2017.

Order

In accordance with section 2 of DIDRA, relief is hereby granted from the provisions of Title XI of FIRREA and the Agencies' appraisal regulations for any real estate-related financial transaction that requires the services of an appraiser under those provisions, provided that the institution determines, and maintains documentation made available to the Agencies upon request, of the following:

(1) The transaction involves real property located in one of the 22 parishes declared a major disaster area as a result of severe storms and flooding in Louisiana by the President on August 14, 2016 (identified in the Appendix);

(2) There is a binding commitment to fund a transaction that was entered into on or after August 14, 2016, but no later than December 31, 2017; and

(3) The value of the real property supports the institution's decision to enter into the transaction.

Appendix (Major Disaster Area)

Designated Parishes: Acadia, Ascension, Avoyelles, East Baton Rouge, East Feliciana, Evangeline, Iberia, Iberville, Jefferson Davis, Lafayette, Livingston, Pointe Coupee, St. Helena, St. James, St. Landry, St. Martin, St. Tammany, Tangipahoa, Vermilion, Washington, West Baton Rouge and West Feliciana.

[4] 12 U.S.C. 3352(b).

Dated: October 19, 2016.

Thomas J. Curry,

Comptroller of the Currency.

By order of the Board of Governors of the Federal Reserve System, October 21, 2016.

Margaret McCloskey Shanks,

Deputy Secretary of the Board.

Dated at Washington, DC, October 19, 2016.

By order of the Board of Directors.

Federal Deposit Insurance Corporation.

Robert E. Feldman,

Executive Secretary.

Dated at Alexandria, VA, October 27, 2016.

By order of the Board of Directors.

National Credit Union Administration.

Gerard Poliquin,

Secretary of the Board.

[FR Doc. 2016–26234 Filed 10–28–16; 8:45 am]

BILLING CODE 6210–01–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[TD 9791]

RIN 1545–BN44

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210–AB75

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 146, 147, and 148

[CMS–9932–F]

RIN 0938–AS93

Excepted Benefits; Lifetime and Annual Limits; and 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 rules.

SUMMARY: This document contains final regulations regarding the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage, and standards for travel insurance and supplemental health insurance coverage to be considered excepted benefits. This document also amends a reference in the final regulations relating to the prohibition on lifetime and annual dollar limits.

DATES:

Effective date. These final regulations are effective on December 30, 2016.

Applicability date. These final regulations apply to group health plans and health insurance issuers beginning on the first day of the first plan year (or, in the individual market, the first day of the first policy year) beginning on or after January 1, 2017.

FOR FURTHER INFORMATION CONTACT: Elizabeth Schumacher or Matthew Litton of the Department of Labor, at 202–693–8335, Karen Levin, Internal Revenue Service, Department of the Treasury, at (202) 317–5500, David Mlawsky or Cam Clemmons, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at 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 Web site (*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) Web site (*www.cms.gov/cciio*) and information on health reform can be found at *www.HealthCare.gov.*

SUPPLEMENTARY INFORMATION:

I. Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104–191 (110 Stat. 1936), added title XXVII of the Public Health Service Act (PHS Act), part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and Chapter 100 of 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 consumer protection laws, including the Mental Health Parity Act of 1996,[1] the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act

[1] Public Law 104–204, 110 Stat. 2944 (September 26, 1996).

of 2008,[2] the Newborns' and Mothers' Health Protection Act,[3] the Women's Health and Cancer Rights Act,[4] the Genetic Information Nondiscrimination Act of 2008,[5] the Children's Health Insurance Program Reauthorization Act of 2009,[6] Michelle's Law,[7] and the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (Affordable Care Act).[8]

The Affordable Care Act 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. For this purpose, the term ''group health plan'' includes both insured and self-insured group health plans.[9] The Affordable Care Act added section 715(a)(1) of ERISA and section 9815(a)(1) of the Code to incorporate the 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 to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans.

II. Overview of the Final Regulations

On June 10, 2016, the Departments of Labor, Health and Human Services and the Treasury (the Departments [10]) issued proposed regulations with respect to expatriate health plans, expatriate health plan issuers, and qualified expatriates; requirements for travel insurance, similar supplemental coverage, and hospital indemnity or other fixed indemnity insurance to be excepted benefits; the prohibition on lifetime and annual limits; and short-term, limited-duration insurance.[11] After consideration of comments on the proposed regulations, the Departments are publishing final regulations regarding short-term, limited duration insurance, travel insurance, similar supplemental coverage, and lifetime and annual limits. The Departments intend to address hospital indemnity or other fixed indemnity insurance and expatriate health plans in future rulemaking, taking into account comments received on these issues.[12]

On July 20, 2015, the Internal Revenue Service published Notice 2015–43, 2015–29 IRB 73, to provide interim guidance with respect to the treatment of expatriate health plans, expatriate health plan issuers, and employers in their capacity as plan sponsors of expatriate health plans, as defined in the Expatriate Health Coverage Clarification Act of 2014 (EHCCA).[13] The interim guidance in Notice 2015–43 generally allows a taxpayer to apply the requirements of the EHCCA using a reasonable good faith interpretation of the EHCCA until further guidance is issued, except as otherwise specifically provided with respect to the health insurance providers fee under section 9010 of the Affordable Care Act. Notice 2015–29 provided interim guidance pertaining to the fee under section 9010 for calendar years 2014 and 2015, and Notice 2016–14 provided guidance pertaining to the fee for calendar year 2016. Additionally, the preamble to the Departments' proposed regulations provides that issuers, employers, administrators, and individuals are permitted to rely on the proposed regulations pending the applicability date of final regulations in the **Federal Register**.[14] Until final regulations are issued and effective, this reliance rule as well as the interim guidance in Notice 2015–43 remain in effect.

A. Short-Term, Limited-Duration Insurance

Short-term, limited-duration insurance is a type of health insurance coverage that is designed to fill temporary gaps in coverage when an individual is transitioning from one plan or coverage to another plan or coverage. Although short-term, limited-duration insurance is not an excepted benefit, it is similarly exempt from PHS Act requirements because it is not individual health insurance coverage. Section 2791(b)(5) of the PHS Act provides that the term ''individual health insurance coverage'' means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance. The PHS Act does not define short-term, limited-duration insurance. Under current regulations, short-term, limited-duration insurance means ''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.'' [15]

Before enactment of the Affordable Care Act, short-term, limited-duration insurance was an important means for individuals to obtain health coverage when transitioning from one job to another (and from one group health plan to another) or when faced with other similar situations. However, with guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act, individuals can purchase coverage with the protections of the Affordable Care Act to fill in the gaps in coverage.

The Departments have become aware that short-term, limited-duration insurance is being sold in situations other than those that the exception from the definition of individual health insurance coverage was initially intended to address.[16] In some instances, individuals are purchasing this coverage as their primary form of health coverage and, contrary to the intent of the 12-month coverage limitation in the current definition of short-term, limited-duration insurance, some issuers are providing renewals of the coverage that extend the duration beyond 12 months. Because short-term, limited-duration insurance is exempt from certain consumer protections, the Departments are concerned that these policies may have significant limitations, such as lifetime and annual dollar limits on essential health benefits

[2] Public Law 110–343, 122 Stat. 3881 (October 3, 2008).

[3] Public Law 104–204, 110 Stat. 2935 (September 26, 1996).

[4] Public Law 105–277, 112 Stat. 2681–436 (October 21, 1998).

[5] Public Law 110–233, 122 Stat. 881 (May 21, 2008).

[6] Public Law 111–3, 123 Stat. 65 (February 4, 2009).

[7] Public Law 110–381, 122 Stat. 4081 (October 9, 2008).

[8] 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 known as the ''Affordable Care Act''.)

[9] The term ''group health plan'' is used in title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code, and is distinct from the term ''health plan,'' as used in other provisions of title I of the Affordable Care Act. The term ''health plan'' as used in other provisions of title I of the Affordable Care Act does not include self-insured group health plans.

[10] Note, however, that in sections under headings listing only two of the three Departments, the term ''Departments'' generally refers only to the two Departments listed in the heading.

[11] 81 FR 38019 (June 10, 2016).

[12] The preamble to the proposed regulations also invited public comment on insurance coverage of specified diseases or illnesses as excepted benefits. While not addressed in this rulemaking, the Departments may address this issue in future regulations or guidance.

[13] Division M of the Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113–235.

[14] 81 FR 38019, 38033 (June 10, 2016).

[15] 26 CFR 54.9801–2, 29 CFR 2590.701–2, 45 CFR 144.103.

[16] *See e.g.,* Mathews, Anna W. ''Sales of Short-Term Health Policies Surge,'' *The Wall Street Journal* April 10, 2016, available at *http://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539.*

(EHB) and pre-existing condition exclusions, and therefore may not provide meaningful health coverage. Further, because these policies can be medically underwritten based on health status, healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for Affordable Care Act-compliant coverage.

To address the issue of short-term, limited-duration insurance being sold as a type of primary coverage, the Departments proposed regulations to revise the definition of short-term, limited-duration insurance so that the coverage must be less than three months in duration, including any period for which the policy may be renewed. The proposed regulations also included a requirement that a notice must be prominently displayed in the contract and in any application materials provided in connection with enrollment in such coverage with the following language: 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.

In addition to proposing to reduce the length of short-term, limited-duration insurance to less than three months, the proposed regulations modified the permitted coverage period to take into account extensions made by the policyholder ''with or without the issuer's consent.'' This modification was intended to address the Departments' concern that some issuers are taking liberty with the current definition of short-term, limited-duration insurance—either by automatically renewing such policies or having a simplified reapplication process with the result being that such coverage, which does not contain the important protections of the Affordable Care Act, lasts longer than 12 months and serves as an individual's primary health coverage.

The Departments received a number of comments relating to the treatment of short-term, limited-duration insurance. Several commenters supported the proposed rules and the reasoning behind them, noting that short-term, limited-duration insurance is not subject to the same consumer protections as major medical coverage and can discriminate based on health status by recruiting healthier consumers to the exclusion of sicker consumers. These commenters suggested the proposed rules would limit the number of consumers relying on short-term, limited-duration insurance as their primary form of coverage and improve the Affordable Care Act's single risk pool.

Some commenters requested that the Departments go further and prohibit issuers from offering short-term, limited-duration insurance to consumers who have previously purchased this type of coverage to prevent consumers from stringing together coverage under policies offered by the same or different issuers. However, in the Departments' view, such a restriction is not warranted. The individual shared responsibility provision of the Code,[17] which generally requires individuals to obtain minimum essential coverage in order to avoid an additional payment with their taxes, provides sufficient incentive to discourage consumers from purchasing multiple successive short-term, limited-duration insurance policies. The added notice requirement ensures that individuals purchasing such policies are aware of the individual shared responsibility requirement and its potential implications. Furthermore, such a prohibition would be difficult for State regulators to enforce, since prior coverage of a consumer would have to be tracked.

Other commenters expressed general opposition to the proposed rules or requested that short-term, limited-duration insurance be allowed to provide coverage for a longer period. Several commenters stated that some individuals who lose their employer-sponsored coverage may not be able to obtain COBRA continuation coverage [18] and that a job search can often take longer than three months. One commenter suggested alignment of short-term, limited-duration insurance with the employer waiting period rules by permitting a coverage period of up to four months.[19] Another commenter asked that issuers be allowed to renew coverage beyond the three-month period in certain situations, such as when an individual experiences a triggering event for a special enrollment period.[20] The Departments decline to adopt these suggestions. Short-term, limited-duration insurance allows for coverage to fill temporary coverage gaps when an individual transitions between sources of primary coverage. As explained above, for longer gaps in coverage, guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act ensure that individuals can purchase individual market coverage through or outside of the Exchange that is minimum essential coverage and includes the consumer protections of the Affordable Care Act. Further, limiting the coverage of short-term, limited-duration insurance to less than three months is consistent with the exemption from the individual shared responsibility provision for gaps in coverage of less than three months (the short coverage gap exemption).[21] Under current law, an individual who is not enrolled in minimum essential coverage (whether enrolled in short-term, limited-duration coverage or otherwise) for a period of three months or more generally cannot claim the short coverage gap exemption for any of those months. The final regulations help ensure that individuals who purchase a short-term, limited-duration insurance policy will be eligible for the short coverage gap exemption (assuming other requirements are met) during the temporary coverage period.

After consideration of the comments and feedback received from stakeholders, the Departments are finalizing the proposed regulations without change.

The revised definition of short-term, limited-duration insurance applies for policy years beginning on or after January 1, 2017. The Departments recognize, however, that State regulators may have approved short-term, limited-duration insurance products for sale in 2017 that met the definition in effect prior to January 1, 2017. Accordingly, the Department of Health and Human Services (HHS) will not take enforcement action against an issuer with respect to the issuer's sale of a short-term, limited-duration insurance product before April 1, 2017 on the ground that the coverage period is three months or more, provided that the coverage ends on or before December 31, 2017 and otherwise complies with the definition of short-term, limited-duration insurance in effect under the regulations.[22] States may also elect not

[17] *See* Code section 5000A.

[18] COBRA continuation coverage means coverage that satisfies an applicable COBRA continuation provision. These provisions are sections 601–608 of ERISA, section 4980B of the Code (other than paragraph (f)(1) of such section 4980B insofar as it relates to pediatric vaccines), or Title XXII of the PHS Act.

[19] *See* 26 CFR 54.9815–2708; 29 CFR 2590.715–2708; 45 CFR 147.116.

[20] *See* 26 CFR 54.9801–6; 29 CFR 2590.701–6; 45 CFR 146.117 and 147.104.

[21] 26 CFR 1.5000A–3(j).

[22] This non-enforcement policy is limited to the requirement that short-term, limited-duration insurance must be less than three months. It does not relieve issuers of short-term, limited-duration insurance of the notice requirement, which applies for policy years beginning on or after January 1, 2017.

to take enforcement actions against issuers with respect to such coverage sold before April 1, 2017.

B. Excepted Benefits

Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the respective requirements of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code generally do not apply to the provision of certain types of benefits, known as ''excepted benefits.'' Excepted benefits are described in section 2791(c) of the PHS Act, section 733(c) of ERISA, and section 9832(c) of the Code.

The parallel statutory provisions establish four categories of excepted benefits. The first category, under section 2791(c)(1) of the PHS Act, section 733(c)(1) of ERISA and section 9832(c)(1) of the Code, includes benefits that are generally not health coverage (such as automobile insurance, liability insurance, workers compensation, and accidental death and dismemberment coverage). The benefits in this category are excepted in all circumstances. In contrast, the benefits in the second, third, and fourth categories are types of health coverage that are excepted only if certain conditions are met.

The second category of excepted benefits is limited excepted benefits, which may include limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community-based care. Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code authorize the Secretaries of HHS, Labor, and the Treasury (collectively, the Secretaries) to issue regulations establishing other, similar limited benefits as excepted benefits. The Secretaries exercised this authority previously with respect to certain health flexible spending arrangements.[23] To be excepted under this second category, the benefits must either: (1) Be provided under a separate policy, certificate, or contract of insurance; or (2) otherwise not be an integral part of a group health plan, whether insured or self-insured.[24]

The third category of excepted benefits, referred to as ''noncoordinated excepted benefits,'' includes both coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. These benefits are excepted under section 2722(c)(2) of the PHS Act, section 732(c)(2) of ERISA, and section 9831(c)(2) of the Code only if all of the following conditions are met: (1) The benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to any event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.

The fourth category, under section 2791(c)(4) of the PHS Act, section 733(c)(4) of ERISA, and section 9832(c)(4) of the Code, is supplemental excepted benefits. These benefits are excepted only if they are provided under a separate policy, certificate, or contract of insurance and are Medicare supplemental health insurance (also known as Medigap), TRICARE supplemental programs, or ''similar supplemental coverage provided to coverage under a group health plan.'' The phrase ''similar supplemental coverage provided to coverage under a group health plan'' is not defined in the statute or regulations. However, the Departments issued regulations clarifying that one requirement to be similar supplemental coverage is that the coverage ''must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles.'' [25]

In 2007 and 2008, the Departments issued guidance on the circumstances under which supplemental health insurance would be considered excepted benefits under section 2791(c)(4) of the PHS Act (and the parallel provisions of ERISA and the Code).[26] The guidance identifies several factors the Departments will apply when evaluating whether supplemental health insurance will be considered to be ''similar supplemental coverage provided to coverage under a group health plan.'' The guidance provides a safe harbor that supplemental health insurance will be considered an excepted benefit if it is provided through a policy, certificate, or contract of insurance separate from the primary coverage under the plan and meets all of the following requirements: (1) The supplemental policy, certificate, or contract of insurance is issued by an entity that does not provide the primary coverage under the plan; (2) the supplemental policy, certificate, or contract of insurance is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not become secondary or supplemental only under a coordination of benefits provision; (3) the cost of the supplemental coverage is 15 percent or less of the cost of primary coverage (determined in the same manner as the applicable premium is calculated under a COBRA continuation provision); and (4) the supplemental coverage sold in the group health insurance market does not differentiate among individuals in eligibility, benefits, or premiums based upon any health factor of the individual (or any dependents of the individual).

On February 13, 2015, the Departments issued Affordable Care Act Implementation FAQs Part XXIII, providing additional guidance on the circumstances under which health insurance coverage that supplements group health plan coverage may be considered supplemental excepted benefits.[27] The FAQ states that the Departments intend to propose regulations clarifying the circumstances under which supplemental insurance products that do not fill in cost-sharing gaps under the primary plan are considered to be specifically designed to fill gaps in primary coverage. Specifically, the FAQ provides that health insurance coverage that supplements group health coverage by providing coverage of additional categories of benefits (as opposed to filling in cost-sharing gaps under the primary plan) would be considered to be designed to ''fill in the gaps'' of the primary coverage only if the benefits covered by the supplemental insurance product are not EHB, as defined under section 1302(b) of the Affordable Care Act, in the State in which the product is being marketed. The FAQ further states that, until regulations are issued and effective, the Departments will not take enforcement action against an issuer of group or individual market coverage that otherwise meets the conditions to be supplemental excepted benefits that does not fill cost-sharing gaps in the group health plan and only provides coverage of additional categories of benefits that are not

[23] 26 CFR 54.9831–1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), 45 CFR 146.145(b)(3)(v).

[24] PHS Act section 2722(c)(1), ERISA section 732(c)(1), Code section 9831(c)(1).

[25] 26 CFR 54.9831–1(c)(5)(i)(C), 29 CFR 2590.732(c)(5)(i)(C), and 45 CFR 146.145(b)(5)(i)(C).

[26] *See* EBSA Field Assistance Bulletin No. 2007–04 (available at *http://www.dol.gov/ebsa/regs/fab2007-4.html*); CMS Insurance Standards Bulletin 08–01 (available at *http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf*); and IRS Notice 2008–23 (available at *http://www.irs.gov/irb/2008-07_IRB/ar09.html*).

[27] Frequently Asked Questions about Affordable Care Act Implementation (Part XXIII), available at *http://www.dol.gov/ebsa/pdf/faq-AffordableCareAct23.pdf* and *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Supplmental-FAQ_2-13-15-final.pdf*.

covered by the group health plan and are not EHB in the applicable State. States were encouraged to exercise similar enforcement discretion.

1. Similar Supplemental Coverage

The proposed regulations incorporated guidance from the Affordable Care Act Implementation FAQs Part XXIII addressing supplemental health insurance products that provide categories of benefits in addition to those in the primary coverage. Under the proposed regulations, if group or individual supplemental health insurance covers items and services not included in the primary coverage (referred to as providing ''additional categories of benefits''), the coverage will be considered to be designed ''to fill gaps in primary coverage,'' for purposes of being supplemental excepted benefits if none of the benefits provided by the supplemental policy are an EHB, as defined under section 1302(b) of the Affordable Care Act, in the State in which the coverage is issued.[28] Thus, if any benefit provided by the supplemental policy is either included in the primary coverage or is an EHB in the State where the coverage is issued, the insurance coverage would not be supplemental excepted benefits under the proposed regulations. Furthermore, supplemental health insurance products that both fill in cost sharing in the primary coverage, such as coinsurance or deductibles, and cover additional categories of benefits that are not EHB, would be considered supplemental excepted benefits under the proposed regulations provided all other criteria are met.

The Departments received several comments in support of the proposed regulations. One commenter expressed support but requested that the Departments provide additional examples in the regulations. Another commenter requested clarification regarding the application of the standards for similar supplemental coverage that provides benefits outside of the United States, noting that no State's EHB rules require coverage for services outside of the United States. If any benefit provided by the supplemental policy is a type of service that is an EHB in the State where the coverage is issued, the coverage would not be supplemental excepted benefits under the final regulations, even if the supplemental coverage was limited to covering the benefit in a location or setting where it would not be covered as an EHB.

After consideration of the comments, the Departments are finalizing the proposed regulations on similar supplemental coverage without substantive change. For purposes of consistency and clarity, HHS is also including a cross reference in the individual market excepted benefits regulations at 45 CFR 148.220 to reflect the standard for similar supplemental coverage under the group market regulations at 45 CFR 146.145(b)(5)(i)(C). The Departments may provide additional guidance on similar supplemental coverage that meets the criteria to be excepted benefits in the future.

2. Travel Insurance

The Departments are aware that certain travel insurance products may include limited health benefits. However, these products typically are not designed as major medical coverage. Instead, the risks being insured relate primarily to: (1) The interruption or cancellation of a trip; (2) the loss of baggage or personal effects; (3) damages to accommodations or rental vehicles; or (4) sickness, accident, disability, or death occurring during travel, with any health benefits usually incidental to other coverage.

Section 2791(c)(1)(H) of the PHS Act, section 733(c)(1)(H) of ERISA, and section 9832(c)(1)(H) of the Code provide that the Departments may, in regulations, designate as excepted benefits ''benefits for medical care [that] are secondary or incidental to other insurance benefits.'' Pursuant to this authority, and to clarify which types of travel-related insurance products are excepted benefits under the PHS Act, ERISA, and the Code, the Departments' proposed regulations identified travel insurance as an excepted benefit under the first category of excepted benefits and proposed a definition of travel insurance consistent with the definition of travel insurance under final regulations issued by the Treasury Department and the IRS for the health insurance providers fee imposed by section 9010 of the Affordable Care Act,[29] which uses a modified version of the National Association of Insurance Commissioners definition of travel insurance.

The proposed regulations defined the term ''travel insurance'' as insurance coverage for personal risks incident to planned travel, which may include, but are not limited to, interruption or cancellation of a trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting six months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

The Departments received a number of comments in favor of the treatment of travel insurance as an excepted benefit, as well as the proposed definition of travel insurance. Several comments expressed support for the proposed definition's consistency with regulations governing the health insurance providers fee. One commenter requested clarification that the requirement that health benefits are incidental to other coverage be determined based solely on coverage under the travel insurance policy, without regard to other coverage provided by an employer or plan sponsor; the Departments agree that this is correct. The Departments are finalizing without change the proposed regulations defining travel insurance and treating such coverage as an excepted benefit.

C. Definition of EHB for Purposes of the Prohibition on Lifetime and Annual Limits

Section 2711 of the PHS Act, as added by the Affordable Care Act, generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime and annual dollar limits on EHB, as defined under section 1302(b) of the Affordable Care Act. These prohibitions apply to both grandfathered and non-grandfathered health plans, except the annual limits prohibition does not apply to grandfathered individual health insurance coverage.

Under the Affordable Care Act, self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer EHB, but they generally cannot place lifetime or annual dollar limits on services they cover that are considered EHB. On November 18, 2015, the Departments issued final regulations implementing section 2711 of the PHS Act.[30] The final regulations provide that, for plan years (in the individual

[28] For this purpose, a supplemental plan would determine what benefits are EHB based on the EHB-benchmark plan applicable in the State, along with any additional benefits that are considered EHB consistent with 45 CFR 155.170(a)(2).

[29] 26 CFR 57.2(h)(4).

[30] 80 FR 72192.

market, policy years) beginning on or after January 1, 2017, a plan or issuer that is not required to provide EHB must define EHB, for purposes of the prohibition on lifetime and annual dollar limits, in a manner consistent with any of the 51 EHB base-benchmark plans applicable in a State or the District of Columbia, or one of the three Federal Employees Health Benefits Program (FEHBP) EHB base-benchmark plans, as specified under 45 CFR 156.100.[31]

The final regulations under section 2711 of the PHS Act include a reference to selecting a ''base-benchmark'' plan, as specified under 45 CFR 156.100, for purposes of determining which benefits cannot be subject to lifetime or annual dollar limits. The base-benchmark plan selected by a State or applied by default under 45 CFR 156.100, however, may not reflect the complete definition of EHB in the applicable State. For that reason, the Departments are amending the regulations at 26 CFR 54.9815–2711(c), 29 CFR 2590.715–2711(c), and 45 CFR 147.126(c) to refer to the provisions that capture the complete definition of EHB in a State.

Specifically, in these final regulations, the Departments replace the phrase ''in a manner consistent with one of the three Federal Employees Health Benefit Program (FEHBP) options as defined by 45 CFR 156.100(a)(3) or one of the base-benchmark plans selected by a State or applied by default pursuant to 45 CFR 156.100'' in each of the regulations with the following: ''in a manner that is consistent with (1) one of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered EHB consistent with 45 CFR 155.170(a)(2); or (2) one of the three Federal Employees Health Benefit Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.'' This change reflects the possibility that base-benchmark plans, including the FEHBP plan options, could require supplementation under 45 CFR 156.110, and ensures the inclusion of State-required benefit mandates enacted on or before December 31, 2011 in accordance with 45 CFR 155.170, which when coupled with a State's EHB-benchmark plan, establish the definition of EHB in that State under regulations implementing section 1302(b) of the Affordable Care Act.[32]

Some commenters requested clarification that self-insured group health plans, large group market health plans and grandfathered plans are not required to include as covered benefits any specific items and services covered by the State-EHB benchmark plan, including any additional State-required benefits considered EHB under 45 CFR 155.170(a)(2). The requirement in section 2707(a) of the PHS Act to provide the EHB package required under section 1302(a) of the Affordable Care Act applies only to non-grandfathered health insurance coverage in the individual and small group markets. Self-insured group health plans, large group market health plans and grandfathered health plans are not required to include coverage of EHB, but cannot place lifetime or annual dollar limits on any EHB covered by these plans.[33] These plans are permitted to impose limits other than dollar limits on EHB, as long as they comply with other applicable statutory provisions. In addition, these plans can continue to impose annual and lifetime dollar limits on benefits that do not fall within the definition of EHB.

One commenter urged the Departments to eliminate the option for large group market health plans to define EHB based on one of the three largest nationally available FEHBP benchmark plan options to ensure consistency with the definition of EHB in the individual and small group markets. However, these FEHBP plan options[34] are unique among benchmark plans in that they are available nationally, and thus can more appropriately be utilized to determine what benefits would be categorized as EHB for those employers that provide health coverage to employees throughout the United States and are not situated only in a single State. The Departments are finalizing the proposed clarification to the lifetime and annual limit regulations without change.

D. Applicability Date

These final regulations are applicable for plan years (or, in the individual market, policy years) beginning on or after January 1, 2017. The HHS final regulations specify the applicability dates in the group market regulations at 45 CFR 146.125 and in the individual market regulations at 45 CFR 148.102.

III. Economic Impact and Paperwork Burden

A. Summary—Department of Labor and Department of Health and Human Services

These final regulations specify the conditions for similar supplemental coverage products that are designed to fill gaps in primary coverage by providing coverage of additional categories of benefits (as opposed to filling in gaps in cost sharing) to constitute supplemental excepted benefits, and clarify that certain travel-related insurance products that provide only incidental health benefits constitute excepted benefits.

These final regulations also revise the definition of short-term, limited-duration insurance so that the coverage (including renewals) has to be less than three months in total duration (as opposed to the current definition of less than 12 months in duration), and provide that a notice must be prominently displayed in the contract and in any application materials provided in connection with enrollment in the coverage indicating that such coverage is not minimum essential coverage.

Finally, the regulations amend the definition of ''essential health benefits'' for purposes of the prohibition on lifetime and annual dollar limits with respect to group health plans and health insurance issuers that are not required to provide essential health benefits, including self-insured group health plans, large group market health plans, and grandfathered health plans.

The Departments are publishing these final regulations to implement the protections intended by the Congress in the most economically efficient manner possible. The Departments have examined the effects of this rule as required by Executive Order 13563 (76 FR 3821, January 21, 2011), Executive Order 12866 (58 FR 51735, September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (September 19, 1980, Pub. L. 96–354), the Unfunded Mandates Reform Act of

[31] 26 CFR 54.9815–2711(c), 29 CFR 2590.715–2711(c), 45 CFR 147.126(c).

[32] In the HHS Notice of Benefit and Payment Parameters for 2016 published February 27, 2015 (80 FR 10750), HHS instructed States to select a new base-benchmark plan to take effect beginning with plan or policy years beginning in 2017. The new final EHB base-benchmark plans selected as a result of this process are publicly available at *downloads.cms.gov/cciio/Final%20List%20of%20BMPs_15_10_21.pdf.* Additional information about the new base-benchmark plans, including plan documents and summaries of benefits, is available at *www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.* The definition of EHB in each of the 50 states and the District of Columbia is based on the base-benchmark plan, and takes into account any additions to the base-benchmark plan, such as supplementation under 45 CFR 156.110, and State-required benefit mandates in accordance with 45 CFR 155.170.

[33] The annual limits prohibition does not apply to grandfathered individual market coverage.

[34] The three largest nationally available FEHBP plan options are available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Top3ListFinal-5-19-2015.pdf.*

1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)).

B. Executive Orders 12866 and 13563—Department of Labor and Department of Health and Human Services

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 final rule—(1) having an annual effect on the economy of $100 million or more in any one 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 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. The Departments have determined that this regulatory action is not likely to have economic impacts of $100 million or more in any one year, and is not significant within the meaning of Executive Order 12866. However, the Departments are nonetheless providing a discussion of the benefits and costs that might stem from these final regulations in the Summary of Impacts section below.

1. Need for Regulatory Action

These final regulations clarify the conditions for similar supplemental coverage and travel insurance to be recognized as excepted benefits. These clarifications are necessary to provide health insurance issuers offering supplemental coverage and travel insurance products with a clearer understanding of the Federal standards that apply to these types of coverage. These final regulations also amend the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage and impose a new notice requirement in response to reports that short-term, limited-duration insurance coverage is being sold to individuals as primary coverage.

2. Summary of Impacts

The final regulations outline the conditions for travel insurance and similar supplemental health insurance coverage to be considered excepted benefits, and revise the definition of short-term, limited-duration insurance.

The Departments received comments suggesting that the majority of travel insurance policies are issued for trips of short duration, with the average policy length being approximately three months, and these policies generally provide limited medical coverage and property and casualty coverage to protect against risks related to travel. The Departments believe that the designation of certain travel insurance products (as defined by the regulations) as excepted benefits is consistent with prevailing industry practices, and therefore, will not result in significant cost to issuers of these products or consumers who purchase them.

Short-term, limited-duration policies represent a very small fraction of the health insurance market, though their use is increasing. In 2015, total premiums earned for short-term, limited-duration insurance was approximately $160 million for approximately 1,517,000 member months and with approximately 148,000 covered lives at the end of the year,[35] while in 2013, total premiums were approximately $98 million for 1,031,000 member months with approximately 80,400 covered lives at the end of the year.[36]

The Departments received comments indicating that a large majority of the short-term, limited-duration insurance plans are sold as transitional coverage, particularly for individuals seeking to cover periods of unemployment or gaps between employer-sponsored coverage, and typically provide coverage for less than three months. Therefore, the Departments believe that the final regulations will have no effect on the majority of consumers who purchase such coverage and issuers of those policies. The small fraction of consumers who purchase such policies for longer periods and who may have to transition to individual market coverage will benefit from the protections afforded by the Affordable Care Act, such as no preexisting condition exclusions, essential health benefits without annual or lifetime dollar limits, and guaranteed renewability. While some of these consumers may experience an increase in costs due to higher premiums compared with short-term, limited-duration coverage, they will also avoid potential tax liability by having minimum essential coverage. Some consumers may also be eligible for premium tax credits and cost-sharing reductions for coverage offered through the Exchanges. Finally, inclusion of these individuals, often relatively healthier individuals, in the individual market will help strengthen the individual market's single risk pool. The notice requirement will help ensure that consumers do not inadvertently purchase these products expecting them to be minimum essential coverage. Further, the Departments believe that any costs incurred by issuers of short-term, limited-duration insurance to include the required notice in application or enrollment materials will be negligible since the Departments have provided the exact text for the notice.

As a result, the Departments have concluded that the impacts of these final regulations are not economically significant.

C. Paperwork Reduction Act—Department of Health and Human Services

The final regulations provide that to be considered short-term, limited-duration insurance for policy years beginning on or after January 1, 2017, a notice must be prominently displayed in the contract and in any application materials, stating that the coverage is not minimum essential coverage and that failure to have minimum essential coverage may result in an additional tax payment. The Departments have provided the exact text for these notice requirements and the language will not need to be customized. The burden associated with these notices is not subject to the Paperwork Reduction Act

[35] National Association of Insurance Commissioners, 2015 Accident and Health Policy Experience Report, 2016, available at *http://naic.org/prod_serv/AHP-LR-16.pdf.*

[36] National Association of Insurance Commissioners, 2013 Accident and Health Policy Experience Report, 2014, available at *http://naic.org/prod_serv/AHP-LR-14.pdf.*

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).

D. 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 proposed rule is not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. 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 revenues of more than 3 to 5 percent.

The Departments expect the impact of these final regulations to be limited because the provisions are generally consistent with current industry practices and impact only a small fraction of the health insurance market. Therefore, the Departments certify that the final regulations 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. These final regulations will not affect small rural hospitals. Therefore, the Departments have determined that these final regulations will not have a significant impact on the operations of a substantial number of small rural hospitals.

E. Special Analysis—Department of the Treasury

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory impact assessment is not required. For applicability of RFA, see paragraph D of this section III.

Pursuant to section 7805(f) of the Code, these regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business.

F. Unfunded Mandates Reform Act

For purposes of the Unfunded Mandates Reform Act of 1995 (2 U.S.C. 1501 *et seq.*), as well as Executive Order 12875, these final regulations do not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, which may impose an annual burden of $146 million adjusted for inflation since 1995.

G. Federalism—Department of Labor and Department of Health and Human Services

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.

In the Departments' view, these final regulations have federalism implications because they would have direct effects on the States, the relationship between the national government and the States, or on the distribution of power and responsibilities among various levels of government. Under these final regulations, health insurance issuers offering short-term, limited-duration insurance, travel insurance and similar supplemental coverage will be required to follow the minimum Federal standards to not be subject to the market reform provisions under the PHS Act, ERISA and the Code. However, in the Departments' view, the federalism implications of these final regulations are substantially mitigated because, with respect to health insurance issuers, the Departments expect that the majority of States will enact laws or take other appropriate action resulting in their meeting or exceeding the Federal standards.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating an employee benefit plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and section 2724 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a) and 148.210(b)) apply so that the requirements in title XXVII of the PHS Act (including those added by the Affordable Care Act) are not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a Federal requirement. The conference report accompanying HIPAA indicates that this is intended to be the ''narrowest'' preemption of State laws (See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018).

States may continue to apply State law requirements except to the extent that such requirements prevent the application of the market reform requirements that are the subject of this rulemaking. Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive than the Federal law.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have federalism implications or limit the policy making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected States, including consulting with, and attending conferences of, the National Association of Insurance Commissioners and consulting with State insurance officials on an individual basis. It is expected that the Departments will act in a similar fashion in enforcing the market reform provisions of the Affordable Care Act.

Throughout the process of developing these final regulations, to the extent

feasible within the applicable preemption provisions, the Departments have attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this final rule, the Departments certify that the Employee Benefits Security Administration and the Centers for Medicare & Medicaid Services have complied with the requirements of Executive Order 13132 for the attached final rules in a meaningful and timely manner.

H. Congressional Review Act

These final regulations are 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.

I. Statement of Availability of IRS Documents

IRS Revenue Procedures, Revenue Rulings notices, and other guidance cited in this document are published in the Internal Revenue Bulletin (or Cumulative Bulletin) and are available from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, or by visiting the IRS Web site at *http://www.irs.gov.*

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, and 2792 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

List of Subjects

26 CFR Part 54

Pension and 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, 146 and 147

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.

John Dalrymple,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Approved: October 25, 2016.

Mark J. Mazur,

Assistant Secretary of the Treasury (Tax Policy).

Signed this 25th day of October 2016.

Phyllis C. Borzi,

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

Dated: October 24, 2016.

Andrew M. Slavitt,

Acting Administrator, Centers for Medicare & Medicaid Services.

Dated: October 25, 2016.

Sylvia M. Burwell,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Chapter I

Accordingly, 26 CFR part 54 is amended as follows:

PART 54—PENSION AND EXCISE TAXES

■ **Par. 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'', and adding a definition of ''travel insurance'' in alphabetical order. The revision and addition 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 (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 3 months after the original effective date of the contract; and

(2) 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 following: ''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.''

* * * * *

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

* * * * *

■ **Par. 3.** Section 54.9815–2711 is amended by revising paragraph (c) to read as follows:

§ 54.9815–2711 No lifetime or annual limits.

* * * * *

(c) *Definition of essential health benefits.* The term ''essential health benefits'' means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For this purpose, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define ''essential health benefits'' in a manner that is consistent with—

(1) One of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2); or

(2) One of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.

* * * * *

■ **Par. 4.** Section 54.9831–1 is amended:

■ a. In paragraph (b)(1) by removing the reference ''54.9812–1T'' and adding in its place the reference ''54.9812–1, 54.9815–1251 through 54.9815–2719A,'' and in paragraph (c)(1) by removing the reference ''54.9811–1T, 54.9812–1T'' and adding in its place the phrase ''54.9811–1, 54.9812–1, 54.9815–1251 through 54.9815–2719A'';

■ b. In paragraph (c)(2)(vii) by removing ''and'' at the end;

■ c. In paragraph (c)(2)(viii) by removing the period and adding ''; and'' at the end;

■ d. Adding paragraph (c)(2)(ix); and

■ e. Revising paragraph (c)(5)(i)(C).

The revisions and additions are as follows:

§ 54.9831–1 Special rules relating to group health plans.

* * * * *

(c) * * *

(2) * * *

(ix) Travel insurance, within the meaning of § 54.9801–2.

* * * * *

(5) * * *

(i) * * *

(C) *Similar supplemental coverage provided to coverage under a group health plan.* To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in the primary coverage. The preceding sentence is satisfied if the coverage is designed to fill gaps in cost sharing in the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits (as defined under section 1302(b) of the Patient Protection and Affordable Care Act) in the State where the coverage is issued, or the coverage is designed to both fill such gaps in cost sharing under, and cover such benefits not covered by, the primary coverage. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

* * * * *

■ **Par. 5.** Section 54.9833–1 is amended by adding a sentence at the end to read as follows:

§ 54.9833–1 Effective dates.

* * * Notwithstanding the previous sentence, the definition of ''short-term, limited-duration insurance'' in § 54.9801–2 and paragraph (c)(5)(i)(C) of § 54.9831–1 apply for plan years beginning on or after January 1, 2017.

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

■ 6. The authority citation for part 2590 is revised 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).

■ 7. Section 2590.701–2 is amended by revising the definition of ''short-term, limited-duration insurance'', and adding a definition of ''travel insurance'' in alphabetical order. The addition and revision 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 (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 3 months after the original effective date of the contract; and

(2) 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 following: ''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.''

* * * * *

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

* * * * *

■ 8. Section 2590.715–2711 is amended by revising paragraph (c) to read as follows:

§ 2590.715–2711 No lifetime or annual limits.

* * * * *

(c) *Definition of essential health benefits.* The term ''essential health benefits'' means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For this purpose, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define ''essential health benefits'' in a manner that is consistent with—

(1) One of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2); or

(2) One of the three Federal Employees Health Benefits Program (FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.

* * * * *

■ 9. Section 2590.732 is amended by adding paragraph (c)(2)(ix) and revising paragraph (c)(5)(i)(C) to read as follows:

§ 2590.732 Special rules relating to group health plans.

* * * * *

(c) * * *

(2) * * *

(ix) Travel insurance, within the meaning of § 2590.701–2.

* * * * *

(5) * * *

(i) * * *

(C) *Similar supplemental coverage provided to coverage under a group health plan.* To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in the primary coverage. The preceding sentence is satisfied if the coverage is designed to fill gaps in cost sharing in

the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits (as defined under section 1302(b) of the Patient Protection and Affordable Care Act) in the State where the coverage is issued, or the coverage is designed to both fill such gaps in cost sharing under, and cover such benefits not covered by, the primary coverage. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

* * * * *

■ 10. Section 2590.736 is amended by adding a sentence at the end to read as follows:

§ 2590.736 Applicability dates.

* * * Notwithstanding the previous sentence, the definition of ''short-term, limited-duration insurance'' in § 2590.701–2 and paragraph (c)(5)(i)(C) of § 2590.732 apply for plan years beginning on or after January 1, 2017.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Chapter 1

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR parts 144, 146, 147, and 148 as set forth below:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

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

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

■ 12. Section 144.103 is amended by revising the definition of ''short-term, limited-duration insurance'' and adding a definition of ''travel insurance'' in alphabetical order. The revision and addition 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 (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 3 months after the original effective date of the contract; and

(2) 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 following: ''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.''

* * * * *

Travel insurance means insurance coverage for personal risks incident to planned travel, which may include, but is not limited to, interruption or cancellation of trip or event, loss of baggage or personal effects, damages to accommodations or rental vehicles, and sickness, accident, disability, or death occurring during travel, provided that the health benefits are not offered on a stand-alone basis and are incidental to other coverage. For this purpose, the term travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting 6 months or longer, including, for example, those working overseas as an expatriate or military personnel being deployed.

* * * * *

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ 13. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92.

■ 14. Section 146.125 is amended by adding a sentence at the end 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 and paragraph (c)(5)(i)(C) of § 146.145 apply for policy years and plan years beginning on or after January 1, 2017.

■ 15. Section 146.145 is amended by adding paragraph (b)(2)(ix) and revising paragraph (b)(5)(i)(C) to read as follows:

§ 146.145 Special rules relating to group health plans.

* * * * *

(b) * * *

(2) * * *

(ix) Travel insurance, within the meaning of § 144.103 of this subchapter.

* * * * *

(5) * * *

(i) * * *

(C) *Similar supplemental coverage provided to coverage under a group health plan.* To be similar supplemental coverage, the coverage must be specifically designed to fill gaps in the primary coverage. The preceding sentence is satisfied if the coverage is designed to fill gaps in cost sharing in the primary coverage, such as coinsurance or deductibles, or the coverage is designed to provide benefits for items and services not covered by the primary coverage and that are not essential health benefits (as defined under section 1302(b) of the Patient Protection and Affordable Care Act) in the State where the coverage is issued, or the coverage is designed to both fill such gaps in cost sharing under, and cover such benefits not covered by, the primary coverage. Similar supplemental coverage does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision.

* * * * *

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 16. The authority citation for part 147 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 17. Section 147.126 is amended by revising paragraph (c) to read as follows:

§ 147.126 No lifetime or annual limits.

* * * * *

(c) *Definition of essential health benefits.* The term ''essential health benefits'' means essential health benefits under section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. For this purpose, a group health plan or a health insurance issuer that is not required to provide essential health benefits under section 1302(b) must define ''essential health benefits'' in a manner that is consistent with—

(1) One of the EHB-benchmark plans applicable in a State under 45 CFR 156.110, and includes coverage of any additional required benefits that are considered essential health benefits consistent with 45 CFR 155.170(a)(2); or

(2) One of the three Federal Employees Health Benefits Program

(FEHBP) plan options as defined by 45 CFR 156.100(a)(3), supplemented, as necessary, to meet the standards in 45 CFR 156.110.

* * * * *

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

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

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 19. Section 148.102 is amended by adding a sentence at the end of paragraph (b) to read as follows:

§ 148.102 Scope, applicability, and effective dates.

(b) * * * Notwithstanding the previous sentence, the definition of ''short-term, limited-duration insurance'' in § 144.103 of this subchapter and paragraph (b)(7) of § 148.220 apply for policy years beginning on or after January 1, 2017.

■ 20. Section 148.220 is amended by adding paragraph (a)(9) and revising paragraph (b)(7) to read as follows:

§ 148.220 Excepted benefits.

* * * * *

(a) * * *

(9) Travel insurance, within the meaning of § 144.103 of this subchapter.

(b) * * *

(7) Similar supplemental coverage provided to coverage under a group health plan (as described in § 146.145(b)(5)(i)(C) of this subchapter).

[FR Doc. 2016–26162 Filed 10–28–16; 8:45 am]

BILLING CODE 4830–01–P; 4120–01–P; 4510–29–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2016–0956]

Drawbridge Operation Regulation; Upper Mississippi River, Clinton, IA

AGENCY: Coast Guard, DHS.

ACTION: Notice of deviation from drawbridge regulation.

SUMMARY: The Coast Guard has issued a temporary deviation from the operating schedule that governs three drawbridges crossing the Upper Mississippi River in Iowa: The Illinois Central Railroad Drawbridge, mile 579.9, Dubuque, IA; the Sabula Railroad Drawbridge, mile 535.0, Sabula, IA; and the Clinton Railroad Drawbridge, mile 518.0, Clinton, IA. The deviation is necessary to allow the bridge owners time to perform preventive maintenance that is essential to the continued safe operation of the drawbridges and allows for a seasonal deviation issued for these bridges each year. Maintenance is scheduled in the winter, when there is less impact on navigation due to less traffic. This deviation allows the bridges to open on signal if at least 24 hours advance notice is given.

DATES: This deviation is effective from 5 p.m., December 13, 2016 until 9 a.m., March 2, 2017.

ADDRESSES: The docket for this deviation, (USCG–2016–0956) is available at *http://www.regulations.gov.* Type the docket number in the ''SEARCH'' box and click ''SEARCH.'' Click on Open Docket Folder on the line associated with this deviation.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary deviation, call or email Eric A. Washburn, Bridge Administrator, Western Rivers, Coast Guard; telephone 314–269–2378, email *Eric.Washburn@uscg.mil.*

SUPPLEMENTARY INFORMATION: The Illinois Central, Canadian Pacific, and Union Pacific Railroads requested a temporary deviation for the Illinois Central Railroad Drawbridge, mile 579.9, Dubuque, Iowa, Sabula Railroad Drawbridge, mile 535.0, Sabula, Iowa, and Clinton Railroad Drawbridge, mile 518.0, Clinton, Iowa, across the Upper Mississippi River to open on signal if at least 24 hours advance notice is given for 79 days from 5 p.m., December 13, 2016 to 9 a.m., March 2, 2017 for scheduled maintenance on the bridges.

The Illinois Central, Sabula, and Clinton Railroad Drawbridges currently operate in accordance with 33 CFR 117.5, which states the general requirement that drawbridges open on signal.

There are no alternate routes for vessels transiting these sections of the Upper Mississippi River. The bridges cannot open in case of emergency.

The Illinois Central Railroad Drawbridge provides a vertical clearance of 19.9 feet, Sabula Railroad Drawbridge provides a vertical clearance of 18.1 feet, and Clinton Railroad Drawbridge provides a vertical clearance of 18.7 feet, above normal pool in their closed-to-navigation positions. Navigation on the waterway consists primarily of commercial tows and recreational watercraft and will not be significantly impacted. This temporary deviation has been coordinated with waterway users. No objections were received.

In accordance with 33 CFR 117.35(e), each of these drawbridges must return to its regular operating schedule immediately at the end of the effective period of this temporary deviation. This deviation from the operating regulations is authorized under 33 CFR 117.35.

Dated: October 25, 2016.

Eric A. Washburn,

Bridge Administrator, Western Rivers.

[FR Doc. 2016–26150 Filed 10–28–16; 8:45 am]

BILLING CODE 9110–04–P

DEPARTMENT OF HOMELAND SECURITY

Coast Guard

33 CFR Part 117

[Docket No. USCG–2016–0948]

Drawbridge Operation Regulation; Newtown Creek, Brooklyn and Queens, NY

AGENCY: Coast Guard, DHS.

ACTION: Notice of deviation from drawbridge regulation.

SUMMARY: The Coast Guard has issued a temporary deviation from the operating schedule that governs the Pulaski Bridge across the Newtown Creek, mile 0.6, between Brooklyn and Queens, New York. This deviation is necessary to allow the bridge owner to perform span locks adjustment at the bridge.

DATES: This deviation is effective from 12:01 a.m. on November 8, 2016 to 5 a.m. on December 2, 2016.

ADDRESSES: The docket for this deviation, [USCG–2016–0948] is available at *http://www.regulations.gov.* Type the docket number in the ''SEARCH'' box and click ''SEARCH''. Click on Open Docket Folder on the line associated with this deviation.

FOR FURTHER INFORMATION CONTACT: If you have questions on this temporary deviation, call or email Judy Leung-Yee, Project Officer, First Coast Guard District, telephone (212) 514–4330, email *judy.k.leung-yee@uscg.mil.*

SUPPLEMENTARY INFORMATION: The Pulaski Bridge, mile 0.6, across the Newtown Creek, has a vertical clearance in the closed position of 39 feet at mean high water and 43 feet at mean low water. The existing bridge operating regulations are found at 33 CFR 117.801(g)(1).

The waterway is transited by commercial barge traffic of various sizes.

PUBLIC SUBMISSION

As of: October 31, 2018
Received: February 20, 2018
Status: Posted
Posted: March 02, 2018
Tracking No. 1k2-91lu-xdbr
Comments Due: February 21, 2018
Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0003
Erich Shanholtzer, CO

Submitter Information

Name: Erich Shanholtzer
Address:
Aurora, CO, 80011
Email: eshanholtzer@healthmarkets.com
Organization: NA

General Comment

Short term insurance plans are meant to get people to the next enrollment period, Limiting them to 3 Months means that 60% of the time that is impossible.

Re-enrolling every three months is inconvenient and opens people up for being prevented from enrolling due to pre-existing conditions and chances are coverage will drop during treatment leaving a person without coverage and no way to get coverage.

PUBLIC SUBMISSION

As of: October 31, 2018
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Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0011
Anonymous, CO

Submitter Information

Name: Anonymous Anonymous
Address:
Grand Junction, CO, 81504
Email: cqlandscapes@gmail.com
Organization: NA

General Comment

As an insurance broker we greatly need the short term health plans to be restored in length. Every year when signing people up for health insurance during the way to short of an enrollment period many people for a variety of reasons do not get coverage for example one insured did an online bill pay through his bank and the initial premium went to Anthem BCBS's Medicare dept instead of the individual dept and his coverage was termed with no way to reinstate the policy so now the insured has to go the entire year without coverage because we have no options available and others do not understand DHS letters that they have lost Medicaid and did not know they lost coverage before the 60 day limit to get other coverage. People are not going to flee Obamacare if lengths are restored on short term health plans because the majority are getting way to good of deals and don't have to pay much for coverage. Most Americans have already fled Obamacare because it costs more than their mortgages! The Unaffordable Care Act is and has been a failure since the beginning and no way to save that sinking ship no matter if short term plans are restored or not.

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PUBLIC SUBMISSION

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0017
Daniel Walterman, IA

Submitter Information

Name: Daniel Walterman
Address:
Cedar Rapids, IA, 52402
Email: danwalterman@premierhealthia.com
Organization: NA

General Comment

Thank you for extending these plans for 12 months. The 3 month regulation was an obvious attempt to push people into the much more expensive ACA plans with limited healthcare providers and higher out of pocket expenses. In Iowa, a 60 year old could purchase health insurance from Wellmark Blue Cross for $190 per month in 2013 with a $2500 deductible. That similiar coverage is now closer to $1300 per month. As I am in the insurance business, we find more and more people simply cannot afford the Affordable Care Act plans unless they are receiving a substantial tax credit. I have plenty of customers who would be paying over 50% of their income in premium and deductibles if they had chosen one of the ACA plans....and not be able to have their doctors covered either.

I would be more than happy to provide proof of these premium changes from prior to post ACA if needed.

Once again, Thank You for providing the American people freedom and liberty that our veterans and founding fathers fought so hard to defend.

PUBLIC SUBMISSION

As of: October 31, 2018
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Comments Due: February 21, 2018
Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0028
MO

Submitter Information

Name: Christina Diehl
Address:
Jefferson City, MO, 65109
Email: christy@mdis4dds.com
Organization: NA

General Comment

I'm in favor of extending the short term health insurance policy duration (back to the original duration of 6-12 months), as it fits the needs of many Americans that cannot afford major medical coverage. Regardless of the backlash of many stating that underwriting and pre-existing conditions won't serve the a large percentage of the population, it will be an excellent option for those that don't have pre-existing conditions, don't need maternity, and don't need mental health coverage. It is a real burden for Americans to have to reapply and go through underwriting for short term coverage every two months under the current law.

PUBLIC SUBMISSION

As of: October 31, 2018
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Tracking No. 1k2-91mf-xrqy
Comments Due: February 21, 2018
Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0029
FL

Submitter Information

Name: Patricia Riccio
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North Port, FL, 34291
Email: szczepka@sbcglobal.net
Organization: NA

General Comment

I am 64 years old and have had individual insurance since my COBRA coverage expired in August 2016. The cost of coverage in 2017 was $630 per month, which increased more than 16% from 2017 to 2018. I do not qualify for a subsidy and, as a result, nothing about this coverage has been "affordable," especially when you consider the plan comes with an $8,000 deductible. I enrolled in short-term coverage January 1, 2018 as I will be eligible for Medicare beginning June 1, 2018. However, it would have been much more cost effective for me if I was able to obtain short-term coverage at the end of my COBRA period particularly since I do not need some of the "essential health benefits" mandated by the PPACA. I am writing to you today to let you know that I am in full support of the proposed change to the PPACA and hope that renewable short-term coverage becomes available to others in a similar position and that the penalty for having non-PPACA qualifying coverage is eliminated effective for 2018. Thank you for your consideration.

PUBLIC SUBMISSION

As of: October 31, 2018
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Tracking No. 1k2-91mj-5oxe
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Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0051
IL

Submitter Information

Name: Cheryl Jones Das
Address:
IL, 60510
Organization: NA

General Comment

I am against short-term health insurance plans that last more than a few months or are renewable so they turn into a long term permanent plan.

These plans supply health coverage in name only because they don't have to include the minimum essential health benefits - such as mental health care or prescription coverage. And with this type of plan, insurance companies can refuse to offer coverage to someone with a pre-existing medical condition, or charge people more money if they're likely to need more care.

Offering these plans for longer than a few months as a stop gap measure will cause healthy people to leave the ACA market and leave the ACA compliant plans covering a sicker pool with higher premiums! This will hurt the people who need insurance the most.

I believe the strategy is to make the ACA implode by creating a parallel insurance market that does not comply with the ACA's rules.

As of: October 31, 2018
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Tracking No. 1k2-91n3-exwg
Comments Due: April 23, 2018
Submission Type: Web

PUBLIC SUBMISSION

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0065
IA

Submitter Information

Name: Robert Bekins
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Email: bbekins31@gmail.com
Organization: NA

General Comment

Shot term-limited duration health insurance should be limited to the time period it currently is and should not be allowed to be used for longer amounts of time. It should not be allowed to be extended or renewed. Otherwise it is not short-term limited duration insurance. This insurance is intended to fill the gaps between regular insurance and is not supposed to be regular health insurance. But changing the rules though will allow people to start to use it like regular health insurance. But changing the rules will allow people to start using it in this manner. People will be drawn to it by the low rates and save money and it will benefit them, until they have a medical event that is not covered and then they will face large bills that they will either have to pay on their own, or more likely be unable to pay. While the Affordable Care Act has problems, and premiums have increased for people on the individual market who do not get subsidies, this is not the solution. This will only make the situation worse. Unless everyone, regardless of whether they are in a short term, ACA or employer plan are pooled into one large risk pool this will destabilize the risk pools and increase rates on the individual markets. It will hurt those the most who wish to purchase individual health insurance but do not receive a subsidy. Increase what the federal government has to pay in subsidies for those who receive it. And as mentioned earlier, people who buy the new insurance will find that when they do have a medical issue that this insurance likely will not cover it and they will be left with large bills. Many people will not be able to pay these bills and the cost will be left to the hospital or the government. For these reasons I recommend that this change not be made.

PUBLIC SUBMISSION

As of: October 31, 2018
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Comments Due: February 21, 2018
Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0074
LA

Submitter Information

Name: Steven McCarter
Address:
Ruston, LA, 71270
Email: gmccarter@suddenlinkmail.com
Organization: NA

General Comment

Finally, at least one decision concerning health insurance that actually makes sense! A temporary plan is often the best/only solution for someone who just got a raise in January and can now afford to buy health insurance and not have to wait until the next Open Enrollment. I'm all for this change...and more! Now, can you talk the companies that left the market into coming back?

PUBLIC SUBMISSION

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Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0076
OH

Submitter Information

Name: Barbara Silvey
Address:
Uniontown, OH, 44685
Email: barbsilvey@gmail.com
Organization: NA

General Comment

12 month Short Term Medical policies, with a 12 month renewable term, would keep people continuously insured with the limited benefits that they want (they are well aware of the limitations). It is a very good fit for many people, not just those between jobs.

Many have seasonal jobs, or just started a business, and their income will fluctuate, sometimes by 50%.
Some have been hit by the IRS, siting errors in reporting income while on an ACA plan, so they don't want a repeat.
Some prefer the larger provider network offered by STM plans, vs. ACA HMO plans.
Any gaps in coverage can be filled with other insurance products.

The STM policies have always been useful even prior to ACA, and allowing a 12 month coverage is fantastic!
There is no down side to this proposal.

PUBLIC SUBMISSION

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Comments Due: February 21, 2018
Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0093
IL

Submitter Information

Name: Jason Martens
Address:
LaGrange Park, IL, 60526
Email: jmartens@myhst.com
Organization: Healthcare Solutions Team

General Comment

To whom it may concern,

I have been helping my clients sign up for health insurance for over 15 years. The last few years have been the most challenging in finding my clients affordable coverage. Most of my clients do not qualify for any subsidies to help them pay for the high premiums of an ACA plan. Not to mention that ACA plan choices have become very few in recent years and the deductibles, out of pocket and low end networks have made them very challenging and unappealing for my clients. A lot of my clients are choosing Short Term Major Medical plans because they are half the cost of an ACA plan, they can offer much lower deductibles and out of pocket, but more importantly they give my clients access to the top hospitals so that they can get the treatment they need in the event they have a serious illness. The Short Term Major Medical Plans need to go back to a 12 month duration. My clients are choosing these plans because they make sense. With only a 3 month duration it puts my clients in harms way if their plan is coming to an end after a short three months and they develop a condition that may make them ineligible to renew the Short Term Plan. With a 12 month duration, or longer, if possible, that allows them to get into the open enrollment period where they can then sign up for an ACA plan should they need the guaranteed issue acceptance.
My hopes are that Health insurance goes back to how it used to be. You had to be relatively healthy to get coverage, but you had choice and they were affordable. If you make the Essential Health Benefits as options that people can either choose to add or not, like maternity, fertility treatment, preventive care, etc, that allows someone to custom design their own plan based off of their own budget and use of the insurance. If they are too un healthy to qualify for the plan then bring back the CHIP program that provided guaranteed issue coverage for people that were denied coverage from major medical insurance companies. The CHIP plans were more expensive, but if you are unhealthy you should pay more. What we are seeing now with the ACA is the entire country is on the CHIP program weather you are healthy or unhealthy. But, the coverage on an ACA plan today

PUBLIC SUBMISSION

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Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0110
TX

Submitter Information

Name: LEON NELKIN
Address:
HOUSTON, TX, 77071
Email: leonnelkin@aol.com
Organization: PRINCETON FINANCIAL SERVICES

General Comment

As a 40 year insurance agent, I am compelled to observe that the current 3 month short term policies available to consumers is an outright and TOTAL OUTRAGE!! Not only are they limited to 3 month periods, BUT ALSO require that a totally NEW & EXPENSIVE deductible and co-insurance be satisfied EVERY 3 months!! AND....to make matters even MORE DIABOLICAL....conditions encountered during a prior 3 month period are then to be considered NON-COVERED
"PREEXISTING CONDITIONS" for the renewing 3 month periods!!

NEVER, EVER in serving the public for my 40 years have I seen such outrageous and destructive parameters for the American Public! Ever since "temporary medical insurance" has been around, consumers could buy them for up to a full 12 months by paying either a single or monthly premiums that would cover all conditions, EXCEPT those conditions that did exist prior to starting that plan! This was reasonable and fair!

It is an embarrassment for me and I assume to all other professional agents whose mandate it is to offer the BEST protection possible to those that we are honored to serve...that THIS CRAP is now all that is available to people who, for whatever reason, did not enroll under the stupid, arbitrary, and limited 45 days of ACA (which SHOULD be referred to more appropriately as the "UN-Affordable (we DON'T) Care Act!!! FYI----these are the MOST frustrating, maddening, and difficult 45 days each year of my life as I struggle to have to previously unnecessarily RE-ENROLL multiple clients for whom I had just done the same for 1, 2. and even 3 years before!!!

The CURRENT LEGISLATION destroyed the ability of consumers to purchase individual health insurance ANYTIME during the year...subject to preexisting conditions. However, we DID have here in Texas, at least, the Texas Health Insurance Risk Pool for those who did., typically at HIGHER rates than individually underwritten

policies, BUT STILL CHEAPER-...AND with BETTER BENEFITS than today's obamacare plans!

PLEASE, PLEASE, PLEASE at least restore the Temporary Policies as they were so that AMERICAN CITIZENS can purchase and fill their medical insurance gap to DECEMBER 31 of each year at least ONCE...so they can then be given the opportunity to "correctly enroll" during the limited open enrollment period for the following year...until this "Obamanation" is fixed!!

PLEASE feel free to reply to or contact me for any further input on this subject that you can see that I am so passionate about and about which I feel I have so much acquired knowledge and experience! I only wish that I could be invited to consult with or testify before the proper US agency or even Congress itself on this subject that has haunted our country for over 8 years now! Let me know.

Thank you!

Leon Nelkin

PUBLIC SUBMISSION

As of: October 31, 2018
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Tracking No. 1k2-91mn-2yzx
Comments Due: February 21, 2018
Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0111
NE

Submitter Information

Name: Jara Carlson
Address:
Beatrice, NE, 68310
Email: jcarlson1@farmersagent.com
Organization: NA

General Comment

That is great news for me and others. We are in desperate need of major medical that is not the unaffordable ACA plans.

Thank you.

PUBLIC SUBMISSION

As of: October 31, 2018
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Tracking No. 1k2-91nu-a9o1
Comments Due: April 23, 2018
Submission Type: API

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0113
IN

Submitter Information

Name: JAMES VARGO
Address:
MERRILLVILLE, IN, 46410
Email: jimv58@att.net
Organization: Entrust Health Insurance

General Comment

I have been in the Health market for 12 years and I am 71 years old. This STH should be extended to 12 month period with the option to renew if the person can still pass underwriting. This should not be left for our government to decide.

PUBLIC SUBMISSION

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Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0125
VA

Submitter Information

Name: Susan Perri
Address:
Warrenton, VA, 20187
Organization: NA

General Comment

Promoting Healthcare Choice and Competition Across the United States reads like a lot of B.S. ! No mention of co-pays, premium cost, what it really covers, pre-exciting conditions or caps. It reads like a crumb handed to a starving person.
The American people deserve better, we rank 24th for best health care compared to other countries. DO BETTER !!!! The American people should not have to decide between a mortgage payment or health care...DO BETTER, DON'T THROUGH OUT CRUMBS !

PUBLIC SUBMISSION

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Submission Type: API

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0128
NC

Submitter Information

Name: Mike Davignon
Address:
Winston Salem, NC, 27101
Email: mikedavignon@yahoo.com
Organization: Mike Davignon

General Comment

I think the max term should be expanded beyond 12 months. With guaranteed renew-ability. Other permanent options that are not ACA/MEC types of coverage that let the consumer buy the insurance they want and need. Consumers need other options. In the 2 states I sell insurance we have only one carrier. BCBS, Monopoly?

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Received: February 25, 2018
Status: Posted
Posted: March 02, 2018
Tracking No. 1k2-91p3-2rhg
Comments Due: April 23, 2018
Submission Type: Web

PUBLIC SUBMISSION

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0140
TN

Submitter Information

Name: Joseph Graves
Address:
Nashville, TN, 37207
Email: joe@ihatebuyinginsurance.com
Organization: NA

General Comment

YES ... Make Short Term Medical Plans available for 364 days once again. There are MANY reasons...

1. Buying 3 months at a time is HURTING our health - The rule opens up the possibility of 4 Preexisting loopholes" in a year vs. one. If you break your leg on day 89, you currently fall into a Pre-X period the next day. FOUR is far too many.

2. Increased costs - Each term is faced with a NEW application fee and possibly new rates. Americans are paying FOUR policy fees when they should pay just one time. The cost of these fees can be the equivalent of 1 - 3 months of premium lost to fees. (

3. ACA is truly Unaffordable for many who make just a little more than the 400% FPL. $48,241, the point you exceed 400%, is NOT RICH. In many cities, it's hardly a "Good Living". Yet, at that level 100% of your eligibility for a subsidy goes away. In TN the premium for an ACA Plan can be as much as 26.85% of your annual income!! Yet, we don't have a "market for alternatives" to shop from. Short term plans will give consumers a fantastic option that is dramatically more affordable.

4. Freedom - Please give the consumer the freedom to choose what they believe is best for them self. Is it a guarantee issue plan such as the ACA mandates, then let them choose. Is it an underwritten plan, possibly with no coverage for Pre-X, then LET THEM CHOOSE.

Rather than just complaining, here are my solutions:

1. Make standardized language that all carriers use when offering a Short Term plan that informs the consumer

that:
a. This is not a permanent plan and you will be subject to an underwriting review annually.
b. This is intended for future events and NO preexisting condition is covered unless the insurance carrier opts to include the condition per the underwriting review.
c. Indicate that preventative services are not (typically not) included unless the individual carriers include limited benefits in their contract.

- TELL THE CONSUMER what they are NOT getting up front and there are no surprises later. IT WORKS because that is exactly what my agency does.

Solutions to the "short falls" of a short term plan:
It is MUCH more affordable to overcome the shortfalls of a Short Term Plan (& ACA plans) by supplementing the core plan with additional policies. SAME PRINCIPLE as Medicare. Allow carriers & their licensed, trained, and insured (errors & omissions) agents/brokers show the consumer the BASE plan, and then how we supplement the gaps.
We do the same right now for major medical with carriers like Aflac.
No Annual Exam!! There are plans that pay cash to the consumer for getting an exam.
I break a leg soon before the end of my term... There are accident plans with as much as $250,000 in stand alone accident protection. Many more with $25,000. Those plans can handle most of the short fall.
It's cancer, what do I do if my Short Term comes to an end? Again, there are many "cash for cancer" plans in the free market. Some with benefits as high as $500,000.
I don't have an office co-pay to see a doctor. Just use tele-medicine. Who WANTS to take a half day off work, sit in a crowded room with other sick people, to see someone for THREE minutes, for them to tell you, "You have the flu." I KNOW I DO. Yet I need YOU to write a prescription. Almost everyone can have "Doctor on demand in the palm of our hand".
It's only good for one year!! Allow carriers to design plans that are good for 2, 3, even 10 years if they choose.

Please allow, once again, Short Term Plans to last 364 days, if not longer. So many consumers are taking a huge financial risk because they make too much for a subsidy and don't have a solid solution to pick form other than paying the UNAFFORDABLE ACA premiums. We have "minimum coverage" for car insurance throughout the country. This can be the "minimum essential" of the future.

Thank you...

As of: October 31, 2018
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Comments Due: April 23, 2018
Submission Type: Web

PUBLIC SUBMISSION

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0149
GA

Submitter Information

Name: Penny Anonymous
Address:
GA, 30269
Email: p.carleton.kramer@gmail.com
Organization: NA

General Comment

I am writing in support of the short term insurance changes. I am a self employed person who has been hurt by the ACA. I am too "rich" for subsidies so I pay full price for health insurance for my family of four. The first year of the ACA my premium was $850/mo and there were 6 or so choices of companies with point of service plans (non hmo). 2018 saw my premiums over $2200/mo with only two companies with only narrow network hmo plans (terrible plans). We have left the insurance market altogether and belong to a health sharing ministry. I would welcome the addition of short term plans that I could consider to use. The ACA has made it clear that Feds think people like me should either have a cadillac plan that will bankrupt me OR no plan at all. I've already left the market, so offering me choices would only help the ACA mess, not hurt it.
These plans should be stripped of the ACA minimum essential benefits BS like
Childrens dental
Maternity (don't need)
Preventive care (I'll pay for what I want thk u)
Birth control
make it renewable year to year so I don't have to start with a new policy every year

I want health insurance with high deductibles but let me pay for the small stuff. I need protection should something big happen. The ACA has hurt my family and I would prefer ACA repeal but this proposed rule could help us.

As of: October 31, 2018
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Posted: March 02, 2018
Tracking No. 1k2-91r2-wtsc
Comments Due: April 23, 2018
Submission Type: Web

PUBLIC SUBMISSION

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0155
VA

Submitter Information

Name: Anonymous Anonymous
Address:
VA, 22301
Organization: Better Health Care Solutions

General Comment

These policies are a sham. They do not offer enough coverage to be worth the premiums.
They do not cover any pre-exiting conditions.
They do not help anyone but the healthiest, and even then they can drop someone with a large unexpected claim.
Medical bankruptcies will stem from these policies.
Keep them for 3 months only.
They cannot be renewable.
These policies are the very reason the Affordable Care Act was created.
Don't go back.

PUBLIC SUBMISSION

As of: October 31, 2018
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Posted: March 06, 2018
Tracking No. 1k2-91ml-b3q4
Comments Due: February 21, 2018
Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0001
Short Term Limited Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0168
GA

Submitter Information

Name: Janet Salyer
Address:
Canton, GA, 30114
Email: jsalyer@insuranceplanningsolutions.com
Organization: NA

General Comment

I hope that you will allow the individuals to enroll in a short term plan for as long as a year. The short term plans require underwriting and do not cover pre-existing conditions, but are lower cost than the ACA qualified plans. There are many situations when a short term policy is effective. (1) When someone is starting their own business and is unsure of the income they will have. When someone is working for a smaller company, and paying for each healthy dependent at group rates is unaffordable. (3) when a person is out of college and looking for a job, but has not found one. (4) when someone has moved or is planning to move to a new location and they want coverage until they find their new home (5) seniors who are healthy and can't afford $1200 a month in premiums but don't qualify for assistance.
I would love to see major medical plans that require underwriting and have a lower lifetime maximum offered as well. People are choosing not to have coverage because the premiums are too high. I think if someone has had coverage and changes coverage, the pre-existing waiting period can be waived. But if they are jumping in and out of insurance, which is happening now, they will have the pre-existing waiting period. No one should have to pay tax on health insurance.

PUBLIC SUBMISSION

As of: October 31, 2018
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Tracking No. 1k2-91mj-ix1w
Comments Due: April 23, 2018
Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0196
TX

Submitter Information

Name: Debbie Love
Address:
Jonestown, TX, 78645
Email: dwlove10@gmail.com
Organization: NA

General Comment

Debbie Love
17524 Lighthouse Lane
Jonestown, Texas 78645

February 21, 2018

To Whom It May Concern:

I am writing to request that the proposed rule for Short Term, Limited-Duration Insurance CMS-9924-P be extended/changed back to a 12 month cap for coverage. With this proposed change back to the 12 month cap, this will again give consumers such as myself, a viable option in lieu of an ACA plan without the risk of not having a plan after 3 months because a chronic condition develops.

Short Term plans typically provide lower cost options and a much broader PPO network than any of the ACA compliant plans have.

I am a realtor, therefore, I am self employed. My husband is also self employed. We are both 63. The Marketplace policies available to us this year cost $1,260.00 for the 2 of us. Neither of us knows what our income will be for 2018, it changes every year. We cannot afford health insurance at this cost. Some years we might qualify for a subsidy, but, we never know until the end of the year, a fatal flaw for self-employed people with the Obama plan.

Last year we purchased the short term coverage for 12 months, it was what we could afford, if cost us around $550.00 a month. The least expensive Marketplace coverage would have cost us over $1,100.00 a month.

We wanted to purchase the short-term affordable coverage again for 2018 but, we could only get it for 3 months at a time. What happens if one of us gets sick during that 3 month period? We would not be able to purchase any insurance to cover that condition until January 2019. This could wipe out our retirement savings, affect our ability to pay our mortgage and so many other disasters. So, for now, we have a Marketplace policy. If our income is low enough, we can qualify for a subsidy, but, otherwise, the cost is $1,260.00 a month, AND, I'm already finding that some items that were covered on the short term policy are more expensive on this policy.

I implore you to change the cap on the limit from 3 months back to 12 months to help hardworking Americans such as myself and my husband.

Thank you for your time and consideration.

Sincerely,

Debbie Love

PUBLIC SUBMISSION

As of: October 31, 2018
Received: February 21, 2018
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Posted: March 06, 2018
Tracking No. 1k2-91ml-3t7o
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Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0198
TX

Submitter Information

Name: Jeffrey Weislow
Address:
El Paso, TX, 79912
Email: jweislow@sbcglobal.net
Organization: NA

General Comment

I am in FAVOR of this new rule to extend temporary insurance to less than 12 months. This will help me as a small business owner for whom insurance on the health.gov site is an unaffordable option. Having temporary insurance instead of being uninsured is preferred. I realize these plans are not optimal, but they are better than going bare. I make too much for subsidies but not enough to afford my family insurance bill in 2018 which would be $20000.00 per year with a $8000 deductible.
Please allow this new rule to be put in place and help the uninsured middle class business owners in America.

PUBLIC SUBMISSION

As of: October 31, 2018
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Status: Posted
Posted: March 06, 2018
Tracking No. 1k2-91n7-xl2z
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Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0210
IN

Submitter Information

Name: Brenda Kindy
Address:
IN, 47201
Organization: NA

General Comment

This is a wonderful change in the regulations! Thank goodness that President Trump recognizes that for people who do not get subsidized from the Government to purchase health care that the premiums for ACA-compliant coverage have become totally unaffordable. This will provide at least an option to those people that are healthy. Obamacare must be repealed and replaced.

As of: October 31, 2018
Received: February 23, 2018
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Tracking No. 1k2-91no-8ubt
Comments Due: April 23, 2018
Submission Type: API

PUBLIC SUBMISSION

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0219
GA

Submitter Information

Name: David Davidson
Address:
Greensboro, GA, 30642
Email: daved@windstream.net
Organization: Davidson Insurance

General Comment

Comments from an insurance agent:

As an independent insurance agent with thirty years experience in the field of life and health insurance, I have successfully used Short-Term Medical (STM) plans for many of my clients.

This type of plan has been and is a perfect vehicle for people caught without standard coverage due to many factors.

Prior to the Obama administration changing the policy term to only three months, an individual could use the STM for nearly a full year and then had the option to renew the policy again.

The three-month limit imposes severe hardships on the policyholder and the agent involved since they have to duplicate all of the initial effort necessary to place the first policy in place.

The current proposed rule will help many thousands of folks be protected until their situation changes where they can obtain either insurance through an employer or new insurance through the individual market place.

STMs are particularly helpful in rural areas where the ACA system now has caused EXTREMELY limited choices for insurance plans -- or no choices at all.

Please process the change to a full year policy period as well as make the STM eligible for renewal for another full year policy period.

PUBLIC SUBMISSION

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Posted: March 06, 2018
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Comments Due: April 23, 2018
Submission Type: API

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0228
SC

Submitter Information

Name: John Anonymous
Address:
SC, 29464
Organization: None

General Comment

My monthly premium before ACA in 2013 was $180 with a $5,000 deductible. Starting in 2014 the premium went up 30%. As of 2018 the ACA least expensive plan with BlueCross BlueShield for me is $714 with a $7,000 deductible. I live in SC and I am age 59. I dropped ACA plan is 2015 and Have been using Short Term Medical ever since with average premium being $150 per month. The downside of STM is that I have to renew every 3 months. The ACA also did away with STM with a 12 month term period and now it has to be renewed every 3 months.

It seems to me that the middle class have been forgotten by Washington politicians that are more concerned for giveaways to the poor and illegal aliens.

PUBLIC SUBMISSION

As of: October 31, 2018
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Status: Posted
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Tracking No. 1k2-91nu-rb5o
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Submission Type: Web

Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0230
FL

Submitter Information

Name: Alexander Lewis
Address:
Leesburg, FL, 34797
Email: lewdog2000@hotmail.com
Organization: NA

General Comment

The extension of Short Term plans to 364 days could only serve to improve options to those individuals that are healthy, but want catastrophic coverage. These plans are far more affordable than the average Bronze plan that is offered on the marketplace, and in most cases have lower deductibles. These plans offer flexible deductibles, national PPO networks and optional Supplemental Accident benefits. Authorizing these 364 day terms would also create more convenience for those individuals that would otherwise have to renew their short term plans every 6 months.
Folks that say that these plans would further damage the ACA are usually not on the front lines of the insurance business. As a licensed insurance agent I can tell you, this would not adversely affect the ACA at all, since those individuals wouldn't purchase an ACA due to high costs anyway! This provides a reasonable source of coverage to people that would otherwise have none.

PUBLIC SUBMISSION

As of: October 31, 2018
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Docket: CMS-2018-0015
Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0598
CO

Submitter Information

Name: Pam Ruzicka
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Glenwood Springs, CO, 81601
Email: pam@insurance4uco.com
Organization: NA

General Comment

Please I urge you to allow these plans to be allowed up to 11 months like they were before the ACA came in and took away our freedom.
I am an agent in rural Colorado where our rates are off the charts unaffordable. This year as a 52 year old, the lowest costing plan for myself was $1000/month for the worst coverage.
Many of my clients would appreciate the option to buy a lesser plan that does not offer all of the perks that the ACA requires be covered which only increases the cost of the premium.
Many people do not want maternity or fertility coverage, or mental health. They are willing to pay for their own preventative benefits if they can lower their monthly premium and still have some assurance of coverage in a worst case scenario.
Cost is the main reason most of my uninsured clients are giving me. It's just not right. We seriously need changes to get the cost of medical treatment lowered so the premiums can also be lowered.
Multiple issues are causing the cost of the premiums to be high but at least a temporary short term plan at a lesser cost still protects most folks who don't have pre-existing conditions.
Thank you for your consideration!!!

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Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0599
NV

Submitter Information

Name: Anonymous Anonymous
Address:
Henderson, NV, 89014
Organization: NA

General Comment

Short Term Medical plans should be extended to a minimum of 12 months as soon as possible. The ACA was the single most expensive scam ever forced upon the American public. Premiums are now greater than many pay for rent or mortgage payments. Short Term Medical gives the public the choice to enroll in plans that give good, solid coverage for a much-reduced premium. Thank president Trump for recognizing the importance of these plans and implementing his Executive Order to get this moving ASAP!

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Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
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Document: CMS-2018-0015-0604
SC

Submitter Information

Name: Maria Overcash
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Fort Mill, SC, 29715
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Organization: NA

General Comment

With individual ACA health insurance plans having increased as much as 350% over the individual health plans of 2013, many Americans who do not have access to subsidized group/employer health insurance simple can not afford them. We need to have options that are affordable and per the ACA guidelines that means they cost less then 8.4% of the families Adjusted Gross Household Income (AGHI) while providing enough coverage so that if an individual has a major medical event the Hospital bills won't bankrupt them. As long as the Affordable Care Act is in place the only real option available is Short Term Medical plans. Many Short Term Medical plans have $1 million to $2 million in coverage, which is enough to take care of 99% of medical bills during a 12 month period.

Example of how the ACA has impacted self employed families.:
NC family of 4 parents in there 50's with 2 teenage children in 2017 were paying $730 per month for a Grandfathered Blue Cross Blue Shield health plan. BCBS of NC dropped all of their grandfathered plans on December 31, 2018 leaving the only option as their ACA individual plans (since they are the only carrier still offering ACA plans in NC) at a monthly cost of $2,500. That is an annual cost of $28,000 which is more than the mortgage, utilities and health insurance cost in 2017 and 28% of their annual income. The only real option is Short-term Medical coverage, but when it is limited to 90 days it causes a major issue if one of the members of the family gets diagnosed with a medical condition during that 90 days, now they won't be eligible to renew their coverage and will have no health insurance. By allowing Short Term medical plans to be issued for up to 12 months or longer, if a family member gets sick they can be moved to an ACA plan at the first of the year and will be able to have continual coverage without worrying about going up to 9 months with no medical insurance. Many Americans are trying to cover their families with health insurance, but for those who earn over 400% of Federal Poverty Level the price of the ACA plans is simply UnAffordable and until congress figures out a solution we really need Short-Term medical policies to be issued for at least 12 months and be able to auto renew

them.

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Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0610
AZ

Submitter Information

Name: Anonymous Anonymous
Address:
Tempe, AZ, 85284
Organization: NA

General Comment

Please extend the short term policies to a minimum allowable period in all states of 12 months. Many of my clients do not need or want the mandated coverages included in ACA policies and would prefer to have the major medical benefits that would allow them to get lower deductibles for less money. Also the ACA policies in Arizona are county specific so for those of us who have kids going to school in a different county, they would only have emergent coverage when coming home on breaks and for the summer, or they are forced to switch policies and start deductibles over each time they come home for summer break and then return to school in the fall. This effectively causes them to have three separate deductibles per calendar year, but they don't get the break for the short term duration of each policy. These students would be much better served to be allowed to take one short term policy of 12 month duration, with the option to renew each year they continue to be a student/ or their situation warrants same. They get premiums for 1/3 of the cost and they get a much lower deductible and out of pocket for the year. This is much more affordable than the ACA products.
I am both a parent and an independent insurance agent. Please bring back choices to the market for my clients and parents like me.

Thank you for your consideration.

PS Please understand that when you talk about the "28million" that are allegedly uninsured many are not, but rather have made the lousy choice to pay the penalty and get the short term coverage. THEY ARE INSURED! I have taken the short term insurance for myself as well, as I am a sole proprietor and none of my doctors are on the ACA plan. They are all on the network for the short term PPO. So instead of paying a high price for coverage that would not give me any benefit I had to choose to pay a penalty to get coverage I could potentially use.
Sad set of choices. Being able to have a 12 month plan rather than 4 90 day policies with new deductibles every 90 days is a much better option for all of us.

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Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0613
CO

Submitter Information

Name: Anonymous Anonymous
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CO, 81505
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Organization: NA

General Comment

As an insurance agent I just wish you could be in my shoes for just one day to see the devastation brought on by Obamacare. Those short term policies are a life saver too so many people that cannot AFFORD coverage with the UNAFFORDABLE CARE ACT. Short term policies cover 2 Million in benefits and so what they don't cover Maternity or Mental Health because Medicaid and CHP cover those people in my state and the liberal media calls them junk policies because not a one of them actually knows what a short term policy covers but before the UNAFFORDABLE CARE ACT a family of 4 paid a premium for a major medical policy at $300 a month that covered preventive care, maternity and all the so called minimal essential benefits and NOW people's premiums are $2000 to $3000 a month for the same so called minimal essential benefits so don't listen to the crap they keep trying to feed you and get rid of the UNAFFORDABLE CARE ACT once and for all please!

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Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0615
MI

Submitter Information

Name: Tim Elkins
Address:
MI, 48423
Organization: NA

General Comment

CMS-9924-P
Short Term Medical Policies have been around for years and serve a purpose. They are used to bridge the gap when moving from one employer or Individual plan to another. With Obamacare, they have even a great row to plan. With the Marketplace being so cumbersome to deal with. I have two clients right now that have waited three months for the Marketplace to verify their identity before a policy will be issued. When this happens, people need this coverage, so they don't go months without. Yes, this does happen more often than you think. In Michigan prior to Obamacare, you could purchase a Short Term Medical Plan for 6 months and then renew it for up to an additional 6 months (for a max total of 12 months). This is very helpful for people that are changing careers and have no idea if their next employer will be offering coverage.

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Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0616
NV

Submitter Information

Name: Someone Someone
Address:
Las Vegas, NV, 89130
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Organization: NA

General Comment

I sell health insurance, the ACA has been a total mess!!!! I am in favor of the 364+ day policies that are renewable.

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Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0617
VA

Submitter Information

Name: Nancy Piotter
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Organization: Virginians for Quality Healthcare

General Comment

This rule is welcome and can be improved by making the plans renewable.

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Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0625
CA

Submitter Information

Name: Debra Hoffman
Address:
Los Angeles, CA, 90045
Email: debbie@debbiehoffman.com
Organization: NA

General Comment

I am PLEADING for our government to remove the restrictions on short-term health insurance plans. As an independent agent with over 1000 clients, it is with much dismay that I lost numerous clients this year because they can no longer afford ACA Compliant insurance and elected to go without insurance this year for the FIRST TIME in their lives! These are hard-working families that earn just above the income limit for a subsidy and therefore have to pay full price for a plan. They also want a choice of providers (EPO or PPO) and since many carriers have departed our state, the only remaining carriers are charging a small fortune. I've had to choke back words when quoting upwards of $4,500/month for a family of 4 with only mediocre benefits...DOUBLE their mortgage! As a 58 year old single-income woman that owns a home in LA County, my own policy increased to $720/month for a high-deductible HSA PPO plan that has a $6,500 maximum out of pocket. Let's see, I would have to pay $8,640 per year for the premium for the privilege of spending another $6,500 before the insurance company pays ANYTHING (other than my preventive). Does this make sense to anyone? By the way, before the ACA, I paid $180 for an HSA plan with a lower maximum out of pocket and a better network of providers. For the first time in my life, I personally elected to forgo my ACA Compliant plan and elected a short-term insurance plan. I am paying a reasonable amount over the ACA Compliant plan and still have good coverage with my short-term plan. However, if I have a health issue, that becomes a pre-existing condition and won't be covered during the next period. If something major happens, I guess I would just file for bankruptcy. Not anything I would have ever thought would happen in our country to hard-working, middle-class people.

I would have had many more people elect short-term plans however many of them were not comfortable with risks of the 90-day and severe restrictions. We need to be able to have these plans for a much longer duration, beyond 12 months.

I am imploring you to please change the regulations on short-term plans so that we can elect them ourselves,

offer them to our clients and keep them longer. We need a CHOICE to continue protecting ourselves and our families!

Thank you so much for your consideration!

Warmest regards,

Debbie

Debra R Hoffman
CA Insurance License #: 0D06149
323.455.4961
Debbie@DebbieHoffman.com

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Short Term Limited Duration Insurance CMS-9924-P

Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-0768
TX

Submitter Information

Name: Faris Mona
Address:
Houston, TX, 77056
Email: faris2258@yahoo.com
Organization: NA

General Comment

I believe Extended Short Term plans period to 1 year is a great benefit for those of us that can not afford the Unaffordable
Obamacare plans that was forced on us. I believe people should have a say on what type of insurance they choose to cover themselves and their families.

CITIZENS AGAINST GOVERNMENT WASTE

Thomas A. Schatz, *President*
1100 Connecticut Ave., N.W., Suite 650
Washington, D.C. 20036
cagw.org

April 2, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201.

Attention:

CMS-9924-P
Proposed Rule Amending the Definition of Short-term, Limited-duration Insurance for Purposes of its Exclusion from the Definition of Individual Health Insurance Coverage

Background:

Citizens Against Government Waste (CAGW) is a private, nonpartisan, nonprofit organization representing more than one million members and supporters nationwide. CAGW's mission is to eliminate waste, mismanagement, and inefficiency in government. Founded in 1984 by the late industrialist J. Peter Grace and syndicated columnist Jack Anderson, CAGW was created to follow up on the report of the President's Private Sector Survey on Cost Control, also known as the Grace Commission.

CAGW has opposed the Patient Protection and Affordable Care Act (ACA), or Obamacare, since its inception. It has disrupted the individual health insurance market, caused premiums to more than double between 2013 and 2017, and forced people to purchase insurance coverage they do not want or need. For years, Republicans in Congress promised to repeal and replace Obamacare but, so far, have failed to do so. Congress's biggest accomplishment has been to reduce the individual tax penalty to $0.00 for not purchasing health insurance. Thus, people are no longer forced to pay a tax for not purchasing an over-priced Obamacare-compliant health insurance plan. CAGW continues to hope that Congress will eventually come to an agreement and relieve the American people of this failed law.

Comment:

CAGW's more than 1 million members and supporters are supportive of President Trump's efforts to offer relief to Obamacare via the regulatory process wherever it is possible under the law. For example, by providing more flexibility in how states utilize ACA's Section 1332 state innovation waivers and Medicaid's Sec. 1115 demonstration waivers, governors can pursue new healthcare strategies that will better serve their population and their state.

On October 12, 2017, President Trump added to this effort by issuing Executive Order #13813, "Promoting Healthcare Choice and Competition Across the United States." He asked the secretaries of the Department of Health and Human Services (HHS), the Department of Labor, and the Treasury Department to, within 120 days, propose regulations or revise guidance consistent with the law, and expand access to Association Health Plans (AHPs), health reimbursement arrangements (HRAs), and short-term, limited-duration health insurance (STLDI) plans. These changes are important steps forward in helping to bring down healthcare costs.

CAGW is particularly pleased with the changes being made to STLDI plans. The rule would reverse a 2016 regulation, which restricted STLDI plans to less than three months of duration and barred renewal. The Obama administration implemented the rule to prevent citizens from utilizing these less-expensive plans instead of costly ACA-compliant plans.

This action, coupled with the elimination of the individual mandate fine, will give citizens more choices for obtaining health insurance coverage. The benefit of STLDI plans is federal law exempts them from the expensive and onerous Obamacare mandates, such as guarantee issue or the 10 essential mandates. For example, a single man would not be forced to purchase maternity/newborn care or pediatric coverage.

While the proposed rule will allow a STLDI to provide coverage for nearly 12 months, CMS does not allow a plan to offer a renewal guarantee. Even though the comment period is still open, CAGW was disappointed to read in a March 26, 2018 *Inside Health Policy* article that CMS would not allow guaranteed renewability in short-term plans. According to *Inside Health Policy*, HHS Secretary Alex Azar had earlier expressed that, "We'd like to see the ability to give people the option of renewability in whatever form we can have it." At minimum, insurers should be allowed to renew their plans. Prior to the Obama-era change, some insurers permitted their STLDI plans to have a duration of almost 12 months and to be renewed. Therefore, there is precedent for this policy.

In January 2018, UnitedHealthcare CEO David Wichmann announced that his company supports the efforts by the Trump administration to expand access to AHPs and for short-term plans to have a longer duration. He said UnitedHealthcare was supportive of the administration's efforts to provide more choice and access to lower-cost alternatives for health insurance and that market competition leads to market stability.

CAGW agrees that the STLDI plans must be fully transparent on benefits and coverage so that people thoroughly understand what they can expect and whether it makes sense for them to purchase such a plan.

A March 2018 eHealth report, "Short-Term Health Insurance," found that demand for these plans remained strong despite the 90 day Obama-era rule. The report found that short-term policy holders want longer coverage periods; without access to short-term plans, 51 percent of policy holders believe they would have been without insurance during their coverage period; short-term plans are becoming popular with older consumers; nearly three-in-ten short-term policy holders used their coverage; and STLDI plans were immune to inflation in 2017.

Conclusion:

It is clear STLDI plans are well-liked, should have their duration expanded to just under 12 months, and should be allowed to be renewable. Implementing this rule will go a long way to give citizens more options on health insurance and will put mounting pressure on congressional Republicans to fulfill their promise to repeal and replace Obamacare.

Sincerely,

Thomas Schatz

April 6, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445–G, Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Re: **CMS–9924–P**—Short-Term, Limited-Duration Insurance

To Whom It May Concern,

On behalf of the Individual and Small Group Markets Committee of the American Academy of Actuaries[1] Health Practice Council, I would like to offer comments in response to the departments of the Treasury, Labor, and the Health and Human Services proposed rule that would lengthen the maximum period of short-term, limited-duration (STLD) insurance through amending the definition of STLD. In particular, the maximum duration of STLD plans would be lengthened from three months to less than 12 months. This comment letter focuses on policy implications of the proposed rules and highlights the potential effects of expanded STLD insurance on the stability and sustainability of the existing Affordable Care Act- (ACA-) compliant individual market.

Comparison of ACA and STLD Coverage Requirements and Implications for the ACA Markets

STLD coverage traditionally has been used by healthy people who know they will only have a short-term gap in coverage, for instance between jobs. Under the proposed rule, the duration of STLD plans would be lengthened from three months to less than 12 months. We understand that considerations are also being made for STLD coverage to be renewable.

STLD plans are exempt from many of the rules applicable to ACA plans. In particular, STLD plans are not be required to follow the issue and rating rules or benefit coverage requirements applicable to ACA plans. As a result, STLD plans likely would be more attractive to lower-cost individuals, who could pay lower premiums for STLD plans compared with ACA plans. Market

[1] The American Academy of Actuaries is a 19,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

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segmentation and adverse selection for ACA plans could result if healthier individuals purchase STLD plans instead of ACA plans, leading to higher premiums for ACA plans. These effects could be dampened in states that implement additional rules limiting the availability of short-term policies or requiring that they meet rules governing ACA plans.

Issue and rating rules. Unlike ACA plans, STLD plans would not be subject to guaranteed issue requirements and would not have to provide pre-existing condition protections. STLD plans would be allowed to underwrite, exclude coverage for pre-existing conditions, and charge higher premiums or deny coverage altogether for individuals with pre-existing conditions (table 1). These differences would allow some consumers, especially younger individuals and those without pre-existing health conditions, to face lower premiums for short-term plans when compared to their ACA alternatives. Individuals with higher expected health costs would more likely remain in the ACA market. Because the short-term policies would not be part of the single risk pool and would not be part of the risk adjustment program, there would be no transfer of funds from short-term plans to the ACA market to reflect the different underlying risks between these segments.[2] Premiums for ACA plans would increase as a result.

Table 1. Comparison of ACA and STLD Plans: Issue and Rating Rules

	ACA Plans	Short-Term Plans
Issue Rules		
Guaranteed issue	Yes	No
Underwriting prohibited	Yes	No—insurers can underwrite at time of enrollment and/or at time of claim
Pre-existing condition exclusions prohibited	Yes	No
Renewability	Guaranteed renewable: Renewable at option of insured	Proposed rules would allow renewal at option of insurer
Open enrollment periods	Limited annual open enrollment period outside of which enrollment is available only for those meeting special enrollment period eligibility	No open enrollment period; individuals can apply throughout the year
Rating Rules		
Premium variations by health conditions prohibited	Yes	No
Premium variations by age limited	Age variations limited to 3:1 ratio	No
Premium variations by gender prohibited	Yes	No
Geographic rating areas are defined	Yes	No

[2] While including STLD plans in risk adjustment is not currently being proposed, we note that it would be difficult to effectively risk adjust between the ACA market and STLD plans because of the large differences in rating rules and underlying benefits.

Benefit coverage requirements. Whereas ACA plans must adhere to essential health benefit (EHB) and other plan design requirements, short-term plans are exempt from these requirements (table 2). ACA plans must include coverage for the 10 EHB categories, including maternity care, preventive services at zero cost sharing, pediatric dental and vision care, mental health and substance abuse services, prescription drugs, and rehabilitative and habilitative services. Unless required by state rules, short-term plans are not subject to these requirements. Although short-term coverage can be somewhat comprehensive, it usually excludes or limits coverage for certain benefit categories, such as maternity care, physical therapy, and mental health and substance abuse treatment. Short-term plans also usually have overall coverage limits, for instance $1 million.

Table 2. Comparison of ACA and STLD Plans: Benefit Coverage Requirements

	ACA Plans	Short-Term Plans
EHB requirements	Yes	No
Maximum out-of-pocket limits required	Yes	No
Lifetime and/or annual dollar limits prohibited	Yes	No
Specified actuarial value requirements	Yes	No
Network adequacy requirements	Yes	No

To the extent that coverage under short-term plans is more narrow than that available under ACA plans, it will be more attractive to individuals in good health. Similar to the implications of differences in issue and rating rules, such benefit coverage differences would result in market segmentation, leading to higher ACA premiums.

It is unclear how insurers would react to the new short-term market rules. Insurers could decide to offer new short-term products that are more comprehensive than those in the existing short-term market to provide individual coverage at a lower cost while avoiding ACA requirements. Nevertheless, the comprehensiveness of short-term coverage can be misleading; individuals who are expected to need expensive services because of pre-existing conditions would likely either have services for those conditions excluded from coverage or be denied coverage altogether.

Other characteristics. In addition to differences in issue and rating rules and benefit coverage requirements, other differences between short-term plans and ACA plans can affect enrollment in those plans and have an impact on ACA premiums (table 3). Short-term plans do not meet the individual mandate requirements, which would lessen the demand for those plans. However, the financial penalty for not having coverage is eliminated beginning in 2019, thus reducing the barriers to short-term plans. The combination of increased availability of short-term plans and the elimination of the mandate penalty could exacerbate adverse selection in the ACA market. On the other hand, premium and cost-sharing subsidies are available only for ACA plans, providing incentives for healthy lower-income individuals to remain in ACA plans. This could provide a backstop on the deterioration of the ACA market. Nevertheless, adverse selection in the ACA markets would cause premiums to increase. Individuals eligible for premium subsidies

would be shielded from the premium increases as federal premium subsidies would increase. Unsubsidized individuals would not and, among the healthy, higher ACA premiums would increase the attractiveness of lower-premium short-term plans.

Table 3. Comparison of ACA and STLD Plans: Other Characteristics

	ACA Plans	Short-Term Plans
Satisfy individual mandate ($0 financial penalty beginning in 2019)	Yes	No
Eligible for premium and cost-sharing subsidies	Yes, for eligible enrollees	No

STLD Renewability

Under current federal regulation, STLD plans are limited to less than three months of coverage, including any extensions (renewal). The proposed rule would increase the allowable duration to less than 12 months of coverage. The proposed rule asks for comments about reapplication. The implications of reapplication or guaranteed renewability would depend on how these terms are defined.

Reapplication would make the STLD policies available for a longer duration for those who need them. Under a reapplication process, the enrollee would likely be subject to underwriting, possibly simplified from the initial application. In the past, when STLD policies were re-underwritten at reapplication, coverage could be denied or re-priced at significantly higher rates based on health conditions. This was a benefit to individuals who were healthy and could pass underwriting at renewal. Being able to reapply was particularly beneficial to healthy individuals who only needed coverage until they found a job with health coverage and did not know how long that would take. On the other hand, individuals who could not pass re-underwriting would face coverage denials or high premium increases.

Potentially, pre-existing condition exclusions would begin again upon reapplication, meaning any conditions that began in the prior coverage period would not be covered in the next period. Pre-existing conditions may be identified by the insurer during the underwriting process or based on claims submitted by the enrollee, if related to a pre-existing condition that was not identified during underwriting. In this case, premiums would likely not increase substantially at reapplication due to any worsening health status; instead, existing health conditions would be subject to pre-existing condition exclusions (or coverage could be denied altogether). However, out-of-pocket expenses for the uncovered services could be high and the premium could increase for other factors, such as for age and trends in health care costs.

Separately, legislation has been introduced in Congress to make STLD guaranteed renewable. Under a typical guaranteed renewability provision, the insurer must accept enrollees for renewal; coverage could not be denied due to health conditions. But guaranteed renewability does not typically prohibit premium increases at renewal due to health conditions. Unlike current short-term policies, generally guaranteed renewable coverage cannot reset the pre-existing conditions

exclusion for conditions that develop after the enrollee's initial application. As a result, the underwriting process at initial application would likely be more thorough under a guaranteed renewability environment than currently done for STLD. However, if a new serious medical condition is found during renewal underwriting, the insurer would likely be able to increase the rates accordingly.

If insurers 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. If there are no limits on the allowable rate increases, premiums for some individuals could exceed those in the ACA market. In such a case, the enrollee would be incented to move back to the ACA pool, increasing the health care costs of the ACA pool.

If rating rules are put in place that prohibit basing renewal rates on health evaluations at an enrollee level, the premiums for the block of business with the unhealthy enrollees will be higher than a similar STLD block of new business or blocks that may be able to charge based on health status. Insurers may be incented to provide lower rates to newly underwritten enrollees by using multiple risk pools for products. Healthy enrollees may be able to move to new products where they can pass underwriting.

Guaranteed renewable STLD would be more similar to pre-ACA individual market coverage than to current STLD products. This product may be more attractive to ACA enrollees than a non-guaranteed renewable STLD plan due to a perception that it is a product designed for longer-term use. Because of medical underwriting at issue, STLD is expected to attract healthier individuals with a lower premium and could put upward pressure on ACA rates as healthier enrollees leave the ACA pool. Enrollees could move back to the ACA market if they develop health conditions and face large premium increases on their short-term policy and then move back to the short-term market if the condition is resolved. Guaranteed renewable STLD may not be as attractive for people with short-term needs because the premiums could be higher than non-guaranteed renewable coverage.

Potential Enrollment in STLD

Although currently a relatively small share of the market, enrollment in short-term plans has been growing, and could grow faster if the rules expand availability further. The National Association of Insurance Commissioners (NAIC) reports that as of Dec. 31, 2016, just over 160,000 individuals had short-term medical coverage in the individual market, up from 148,000 in 2015.[3] These numbers are believed to be understated because some insurers provide STLD coverage through group policies, which are reported with other group business in NAIC filings. Using these coverage numbers likely understates the potential enrollment in STLD plans, perhaps significantly, if the allowed coverage duration is lengthened. Lengthening the coverage duration, especially if coverage is required to be guaranteed renewable, would result in STLD plans that are more akin to pre-ACA individual market coverage. And the ability to move back into an ACA plan (albeit at the next open enrollment period, if ineligible for a special enrollment period) reduces the risk of enrolling in a short-term plan.

[3] National Association of Insurance Commissioners, *2016 Accident and Health Policy Experience Report*, July 2017, and *2015 Accident and Health Policy Experience Report*, 2016.

Rate Filing Considerations

The proposed rule does not include an effective date. Premiums for 2018 ACA-compliant plans are finalized and in effect. These premiums were developed assuming current STLD rules. If the effective date occurs at any time during 2018, premiums for ACA-compliant plans could be understated to the extent that healthier ACA plan enrollees switch to STLD plans, worsening the risk profile of the ACA-compliant markets. Insurers are not allowed to submit midyear premium changes in the individual market. ACA premiums could be inadequate as a result.

However, even if midyear rate changes were allowed, such changes would be extremely difficult to implement. Resource constraints for insurers and regulators could make it difficult to simultaneously develop and approve revised rates for 2018, especially on a compressed timeline, alongside the 2019 rate filing process. State laws and regulations typically require rates and coverage to be effective for a period of 12 months. An additional complication is that if midyear rate changes are allowed, a midyear open enrollment period or special enrollment periods might need to be provided so that individuals could reassess their options. Like midyear rate changes, an additional open enrollment period or special enrollment periods would be very difficult to implement.

If the rule is not finalized before insurers must finalize rates for 2019, we suggest that insurers should be given an opportunity to adjust 2019 individual rates to reflect the impact of the expansion of STLDs. Insurers are already beginning the process of developing ACA market premiums for 2019; initial rates will likely need to be filed during the spring or early summer of 2018 depending on the state.[4]

* * * * *

We appreciate the opportunity to provide these comments and would welcome the opportunity to speak with you in more detail and answer any questions you have. If you have any questions or would like to discuss further, please contact David Linn, the Academy's senior health policy analyst, at 202-223-8196 or linn@actuary.org.

Sincerely,

Barbara Klever, MAAA, FSA
Chairperson, Individual and Small Group Markets Committee
American Academy of Actuaries

[4] Samara Lorenz, "DRAFT Bulletin: Proposed Timing of Submission of Rate Filing Justifications for the 2018 Filing Year for Single Risk Pool Coverage Effective on or after January 1, 2019," Center for Consumer Information and Insurance Oversight, Nov. 27, 2017.

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Document: CMS-2018-0015-1542
VA

Submitter Information

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Organization: NA

General Comment

We must not go back in time ! Where pre-existing continions and life time caps prevented people from getting the health care they needed. You sell people junk plans and thats what they get JUNK . Sure yes they pay lower rates till they get sick or injured, thats when they find out what their insurance will not cover.

My son was born with cystic fibrosis, he would meet a life time cap in one year. Difficult to believe but true, just one of his medications is $390,000 a year. Add to that numerous hospital stays and the possibility of a lung transplant.
Please do not think it could not happen to you, that would be a mistake. Every American that would be covered under these Short-Term Junk Plans could be a illness or accident away from bankruptcy. Sure you may be ok now , but you find out you have cancer, you give birth to a child with a genetic disease, your child on this plan has something just diagnosed . You can not put the trust of your health into these plans. What else is more important to you then your health and that of your family.

I say this to those politicians thinking about bringing Short-Term Junk Plans to your state, you must not care about your constituents . Think about this, if we keep going like this Health Care will only be available for the wealthy. Americans should not have to choose between making a mortgage payment or health care.

We want the same kind of health care available to us that our politicians have, what makes their families more important than ours, NOTHING!
REMEMBER THIS, ANYONE COULD BE AN ILLNESS OR ACCIDENT AWAY !

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NC

Submitter Information

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General Comment

As someone who has been priced out of the individual market, I will welcome the short-term plans as an option. Paying over $1400.00 a month was unacceptable to me this year. After having insurance my entire life, I dropped it in 2018 and joined a Health Sharing Ministry. Many of my friends have done the same thing this year. I would have purchased a short-term plan but didn't want to deal with renewing it every 3 months. We need additional, lower cost options for health insurance.

National Association of Insurance
and Financial Advisors

April 18 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert Humphry Building
200 Independence Avenue, SW
Washington, D.C. 20201

Re: Short-Term, Limited Duration Insurance (STLDI) - RIN 1545-BO41, RIN 1210-AB86, RIN 0938-AT48

This letter provides comments from the National Association of Insurance and Financial Advisors (NAIFA) on proposed regulations to amend 26 CFR Part 54, 29 CFR Part 2590, and 45 CFR Parts 144, 146, and 148 to lengthen the maximum coverage period for STLDI from less than 3 months to less than 12 months and to revise the notice required in STLDI plan materials.

Founded in 1890 as The National Association of Life Underwriters, NAIFA is the oldest, largest and most prestigious association representing the interests of insurance professionals from every Congressional district in the United States. Our mission – to advocate for a positive legislative and regulatory environment, enhance business and professional skills, and promote the ethical conduct of its members – is the reason NAIFA has consistently and resoundingly stood up for agents and called upon members to grow their knowledge while following the highest ethical standards in the industry.

NAIFA generally supports proposals that aim to increase consumer choice, lower premiums, and foster greater competition in the health insurance market for both individuals as well as large and small groups. To achieve these goals, the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services ("The Departments") propose a regulation with the purpose of ensuring that consumers have access to STDLI policies that provide health insurance coverage for up to approximately one year.

NAIFA supports the proposed rule, which would effectively repeal the federal regulation that limits STLDI policies to only 90 days. We believe this measure could ensure that consumers can maintain critical and temporary health insurance coverage in instances where a consumer lost his or her individual market or group policy and needs sufficient time to obtain a more comprehensive insurance policy. Also, in some health insurance markets where there are very few and cost prohibitive plans available for consumers, STDLI policies may offer consumers the only affordable, albeit temporary, option. In our comments below, we outline how STDLI is an important option for consumers in these circumstances and express our support for the Departments' proposal to permit these policies to last in duration for up to 12 months.

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STLDI Provides Critical Temporary Coverage

STLDI plans provide consumers access to temporary, basic, and affordable coverage, especially in periods of dire need. Although STLDI plans are not required to cover a minimum set of benefits like individual market policies, they can and do provide necessary stop-gap coverage while consumers shop for a more comprehensive health insurance plan. For example, if a consumer loses his or her group insurance coverage due to job loss or another factor, the consumer may have to wait until the next open enrollment period to purchase an individual market policy or obtain coverage through a new employer. This waiting period could well exceed 90 days since open enrollment does not begin until mid-November. Theoretically, a consumer could experience a loss of individual or group market coverage early in the calendar year resulting in a potentially significant time period which could expose the consumer to an unexpectedly lengthy time without health insurance coverage. For many consumers, a STLDI policy may be the only option to secure temporary coverage until the next open-enrollment period or until the consumer gets covered under a new group insurance plan. In instances such as this, a STLDI policy that lasts beyond 90 days is critical so that the consumer can maintain a sufficient and affordable plan and not suffer a coverage gap.

STLDI policies may also serve as temporary coverage or even as a supplemental benefit in other circumstances, and NAIFA members have shared some specific instances where STLDI has been a particularly viable option for clients who need temporary and additional coverage beyond a 90-day period:

- Individuals seeking health insurance coverage while in a job transition and who discover COBRA payments to be too costly.
- Clients who qualify for an individual mandate hardship exemption, particularly those who fall into a Medicaid coverage gap
- New retirees seeking a temporary health insurance plan while waiting to enroll in Medicare
- Clients seeking coverage to ease financial hardship in the event of a critical illness or injury
- Self-employed persons who need additional coverage to complement their major medical plans
- Clients who recently turned 26 and are therefore ineligible to be covered under their parent's plan
- Recent college graduates who have yet to secure coverage under a group health insurance plan through an employer
- Clients going through a life transition such as divorce or early retirement

- Individuals needing supplemental coverage to defray high costs of prescription medication
- Parents purchasing STLDI as coverage for their dependent children as a more affordable option than paying higher costs to cover them under an employer-sponsored group plan
- Students who have lost their coverage through their university and do not qualify for the special enrollment period
- American students studying abroad
- Individuals temporarily in the United States on VISA programs
- Families seeking temporary coverage for their children moving out of state

Prior to the regulation that limited the duration of these policies, NAIFA members who sell these plans have reported that the average duration of a STDLI policy is five to six months. In cases such as the ones we noted above, the 90-day limitation may not provide a sufficient length of time to ensure these individuals can maintain vital health insurance coverage while searching for a more comprehensive plan. Further, the current federal restrictions impede the ability of individuals to use STLDI policies as important supplemental coverage for specific conditions. Repealing the STLDI duration limit will enable consumers to retain affordable coverage for a sufficient period in critical instances.

STLDI May Provide an Affordable Option to Costly Individual Market Policies

The regulation limiting STLDI plans to only 90 days is especially harmful to consumers by restricting their options for health insurance coverage at a time when some health insurers have exited certain markets and state and federal health insurance exchanges. Many consumers now reside in areas where the very few available choices for health insurance coverage are often cost-prohibitive, and an STLDI policy may be the only affordable option. In one instance reported by a NAIFA member in Nebraska, a family of 4 with a household income of about $100,000 a year was in the market for health insurance coverage and found that the cheapest plan available was almost $2,000 per month with a $12,000 deductible. With an STDLI plan, this family obtained coverage for about $317 per month. In another case, a NAIFA member reported that a client, a 49-year-old male, who was in need of a health insurance policy discovered that the least expensive plan available would cost $710 per month and the policy did not include the client's doctors in the plan network. The client was able to purchase a STLDI plan for $460 per month that included the client's preferred doctors and coverage for certain protections. STDLI would give individuals and families more options and affordable choices in the individual health insurance market, especially to those consumers such as the ones in these examples who do not qualify for ACA premium tax credits.

Given the role of STLDI in providing temporary coverage and even serving as an alternative to costly individual market plans, we reiterate our view that the Departments should rescind the

regulation which limits the duration of these policies. We, therefore, urge the Departments to approve the proposal to permit individuals to retain an STLDI policy for at least up to 12 months.

NAIFA commends the Departments for producing a proposal intended to ensure that consumers have greater choice and affordable options in the health insurance market. We thank the Departments for their time and consideration of our views. Should you have any questions, please contact Steve Kline in the NAIFA Government Relations office at skline@naifa.org or (703) 770-8187.

Sincerely,

Keith M. Gillies, CFP, CLU, ChFC
NAIFA-National President

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VA

Submitter Information

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Organization: NA

General Comment

I am writing to express my full support for the proposed rule related to Short-Term Limited Duration Insurance. I applaud the Presidents Executive Order 13813 issued on October 12, 2017, and his effort to increase affordability of health insurance for those individuals who cannot afford the insurance offered through the federal exchange.
In Virginia, for the 2018 plan year, several insurers dropped out of the market, nearly half of all counties have only one insurer offering plans, and average premium rates increased anywhere from 35 to 81 percent, with even higher increases in certain markets like Charlottesville where some individuals saw their premiums triple from the year before. For those individuals with income above 400 percent of poverty and receive no federal subsidy, the premiums are just unaffordable. This leaves them and their families with little choice but to drop coverage altogether.
Short-Term Limited Duration Insurance (STLDI) offers an alternative for these individuals. I understand the concern expressed by many people that such an alternative undermines the federal marketplace because more people will leave it making the risk pool smaller. I would argue that many people who will purchase STLDI plans are already leaving the market, or will, because they cannot afford the plans being offered. So the options are to allow them to be uninsured (and assume huge personal financial risk) or provide some level of health care coverage for these individuals.
Modifying the definition of STLDI from being limited to three-months, which was implemented in 2016, to just under 12 months is a step in the right direction to restore this type of insurance as a viable option for those individuals that need a short-term policy longer than three months, and for those that cannot afford federal marketplace insurance.
In Virginia, the General Assembly passed Senate Bill 844, which I sponsored with another Senator, which will insure Virginias state insurance rules permit the adoption of any federal changes to STLDI policies.
I urge you to ensure that these short-term policies are renewable at the end of their expiration date since for many people such policies will be the only affordable insurance available to them.

Again, I strongly support the proposed rule changes and encourage adoption of the final rule as quickly as possible so that individuals have a viable choice for more affordable health insurance.

Sincerely,

The Honorable Bryce E. Reeves

State Senator, 17th Senatorial District

April 20, 2018

Short-Term Limited Duration Insurance Proposed Rule, CMS-9924-P

Comment of Timothy Stoltzfus Jost

My name is Timothy Stoltzfus Jost. I am an emeritus professor at the Washington and Lee University School of Law. I taught the Public Health Services Act in health law courses for many years and am the author of the HIPAA and ACA sections of West Publishing Company's Health Law teaching book, about to launch its eighth edition and for many years the most widely used book for teaching health law in American law schools. I have followed the implementation of the Affordable Care Act since its inception until the end of 2017 at the Health Affairs blog. I was from 2011 until 2017 an appointed consumer representative to the National Association of Insurance Commissioners. I am an elected member of the National Academy of Medicine.

This comment is submitted in response to the proposed regulation governing short-term, limited duration coverage published on February 20, 2018 by the Departments of Health and Human Services, Treasury, and Labor. The proposed regulation is not only ill-advised for policy reasons but also illegal. I urge the departments not to finalize the proposed regulation.

The proposed regulation would amend the current short-term limited duration definition rule adopted by the Departments in 2016, which defined short-term limited duration coverage as coverage that "has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder with or without the issuer's consent) that is less than 3 months after the original effective date." Under the new definition, short-term limited duration coverage could cover any period of time at long as it was less than 12 months, including renewals that could be elected without the insurers consent. The new proposed rule is contrary to the Public Health Services Act, (PHSA) and is thus "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law" under 5 U.S.C. 706(2)(A) and should not be finalized.

Short-Term Limited Duration Coverage Threatens Health Insurance Consumers and Markets.

The Affordable Care Act nowhere mentions short-term limited duration coverage. Most of the insurance reforms of the ACA, however apply to "a group health plan, or a health insurance issuer offering group or individual health insurance coverage." See, e.g. 42 U.S.C. 300gg-3. The ACA adopted the preexisting insurance definitions from the Health Insurance Portability and Accountability Act, which defined individual market coverage to "not include short-term limited duration insurance." 42 U.S.C. 300gg-91(b)(5).

Short-term limited duration coverage, therefore, is not subject to many of the consumer protections of the ACA.[1] Issuers of short-term limited duration coverage thus refuse to cover people with preexisting conditions or charge them higher premiums based on their health status, impose annual or lifetime limits, fail to cover essential health benefits, and require higher out-of-pocket cost sharing than the maximums allowable under the ACA. They rescind coverage when

[1] Several of the provisions of the ACA apply to the individual market generally, not just to "individual health insurance coverage," including guaranteed issue (PHSA § 2702), community rating (PHSA § 2701), and the single risk pool (ACA § 1312(c)(1)). The administration seems to assume that these provisions do not apply to short-term limited duration coverage, but this issue may be subject to litigation.

they can argue that consumers failed to report preexisting conditions,[2] and deny of claims under preexisting condition exclusions.[3]

Because short-term limited duration coverage is much cheaper than ACA-compliant coverage for healthy individuals, it is likely that healthy people will abandon ACA-compliant plans for short-term limited duration coverage, seriously undermining the ACA risk pool. Short-term limited duration coverage is also not subject to the risk adjustment and single risk pool provisions that apply to ACA-compliant individual coverage. 42 U.S.C. 18032(c)(1), 18063. As long as the individual responsibility penalty remains in effect (until 2019) a consumer who has only short-term coverage for three months or more will have to pay the individual responsibility tax because short-term limited duration coverage is not considered minimum essential coverage. But once the penalty ends, the danger to the risk pool becomes greater.

The Urban Institute estimates 4.2 million consumers will likely enroll in short-term limited duration plans, increasing the number of people without minimum essential coverage by 2.5 million. Another study by Wakely Consulting concludes that the combination of the elimination of the individual mandate penalty and the broader availability of short-term plans could reduce membership in the ACA compliant market by 3 to 3.9 million members. Consumers may purchase short-term limited duration coverage without understanding how skimpy this coverage is or that they will still need to pay the individual responsibility penalty for 2018 if they only have such coverage.

Short-term limited duration coverage is only loosely regulated under the laws of many states. New York and New Jersey require short-term limited duration plans to comply with all ACA requirements. Some states limit short-term limited duration coverage to six months. But many either do not impose any durational limit at all or permit it to last for any period less than a year. Moreover, many states explicitly exempt short-term limited duration coverage from the state law benefit or coverage mandates that otherwise apply to the individual market.

Premium tax credits and cost-sharing reductions will not be available for short-term limited duration coverage, thus it is likely that it will be unattractive to people with incomes not exceeding 400 percent of the federal poverty level who will be able to get subsidized comprehensive coverage. The abandonment of the ACA-compliant market of healthy people for short-term limited duration products, however, will certainly drive up premiums in the marketplaces, limiting access for consumers with incomes exceeding subsidy levels. The Urban Institute estimates that the combination of the individual mandate repeal and promulgation of the short-term rule will drive up premiums in the ACA compliant market by 18.2 percent, while Wakely projects premiums will increase from 8.2 to 12.8 percent.

The History of Short-Term Limited Duration Coverage in Federal Law

The exclusion of short-term limited duration coverage from the definition of individual insurance coverage was established by the Health Insurance Portability and Accountability Act of 1996. HIPAA was a bipartisan bill that put in place a number of health insurance reforms in the wake

[2] See, HCC Life Ins. v. Conroy 2017 WL 1080742 (S.D. Calif, 2017); McLin v. Companion Life, 2016 WL 2851553 (M.D. La, 2016); and Grimm v. Golden Rule, 880 N.E.2d 335 (Ind. 2008).
[3] See Jones v. Golden Rule, 2017 WL 3485787 (N.D. Ga. 2017); Novak v. American Community Mutual, 718 N.E.2d 958 (Ohio 1998); DeMatteis v. American Community Mutual, 616 NE.2d 1208 (Ohio 1992); Owens v. Tennessee Rural Health Improvement Assn., 213 SW3d 283 (Tenn. 2006).

of the failed Clinton health reform plan, which would have instituted much more comprehensive reforms. Most of HIPAA's reforms applied to group coverage, but two affected the individual insurance market.

First, HIPAA provided for "guaranteed availability" of coverage (without preexisting condition exclusions) in the individual market for individuals who had lost group coverage, had "creditable coverage" for at least 18 months, and met several additional requirements. Insurers could fulfil the guaranteed availability requirement by offering eligible individuals two policies that met certain requirements. Alternatively, states could provide an "alternative mechanism" to provide individuals access to health coverage, such as a high-risk pool. Most states adopted an "alternative mechanism," most commonly a high-risk pool. Insurers that offered individual policies under the guaranteed availability requirement charged such high premiums that the coverage became effectively unavailable. HIPAA's individual market reforms were generally regarded as a failure, opening the door for the much more comprehensive ACA reforms.

HIPAA's second-individual market reform was guaranteed renewability. HIPAA required insurers to renew individual health plan policies regardless of the health status or claims experience of plan participants. The guaranteed renewal requirement was subject to limited exceptions for fraud, failure to pay premiums, enrollee movement out of a plan service area, cessation of association health plan membership, and withdrawal of an issuer from the market with proper notice.

Individual market coverage was relevant under HIPAA in one other respect. It could be counted as "creditable coverage" for purposes of a prohibition against group health plans imposing preexisting condition exclusions on individuals with 12 months of "creditable coverage" with no break in coverage exceeding 63 days.

HIPAA defined individual market coverage to exclude "short-term limited duration" coverage. Initial drafts of the legislation excluded short-term limited duration coverage from the definitions of group and individual health plan and from the definition of "health insurance coverage." Under these definitions, short-term limited duration coverage would not have been subject to the guaranteed availability and renewability requirements, and would also not have been counted as creditable coverage.

The final conference committee version of HIPAA established the current definitions of insurance terms now found in the Public Health Services Act at 42 U.S.C. 300gg-91. It took a somewhat different approach to short-term limited duration coverage than had earlier drafts. It created a list of "excepted benefits," such as dental and vision, disability, long-term care, specific disease, or fixed indemnity coverage, that were not subject to HIPAA requirements if certain conditions were met. (The ACA explicitly provides that excepted benefits are not minimum essential coverage 26 U.S.C. 5000A(f)(3)). The list of excepted benefits in the final bill tracked the lists of forms of coverage excluded from the definition of health insurance coverage in earlier bills, except that it did not include short-term limited duration coverage.

Rather, the conference committee bill defined "individual health insurance coverage" to exclude short-term limited duration coverage. "Creditable coverage," was defined to include all "health insurance coverage" except for "excepted benefit" coverage. The conference report clarified that the intent of Congress was to qualify short-term limited duration coverage as creditable coverage for purposes of the preexisting condition exclusion period. In other words, short-term limited

duration coverage did not qualify as "individual health insurance coverage" for the guaranteed renewability or guaranteed availability sections of HIPAA, but did qualify as "health insurance coverage" for the creditable coverage requirement. The idea was apparently that if individuals had a short period of gap coverage between two periods of group or individual coverage, the short-term limited duration coverage should still count toward the twelve months of coverage that an individual had to accumulate to avoid preexisting condition exclusions.

HHS released interim final regulations implementing HIPAA in April of 1997. The 1997 interim final rules defined "short-term limited duration coverage" to mean: "health insurance coverage provided under 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 within 12 months of the date the contract becomes effective," and defined "individual health insurance coverage" to mean individual coverage that is not short-term limited duration as so defined. The rules also specified that "health insurance coverage" includes short-term limited duration coverage thus clarifying that it was creditable coverage. The preamble explained that short-term limited duration coverage insurers did not need to provide a certificate of coverage, as other insurers were required to do, but offered no explanation of the rule's definition of short-term coverage. Final HIPAA regulations adopted in 2004 included the same definitions, but contained no further explanation or justification of why short-term coverage was defined as it was.

The 1997 and 2004 Definitions of Short-Term Limited Duration Were Arbitrary, Capricious, and Not in Accordance with Law

The 1997 and 2004 regulations defined short-term limited duration as coverage lasting less than 12 months. A policy that lasted 364 days and 23 hours would qualify. Standard major medical coverage then, as now, had a term of 365 days. The departments seek to reinstate this earlier regulatory definition.

The American Heritage Dictionary, 5th edition (2011) defines "short" as referring to duration as meaning "lasting a brief time." Synonyms provided by Google include "brief, momentary, temporary, short-lived, impermanent, cursory, fleeting, passing, fugitive, lightning, transitory, transient, ephemeral, quick." No one would call a 119-minute movie a short movie, compared to a 120-minute movie, or a 13-day 23-hour vacation a short vacation compared to a 2-week vacation.

Short-term coverage was a product widely marketed in 1996 when HIPAA was adopted as a gap filler, purchased by people who, for example, were between jobs or school terms. Coverage terms were generally "short" as the term is commonly understood. Several states defined short term coverage as lasting no more than six or seven or excepted "short term" coverage from certain state benefit mandates if coverage lasted for no more than six months.[4]

The primary innovation of HIPAA in the individual market was guaranteed renewability. HIPAA provided that individual market coverage was guaranteed renewable, but that short-term coverage was not. The term used for short-term coverage in HIPAA was, as has already been noted, "short-term limited duration" coverage. "Limited duration" in this definition is not redundant surplusage, but refers specifically to the fact that short-term coverage was under

[4] See I.C. 27-8-15-9; 376.1200 R.S. Mo.; O.R.S. 743.70; Tenn. Code Ann. 56-7-2504, 56-70-2506.

HIPAA non-renewable—non-renewability was its distinguishing characteristic. The 1997 and 2004 rules capture this concept by stipulating that the length of short-term coverage had to be calculated considering all extensions that could be elected by the policyholder without the issuer's consent. But in doing so the rule allowed short-term coverage that was essentially indistinguishable in length from standard coverage.

In allowing short-term coverage to last essentially as long as standard coverage, the 1997 and 2004 rules were arbitrary, capricious, and not in accordance with law. 5 U.S.C. 706(2)(A). They were not challenged in court, however, because so little turned on this. Short-term coverage was not guaranteed renewable and could not serve as guaranteed available coverage in the minority of states that did not make available an "alternative mechanism" for coverage of people who lost group coverage with at least 18 months of creditable coverage. But otherwise it was indistinguishable from standard coverage—neither form of coverage was subject to federal benefit or coverage requirements or underwriting or cost-sharing limitations. Thus, although the rules violated federal law, they did not result in litigation.

Short Term Coverage Under the ACA

With the adoption of the ACA in 2010, however, the significance of the short-term limited duration rule changed dramatically. As noted earlier, the ACA nowhere uses the term "short-term limited duration" coverage, rather cross-referencing HIPAA's statutory definitions. Because implementation of the ACA requirements that most clearly required a distinction between short-term limited duration and major medical coverage was delayed under the ACA until 2014, there was no need to revisit immediately the HIPAA definitions.

A number of the early ACA implementing regulations referred to short-term limited duration coverage. Most importantly, the minimum essential coverage (MEC) regulations specified that short-term limited duration coverage was not MEC, and thus that a consumer who enrolled in short-term limited duration coverage would remain subject to the individual shared responsibility penalty. Regulations implementing the ACA's changes to HIPAA's guaranteed availability and renewability requirements included a new definition of "individual health insurance coverage," which excluded short-term limited duration coverage, but the regulation simply cross-referenced the HIPAA short-term limited duration definition and did not clarify the meaning of short-term limited duration coverage under the ACA.

In 2014, however, as the ACA's key insurance market reforms came into effect, it became clearer that continued application of the HIPAA short-term limited duration coverage definition would undermine the ACA's individual market reforms. Under the pre-existing HIPAA definition, an insurer would be able to avoid all of the ACA's reforms simply by limiting coverage to 364 days and specifying that the insurer had to consent for the policy to be renewed. This would obviously deprive consumers of the ACA's protections. It could also seriously threaten the ACA's individual market risk pools, since healthy people could purchase underwritten short-term limited duration coverage that excluded preexisting conditions for far less than the cost of ACA exchange coverage, leaving people with health problems in an ever smaller and costlier individual coverage market. Finally, continuing the existing definition would create a serious risk of consumer confusion—consumers who bought short-term limited duration coverage might not fully appreciate how limited the coverage was would still owe the individual mandate penalty if they purchased it.

By 2016 these effects of the short-term limited duration coverage exception were becoming manifest. In 2016, therefore, HHS, DOL, and Treasury proposed and then finalized new regulations governing short-term limited duration coverage The new rule limited short term limited duration coverage to a period less than three months. It also required a short-term limited duration policy contract and all application materials connected with enrollment to display prominently a warning stating that the short-term limited duration coverage did not satisfy the individual shared-responsibility coverage mandate. The preamble to the final regulation explained the concerns underlying the change as follows:

> Before enactment of the Affordable Care Act, short-term, limited-duration insurance was an important means for individuals to obtain health coverage when transitioning from one job to another (and from one group health plan to another) or when faced with other similar situations. However, with guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act, individuals can purchase coverage with the protections of the Affordable Care Act to fill in the gaps in coverage.
>
> The Departments have become aware that short-term, limited-duration insurance is being sold in situations other than those that the exception from the definition of individual health insurance coverage was initially intended to address. In some instances, individuals are purchasing this coverage as their primary form of health coverage and, contrary to the intent of the 12-month coverage limitation in the current definition of short-term, limited-duration insurance, some issuers are providing renewals of the coverage that extend the duration beyond 12 months. Because short-term, limited-duration insurance is exempt from certain consumer protections, the Departments are concerned that these policies may have significant limitations, such as lifetime and annual dollar limits on essential health benefits (EHB) and pre-existing condition exclusions, and therefore may not provide meaningful health coverage. Further, because these policies can be medically underwritten based on health status, healthier individuals may be targeted for this type of coverage, thus adversely impacting the risk pool for Affordable Care Act-compliant coverage.
>
> To address the issue of short-term, limited-duration insurance being sold as a type of primary coverage, the Departments proposed regulations to revise the definition of short-term limited duration, limited-duration insurance so that the coverage must be less than three months in duration, including any period for which the policy may be renewed. . .

The 2016 regulation provided that the less-than-three-month limit applied to any extensions "that may be elected with or without the issuer's consent." This provision was intended to keep insurers from indefinitely extending short-term limited duration coverage and thus evading the rule. It effectively implemented the "limited duration" exception.

To justify the three-month limit, the departments stated:

> Short-term limited duration, limited-duration insurance allows for coverage to fill temporary coverage gaps when an individual transitions between sources of primary coverage. . . . [F]or longer gaps in coverage, guaranteed availability of coverage and special enrollment period requirements in the individual health insurance market under the Affordable Care Act ensure that individuals can purchase individual market coverage

> through or outside of the Exchange that is minimum essential coverage and includes the consumer protections of the Affordable Care Act. Further, limiting the coverage of short-term, limited-duration insurance to less than three months is consistent with the exemption from the individual shared responsibility provision for gaps in coverage of less than three months (the short coverage gap exemption).

In other words, short-term limited duration coverage remained available to fill short-term gaps in coverage, its historic purpose. But the regulation sought to keep short-term limited duration coverage from simply becoming a means for issuers to avoid ACA consumer protections.

Although the definition of short-term in the original HIPAA rules, which allowed 364-day coverage, was contrary to the law, the enactment of the ACA made a rule that truly reflected the plain meaning of "short-term" more urgently necessary.

The meaning of a word in a statue depends on the intent of Congress in using the word. Even when the same word is used at different places in the same statute, or when two words in a statute share a common definition, the terms can have different meanings depending on their purpose and context. Environmental Defense Fund v. Duke Energy, 549 U.S. 561 (2007); Robinson v. Shell Oil Co., 519 U. S. 337, 343-344 (1997). Moreover, even when a term used in a statute is not amended, the term can take on a different meaning over time when the broader context in which it is used and the policies that it implements change. Bob Jones University v. United States, 461 U.S. 574 (1983). Even if the definition of short-term limited duration in the 1997 and 2004 rules was permissible, it was no longer in accordance with the law once the ACA was adopted. The 2016 redefinition of the term was, therefore, required by law. A return to the 1997 and 2004 definition after the ACA would violate the ACA.

Moreover, the departments' proposal to once again amend the definition of short-term coverage only a year after the current definition went into effect also raises serious legal issues. The departments have so far failed to offer a "reasoned explanation" as to why so rapid a change is required. Given the fact that issuers in the ACA compliant market have set their rates for 2018 assuming that short-term coverage is limited to less than 3 months, a change of the rule at this point would violate serious reliance interests. See Encino Motorcars v. Navarro (2016).

Short-Term Limited Duration Plans Cannot be Made Guaranteed Renewable

The President's Executive Order of October 12, 2017 asked HHS to consider making short-term limited duration coverage renewable, and statements by the administration made subsequent to the publication of the proposed rule suggest that HHS is considering doing so. A rule that would make short-term, limited duration coverage renewable, however, would not be "in accordance with law."

As noted above, the concept of short-term limited duration coverage was introduced into the Public Health Services Act in 1996 by HIPAA, which defined individual health insurance coverage to exclude "short-term limited duration insurance." The ACA incorporates the HIPAA definition by reference. HIPAA guaranteed the renewability of individual health insurance coverage. By excluding short-term limited duration insurance from individual market coverage in adopting HIPAA, therefore, Congress intended that short-term limited duration coverage be non-renewable. This is confirmed by the phrase "limited duration" which is not redundant with

"short-term"—and thus surplusage—by rather means that the coverage must not only be limited to a brief period of time, but also must not be renewable so as to endure beyond that time period.

Further confirmation is found in the fact that about half of the states refer to short-term coverage as non-renewable or non-renewable beyond a specified time period, either in their definition of short-term coverage or in consumer protection laws that exclude short-term coverage. Several of these state laws antedate HIPAA and all antedate the ACA.

Conclusion

The ACA adopted the HIPAA definition of individual market coverage, which excluded short-term limited duration coverage. The definition of short-term limited duration adopted by the Departments in 1997 and 2004 was not in accordance with the meaning of the phrase, "short-term." The purposes, policies, and requirements of the ACA, moreover, have made it even more imperative that "short-term limited duration" be defined to limit its scope to actual short-term coverage. The 2016 rule did this. The departments now seek to reinstate the HIPAA definition, which was never legal but is now even more clearly not legal. The proposed rule should not be finalized. And, in any event, short-term limited duration coverage cannot legally be made guaranteed renewable.

ACAP
Association for Community Affiliated Plans

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John Lovelace, Chairman | Margaret A. Murray, Chief Executive Officer

April 20, 2018

David J. Kautter, Acting Commissioner
Internal Revenue Service
Department of the Treasury

Preston Rutledge, Assistant Secretary
Employee Benefits Security Administration
Department of Labor

Randy Pate, Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health & Human Services

Submitted electronically via: www.regulations.gov

RE: CMS-9924-P

Dear Acting Commissioner Kautter, Assistant Secretary Rutledge, and Deputy Administrator and Director Pate:

The Association for Community Affiliated Plans (ACAP) respectfully submits comments regarding the proposed rule on *Short-Term, Limited-Duration Insurance.*

ACAP is an association of 61 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 29 states. Our member plans provide coverage to more than 20 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible individuals, including over 700,000 Marketplace enrollees. Nationally, Safety Net Health Plans serve almost half of all Medicaid managed care enrollees. Sixteen of ACAP's Safety Net Health Plan members offer qualified health plans (QHPs) or a Basic Health Plan option in the Marketplaces in 2018.

Summary of ACAP's Comments

ACAP has chosen to respond to the impact the proposed Short-Term, Limited-Duration Insurance rule that are particularly relevant to both Safety Net Health Plans (SNHPs) and the consumers they serve. Specifically, our comments are focused so as to ensure business stability

for SNHPs and to not place undue burden or harm on consumers, in particular the low-income and vulnerable populations that are traditionally served by SNHPs.

ACAP would also like to emphasize that the comments herein support SNHPs in their efforts to serve their communities, which they are generally well-acquainted to by way of their experience serving Medicaid enrollees. We believe there is a careful balance that must be struck in order to support issuers in the Marketplace while at the same time not instituting policies that would have a deleterious impact on consumers.

ACAP previously commented in support of the previous Administration's proposed rule to limit short-term, limited duration insurance (STLDI) to three months or less. Our comments on this proposed regulation are in the same vein, as we believe STLDI coverage should be used as it was originally intended—to fill short-term, temporary gaps in coverage—and not as an alternative to meaningful individual health insurance coverage. ACAP encourages the Administration not to finalize this rule and has a number of specific comments addressed herein. In particular, we wish to draw attention to the following recommendations from our comments:

- **Duration:** ACAP objects to the Departments' proposal to permit STLDI coverage for up to 364 days and urges the Departments to ensure that short-term coverage is truly short-term. ACAP urges the Departments to establish that the policy term for any STLDI plan must end by December 31 of that calendar year.
- **Renewability:** ACAP objects to the Departments' proposal to change the language surrounding extensions "with or without the issuer's consent" to simply "without the issuer's consent." Specifically, ACAP objects to any renewals of STLDI coverage, much less a streamlined renewal process.
- **Impact:** ACAP rejects the Departments' estimates of the impact of the proposed rule and instead wishes to submit for the record a full actuarial analysis produced by the Wakely Consulting Group, which is included as Appendix A herein.
- **Disclosure Statement:** ACAP appreciates the Departments' proposal to require a continued disclosure statement on all contract and application materials. We urge the Departments to also require a disclosure statement on marketing materials and to change the wording of the proposed disclosure statement to make it clear that STLDI coverage does not comply with the federally-mandated ACA requirements.
- **Effective Date:** ACAP urges the Departments not to institute an effective date for the proposal prior to January 1, 2020.

Expanded Comments

As the Administration notes in its proposed regulation, STLDI coverage "is not individual health insurance coverage." We believe that for this reason, among others, STLDI coverage should not be marketed as an alternative to ACA-compliant coverage, as it simply is not a meaningful alternative. Additionally, the proposed regulation, especially when combined with recent other regulations recently finalized by this Administration, will have a deleterious impact on the individual market single risk pool – thus impacting the business stability for SNHPs offering individual market products.

First and foremost, STLDI plans do not represent meaningful coverage as they may rate based on age, gender, and health status, and deny selected benefits to individuals based on their health status or cost. Such plans also tend to have extraordinarily high deductibles (often well above the ACA-compliant maximum), no annual or lifetime limits for consumers; further, they are not required to follow medical loss ratio (MLR) requirements, and regularly engage in rescissions. The confluence of these factors means that they are focused primarily on profits rather than providing needed care to enrollees. Such skimpy benefit packages will undoubtedly lead to an increase in uncompensated care to boot. STLDI plans offered in recent years have had a medical loss ratio below 50% and/or deductibles of $20,000 for each three months of coverage. Historically, issuers offering such coverage have been notoriously unscrupulous—often rescinding coverage as soon as individuals file substantial claims. This issue continues to remain pervasive, as evidenced earlier this month by a recent $5 million, multi-state settlement by one such STLDI issuer in response to its business practices.[1]

For these reasons, we object to expanding access to STLDI coverage in its entirety. We respond to the specific issues raised in the regulation, with expanded detail, below.

COVERAGE DURATION

The Departments request feedback on the appropriate length of short-term, limited duration insurance. While the Departments have proposed up to 364 days, we believe that is, by definition, not "short-term." We supported previous efforts to limit such coverage to 3 months or less and would argue that is a reasonable timeframe for such coverage—and certainly no longer than 6 months.

Additionally, while there is an argument to be made regarding the need for STLDI coverage as an option for consumers outside the annual open enrollment period or who do not have access to

[1] http://www.insurance.ca.gov/0400-news/0100-press-releases/2018/upload/nr036HCCLifeSettlement.pdf

ACA-compliant coverage through a special enrollment period, such options should not go beyond the end of the calendar year so that consumers will have the full set of coverage options that are available during open enrollment For this reason, we encourage the Departments to require, as part of the final rule, that regardless of duration, any such STLDI coverage must end by December 31st of a given year, in order to better align consumers with the individual market open enrollment period so that they have a full plethora of coverage options to choose from.

ACAP objects to the Departments' proposal to permit STLDI coverage for up to 364 days and urges the Departments to ensure that short-term coverage is truly short-term. Additionally, regardless of when such a policy is effectuated, ACAP urges the Departments to establish that the policy term for any STLDI plan must end by December 31 of that calendar year. STLDI coverage is meant to fill temporary gaps in coverage and as such should not be viewed as an alternative to comprehensive, meaningful health insurance coverage.

RENEWABILITY

The Departments also request comment on under what conditions issuers should be permitted to continue STLDI coverage for consumers for 12 months or longer. Again, by definition, we argue that issuers should not be permitted to renew STLDI coverage, as it immediately ceases to be of "limited duration."

The proposed regulation's considerations surrounding renewability are twofold. The proposed language would effectively permit extensions of coverage of 12 months and beyond *with* the issuer's consent. It seeks information on the conditions under which issuers should be permitted to allow coverage for 12 months or longer and whether there should be an expedited or streamlined reapplication process. We urge the Departments to reject both of these options. By permitting coverage to be extended based on the issuer's consent, the impact on the individual market risk pool will be even more striking, as issuers will choose to permit renewals for only the healthiest, least-risky, or least-expensive consumers. There is already a level of self-selection by young or healthy consumers enrolling in STLDI coverage, which the Departments recognize in the preamble, and permitting further extension of such coverage options will only serve to increase the adverse selection impact on the individual market. Additionally, as soon as there is a reapplication process for extended coverage beyond a year, STLDI plans will become QHP alternatives—again moving beyond their defined purpose of serving consumers needing to fill temporary gaps in coverage. Put simply, there should not be a reapplication process for STLDI coverage, much less a streamlined process.

ACAP objects to the Departments' proposal to change the language surrounding "extensions that may be elected by the policyholder with or without the issuer's consent" to simply "without

the issuer's consent." Specifically, ACAP objects to any renewals of STLDI coverage, much less a streamlined renewal process.

IMPACT

In response to the Departments' request for feedback on their take-up and premium estimates, ACAP asked an actuarial firm to model the impact of the proposed regulation. Please see Appendix A for the full report, produced by the Wakely Consulting Group.

Wakely states that "the difference in benefits and premiums between the plans that comply with ACA regulations and STLDI plans would effectively create separate risk pools and risk segmentation….Given the regulatory flexibility, STLDI plans would attract healthier enrollees, removing them from the ACA-compliant risk pool, increasing risk selection, and further increasing premiums, continuing the downward spiral. Over time the difference between the two risk pools would increase and escalate the instability and uncertainty in the ACA-compliant individual market."

Wakely provide three alternate estimates of the impact of the proposed regulation on the ACA-compliant market, all of which are at least four times higher than the Departments' stated estimate of 100,000—200,000 enrollees who will drop ACA-compliant coverage. First, Wakely notes that the Departments' estimate does not include plans purchased "off-Exchange." When the Departments' own estimates are applied to the off-Exchange market, Wakely found that the entire ACA-compliant individual market would actually decrease between 400,000—790,000 enrollees, resulting in a premium increase of 0.7 to 1.4% in 2019 alone.

Wakely then proceeds to use the experience of "transitional" plans to guide an estimate of the likelihood consumers will take up an ACA- compliant coverage alternative. Wakely notes that STLDI plans are not even as generous as transitional plans and so reduces the number of people enrolled by half to create a proxy for the potential STLDI market. In this case, Wakely estimates that 826,000 consumers are expected to leave the ACA-compliant market to purchase STLDI coverage.

And finally, Wakely estimates a longer-term impact, over the next 4 to 5 years, once issuers have had a chance to fully re-build underwriting capabilities and roll out STLDI products. Wakely used claims and metal level data to estimate which consumers are most likely to drop ACA-compliant coverage for STLDI. Their analysis found that 1.07 to 1.95 million enrollees are likely to switch coverage, which would also result in a 2.2 to 6.6 percent increase in premiums in the ACA-compliant market.

It is also worth noting that all of the estimates discussed above are *after* the impact of the zeroing of the individual mandate penalty is factored in. Yet we know that many of the consumers most likely to drop coverage after elimination of the mandate penalty are in fact the same consumers who are most likely to take up STLDI coverage as an "alternative" policy. Wakely also provides an estimate looking at the combined impact of the mandate penalty repeal and the STLDI proposal to show the overarching impact of those moving to STLDI coverage. Ultimately, Wakely found that with the combined impact of the repeal of the mandate and the STDLI proposal, when looking at all three scenarios modeled, 20.9 to 26.3 percent of the total individual market are likely to switch to STLDI coverage—resulting in total ACA-compliant market premium increases of 10.8 to 12.8 percent.

ACAP rejects the Departments' estimates of the impact of the proposed rule and instead wishes to submit for the record a full actuarial analysis produced by the Wakely Consulting Group, which is included as Appendix A herein.

DISCLOSURE

The Departments also solicit feedback on proposed changes to the disclosure statement required in all contract and application materials. We urge the Departments, first and foremost, to also require a disclosure statement to be included in marketing materials, so that consumers are aware that such plans are not ACA-compliant. Put simply, consumers deserve to know whether or not their health coverage is comprehensive and meaningful.

Unfortunately, we know that health literacy is low throughout America, and as such, it is important to ensure that consumers are easily able to determine what they are purchasing. We appreciate the Departments' recognition of this and their plan to continue a disclosure statement in contract and application materials. We believe a similar, shortened disclosure statement should be extended to marketing materials. Furthermore, we urge the Departments to make clear in the disclosure statement not just that STLDI coverage "is not required to comply" with the ACA requirements, but that it "does not comply." We believe a greater due-diligence is due to consumers than to simply tell them to read and understand their policy, especially as full policy documents for these plans may not accessible to consumers until after they have enrolled in said plan.

ACAP appreciates the Departments' proposal to require a continued disclosure statement on all contract and application materials. We urge the Departments to also require a disclosure statement on marketing materials and to change the wording of the proposed disclosure statement to make it clear that STLDI coverage does not comply with the federally-mandated ACA requirements.

EFFECTIVE DATE

Finally, ACAP wishes to respond to the proposed effective date. For multiple reasons, we object to the Departments' proposal to permit the sale of STLDI coverage within 60 days of finalizing the rule. First, given the destabilizing effect STLDI coverage will have on the ACA-compliant market, we believe it would be detrimental to QHP issuers whose rates will have long-since been set for that policy year—and will not have factored in the impact of the rule.

Additionally, as the Departments recognize, states also have the authority to regulate STLDI. However, given the infrequency with which some state legislatures meet, we believe it is important to give states adequate time to respond to the changes and that the proposal should not go into effect prior to 2020.

ACAP urges the Departments not to institute an effective date for the proposal prior to January 1, 2020.

Conclusion

The proposed regulation is certain to introduce a new level of instability to the individual market due to adverse selection, increased enrollee churn, and rising premium costs. According to research by Wakely, we also know that it is unsubsidized enrollees in need of comprehensive coverage who will be most harmed—not helped—by this proposal. While this proposal is ostensibly about improving access to coverage choices, for the unsubsidized consumers most in need of access to affordable coverage, this proposal will only serve to put comprehensive coverage out of reach. We urge the Departments not to finalize the proposed regulation.

ACAP thanks the IRS, EBSA, and CMS for their willingness to consider the aforementioned issues. If you have any additional questions or comments, please do not hesitate to contact Heather Foster (202-204-7508 or hfoster@communityplans.net).

Sincerely,

/s/

Margaret A. Murray
Chief Executive Office

CENTENE Corporation

April 23, 2018

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9924-P
P.O. Box 8010
Baltimore, MD 21244-8010

Submitted electronically via www.regulations.gov

Re: Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P)

Dear Administrator Verma:

Founded as a single health plan in 1984, Centene Corporation (hereinafter "Centene") has established itself as a national leader in the healthcare services field. Today, Centene's managed care organizations service over 12.2 million members across 26 states. Centene provides health plans through Medicaid, Medicare, the Health Insurance Marketplace and other Health Solutions through our specialty services companies. We believe quality healthcare is best delivered locally. Our local approach enables us to provide accessible, high quality, and culturally sensitive healthcare services to our members. For plan year 2018, Centene has Qualified Health Plan (hereinafter "QHP") products in 15 states.

Centene appreciates the opportunity to review the Proposed Short-Term, Limited Duration Insurance regulation (hereinafter "proposed rule"). Centene appreciates the Administration's attempts to create affordable coverage options for all, including individuals who are ineligible for subsidies. However, Short-Term, Limited Duration Insurance (hereinafter "STLDI") will not solve this issue, as it is not comprehensive health insurance. STLDI should be used as intended, to fill temporary gaps in coverage that may occur when individuals are between comprehensive major medical health insurance policies, for example, for students taking a semester off school or for individuals who are between jobs.

While STLDI may appear to provide a more affordable coverage option than an insurance policy that complies with the requirements of the Affordable Care Act (hereinafter "ACA"), the lower premium often comes with much less coverage than ACA-compliant plans. STLDI does not have to include any of the elements of ACA-compliant plans, such as preexisting condition exclusion prohibitions, coverage of essential health benefits (hereinafter "EHBs"), including

preventive care services, prescription drug coverage, maternity care coverage, exclusion of annual or lifetime dollar limits on EHBs, and rating restrictions.

Length of Time

Within the proposed rule, HHS recommends expanding STLDI from 3 months to less than 12 months after the initial effective date of the contract. Centene does not agree with this recommendation. Lengthening the time period to have a longer coverage duration will negatively impact the individual market single-risk pool if those currently covered under an ACA plan (on or off exchange) elect STLDI. STLDI is not subject to the same protections as major medical coverage and can discriminate based on health status and deny coverage for pre-existing conditions. STLDI plans typically have low premiums, since coverage is individually underwritten. The low premiums associated with these plans and the ability for the plans to last almost a full calendar year can be used to recruit healthier consumers while excluding those with pre-existing conditions, which would impact the integrity of the individual market single-risk pool.

Individuals with pre-existing conditions or those who have a higher morbidity would be left in the individual market single-risk pool, as they would be denied coverage under STLDI. This movement would cause premiums to rise for those currently insured under ACA-compliant insurance. We strongly recommend leaving the duration maximum for STLDI to 3 months. However, should HHS move forward with lengthening the timeframe, Centene recommends that coverage be allowed for no more than 6 months in totality, which would include any renewal of coverage.

Renewability

HHS also seeks comments on the conditions under which issuers should be able to allow STLDI to continue for 12 months or longer. Centene recommends that STLDI should not be allowed to renew or continue for longer than one term. The length of time an individual should be allowed to be enrolled in a plan should also take into account the ability to renew. The ability to renew STLDI would no longer make these plans short term or limited duration. Consumers may need to reapply upon each renewal and because STLDI is underwritten, the consumer may be denied coverage at time of renewal. Consumers may be surprised when they are unable to renew and also are outside of Open Enrollment, therefore having no healthcare option.

Allowing continuous renewability of STLDI, dissolves the reason STLDI was created, to cover gaps in coverage. STLDI should not become a way to circumvent the purchase of comprehensive coverage, nor should consumers rely on STLDI as comprehensive as they are not guaranteed renewal into these plans and can lose coverage at any time through rescissions based on utilization.

Disclosures

Centene is in agreement with the revised disclosure requirements within the proposed rule, however, believes that additional requirements should be added to the proposed disclosure. The

proposed disclosure for plan 2019 and after states, "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." In addition to this disclosure, HHS should also mandate that the disclosures provide explicit information on which EHB's are not covered, and require information that the policy for purchase is not comprehensive coverage. Additionally, if the plan contains dollar limits for covered services or care, these should be disclosed to the consumer.

The proposed disclosures should also include language that the termination of the STLDI plan does not qualify an individual for a Special Enrollment Period into an ACA-compliant plan. Information about the plans being underwritten should also be included in the disclosures. Consumers may not understand that these plans are not guaranteed renewable and that they may be subject to underwriting upon renewal. Therefore, the disclosures should advise that there is no guaranteed renewal and each time the plan is renewed the consumers health history will be re-reviewed to determine if they qualify to renew on the plan. Application materials should also advise consumers that if they have a pre-existing condition, they can be declined coverage or charged a higher premium.

The additional recommended language would best ensure that it is understandable and sufficiently apprise individuals of the nature of the coverage offered by STLDI. These disclosures should be provided on all application and enrollment materials, including evidence of coverage and member materials.

Medical Loss Ratio (MLR)

Another item to consider, is that STLDI is not subject to Medical Loss Ratio (MLR) Reporting. STLDI carriers have no incentive to have higher morbidity individuals, as they are not required to spend a certain amount of premium dollars on medical care. The ACA requires insurance companies offering health insurance coverage to spend 80% of premium dollars on medical care, although that percentage may vary by state. If issuers fail to meet this criteria within a year, they must issue a premium rebate to their members. It should also be noted that these plans are not subject to Risk Adjustment either. STLDI plans have no minimum percentage of premium they must spend on medical expenses, therefore, they are not adverse to rescinding policies and denying claims.

State Regulatory Oversight

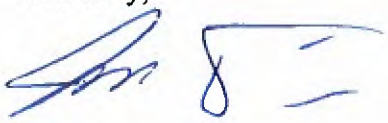
Should the rule be published as proposed, then regulatory authority for this line of insurance should defer to the states. While state regulatory oversight over SLTDI is important to protect consumers from the significant limitations offered by SLTDI, Centene recommends that current federal law restrictions limiting STLDI to 3 months also remain in place.

Effective Date

Lastly, the Department seeks comment on the proposed effective and applicably dates of the rule, if finalized. Should the proposed rule be finalized in any form, the changes should not go into effect until January 1, 2020 at the earliest. This will provide issuers time to review impacts of these plans on the market and accurately include any impacts within their pricing. If the rule is made effective January 1, 2019, this does not allow issuers enough time to adequately price for the upcoming year.

Thank you for your consideration. If you have any questions, please contact me at jdinesman@centene.com or 314.505.6739.

Sincerely,



Jonathan Dinesman
Senior Vice President, Government Relations

PUBLIC SUBMISSION

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Comment On: CMS-2018-0015-0002
Short-Term, Limited-Duration Insurance CMS-9924-P

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VA

Submitter Information

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General Comment

See attached file(s)

Attachments

FP AFP GenOpp LIBRE STLDI Comment

RE: SHORT-TERM, LIMITED-DURATION INSURANCE PLANS (CMS-9924-P)

Alex M. Azar
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
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Steven T. Mnuchin
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

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Secretary
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Washington, DC 20210

April 16, 2018

Dear Secretary Azar, Secretary Mnuchin, and Secretary Acosta:

On behalf of Americans For Prosperity, Generation Opportunity, and LIBRE Initiative activists and Freedom Partners Chamber of Commerce members and business owners in all 50 states, we write to submit the following comment in broad support of the proposed rule titled "Short-Term, Limited-Duration Insurance" (CMS-9924-P) published on February 21, 2018. The proposed rule seeks to modify current departmental regulations to expand the maximum duration of short-term, limited-duration (STLD) insurance plans from three months to 12.

Our vision of America is one in which truly free markets allow for free and prosperous people. As such, it is our belief that quality, affordable health care is best fostered by a marketplace with as much consumer choice and competition as possible. One of the more onerous governmental burdens on Americans – especially young people – are the mandates of the Affordable Care Act (ACA), which stifle choice to an alarming degree. Customized options in all facets of life are important to those who are beginning their careers, starting families and working to build their futures. The one-size-fits-all regulations of the ACA exchange don't work for them – or most Americans, for that matter. Expanding the availability of STLD insurance plans, as the proposed rule would do, is a step in the right direction toward the goal of creating more choice and competition. While we fully support the proposed rule, it could still be improved by providing for guaranteed plan renewability and, when legally feasible, exemption from the ACA's individual mandate penalty for the remainder of 2018.

These plans would be free from the one-size-fits-all regulations of the ACA's exchanges, allowing consumers to pick and choose the cost-sharing, benefit coverage, and networks that fit their families' needs. Premiums would be lower because families would no longer be forced to buy policies that covered the "essential health benefits" that Washington politicians decided were important, but instead the benefit packages that they deem are essential. Many would see sky high deductibles finally start decreasing. People who have an extremely limited choice of insurers on exchanges would now be able to buy policies from a range of insurance carriers competing for their business, not just HMO-type plans with ultra-narrow networks of providers.

We've seen the Hispanic community, in particular, impacted by limited options and soaring costs. More than twice as many Hispanics are without health insurance as compared to white Americans, and twenty-two percent of Hispanics went without care in the last year due to cost, according to the Kaiser Family Foundation. These are realities that we cannot ignore. Fortunately, however, this reform has the potential to deliver better insurance options for many families – including low and middle-income Latinos, who have been left behind by ineffective reforms in Washington. Ultimately, Congress and the president must come together on a plan to put consumers – in consultation with their doctors – back in charge of important health care decisions.

An expansion of STLD plans' maximum duration would be a vital escape valve to hundreds of thousands of consumers seeking relief. Since the enactment of the ACA, health insurance premiums have skyrocketed, and providers have consolidated themselves or all but disappeared. With such a contracting health insurance marketplace comes a sharp reduction in access to quality care at an affordable price. The proposed rule, however, can facilitate a much-needed alternative for those consumers stuck between

an insurance plan that is too expensive and going completely without insurance altogether. STLD plans, in their flexibility and affordability, are precisely the kinds of market-based health coverage options that Americans deserve.

That said, we recommend that, in addition to the provisions already included, the option for guaranteed plan renewability and exemption from the ACA's individual mandate penalty be considered for inclusion in the proposed rule. As is, STLD plans are not automatically renewable without additional medical underwriting, which means if a person developed a high-cost medical condition while insured, they could be charged more when renewing a policy. Without requiring that all policies be required to automatically renew, it should be an option. This will create more robust competition and lower premiums.

Prohibiting coverage renewals, as the Obama Administration did at the last hour through its own STLD regulation, harms individuals with pre-existing conditions because it forbids consumers who develop a pre-existing condition while on STLD plans from continuing their coverage. In discouraging these plans, the Obama Administration essentially preferred that individuals be without health coverage entirely as opposed to seeing anyone purchase a policy that lacked benefits approved by the federal government.

Additionally, we recommend that, either through lawful regulatory action or legislation, those consumers who choose to purchase STLD plans are not penalized for buying plans that do not meet the ACA's minimum coverage standards. While Congress reduced this penalty from $695 per year to $0 beginning in 2019, the penalty still remains in effect for 2018 and leaves many consumers with a sizable potential tax liability.

Taken together, an expanded STLD coverage duration with guaranteed plan renewability will give consumers the flexibility and assurance of quality, affordable health insurance. As Americans begin to recover from the regulatory weight of the ACA, this proposed rule is a reassuring step toward a freer and more effective health insurance marketplace.

On behalf of our constituencies, we thank the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor for the opportunity to comment on the proposed rule. If approved, this rule will expand affordable coverage to those who seek it and do so in a transparent and compliant manner. Expanding automatically renewable STLD insurance plans, while not a panacea, is a step in the right direction toward reducing the regulatory burden on Americans everywhere and ensuring that consumers have the type of health coverage they decide is best for them. We are encouraged by your progress in this matter and look forward to your decision.

Sincerely,

Brent Gardner
Chief Government Affairs Officer
Americans for Prosperity

Nathan Nascimento
Executive Vice President
Freedom Partners

David Barnes
Policy Director
Generation Opportunity

Daniel Garza
President
The LIBRE Initiative

AMERICANS FOR PROSPERITY.

FREEDOM PARTNERS

GENERATION OPPORTUNITY.

THE LIBRE INITIATIVE.
LIMITED GOVERNMENT · UNLIMITED OPPORTUNITIES

April 23, 2018

Honorable Alex Azar
Secretary
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P.O. Box 8010
Baltimore, MD 21244-8010

Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
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Mr. David Kautter
Acting Commissioner, Internal Revenue Service
Department of the Treasury
1111 Constitution Avenue, NW
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Mr. Preston Rutledge
Assistant Secretary, Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

RE: Comments on Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P)

Dear Secretary Azar, Administrator Verma, Acting Commissioner Kautter, and Assistant Secretary Rutledge,

EverThrive Illinois appreciates the opportunity to comment in response to the proposed rule on short-term limited-duration insurance. EverThrive Illinois works to improve the health of women, children, and families across the lifespan. We have advocated on behalf of high-quality, affordable health insurance for Illinois families for thirty years.

EverThrive Illinois writes with strong objection to the proposed rule on short-term limited-duration insurance. The proposed rule rescinds restrictions on short-term plans, thereby allowing insurers to offer junk insurance policies to millions of consumers. These plans exclude coverage for critically important health care services; vary premium rates by gender, health status, and age; and put individuals and families at significant financial risk. In addition, expanding these types of plans will undermine the individual market by pulling healthy individuals away and leaving an older, sicker risk pool behind. Many individuals who rely on comprehensive coverage – including women, older adults, and people with chronic conditions – would be left without affordable, comprehensive options.

Short-term policies offer junk insurance that fails to meet the needs of consumers.

Short-term, limited-duration insurance is intended to provide *temporary* insurance during unexpected coverage gaps. This type of coverage is exempt from the definition of individual health insurance coverage under the Affordable Care Act (ACA) and, therefore, does not have to comply with the law's core consumer protections. The proposed rule, therefore, promotes and will increase take up of skimpy, junk insurance coverage with minimal protections for consumers. Specifically, such coverage:

- Has high out of pocket costs,
- Limits the coverage people can receive each year and over their lifetime,
- Discriminates against individuals, and
- Excludes basic health care services.

Further, the carriers that sell these plans often employ intentionally vague or confusing marketing tactics to entice enrollees who might otherwise be eligible for and interested in comprehensive, ACA-compliant coverage.

Short-term plans discriminate against individuals based on their health status. Because short-term plans are exempt from the ACA's pre-existing condition protections, plans deny coverage altogether or deny coverage of specific services based on health status and medical history. In reviewing short-term plans available in Illinois, we found it was common for insurers to define a condition to be pre-existing if a member had symptoms in the prior 12 months "that would cause a reasonable person to seek diagnosis, care or treatment," even if she did not receive care, and even if she was not aware of the condition. For example, we have spoken with a woman living in the northern suburbs of Chicago who had a short-term policy in 2008. While covered under this policy, she experienced extremely heavy bleeding during her period. She called an ambulance and, by time she arrived at the hospital, she had lost half of her blood. She was diagnosed with menorrhagia and chronic anemia and received an emergency hysterectomy, requiring her to be hospitalized for five days. She was forced to pay tens of thousands of dollars in medical bills when the carrier denied all claims because they determined that her regular menstrual cycle was a pre-existing condition.

Short-term plans are not required to cover essential health benefits. In addition to being able to exclude coverage for pre-existing conditions, these plans are also allowed to categorically exclude certain benefits, such as routine maternity and newborn care, prescription drugs, mental health care, substance use services, and preventive services like birth control and tobacco cessation. Without these essential benefits consumers will lack adequate coverage. Current examples of common short-term plan exclusions include:

Benefit	Exclusion Language
Emergency care	Excluded: "Charges for use of hospital emergency due to illness." (See for example UnitedHealthOne)[1]
Women's reproductive health	Excluded: "Expenses for the treatment of normal pregnancy or childbirth, except for complications of pregnancy and normal newborn care; expenses for voluntary termination of normal pregnancy or contraception; infertility treatments or sterilization." (See for example IHC Secure Lite)[2]
Gender transition-related services	Excluded "Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies." (See for example IHC Secure Lite)[3]
Mental health care	Excluded: "Treatment of mental health conditions, substance use disorders; and outpatient treatment of mental and nervous disorders, except as specifically covered." (See for example National General)[4]

In reviewing plans currently available in Illinois, we also found that these plans might list particular benefits as covered, but use a lengthy exclusions list to ensure that claims will not actually be paid for covered services. This allows plans to advertise as offering much more comprehensive benefits than the consumer is actually likely to be able to receive. For example, the United Health Golden Rule plan offered in Illinois and a number of other states advertises that hospital care is a covered benefit and that they have a large, nationwide network of hospitals. However, the list of "general exclusions" indicates that "no benefits are payable for hospital room and board and nursing services if admitted on a Friday or Saturday, unless for an emergency, or for medically necessary surgery that is scheduled the next day."

Exclusions such as this are difficult for consumers to understand and make clear that the benefit package for these plans is actually much less generous than advertised.

Insurers who sell short-terms plans frequently discriminate based on gender, including charging women higher premiums. ACA protections prohibit plans from basing premiums on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. Before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating (charging women higher premiums than men). These predatory practices used to cost women approximately $1 billion a year[5] and are still commonplace among insurers selling short-term plans. Health questionnaires are also often used by short-term plans to identify and deny coverage to people with preexisting conditions, like pregnancy. The application process includes explicit language excluding applicants who are pregnant or an expectant father. Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services, such as surgery.

Short-term plans also impose lifetime and annual limits. An individual or family could quickly meet their annual and lifetime limit with expensive health care costs and treatment for a catastrophic medical emergency. The impact to individuals and families could be financially devastating and leave them without coverage. One insurer, for example, caps covered benefits, including treatment, services and supplies at just $750,000 per coverage period. At least one insurer provides per-service limits such as $1000 per day for hospital room and board, $500 per day for emergency room services, $250 per trip for ambulance, and $10,000 for AIDS treatment.[6] These limits amount to woefully inadequate coverage for consumers and their families.

Short-term plans are also not subject to out-of-pocket maximums, which can leave consumers facing major, unpredictable financial risk. The ACA limits out-of-pocket maximums to $7,350 for individual coverage for the entire year, but some short-term plans may require out-of-pocket costs in excess of $20,000 per individual per policy period.[7] In some cases, out-of-pocket maximums for short-term plans are misleading and appear to be smaller than they are because the deductible does not count toward the maximum.

Expanding the availability of short-terms plans creates an uneven playing field. Due to discriminatory, predatory practices, short-term plans are able to offer low premiums and attract younger and healthier individuals. Leaving older, sicker and costlier risk pools behind in the ACA-complaint market. If healthier individuals are syphoned from the individual market, costs will increase and plan choices will decrease for individuals remaining in those markets. Consumers who need comprehensive coverage, including those with pre-existing conditions, and middle-class consumers with incomes too high to qualify for subsidies, would face rising premiums and potentially fewer plan choices.

Specific Recommendations

I. Short-term limited-duration plans should not be expanded to more than three months (§54.9801-2 / §2590.701-2 / §144.103).

Short-term plans are designed to fill *temporary* gaps in coverage. These policies should not exceed three months.

The proposed rule would allow short term plans to enroll individuals for as long as 364 days. Allowing extensions of these policies expands the period of time in which people may be underinsured, leaving consumers with inadequate coverage and at financial risk if they fall ill. Yearlong short-term plans would create consumer confusion about whether the coverage is the same as would be available through ACA-compliant one-year plans. Moreover, consumers could be left with uncovered bills and/or find themselves "uninsurable." Because insurers can deny a new contract if the enrollee becomes sick or injured during the coverage term, consumers may believe they can extend or renew coverage until rejected by the issuer. If their short-term plan ends before Marketplace open enrollment, their loss of coverage would not qualify for a special enrollment period, leaving a consumer to wait until the next annual open enrollment period to select a new plan. This will lead to a gap in coverage for many consumers.

Consumers seeking coverage for three months or longer can get covered through the Marketplaces. Allowing short-term plans longer than three months undermines the ACA and the risk pools in the individual market by encouraging healthy people to use short-term plans as an alternative to ACA plans. This would drive up premiums in the individual market, making comprehensive coverage with pre-existing condition protections less affordable for consumers, particularly those that are ineligible for premium tax credits.[8]

We strongly oppose the proposed changes to the regulation at §54.9801-2 / §2590.701-2 / §144.103. The existing definition limiting the duration of short-term limited-duration insurance to "less than 3 months" should remain, as should the language "taking into account any extensions that may be elected by the policyholder with or without the issuer's consent."

II. Consumer notices should be explicit, in multiple languages, about ACA requirements that do not apply to short term plans (§54.9801-2 / §2590.701-2 / §144.103).

We support efforts in the proposed rule to help consumers who purchase short-term, limited-duration policies to understand the coverage they are purchasing. We believe notice is vital for consumers to understand the limits of short-term plans and that they are not comprehensive coverage. We appreciate the specific language that clarifies that the plan does not comply with federal requirements and that enrollees might have to wait until an open enrollment period to get other health insurance coverage.

We recommend, however, that the notice needs to be clearer to be more easily understood by consumers by eliminating insurance jargon and that the notice be available in multiple languages. Further, we recommend that the notice better meet the needs of people with low literacy, using short, declarative sentences and using regular sentence case, rather than writing in all upper-case letters, which may be more difficult for people with reading disabilities to understand. As the preamble notes, allowing short-term plans to provide coverage for less than one year will make it more difficult for consumers to distinguish between short-term plans and ACA plans. The notice must make clear that short-term plans differ from ACA plans. The draft notice language also is not clear enough that loss of eligibility or coverage in a short-term plan does not trigger a special enrollment period.

The Departments should adjust the proposed notices at §54.9801-2 / §2590.701-2 / §144.103 to the following language:

> WARNING! This plan may not cover all of the health care you need and may leave you with very high medical bills. If you buy this plan, you may not be able to get more complete

insurance when this contract ends. You may be able to get more complete insurance now and help to pay for it at www.healthcare.gov.

III. The effective date of the rule should be delayed (§ 54.9833–1/§2590.736/§146.125).

We recommend that the proposed rule be rescinded in its entirety, but if finalized, insurers need time to appropriately design and price plans. Allowing expanded short-term plans to be offered in 2019 creates risk and uncertainty for health insurers in the individual market.[9] Insurers may have to build in rate increases associated with uncertainty if expanded short-term plans are allowed in 2019. Delaying implementation until 2020 will give insurers time to adjust to the insurance market without the individual mandate penalty and allow them to see which insurers are expanding or entering the short-term market. A delay would also allow states time to respond, through legislative or regulatory changes, to the impact of expanded availability of short-term plans on their markets.

We strongly oppose the proposed effective and applicability date of this rule. The effective date of the rule should be delayed until the 2020 plan year, if the rule is finalized.

IV. Short-term plans should never be allowed to continue for 12 months or longer.

Short-term limited-duration insurance is, by name, meant to be for a short, limited duration. As noted above, allowing these plans to continue for 12 months or longer places people in plans with limited coverage and at significant financial risk. Allowing renewals would suggest clear intent to circumvent the ACA and undermine the risk pools in the ACA-compliant individual market. States are the primary regulators of insurance and should maintain authority to regulate the renewability of these plans and the application and reapplication process. We strongly oppose any consideration of allowing short-term health plans to exceed three months, much less 12 months or longer.

V. Short-term Plans Will Pull Millions Away from ACA Individual Market

The estimates in the fiscal impact statement on the number of people enrolled undercounts the individual insurance market. The NAIC report on which the estimate was based fails to include short-term plans sold by discretionary associations or similar arrangements. Recent reports have suggested enrollment in short-term plans may be closer to one million today.[10] The Urban Institute has estimated that, as a result of this proposed rule, 4.3 million people would enroll in short-term plans in 2019.[11] The Urban Institute also estimated that the effect of the proposed rule, in combination with the elimination of the individual mandate penalty, would reduce enrollment in ACA-compliant plans by 18.3 percent.[12] The American Academy of Actuaries reaffirms the argument that short-terms plans will attract healthy individuals, causing the potential for market segmentation and adverse selection, and therefore increase premiums in the ACA-compliant market. As noted throughout, this rule will have the effect of undermining and weakening the ACA-compliant market – leaving people with higher premiums and fewer plan options.

Thank you for the opportunity to comment on the Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P). We once again urge the Departments to preserve and fully implement the Affordable Care Act as the most effective strategy to promote affordable consumer choice for health coverage. If you have any questions about our comments and recommendations, please contact Kathy

Waligora, Director for the Health Reform Initiative, kwaligora@everthriveil.org.

Sincerely,

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UNITEDHEALTH GROUP®

Daniel J. Schumacher
President & Chief Operating Officer
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April 23, 2018

Secretary Alex M. Azar II
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Hubert H. Humphrey Building
200 Independence Avenue SW
Washington, DC 20201
Attention: CMS–9924–P

RE: Short-Term, Limited-Duration Insurance

Secretary Azar:

UnitedHealth Group (UHG) is pleased to respond to the Department of Treasury, Department of Labor, and the Department of Health and Human Services (the "Tri-Agencies") Proposed Rule regarding short-term, limited-duration insurance (STLDI).

UHG is dedicated to helping people live healthier lives and making our nation's health care system work better for everyone through two distinct business platforms – UnitedHealthcare, our health benefits business, and Optum, our health services business. Our workforce of 285,000 people serves the health care needs of nearly 140 million people worldwide, funding and arranging health care on behalf of individuals, employers, and the government. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, we are also the nation's largest Medicare health plan – serving nearly one in five seniors nationwide – and one of the largest Medicaid health plans, supporting underserved communities in 28 States and the District of Columbia.

UHG supports Federal and State efforts that allow insurers to offer innovative, affordable products that appeal to consumers and provide choice in the individual market. STLDI was a popular coverage option prior to the passage of the Affordable Care Act (ACA), and consumer demand for these products has remained strong because, in some cases, STLDI better meets the needs of consumers compared to Exchange products.

Today, 28 million people do not have insurance coverage and many consumers lack access to affordable coverage options. UHG supports the Tri-Agencies' proposal to extend STLDI policies to a term of up to 12 months as a means of expanding consumer choice and increasing coverage. Further, we recommend that the Tri-Agencies finalize the Proposed Rule in its current form as quickly as possible in order to provide consumers with affordable, high-quality options in 2018. As described in

more detail below, UHG recommends that the Tri-Agencies:

- Finalize the Proposed Rule in its current form, and specifically finalize the extension of STLDI policies to a term of up to 12 months;
- Consistent with the Proposed Rule, do not require STLDI insurers to offer renewable policies in the Final Rule; and
- Provide additional clarity to enable implementation of the Rule.

The Tri-Agencies Should Extend STLDI Policies for a Term of up to 12 Months

STLDI policies – temporary health insurance policies that typically cover a range of medical and pharmaceutical benefits – are an attractive option for consumers interested in lower cost coverage that bridges the gap to longer term coverage. According to a March 2018 eHealth survey, more than 60 percent of respondents said they chose STLDI primarily because they needed coverage for a limited period, and nearly 30 percent did so because it was more affordable than other options.

Under current policy, STLDI may only be offered for 3 months, and this limit is causing consumers to experience gaps in coverage throughout the year. For example, a consumer who misses the Exchange open enrollment period and who buys a 3 month STLDI policy available under current rules could experience a 9 month coverage gap. By extending the term of STLDI policies for up to 12 months, the Proposed Rule would ensure that more consumers have consecutive months of coverage and fewer consumers experience coverage gaps during a year.

By extending the STLDI policy term for up to 12 months, the Tri-Agencies would foster a market that provides consumers with the ability to purchase coverage for the amount of time needed, and restores STLDI as a product that bridges gaps in health care coverage during times of transition. By instituting a term limit of up to 12 months, the Proposed Rule also allows States – who have regulated these products for decades – to continue to set standards that they believe are best for their consumers.

The Tri-Agencies Should Not Require STLDI to Include Guaranteed Renewability

UHG supports the Proposed Rule's definition of STLDI, which exempts insurers from the requirement to renew STLDI policies at the consumer's request. STLDI has never been subject to guaranteed renewability requirements. In fact, current law and regulations specifically exclude STLDI from guaranteed renewability requirements. Requiring STLDI to be guaranteed renewable would significantly impact policies' affordability and limit availability, and run counter to the Tri-Agencies' goal of expanding access to lower cost coverage options.

The most significant rationale for preserving the exemption from guaranteed renewability is the impact requiring it would have on the cost of STLDI policies to consumers. Currently, STLDI premiums are much lower (on average, $110 for individual coverage), relative to Exchange coverage (on average, $378 for individual coverage), because the policy term is set for a short period of time, which allows the insurer to better assess underwriting risk. If renewability were required, STLDI insurers would have to increase premiums to account for the potential costs of covering a purchaser for an indefinite period of time. As a result, STLDI premiums would approach the cost of Exchange products, and far fewer consumers would be able to afford them.

Further, if insurers are required to comply with guaranteed renewability requirements, they are likely to increase the level of underwriting they employ, and, as a result, more people could be denied coverage relative to today's practices. For example, certain populations – such as older individuals – could find it more difficult to purchase STLDI than they do now, if guaranteed renewability were required. Another

possible impact is that fewer insurers would offer STLDI products, as guaranteed renewability makes pricing coverage more complicated.

UHG believes that there is no sound rationale to require STLDI to provide guaranteed renewability, as there are already products with this feature both on and off the Exchange. Further, the Tri-Agencies have already determined that STLDI is similar to other types of insurance for which guaranteed renewability is not appropriate, such as student health insurance, or when employers leave associations. In addition, many States have already put in place limits on the renewability of STLDI, such as Arizona, Michigan, Minnesota, and Oregon. For these reasons, we strongly urge the Tri-Agencies to maintain current regulations that exempt STLDI from guaranteed renewability requirements.

The Tri-Agencies Should Provide Clarification to Aid Implementation

In the Final Rule, we ask the Tri-Agencies to provide additional information to facilitate implementation and ensure rapid access to STLDI products. Specifically, the Tri-Agencies should address:

- **Final Rule Effective Date.** We support the proposed short effective date of 60 days after the Final Rule is issued, and recommend that the Tri-Agencies clarify whether insurers can begin to market policies before the effective date as long as the policies' effective dates are after the 60 day period.
- **STLDI and Student Health Insurance.** In previous rulemaking, CMS has defined student health insurance coverage as a type of individual health coverage issued to institutions of higher education, and has determined that insurers cannot issue STLDI policies as student health insurance coverage. We seek confirmation from the Tri-Agencies that the prohibition on STLDI as student health coverage remains unchanged.
- **Consumer Disclosure.** We ask the Tri-agencies to clarify that insurers can modify the model consumer disclosure language that is included in the Proposed Rule, to allow insurers to provide consumers with additional disclosures about their STLDI product, subject to State approval.

As always, UHG welcomes the opportunity for constructive discussion and collaboration as part of this comment process, and looks forward to sharing any additional data or information that supports increased access to innovative, lower cost and higher value health coverage options.

Thank you for your thoughtful consideration of our comments. Please do not hesitate to contact us.

Sincerely,

Daniel J. Schumacher
President and Chief Operating Officer
UnitedHealthcare

FEDERAL AIDS POLICY PARTNERSHIP
HIV HEALTH CARE ACCESS WORK GROUP

April 23, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244

Attention: CMS-9924-P

To Whom It May Concern:

We are writing on behalf of the HIV Health Care Access Working Group (HHCAWG) – a coalition of over 100 national and community-based HIV service organizations representing HIV medical providers, public health professionals, advocates, and people living with HIV who are all committed to ensuring access to critical HIV- and hepatitis C-related health care and support services. We appreciate the opportunity to provide comments to the proposed rule, *Short-Term, Limited-Duration Insurance*, issued by the Departments of Health and Human Services, Labor, and Treasury ("the Departments"). Standards and protections governing individual and small group private insurance markets must ensure access to comprehensive and affordable coverage for people living with HIV, hepatitis C (HCV), and other chronic conditions. We are concerned that the proposal to expand coverage under short-term, limited duration plans will harm vulnerable populations, and we urge HHS to consider the recommendations and comments detailed below.

Coverage Lasting up to 364 Days Is Not Short-Term

Prior to 2016, some short-term, limited duration plans covered individuals for periods up to or exceeding 12 months. The Departments took regulatory action in 2016 to limit short-term plan duration to under three months because they found that plans were being sold in situations other than those the rules were intended to address.[1] Short-term, limited duration plans are intended as temporary coverage for individuals facing short gaps in insurance—for example, in between jobs—and are not a substitute for long-term coverage. However, consumers were purchasing these plans as a primary form of health coverage for periods up to or exceeding one year. The Departments expressed concerns that short-term, limited duration plans were not "meaningful health coverage"[2] due to limitations such as annual and lifetime benefit limits and

[1] Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg 75,316, 75,317-18 (Oct. 31, 2016).
[2] *Id*.

pre-existing condition exclusions, and therefore imposed a plan duration of under three months in order to protect consumers from financial harm. In keeping with the purpose of short-term coverage, we urge the Departments to maintain the current federal standard to ensure this coverage is actually short-term.

The Rule Would Weaken Important Consumer Protection and Benefits Standards, and Would Restore Pre-ACA Practices That Harmed People with High Health Needs

The proposal to change current rules by allowing issuers to sell short-term plans with a maximum coverage period of less than 12 months would jeopardize important consumer protections. The proposal would allow plans that bypass important Affordable Care Act (ACA) protections, such as essential health benefits (EHBs), rating restrictions, guaranteed issue, the federal medical loss ratio, and the pre-existing condition exclusion prohibition, to be marketed to consumers as a long-term alternative to ACA-compliant coverage. This proposed rule would especially harm people living with HIV, HCV, and other chronic conditions, particularly given the ways that issuers have historically designed short-term, limited duration plans to explicitly discriminate against these populations.

Short-term plans have historically engaged in post-claims underwriting in order to rescind coverage or deny claims for services that may be associated with a pre-existing condition. One analysis of popular short-term plans found that issuers have denied claims for enrollees who experienced symptoms within the prior five years "that would cause a reasonable person to seek diagnosis, care, or treatment," even if the person never received care—for example, because they were uninsured or underinsured.[3] We are concerned that this broad discretion for issuers to deny claims may lead to financial hardship for consumers who purchase short-term plans and later learn that they have an untreated medical condition. Consumers who develop chronic conditions after they enroll in short-term coverage are also unprotected under the proposed rule, which does nothing to strengthen coverage standards under short-term plans or restrict issuer discretion to rescind coverage based on post-claims underwriting.

Short-term plans also often exclude important EHBs such as prescription drug coverage, mental health, and substance use, and it is not always apparent to consumers which benefits are covered and which are excluded. A recent report from the Kaiser Family Foundation examining existing short-term plans found that 71% do not cover prescription drugs, a key EHB for people living with HIV, HCV, and other chronic conditions.[4] Furthermore, short-term plans have historically placed annual and lifetime limits on coverage, including condition-specific caps for chronic illnesses, and tend to have higher consumer cost sharing without annual out-of-pocket maximum caps. Consumers may not know the limits of their plan until after they develop a medical condition or otherwise require a higher level of services. Since health status is not

[3] Dania Palanker, Kevin Lucia, and Emily Curran, *New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market*, THE COMMONWEALTH FUND (Oct. 11, 2017), http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans.

[4] Karen Pollitz et al., *Understanding Short-Term Limited Duration Health Insurance*, KAISER FAMILY FOUND. (Apr. 23, 2018), https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/.

static, enrolling in a deficient plan can be devastating for someone diagnosed with HIV, HCV, or another serious medical condition after enrolling in a short-term plan.

Expanding the Short-Term Market Will Increase Fraud and Other Deceptive Practices

Short-term plans also have a long history of fraud and misrepresentation. Insurance brokers have historically engaged in deceptive sales tactics, leading consumers to purchase short-term coverage because it was falsely represented as being ACA-compliant. Consumers only learned that this was not true after their claims were denied, leaving patients and providers with substantial unpaid claims. Expanding the short-term market could lead to increased consumer confusion about coverage and substantial risk for fraudulent practices to market sub-par plans as ACA-compliant plans. We appreciate the Departments' proposal to revise the required notices that must appear in insurance contracts and application materials, specifically the addition of language clarifying that "short-term, limited duration" plans are not considered minimum essential coverage and that consumers who lose such coverage must wait until the next Open Enrollment to enroll in an ACA-compliant plan. However, we do not feel that this revised notice is sufficient to warn consumers of the value of excluded services or the financial risks associated with such plans. This lack of notice can be especially harmful to people living with HIV and HCV, for whom ACA protections such as EHBs, limits on rescission, and bans on lifetime or annual limits are crucial.

Issuers Should Not Be Allowed to Renew Short -Term Plans

The Departments seek comment on their proposal to allow issuers to renew or extend short-term coverage beyond 12 months, as well as on a proposed streamlined application process that would expedite plan renewals or extensions. We do not believe that the ability to renew or extend coverage is sufficient to make short-term plans a consumer-friendly product. This only encourages longer enrollment in these plans and further undermines the stability of the individual market. We strongly urge the Departments to support policies that encourage consumers to use short-term plans as they were intended, not as a long-term coverage option, but as an option to fill short gaps in coverage. Streamlining the reapplication process is in direct conflict with the entire purpose of a short-term plan, and it does not protect consumers from medical underwriting or pre-existing condition exclusions based on health conditions that began during the prior coverage period.[5] Additionally, federal legislative proposals that would make short-term plans renewable would similarly fail to protect consumers with health conditions. Renewability does not prevent insurers from engaging in medical underwriting and increasing premiums or denying claims for consumers who incur high costs—for example, people living with HIV, HCV, and other chronic conditions.[6] Policies requiring renewability or streamlined application would therefore yield the same result: consumers with health conditions would be denied coverage or priced out of the short-term market and would have

[5] AM. ACAD. OF ACTUARIES, COMMENTS RE: CMS-9924-P—SHORT-TERM, LIMITED DURATION INSURANCE 4-5 (APR. 6, 2018), http://www.actuary.org/files/publications/STLD_Comment%20Letter_040618.pdf.
[6] *Id*.

no choice but to enroll in ACA-compliant plans, leading to higher costs in the ACA-compliant market.

The Rule Would Make Comprehensive ACA-Compliant Coverage More Expensive

Current rules limiting contract length of short-term, limited duration plans to no more than three months are in place to prevent insurers from siphoning healthy enrollees from the individual market. The Departments took regulatory action in 2016 to limit short-term plan duration to under three months based on findings that these plans adversely impacted the risk pool for ACA-compliant coverage.[7] The justification for reversing these rules now, just two years later, is not evinced in the record. In fact, the Departments acknowledge that the proposed rule could weaken states' individual market single risk pools, increase costs to consumers and issuers, and reduce consumer choice by causing issuers to exit the individual market, but do not propose policies that would mitigate these consequences.

If the proposed rule were finalized in its current form, short-term plans could essentially function as long-term coverage that bypasses important ACA protections. These plans would be competing in the same market as ACA-compliant individual plans, but would be subject to different rules. Issuers could structure eligibility rules, benefit designs, and marketing practices in ways that encourage enrollment by healthier individuals while discouraging less healthy individuals, thus enabling issuers to charge lower-than-average premiums. Additionally, short-term plans are medically underwritten, meaning that individuals with pre-existing conditions or known health risks can be denied coverage or charged higher premiums. This would create an uneven playing field and lead to adverse selection because short-term plans could siphon healthy individuals from the ACA-compliant plans and leave the individual market with higher risk enrollees. Since short-term plans would not be part of the single risk pool and the risk adjustment program, there would be no transfer of funds from short-term plans to the ACA-compliant market to reflect the difference in risk between these segments.[8] People that want comprehensive coverage in the individual market could find their options dwindling or that the premiums are unaffordable. This is especially harmful to people living with HIV, HCV, and other chronic conditions who may not be able to find affordable individual coverage that is adequate to meet their health needs.

The Department predicts that the proposed rule would result in 100,000 to 200,000 young and healthy individuals leaving the ACA-compliant market and purchase short-term plans. However, we believe that plan enrollment in these short-term plans would likely be much higher. Researchers predict that as many as 4.3 million individuals would enroll in expanded short-term plans if the proposed rule is finalized in its current form.[9] Additionally, research shows that the combined effect of the proposed rule and the elimination of the individual shared responsibility

[7] Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg at 75,318.

[8] AM. ACAD. OF ACTUARIES, *supra* note 5, at 2.

[9] Linda J. Blumberg, Matthew Buettgens, and Robin Wang, *Updated: The Potential Impact of Short-Term Limited Duration Policies on Insurance Coverage, Premiums, and Federal Spending*, THE URBAN INST. (Mar. 2018), https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf.

payment would increase ACA-compliant individual insurance premiums by 18.3 percent on average.[10] We are concerned that the Departments' predictions are too conservative, and that the proposed rule could result in a mass exodus of healthy individuals from the ACA-compliant market that is likely to leave people with pre-existing conditions like HIV and HCV without viable coverage options.[11]

The Departments Should Focus on Ways to Stabilize the Market

We share the Departments' stated concern that policy interventions are necessary to stabilize the individual market, particularly for individuals not eligible for federal subsidies. We believe that a federal reinsurance program is the best way to stabilize the market. Instead of policies that segment the market, we urge the Departments to focus on policies that shore up the individual market, protecting people living with and at risk for HIV, HCV, and other conditions. In addition to an adequate reinsurance program, we also support increased investment in outreach, education, and enrollment to ensure robust participation by both healthy and sick individuals in the ACA's Marketplaces. We welcome the opportunity to work with the Departments on these efforts.

Thank you for the opportunity to comment this proposed rule. We urge HHS to continue its commitment to ensure that people living with HIV, HCV, and other chronic and complex conditions have access to quality, affordable healthcare coverage. Please contact Amy Killelea with the National Alliance of State and Territorial AIDS Directors at akillelea@nastad.org, Andrea Weddle at aweddle@hivma.org with the HIV Medicine Association, or Robert Greenwald at rgreenwa@law.harvard.edu with the Center for Health Law and Policy Innovation if we can be of assistance.

Respectfully submitted by:

ADAP Educational Initiative | AIDS Alabama | AIDS Action Baltimore | AIDS Alliance for Women, Infants, Children, Youth & Families | AIDS Foundation of Chicago | AIDS Research Consortium of Atlanta | AIDS United | American Academy of HIV Medicine | APLA Health | AIDS Resource Center of Wisconsin | Communities Advocating Emergency AIDS Relief (CAEAR) | Community Access National Network (CANN) | Georgia AIDS Coalition | Harm Reduction Coalition | HealthHIV | HIV Medicine Association| Housing Works | Human Rights Campaign | Legal Council for Health Justice | Michigan Positive Action Coalition | Minnesota AIDS Project | National Alliance of State and Territorial AIDS Directors | National Latino AIDS Action Network | NMAC | Positive Women's Network - USA| Project Inform | Rocky Mountain CARES | San Francisco AIDS Foundation | SisterLove | Southern AIDS Coalition | Southern HIV/AIDS Strategy Initiative | The AIDS Institute | Treatment Access Expansion Project

[10] *Id*.

[11] *See, e.g.*, AM. ACAD. OF ACTUARIES, *supra* note 5, at 5 (predicting that enrollment in short-term plans will likely exceed the Departments' projections).

YOUNG INVINCIBLES

April 23, 2018

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RE: Young Invincible's Comments on Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P)

Dear Secretary Azar, Administrator Verma, Acting Commissioner Kautter, and Assistant Secretary Rutledge:

Young Invincibles (YI) is a non-profit, non-partisan organization committed to expanding economic opportunity for young adults ages 18 to 34, including access to comprehensive, affordable health care and coverage. As one of the leading organizations focused on educating and enrolling young adults in health coverage we appreciate the opportunity to comment in response to the proposed rule on short-term limited-duration insurance.

YI writes with strong objection to the proposed rule on short-term limited-duration insurance. The proposed rule rescinds restrictions on short-term plans, thereby allowing insurers to offer junk insurance policies to millions of consumers, including young adults. These plans exclude coverage for critically important health care services; vary premium rates by gender, health status, and age; and put individuals and families at significant financial risk. In addition, expanding these types of plans will undermine the individual market by pulling healthy individuals away and leaving an older, sicker risk pool behind. Many individuals who rely on comprehensive coverage – including women, older adults, and people with chronic conditions – would be left without affordable, comprehensive options.

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Because short-term limited-duration insurance plans may have lower up-front costs, young adults are likely to be disproportionately targeted by these plans. Additionally, young adults have demonstrated lower levels of health insurance literacy compared to older adults [1], making the ability to identify key differences between ACA plans and short-term plans harder. Young adults may unknowingly enroll in a 364-day short-term plan that is heavily marketed to them, believing they are receiving similarly comprehensive coverage that's available on the marketplace. And contrary to popular belief, young adults not only value health insurance, they need it. Nearly 7 in 10 young adults rate having health insurances as "very important"[2] and furthermore, an estimated 31 million young adults between 18-34 have pre-existing health conditions[3] that may require consistent access to comprehensive, affordable coverage. Because of this, after the passage of the ACA young adults had larger coverage gains than any other age group. Expanding short-term limited-duration plans would undermine the progress that has been made under the ACA to ensure that young adults, and all consumers, have access to comprehensive, affordable health insurance.

Short-term policies offer junk insurance that fails to meet the needs of young adult consumers.

Short-term, limited-duration insurance is intended to provide *temporary* insurance during unexpected coverage gaps. This type of coverage is exempt from the definition of individual health insurance coverage under the Affordable Care Act (ACA) and, therefore, does not have to comply with the law's core consumer protections. The proposed rule, therefore, promotes and will increase take up of skimpy, junk insurance coverage with minimal protections for young adult consumers. Specifically, such coverage:

- Has high out of pocket costs,
- Limits the coverage people can receive each year and over their lifetime,
- Discriminates against individuals, and
- Excludes basic health care services.

Short-term plans discriminate against individuals based on their health status. Because short-term plans are exempt from the ACA's pre-existing condition protections, plans deny coverage altogether or deny coverage of specific services based on health status and medical

[1] American Institutes for Policy Research. (2014). "A Little Knowledge is a Risky Thing: Wide Gap in What People Think They Know About Health Insurance and What they Actually Know." Retrieved April 20, 2018. https://www.air.org/sites/default/files/Health%20Insurance%20Literacy%20brief_Oct%202014_amended.pdf

[2] Kaiser Family Foundation. (2013). Kaiser Health Tracking Poll: June 2013. Princeton Survey Research Associates International. Retrieved from http://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-june-2013/

[3] Center for American Progress. "Number of Americans with Pre-Existing Conditions by Congressional District." April 5, 2017. Retrieved April 20, 2018. https://www.americanprogress.org/issues/healthcare/news/2017/04/05/430059/number-americans-pre-existing-conditions-congressional-district/

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history. Some insurers go as far as defining a condition to be preexisting if a member had symptoms within the prior five years "that would cause a reasonable person to seek diagnosis, care or treatment," even if she did not receive care, and even if she was not aware of the condition. For example, a woman between jobs in Atlanta bought a short-term plan in 2014 unaware that she had breast cancer. The insurer considered the disease a pre-existing condition and refused to cover it. She was left with $400,000 in medical bills.[4]

Short-term plans are not required to cover essential health benefits. In addition to being able to exclude coverage for pre-existing conditions, these plans are also allowed to categorically exclude certain benefits, including services that young adults use the most, such as: mental health care, routine maternity and newborn care, substance use disorder services, prescription drugs, and preventive care like birth control. Without these essential benefits consumers will lack adequate coverage. Current examples of common short-term plan exclusions include:

Benefit	Exclusion Language
Emergency care	Excluded: "Charges for use of hospital emergency due to illness." (See for example UnitedHealthOne)[5]
Women's reproductive health	Excluded: "Expenses for the treatment of normal pregnancy or childbirth, except for complications of pregnancy and normal newborn care; expenses for voluntary termination of normal pregnancy or contraception; infertility treatments or sterilization." (See for example IHC Secure Lite)[6]
Gender transition-related services	Excluded "Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies." (See for example IHC Secure Lite)[7]
Mental health care	Excluded: "Treatment of mental health conditions, substance use disorders; and outpatient treatment of mental and nervous disorders, except as specifically covered." (See for example National General)[8]

Insurers who sell short-terms plans frequently discriminate based on gender, including charging women higher premiums. ACA protections prohibit plans from basing premiums

[4] Lueck, Sarah. (2017, November 29). *Health Care Executive Order Would Destabilize Insurance Markets, Weaken Coverage*. Retrieved 26 March 2018, from https://www.cbpp.org/research/health/health-care-executive-order-would-destabilize-insurance-markets-weaken-coverage
[5] United Health One. "Short Term Medical Plans." Retrieved on 11 April 2018 from https://www.uhone.com/FileHandler.ashx?FileName=43853C1-G201703.pdf
[6] The IHC Group. "Secure Lite: Short-term Medical Insurance for Individuals and Families."
[7] The IHC Group. "Secure Lite: Short-term Medical Insurance for Individuals and Families."
[8] National General Accident and Health. "Short Term Medical." Retrieved on 11 April 2018 from https://www.insubuy.com/national-general/short-term-medical-insurance.pdf

on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. Before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating (charging women higher premiums than men). These predatory practices used to cost women approximately $1 billion a year[9] and are still commonplace among insurers selling short-term plans. Health questionnaires are also often used by short-term plans to identify and deny coverage to people with preexisting conditions, like pregnancy. The application process includes explicit language excluding applicants who are pregnant or an expectant father. Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services, such as surgery.

Short-term plans also impose lifetime and annual limits. An individual or family could quickly meet their annual and lifetime limit with expensive health care costs and treatment for a catastrophic medical emergency. The impact to individuals and families could be financially devastating and leave them without coverage. One insurer, for example, caps covered benefits, including treatment, services and supplies at just $750,000 per coverage period. At least one insurer provides per-service limits such as $1,000 per day for hospital room and board, $500 per day for emergency room services, $250 per trip for ambulance, and $10,000 for AIDS treatment.[10] These limits amount to woefully inadequate coverage for consumers and their families.

Short-term plans are also not subject to out-of-pocket maximums, which can leave consumers facing major, unpredictable financial risk. The ACA limits out-of-pocket maximums to $7,350 for individual coverage for the entire year, but some short-term plans may require out-of-pocket costs in excess of $20,000 per individual per policy period.[11] In some cases, out-of-pocket maximums for short-term plans are misleading and appear to be smaller than they are because the deductible does not count toward the maximum. Hidden and exorbitantly high out-of-pocket costs could be particularly devastating to low- and middle-income young adults who are still feeling the lasting effects of the Great Recession. Median wages have declined or remained unchanged in the last decade in four out of the top five industry sectors employing 18 to 24 year-olds[12]; meanwhile public tuition has skyrocketed in the last twenty years, and today's young adults with college degrees and student debt are left with a net wealth of -$1,900[13]. With little to no personal savings

[9] National Women's Law Center. (2012). Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act. Retrieved 14 December 2016, from http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf
[10] The IHC Group. "Secure Lite: Short-term Medical Insurance for Individuals and Families."
[11] Polliz, Karen. (2018, February 09). *Understanding Short-Term Limited Duration Health Insurance.* Kaiser Family Foundation. Retrieved 26 March, 2018, from https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/
[12] Tom Allison and Konrad Mugglestone. Young Invincibles. "Where Do Young Adults Work?" 2014. Retrieved April 20, 2018. http://younginvincibles.org/wp-content/uploads/2017/04/Where-Do-Young-Adults-Work-12.4.pdf
[13] Tom Allison. Young Invincibles. Financial Health of Young America: Update. April 2018. Retrieved April 20, 2018. http://younginvincibles.org/wp-content/uploads/2018/04/Financial-Health-of-Young-America-update.pdf

available to cover high out-of pocket costs, if those young adults enrolled in short-term plans face serious illness or injury, they could be saddled with medical debt that hinders their financial stability for years to come.

Expanding the availability of short-terms plans creates an uneven playing field. Due to discriminatory, predatory practices, short-term plans are able to offer low premiums and attract younger and healthier individuals. Leaving older, sicker and costlier risk pools behind in the ACA-compliant market. If healthier individuals are syphoned from the individual market, costs will increase and plan choices will decrease for individuals remaining in those markets. Consumers who need comprehensive coverage, including those with pre-existing conditions, and middle-class consumers with incomes too high to qualify for subsidies, would face rising premiums and potentially fewer plan choices.

Proposed Definition Change Inconsistent with Law

In addition to raising serious policy concerns, the proposed rule is also inconsistent with relevant law, as it defines "short-term limited duration coverage" to include coverage that lasts up to 364 days and 23 hours, which is not short-term by any reasonable reading of the statute.

The exclusion of short-term limited duration coverage from the definition of individual insurance coverage was established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In defining short-term limited duration coverage on an interim basis in 1997 and then in finalized regulations in 2004, the department described it as anything shorter than 12 months, which is the standard length for major medical coverage. Such a definition belies the statutory language; no one would call a 119-minute movie a short movie, compared to one lasting 120 minutes, or a 13-day 23-hour vacation a short vacation compared to a 2-week one.

This understanding of the meaning of "short-term" as being for a limited time period, rather than any coverage that is technically shorter than standard coverage, is consistent with how the product was marketed when HIPAA was adopted. Short-term coverage was for people who were between jobs or school terms and coverage terms were generally "short" as the word is commonly understood. Over the years, insurers have typically issued policies that lasted for short terms far less than one year. Online broker eHealth found in its 2011 data on short-term health plans that about 97 percent of its policies were issued in terms of 185 days or less, with the bulk of policies having a duration of 180 to 185 days. eHealth also reported that "the majority of short-term policies are offered on a six-month term."[14]

[14] The Cost & Benefits of Short-Term Individual and Family Health Insurance Plans, eHealth, June 2012. https://news.ehealthinsurance.com/_ir/68/20125/C_and_B_ShortTerm_Ind_and_Fam_071312-1.pdf

The proposed definition of short-term limited duration coverage is not only contrary to the plain statutory language, but also inconsistent with the statutory scheme established by Congress through the ACA. Under the pre-existing HIPAA definition, an insurer would be able to avoid the ACA's insurance reforms simply by limiting coverage to 364 days and specifying that the insurer had to consent for the policy to be renewed. Allowing for such plans would not only deprive consumers of the ACA's protections, but also seriously threaten the ACA's individual market risk pools, since healthy people could purchase underwritten short-term limited duration coverage that excluded preexisting conditions for far less than the cost of ACA exchange coverage, leaving people with health problems in an ever smaller and costlier individual coverage market. Eliminating this very outcome, the creation of separate risk pools for the healthy and the sick, was a primary goal of the ACA. *See* 42 U.S.C. 18032. Finally, allowing for short-term coverage that was virtually the same length as standard coverage would create a serious risk of consumer confusion—consumers, especially younger consumers with less purchasing experience, who bought "short-term" coverage that would cover them for virtually the entire year might not appreciate that they were purchasing something wholly different from individual insurance coverage, and thus might not know that they would still owe the individual mandate penalty if they purchased the so-called "short-term" coverage.

Given that the definition of "short-term" coverage is both inconsistent with the statutory text and the structure of the ACA, as set forth above, the department's proposed regulation as drafted is arbitrary, capricious, and contrary to law.

Making Short-Term Plan "Renewable" Would Be Inconsistent with the Law

The President's Executive Order[15] of October 12, 2017 asked HHS to consider making short-term limited duration coverage renewable, and statements by the administration made subsequent[16] to the publication of the proposed rule suggest that HHS is considering doing so. A rule that would make short-term, limited duration coverage renewable, however, would not be "in accordance with law."[17]

The concept of short-term limited duration coverage was introduced into the Public Health Services Act in 1996 by the Health Insurance Portability and Accountability Act (HIPAA), which defined individual health insurance coverage to exclude "short-term limited duration insurance." The ACA incorporates[18] the HIPAA definition by reference. HIPAA guaranteed

[15] Executive Order Promoting Healthcare Choice and Competition, Exec. Order No. 13813, 80 Fed. Reg. 48385, Retrieved April 23, 2018. https://www.gpo.gov/fdsys/pkg/FR-2017-10-17/pdf/2017-22677.pdf
[16] Sabrina Corlette, Georgetown Center for Health Insurance Reform, "Making Short-Term Plans a Long Term Coverage Option: Risks to Consumers and to Markets" Retrieved April 23, 2018. http://chirblog.org/making-short-term-plans-a-long-term-coverage-option/
[17] Scope of Review, 5 U.S. Code § 706 Retrieved April 23, 2018. https://www.law.cornell.edu/uscode/text/5/706
[18] Definitions, 42 U.S. Code § 18111 Retrieved April 23, 2018. https://www.law.cornell.edu/uscode/text/42/18111

the renewability[19] of individual health insurance coverage. By excluding short-term limited duration insurance from individual market coverage in adopting HIPAA, therefore, Congress intended that short-term limited duration coverage be non-renewable. This is confirmed by the phrase "limited duration" which is not redundant with "short-term"—and thus surplusage—by rather means that the coverage must not only be limited to a brief period of time, but also must not be renewable so as to endure beyond that time period.

Further confirmation is found in the fact that about half of the states refer to short-term coverage as non-renewable or non-renewable beyond a specified time period, either in their definition of short-term coverage or in consumer protection laws that exclude short-term coverage. Several of these state laws antedate HIPAA and all antedate the ACA.[20]

Specific Recommendations

I. Short-term limited-duration plans should not be expanded to more than three months (§54.9801-2 / §2590.701-2 / §144.103).

Short-term plans are designed to fill *temporary* gaps in coverage. These policies should not exceed three months.

The proposed rule would allow short term plans to enroll individuals for as long as 364 days. Allowing extensions of these policies expands the period of time in which people may be underinsured, leaving young adult consumers with inadequate coverage and at financial risk if they fall ill. Yearlong short-term plans would create consumer confusion about whether the coverage is the same as would be available through ACA-compliant one-year plans. Moreover, young adult consumers could be left with uncovered bills and/or find themselves "uninsurable." Because insurers can deny a new contract if the enrollee becomes sick or injured during the coverage term, consumers may believe they can extend or renew coverage until rejected by the issuer. If their short-term plan ends before Marketplace open enrollment, their loss of coverage would not qualify for a special enrollment period, leaving a consumer to wait until the next annual open enrollment period to select a new plan. This will lead to a gap in coverage for many young adult consumers.

Consumers seeking coverage for three months or longer can get covered through the

[19] Public Health Service Act As Amended Through P.L. 111–87, Enacted October 30, 2009, Retrieved on April 23, 2018. https://legcounsel.house.gov/Comps/Public%20Health%20Service%20Act-TITLE%20XXVII(Requirements%20Relating%20to%20Health%20Insurance%20Coverage).pdf

[20] Ohio H.B. 478 (1993), Ida. S.B. 1552 (1994), Minn. S.F. No. 1912 (1994), N.H. S.B. 30 (1995), Ore. S.B. 152 (1995), Ind. S.E.A. 576 (1995), Me. P.L. , c. 342 (1995), Mo. S.B. 27 (1995), Tenn. H.B. 1213 (1995), Tenn. H.B. 2484 (1996), Ct. H.B. 5468 (1996), Fla. S.B. 910 (1996), Va. H.B. 1026 (1996), Mi. S.B. 1007 (1997), Nev. Admin. Code § 689A.434 (Nov. 14, 1997), 28 Tex. Admin. Code § 3.3002 (Dec. 19, 1997), Colo. H.B. 1053 (1998), Cal. A.B. 424 (2002), Ga. H.B. 1100 (2002), Ut. S.B. 122 (2002), S.D. Admin. R. 20:06:39:32 (adopted 2003), Wis. S.B. 27 (2009), Ok. S.B. 778 (2011), and Kan. H.B. 2107 (2013).

Marketplaces. Allowing short-term plans longer than three months undermines the ACA and the risk pools in the individual market by encouraging healthy people to use short-term plans as an alternative to ACA plans. This would drive up premiums in the individual market, making comprehensive coverage with pre-existing condition protections less affordable for young adult consumers, particularly those that are ineligible for premium tax credits.[21]

We strongly oppose the proposed changes to the regulation at §54.9801-2 / §2590.701-2 / §144.103. The existing definition limiting the duration of short-term limited-duration insurance to "less than 3 months" should remain, as should the language "taking into account any extensions that may be elected by the policyholder with or without the issuer's consent."

II. Consumer notices should be explicit, in multiple languages, about ACA requirements that do not apply to short term plans (§54.9801-2 / §2590.701-2 / §144.103).

We support efforts in the proposed rule to help young adult consumers who purchase short-term, limited-duration policies to understand the coverage they are purchasing. We believe notice is vital for consumers to understand the limits of short-term plans and that they are not comprehensive coverage. We appreciate the specific language that clarifies that the plan does not comply with federal requirements and that enrollees might have to wait until an open enrollment period to get other health insurance coverage.

We recommend, however, that the notice needs to be clearer to be more easily understood by young adult consumers and that the notice be available in multiple languages. As the preamble notes, allowing short-term plans to provide coverage for just under one year will make it more difficult for consumers to distinguish between short-term plans and ACA plans. The notice must make clear how short-term plans differ from ACA plans. We recommend listing specific examples of ACA protections in the notice, including pre-existing conditions, essential health benefits like maternity care and mental health services, and preventative services without cost-sharing. The draft notice language also is not clear enough that loss of eligibility or coverage in a short-term plan does not trigger a special enrollment period.

The Departments should adjust the proposed notices at §54.9801-2 / §2590.701-2 / §144.103 to the following language:

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS

[21] American Academy of Actuaries. (2017, November 7) (http://www.actuary.org/files/publications/Executive_Order_Academy_Comments_110717.pdf

FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT, **SUCH AS COVERAGE OF PREEXISTING CONDITIONS, ESSENTIAL HEALTH BENEFITS LIKE MATERNITY CARE AND MENTAL HEALTH SERVICES, AND PREVENTATIVE SERVICES WITHOUT COST-SHARING** . BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOESN'T COVER. **EXPIRATION OR LOSS OF ELIGIBILITY FOR THIS COVERAGE DOES NOT TRIGGER A SPECIAL ENROLLMENT PERIOD**, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE.

III. The effective date of the rule should be delayed (§ 54.9833–1/§2590.736/§146.125).

We recommend that the proposed rule be rescinded in its entirety, but if finalized, insurers need time to appropriately design and price plans. Allowing expanded short-term plans to be offered in 2019 creates risk and uncertainty for health insurers in the individual market.[22] Insurers may have to build in rate increases associated with uncertainty if expanded short-term plans are allowed in 2019. Delaying implementation until 2020 will give insurers time to adjust to the insurance market without the individual mandate penalty and allow them to see which insurers are expanding or entering the short-term market. A delay would also allow states time to respond, through legislative or regulatory changes, to the impact of expanded availability of short-term plans on their markets.

We strongly oppose the proposed effective and applicability date of this rule. The effective date of the rule should be delayed until the 2020 plan year, if the rule is finalized.

IV. Short-term plans should never be allowed to continue for 12 months or longer.

Short-term limited-duration insurance is, by name, meant to be for a short, limited duration. As noted above, allowing these plans to continue for 12 months or longer places people in plans with limited coverage and at significant financial risk. Allowing renewals would suggest clear intent to circumvent the ACA and undermine the risk pools in the ACA-compliant individual market. States are the primary regulators of insurance and should maintain authority to regulate the renewability of these plans and the application and reapplication process. We strongly oppose any consideration of allowing short-term health plans to exceed three months, much less 12 months or longer.

[22] Robert Wood Johnson Foundation (March 2018) Insurers Remaining in Affordable Care Act Markets Prepare for Continued Uncertainty in 2018, 2019. Retrieved 26 March 2018, from https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2018/rwjf444308

YOUNG INVINCIBLES

V. Short-term Plans Will Pull Millions Away from ACA Individual Market

The estimates in the fiscal impact statement on the number of people enrolled undercounts the individual insurance market. The NAIC report on which the estimate was based fails to include short-term plans sold by discretionary associations or similar arrangements. Recent reports have suggested enrollment in short-term plans may be closer to one million today.[23] The Urban Institute has estimated that, as a result of this proposed rule, 4.3 million people would enroll in short-term plans in 2019.[24] The Urban Institute also estimated that the effect of the proposed rule, in combination with the elimination of the individual mandate penalty, would reduce enrollment in ACA-compliant plans by 18.3 percent.[25] The American Academy of Actuaries reaffirms the argument that short-terms plans will attract healthy individuals, causing the potential for market segmentation and adverse selection, and therefore increase premiums in the ACA-compliant market. As noted throughout, this rule will have the effect of undermining and weakening the ACA-compliant market – leaving people with higher premiums and fewer plan options.

Thank you for the opportunity to comment on the Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P). We once again urge the Departments to preserve and fully implement the Affordable Care Act as the most effective strategy to promote affordable consumer choice for health coverage. If you have any questions about our comments and recommendations, please contact Caitlin Morris (caitlin.morris@younginvincibles.org).

Sincerely,

Caitlin Morris
Policy and Research Director
Young Invincibles

[23] Abelson, Reed. (2017, November 30). *Without Obamacare Mandate, 'You Open the Floodgates' for Skimpy Health Plans.* Retrieved 26 March, 2018, from https://www.nytimes.com/2017/11/30/health/health-insurance-obamacare-mandate.html
[24] Blumberg, L., Buettgens, M., Wang, R. (February 2018). *The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending.* Retrieved 26 March, 2018), from https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf
[25] Blumberg, L., Buettgens, M., Wang, R. (February 2018). *The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending.* Retrieved 26 March, 2018), from https://edit.urban.org/sites/default/files/publication/96781/2001727_0.pdf

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THE VOICE FOR HEALTH CARE CONSUMERS

April 23, 2018

Honorable Alex Azar
Secretary
Department of Health and Human Services
P.O. Box 8010
Baltimore, MD 21244-8010

Mr. David Kautter
Acting Commissioner, Internal Revenue Service
Department of the Treasury
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Ms. Seema Verma
Administrator, Centers for Medicare & Medicaid Services
Department of Health and Human Services
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Mr. Preston Rutledge
Assistant Secretary, Employee Benefits Security Administration
Department of Labor
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RE: Comments on Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P)

Dear Secretary Azar, Administrator Verma, Acting Commissioner Kautter, and Assistant Secretary Rutledge,

Families USA appreciates the opportunity to comment in response to the proposed rule on short-term limited-duration insurance. Families USA is national non-profit organization, dedicated to the achievement of high-quality, affordable health care and improved health for all.

Families USA writes with strong objection to the proposed rule on short-term limited-duration insurance. The proposed rule rescinds restrictions on short-term plans, thereby allowing insurers to offer junk insurance policies to millions of consumers. These plans can and do exclude coverage for critically important health care services; vary premium rates by gender, health status, and age; reject some people upfront due to their medical conditions, and for others, subject bills to post-claims underwriting, thus denying payment for treatment after it has already occurred; often have no provider networks; and put individuals and families at significant financial risk. Plan marketing materials are confusing to consumers who do not understand the extremely limited coverage they receive. In many states, oversight and regulation of these plans is minimal: the plans are exempt from all or most state consumer protection laws that apply to comprehensive health coverage, just as they are exempt from the Affordable Care Act's protections. Expanding their duration (and thereby expanding their sales) will thus imperil many consumers.

In addition, expanding these types of plans will undermine the individual market by pulling healthy individuals away and leaving an older, sicker risk pool behind, and disrupting the market dynamic that prevented many "bare counties for the 2018 plan year. Many individuals who rely

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on comprehensive coverage – including women, older adults, and people with chronic conditions – would be left without affordable, comprehensive options.

Short-term policies fail to meet the needs of consumers.

A case that the DC Health Care Ombudsman brought to our attention illustrates this:

> A gentleman bought a short-term policy with a stated maximum of $750,000. After purchasing the policy, he needed heart surgery for which **he was billed $211,690**. Initially, the plan denied payment entirely due to its determination that the member had a pre-existing condition based on his father's medical history and that the patient was treated for conditions that were predisposed to coronary artery disease, even though the patient was never diagnosed. Eventually, as a result of the ombudsman's intervention, the **plan paid $11,780** of this bill, leaving he patient liable for the rest. This low payment resulted because each service was also capped: For the member's hospital stay, the maximum benefit payable was $1000 a day for 6 days, plus $1,250 for one day in the ICU. The surgeon fee maximum was $2500 for a triple bypass surgery. Payment for other medical services, such as testing, labs and xrays, were small payments that did not cover the full cost of services received, and after a time were no longer paid because the maximum payable benefits had been reached for a particular service.
>
> The Ombudsman writes that in other short-term policy cases the office has handled, "a simple wellness check or OB/GYN visit will be denied based on a pre-existing condition, or an agent will contact an individual and tell them that the plan complies with the ACA when it does not."[1]

Short-term, limited-duration insurance is intended to provide *temporary* insurance during unexpected coverage gaps. This type of coverage is exempt from the definition of individual health insurance coverage under the Affordable Care Act (ACA) and, therefore, does not have to comply with the law's core consumer protections. The proposed rule, therefore, promotes and will increase take up of skimpy, junk insurance coverage with minimal protections for consumers. Specifically, such coverage:

- Has high out of pocket costs,
- Limits the coverage people can receive each year and over their lifetime,
- Prices based on health status, age and gender
- Excludes coverage of pre-existing conditions
- Denies coverage based on health status
- Can be retroactively canceled (rescinded)
- Excludes basic health care services, including both entire classes of essential benefits (such as no coverage for mental health/substance use, no coverage for prescription

[1] Personal correspondence with Caridss Jacobs, Associate Health Care Ombudsman, Office of the Health Care Ombudsman and Bill of Rights, District of Columbia Government, February 21, 2018.

drugs) and fine-print exclusions (hernia surgery, school sports injuries, medical treatment following a suicide attempt or self-inflicted injury).
- May have no provider network, leaving the consumer liable for large differences between covered amounts and provider bills

Short-term plans discriminate against individuals based on their health status. Because short-term plans are exempt from the ACA's pre-existing condition protections, plans deny coverage altogether or deny coverage of specific services based on health status and medical history. Some insurers go as far as defining a condition to be preexisting if a member had symptoms within the prior five years "that would cause a reasonable person to seek diagnosis, care or treatment," even if she did not receive care, and even if she was not aware of the condition. For example, a woman between jobs in Atlanta bought a short-term plan in 2014 unaware that she had breast cancer. The insurer considered the disease a pre-existing condition refused to cover it. She was left with $400,000 in medical bills.[i]

Short-term plans are not required to cover essential health benefits. In addition to being able to exclude coverage for pre-existing conditions, these plans are also allowed to categorically exclude certain benefits, such as routine maternity and newborn care, prescription drugs, mental health care, substance use services, and preventive services like birth control and tobacco cessation. Without these essential benefits consumers will lack adequate coverage. Current examples of common short-term plan exclusions include:

Benefit	Exclusion Language
Emergency care	Excluded: "Charges for use of hospital emergency due to illness." (See for example UnitedHealthOne)[ii]
Women's reproductive health	Excluded: "Expenses for the treatment of normal pregnancy or childbirth, except for complications of pregnancy and normal newborn care; expenses for voluntary termination of normal pregnancy or contraception; infertility treatments or sterilization." (See for example IHC Secure Lite)[iii]
Gender transition-related services	Excluded "Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies." (See for example IHC Secure Lite)[iv]
Mental health care	Excluded: "Treatment of mental health conditions, substance use disorders; and outpatient treatment of mental and nervous disorders, except as specifically covered." (See for example National General)[v]
Prescription drugs	Excluded entirely. (See for example LifeShield/Agile); or covers only inpatient drugs (Secure Edge/Standard Security Life)
Pediatric services	Exclude pediatric dental and vision. None of the plans listed above covers pediatric dental care, for example.

Even plans that seem to cover a benefit include fine-print exclusions that consumers are not likely to notice or consider when purchasing a policy.
Examples of these include:
- LifeShield covers mental disorders and substance abuse, but excludes injury resulting from being under the influence of alcohol and drugs and excludes willfully self-inflicted injury or sickness.[vi]

- PivotHealth's brochure says it covers surgery but excludes tonsillectomy, most hysterectomy, herniorraphy, and several other surgeries for 6 months – even though as we understand current regulations, the policy cannot currently be sold for a period longer than 3 months. PivotHealth's website now says "A new feature we offer is the opportunity to apply for a total of four 90-day certificates of insurance at one time, affording you coverage beyond the standard 90-day duration" (https://www.pivothealth.com/product/short-term-health-insurance/). Further, smaller print on the plan's brochure describing benefits explains, "This is a partial list of exclusions and limitations. Please see the certificate for detailed information about these and other policy exclusions and limitations…."[vii]

Insurers who sell short-terms plans frequently discriminate based on gender, including charging women higher premiums. ACA protections prohibit plans from basing premiums on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. Before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating (charging women higher premiums than men). These predatory practices used to cost women approximately $1 billion a year[viii] and are still commonplace among insurers selling short-term plans. Health questionnaires are also often used by short-term plans to identify and deny coverage to people with preexisting conditions, including pregnancy. The application process includes explicit language excluding applicants who are pregnant or an expectant father. Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services, such as surgery.

Short-term plans also impose lifetime and annual limits. An individual or family could quickly meet their annual and lifetime limit with expensive health care costs and treatment for a catastrophic medical emergency. The impact on individuals and families could be financially devastating and leave them without coverage. One insurer, for example, caps covered benefits, including treatment, services and supplies at just $750,000 per coverage period. Another insurer provides per-service limits such as $1000 per day for hospital room and board, $500 per day for emergency room services, $250 per trip for ambulance, and $10,000 for AIDS treatment.[ix] These limits amount to woefully inadequate coverage for consumers and their families.

Short-term plans are also not subject to "out-of-pocket maximum" protections, which can leave consumers facing major, unpredictable financial risk. The ACA limits out-of-pocket maximums to $7,350 for individual coverage for the entire year, but some short-term plans may require out-of-pocket costs in excess of $20,000 per individual per policy period.[x] In some cases, out-of-pocket maximums for short-term plans are misleading and appear to be smaller than they are because the deductible does not count toward the maximum.

Information about provider networks can be misleading or non-existent; short-term plans are not subject to the network adequacy protections of comprehensive plans. For example, browsing IHC short term plans using a District of Columbia zip code yields instant quotes for Secure STM plans. The "Plan Details" brochure includes the following paragraph:

> "Utilize a network provider and save. With your Secure STM short-term medical plan, you have the freedom to choose any provider. In certain markets, you also have access to discounted medical services through national preferred provider organizations (PPOs). These network providers have agreed to negotiated prices for their services and supplies. While you have the flexibility to choose any healthcare provider, the discounts available through network providers for covered services may help to lower your out of-pocket costs."

If the shopper notices that the provider network is only in certain markets, he or she might click on "find a doctor" and then learn that there are none in the District of Columbia. In February, we called the agent number on the website to find out in what markets IHC does have networks. We were transferred to an agent who said, "We are the health insurance marketplace, you'll have to talk to the company for that information." "Do you mean you are healthcare.gov?" I asked. "We are the health insurance marketplace." "How can I talk to STM?" Agent hung up.[xi]

When there is no network, the amount that the consumer is reimbursed may have no relationship to their liability.

Expanding the availability of short-terms plans creates an uneven playing field and will raise the cost of comprehensive care.

Due to discriminatory, predatory practices, short-term plans are able to offer low premiums and attract younger and healthier individuals, leaving older, sicker and costlier risk pools behind in the ACA-complaint market. If healthier individuals are syphoned from the individual market, costs will increase and plan choices will decrease for individuals remaining in those markets. Consumers who need comprehensive coverage, including those with pre-existing conditions, and middle-class consumers with incomes too high to qualify for subsidies, would face rising premiums and likely fewer plan choices. The absence of unfair competition from short-term plans was important in contracting with plans to avoid rural "bare counties" for the 2018 plan year.

Further, if consumers are in plans for long periods of time that do not provide coverage of routine services (such as periodic dental care for children and vaccines), their untreated (but preventable) conditions will be costlier once they do enroll in comprehensive coverage. Last year, due to insurer concerns that consumers were waiting too long to enroll in comprehensive coverage, the administration reduced plan special enrollment periods. Yet the effect of this rule is likely to further delay the enrollment of many consumers into comprehensive plans, and when they do enroll, they will need more care.

Lengthening the duration of short-term coverage to nearly a year is inconsistent with federal law

The proposed rule is inconsistent with relevant law, as it defines "short-term limited duration coverage" to include coverage that is up to 364 days and 23 hours, which is not short-term by

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any reasonable reading of the statute.

The exclusion of short-term limited duration coverage from the definition of individual insurance coverage was established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In defining short-term limited duration coverage on an interim basis in 1997 and then in finalized regulations in 2004, the department described it as anything shorter than 365 days, which is the standard length for major medical coverage. Such a definition belies the statutory language; no one would call a 119-minute movie a short movie, compared to one lasting 120 minutes, or a 13-day 23-hour vacation a short vacation compared to a 2-week one.
This understanding of the meaning of "short-term" as being for a limited time period, rather than any coverage that is technically shorter than standard coverage, is consistent with how the product was marketed when HIPAA was adopted. Short-term coverage was for people who were between jobs or school terms and coverage terms were generally "short" as the word is commonly understood. Some states defined short term coverage as lasting no more than three months or six months; other states excepted "short term" coverage from certain state benefit mandates if coverage lasted for no more than six months.

The proposed definition of short-term limited duration coverage is not only contrary to the plain statutory language, but also inconsistent with the statutory scheme established by Congress through the ACA. Under the pre-existing HIPAA definition, an insurer would be able to avoid the ACA's insurance reforms simply by limiting coverage to 364 days and specifying that the insurer had to consent for the policy to be renewed. Allowing for such plans would not only deprive consumers of the ACA's protections, but also seriously threaten the ACA's individual market risk pools, since healthy people could purchase underwritten short-term limited duration coverage that excluded preexisting conditions for far less than the cost of ACA exchange coverage, leaving people with health problems in an ever smaller and costlier individual coverage market. Eliminating this very problem, the creation of separate risk pools for the healthy and the sick, was a primary goal of the ACA. *See* 42 U.S.C. 18032. Finally, allowing for short-term coverage that was virtually the same length as standard coverage would create a serious risk of consumer confusion—consumers who bought "short-term" coverage that would cover them for virtually the entire year might not appreciate that they were purchasing something wholly different from individual insurance coverage, and thus might not know that they would still owe the individual mandate penalty if they purchased the so-called "short-term" coverage.
Given that the definition of "short-term" coverage is both inconsistent with the statutory text and the structure of the ACA, as set forth above, the department's proposed regulation as drafted is arbitrary, capricious, and contrary to law.

Specific Recommendations

I. Short-term limited-duration plans should not be expanded to more than three months (§54.9801-2 / §2590.701-2 / §144.103).

Short-term plans are designed to fill *temporary* gaps in coverage. These policies should not exceed three months.

The proposed rule would allow short term plans to enroll individuals for as long as 364 days. Allowing extensions of these policies expands the period of time in which people may be underinsured, leaving consumers with inadequate coverage and at financial risk if they fall ill. Yearlong short-term plans would create consumer confusion about whether the coverage is the same as would be available through ACA-compliant one-year plans. Moreover, consumers could be left with uncovered bills and/or find themselves "uninsurable." Because insurers can deny a new contract if the enrollee becomes sick or injured during the coverage term, consumers may believe they can extend or renew coverage until rejected by the issuer. If their short-term plan ends before Marketplace open enrollment, their loss of coverage would not qualify for a special enrollment period, leaving a consumer to wait until the next annual open enrollment period to select a new plan. This will lead to a gap in coverage for many consumers.

Consumers seeking coverage for three months or longer can get covered through the Marketplaces. Federal policymakers should address any remaining enrollment issues through improvements in open and special enrollment periods, and not by undermining comprehensive coverage. Allowing short-term plans longer than three months undermines the ACA and the risk pools in the individual market by encouraging healthy people to use short-term plans as an alternative to ACA plans. This would drive up premiums in the individual market, making comprehensive coverage with pre-existing condition protections less affordable for consumers, particularly those that are ineligible for premium tax credits.[xii]

We strongly oppose the proposed changes to the regulation at §54.9801-2 / §2590.701-2 / §144.103. The existing definition limiting the duration of short-term limited-duration insurance to "less than 3 months" should remain, as should the language "taking into account any extensions that may be elected by the policyholder with or without the issuer's consent."

II. Consumer notices should be explicit, in multiple languages, about ACA requirements that do not apply to short term plans (§54.9801-2 / §2590.701-2 / §144.103).

We support efforts in the proposed rule to help consumers who purchase short-term, limited-duration policies to understand the coverage they are purchasing. We believe notice is vital for consumers to understand the limits of short-term plans and that they are not comprehensive coverage. We appreciate the specific language that clarifies that the plan does not comply with federal requirements and that enrollees might have to wait until an open enrollment period to get other health insurance coverage.

We recommend, however, that the notice be clearer to be more easily understood by consumers, and that the notice be available in multiple languages. As the preamble notes, allowing short-term plans to provide coverage for longer time periods will make it more difficult for consumers to distinguish between short-term plans and ACA plans. The notice must make clear how short-

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term plans differ from ACA plans. We recommend listing specific examples of ACA protections in the notice, including preexisting conditions and essential health benefits. The draft notice language also is not clear enough that loss of eligibility or coverage in a short-term plan does not trigger a special enrollment period.

In addition to adjusting the wording in the large print required notice, we recommend requiring plans to provide an explicit outline of benefits and exclusions, similar to the summary of benefits and coverage requirement that applies to comprehensive coverage. At a minimum, information about provider networks (or lack thereof), each exclusion and benefit limit, and pre-existing condition limitations and look-back periods should be available and easily accessible to consumers on the web before they purchase a policy.

III. If the rule is finalized, contrary to our recommendation, the effective date of the rule should be delayed (§ 54.9833–1/§2590.736/§146.125).

We strongly recommend that the proposed rule be rescinded in its entirety, since it is contrary to the intent of the law and consumers' interests and would undermine comprehensive insurance. But if it is finalized contrary to our recommendation, insurers need time to appropriately design and price comprehensive plans. Allowing expanded short-term plans to be offered in 2019 creates risk and uncertainty for health insurers in the individual market.[xiii] Insurers may have to build in rate increases associated with uncertainty if expanded short-term plans are allowed in 2019. Delaying implementation until 2020 will give insurers time to adjust to the insurance market without the individual mandate penalty and allow them to see which insurers are expanding or entering the short-term market. A delay would also allow states time to respond, through legislative or regulatory changes, to the impact of expanded availability of short-term plans on their markets.

We strongly oppose the proposed effective and applicability date of this rule. The effective date of the rule should be delayed until the 2020 plan year, if the rule is finalized.

IV. Short-term plans should never be allowed to continue for 12 months or longer.

Short-term limited-duration insurance is, by name, meant to be for a short, limited duration. As noted above, allowing these plans to continue for 12 months or longer places people in plans with limited coverage and at significant financial risk. This risk is compounded significantly when the plans are renewable. The case Miller v Fid Sec Life Ins Co, 294 F 3d 762, illustrates this point. When an Ohio consumer purchased a policy for two consecutive three month terms, the insurer would not pay claims during the second policy period for symptoms that manifested during the first policy period. Similar disputes, with various outcomes, are likely if short-term plans are renewed for multiple periods at the insurers' discretion.

Allowing renewals would suggest clear intent to circumvent the ACA and undermine the risk pools in the ACA-compliant individual market. States are the primary regulators of insurance

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and should maintain authority to regulate the renewability of these plans and the application and reapplication process. We strongly oppose any consideration of allowing short-term health plans to exceed three months, much less 12 months or longer.

V. Short-term Plans Will Pull Millions Away from ACA Individual Market

The estimates in the fiscal impact statement on the number of people to be enrolled undercounts the individual insurance market. The NAIC report on which the estimate was based fails to include short-term plans sold by discretionary associations or similar arrangements. Recent reports have suggested enrollment in short-term plans may be closer to one million today under current rules.[xiv] The Urban Institute has estimated that, as a result of this proposed rule, 4.3 million people would enroll in short-term plans in 2019.[xv] The Urban Institute also estimated that the effect of the proposed rule, in combination with the elimination of the individual mandate penalty, would reduce enrollment in ACA-compliant plans by 18.3 percent.[xvi] The American Academy of Actuaries reaffirms the argument that short-terms plans will attract healthy individuals, causing the potential for market segmentation and adverse selection, and therefore increase premiums in the ACA-compliant market. Wakely, in its study for the Association for Community Affiliated Plans, estimates that the extension of short-term plans under this rule would increase premiums in ACA-complaint plans by 0.7%-1.7% the first year, and by 2.2% to 6.6% in future years[xvii].As noted throughout our comment, this rule will have the effect of undermining and weakening the ACA-compliant market – leaving people with higher premiums and fewer plan options.

Thank you for the opportunity to comment on the Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P). We once again urge the Departments to preserve and fully implement the Affordable Care Act as the most effective strategy to promote affordable consumer choice for health coverage. If you have any questions about our comments and recommendations, please contact me at cparcham@familiesusa.org.

Sincerely,

Cheryl Fish-Parcham
Director of Access Initiatives

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[i] Lueck, Sarah. (2017, November 29). *Health Care Executive Order Would Destabilize Insurance Markets, Weaken Coverage.* Retrieved 26 March 2018, from https://www.cbpp.org/research/health/health-care-executive-order-would-destabilize-insurance-markets-weaken-coverage

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[iii] The IHC Group. "Secure Lite: Short-term Medical Insurance for Individuals and Families."

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[iv] The IHC Group. "Secure Lite: Short-term Medical Insurance for Individuals and Families."
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[xvii] M. Cohen, et al, "Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market," Wakely Consulting Group for the Association for Community Affiliated Plans, 2018, https://www.communityplans.net/policy/effects-of-short-term-limited-duration-plans-on-the-aca-compliant-individual-market/.

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April 23, 2018

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Baltimore, MD 21244-8010

Mr. Preston Rutledge
Assistant Secretary, Employee Benefits Security Administration
Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Re: Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P)

Dear Secretary Azar, Administrator Verma, Acting Commissioner Kautter, and Assistant Secretary Rutledge:

Thank you for the opportunity to submit comments on your Departments' proposed rule on Short-Term Limited-Duration (STLD or short-term) insurance. The 21 undersigned organizations urge the

Departments to withdraw this proposed rule unless it is heavily revised to meet our standards of accessibility, affordability, and adequacy that appropriately protects patients and consumers.

Our organizations represent millions of patients and consumers across the country facing serious, acute, and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, manage health, and cure illness. Our diversity enables us to draw upon a wealth of knowledge and expertise that can be an invaluable resource in this discussion. We urge the aforementioned Departments to make the best use of the collective insight and experience that we, and the individuals we represent, offer in response to this proposed rule.

In March 2017, our organizations agreed upon three overarching principles we would use to guide and measure any work to reform and improve the nation's healthcare system.[1] These principles state that: (1) healthcare must be adequate, meaning that healthcare coverage should cover treatments patients need including all the services in the essential health benefits (EHB) package; (2) healthcare should be affordable, enabling patients to access the treatments they need to live healthy and productive lives; and (3) healthcare should be accessible, meaning that coverage should be easy to understand and not pose a barrier to care, the enrollment process should be easy to undertake, and benefits should be clearly defined.

In this proposed rule, your Departments propose to: expand the maximum coverage period of a short-term plan from three months to less than 12 months; revise the consumer notice required within any short-term plan contract and application materials; and implement these changes within 60 days of the publication of a final rule.

Short-Term Insurance is Not a Long-Term Solution

In light of our organizations' principles, we are deeply concerned about the impact the proposed rule on short-term plans will have on the individuals and families we represent—including those who choose not to purchase STLD plans. While STLD plans can offer cheaper premiums for some consumers, they are not required to adhere to important standards, including coverage for the ten essential health benefit categories, guaranteed issue, age and gender rating, prohibitions on discrimination against people with pre-existing conditions, annual out of pocket maximums, prohibitions on annual and lifetime coverage limits, and many other critical patient and consumer protections.

These plans often require consumers to spend enormous sums during the deductible portion of their benefit design, which can quickly eclipse the premium savings consumers may have while covered by one of these plans.[2] In addition to the exclusions listed above, short-term plans also frequently exempt themselves from many routine medical services that average consumers may not realize are not covered.[3,4] This combination of extraordinary financial risk and the lack of basic patient and consumer

[1] Healthcare reform principles. American Heart Association website. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_495416.pdf.

[2] UnitedHealthcare commercial webpage titled "Short-term Health Plans For Individuals and Families." https://www.uhone.com/insurance/short-term. Accessed on April 10, 2018.

[3] Agile Health Insurance, Everest Prime STM, pg. 11, http://dah38g2inbo50.cloudfront.net/everest-34d8af6c22f69da36d58184e5954eed5.pdf. Accessed on April 18, 2018.

[4] K. Pollitz, *Understanding Short-Term Limited Duration Health Insurance*, Feb. 2018, available at http://files.kff.org/attachment/Issue-Brief-Understanding-Short-Term-Limited-Duration-Health-Insurance.

protections led those who sell these plans to acknowledge that such plans are "designed solely to provide temporary insurance during unexpected coverage gaps"[5] and contribute to their status under federal regulation as separate and distinct from "individual health insurance coverage."[6]

The connection between access to health insurance and health outcomes is clear for the individuals we represent.[7,8] For example, Americans with cardiovascular disease or associated risk factors who lack health insurance, or are underinsured, have higher mortality rates[9] and poorer blood pressure control than their insured counterparts.[10] We are concerned that short-term plans, while less expensive than Affordable Care Act (ACA)-compliant plans, would be woefully inadequate for the majority of our patient populations regardless of age, gender, or health status.

Furthermore, many of the individuals represented by our organizations would be unable to purchase short-term plans due to a pre-existing condition. It is also likely that they would be unwilling to purchase such plans when confronted with the lack of vital patient protections and basic services these plans offer. Unfortunately, patients and consumers who choose to remain in the individual insurance markets would still be negatively impacted if the proposed rule is finalized in its current form. Consumers who choose to purchase ACA-compliant health plans would see their premiums increase and their insurance options decrease as people leave the market to purchase short-term plans.

Extending the period and renewability of short-term plans would significantly and negatively impact the families and individuals we represent. As such, our organizations are extremely concerned that implementing these policies will once again leave patients and consumers in the lurch with insufficient coverage, unpaid medical bills, long-term impacts on their financial wellbeing, and lifelong health implications – just as many of these plans did prior to the enactment of the ACA. If implemented, this proposed rule would have downstream impacts on the individual insurance markets jeopardizing access to affordable and adequate health insurance options for consumers who do not intend to purchase short-term plans. To sum up, short-term plans are an insufficient and inadequate solution to addressing premium and out-of-pocket costs and will have many long-lasting impacts on the entire health insurance market, as well as the health and wellbeing of the individuals we represent.

Accessibility

As mentioned above, a key principle adopted by our organizations is that healthcare must be accessible. All people, regardless of employment, health status or geographic location, should be able to gain coverage without waiting periods or undue barriers to coverage. At the same time, important patient protections in current law should be maintained, including prohibitions on preexisting condition exclusions, annual and lifetime limits, insurance policy rescissions, gender rating, and excessive

[5] 83 Fed. Reg. at 7443.

[6] Ibid.

[7] Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Medical Care Research and Review*. 2005; 62(1): 231-249.

[8] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs*. 2004; 23(4): 223-233.

[9] RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report. http://www.heart.org/idc/groups/heart- public/@wcm/@adv/documents/downloadable/ucm_491513.pdf Accessed June 19, 2017.

[10] McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. Health Affairs 2004; 23(4): 223-233.

premiums for older adults. Our organizations agree that every individual needs access to quality and affordable healthcare in order to maintain or improve their health and wellbeing.

Discriminatory Plan Design

Because short-term plans are exempt from the ACA's pre-existing condition protections, these plans can deny coverage of specific services based on health status and medical history of an individual, or deny coverage altogether. Insurers who offer short-term plans can also discriminate based on health status by charging higher premiums. By definition, these plans are widely inaccessible to our patient and consumer populations.

Protections included in the ACA prohibit plans from basing premiums on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. Before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating (charging women higher premiums than men). These predatory practices used to cost women approximately $1 billion a year and are still commonplace among insurers selling short-term plans.[11] Health questionnaires are also often used by short-term plans to identify and deny coverage to people with preexisting conditions, a category that can even include pregnancy. The application process often includes language explicitly excluding applicants who are pregnant, or an expectant father. Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services, such as surgery.

Network Adequacy

Short-term plans would also be exempt from any ACA-related network adequacy requirements. While ACA-compliant Qualified Health Plans (QHPs) must meet certain quantitative standards to ensure beneficiary access to varying medical services, such as primary care, oncology, maternity and newborn care, mental health, and emergency services, short-term plans are not required to comply with these standards. This is particularly concerning for our organizations as we represent individuals who are most in need of access to emergency services, outpatient care, and specialty physicians. These physicians and health services are also often the most expensive. Without regulation and oversight of network adequacy within these short-term plans as this proposal would allow, the physicians and services that patients require could be excluded from short-term provider networks altogether. They may also include facilities or specialists in the network that are far too distant from beneficiaries to be accessible.

Affordability

Our organizations' principles also recognize that illness and disease impact individuals across the economic spectrum. We believe that everyone – regardless of their economic situation – should be able to obtain the treatment they require to manage, maintain, or improve their health. This means that care should be affordable to an individual, including reasonable premiums and cost-sharing, and that individuals with pre-existing conditions should be protected from being charged more for their coverage. The proposed rule fails to achieve these goals.

Market Segmentation

Under the proposed rule, the Departments themselves acknowledge that, "consumers who purchase short-term, limited-duration insurance policies and then develop chronic conditions could face financial

[11] National Women's Law Center. (2012). Turning to Fairness: Insurance Discrimination against Women Today and the Affordable Care Act. Retrieved 14 December 2016, from http://www.nwlc.org/sites/default/files/pdfs/nwlc_2012_turningtofairness_report.pdf

hardship as a result, until they are able to enroll in PPACA-compliant plans that would provide coverage for such conditions".[12] However, allowing short-term plans to proliferate in the market will not only result in more people buying plans that may not cover the services they need, but will also have a negative impact on the stability and viability of the individual market itself. A recent study conducted by the Urban Institute projects that this proposed rule would result in over 2.5 million younger and healthier consumers across the country moving out of minimum essential coverage plans and into short-term plans, increasing premiums for those consumers who remain in the ACA-compliant nongroup insurance market by an average of 18.3 percent.[13] These increases in premiums would also likely be accompanied by an exodus of insurers from the marketplaces as their risk pools become older and sicker.

The Departments expect this very same outcome, stating:

> Allowing [relatively young and healthy] individuals to purchase policies that do not comply with [ACA], but with term lengths that may be similar to those of [ACA]-compliant plans with 12-month terms, could potentially weaken States' individual market single risk pools. As a result, individual market issuers could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market.[14]

They continue, asserting that, "[i]f individual market single risk pools change as a result, it would result in an increase in premiums for the individuals remaining in those risk pools."[15]

Within this proposed rule, the Departments admit that individuals with chronic conditions, which includes nearly half of the adult population in the United States[16] and the very patients and families that we represent, will be harmed by this rule. Individuals with chronic conditions would be ineligible for short-term insurance, either due to discriminatory plan practices or overt and total benefit exclusions, leaving ACA marketplace plans as their only option. For those in the marketplace, the Departments expect the implementation of this rule, if finalized, to raise their premiums by 10 percent on average.[17]

It is clear that the Departments understand the negative impact of the proposed rule. This blatant and intentional segmentation of the individual market will not only harm individuals with chronic, acute or serious health conditions enrolled in short-term plans, but will effectively undermine their ability to obtain affordable comprehensive coverage by exacerbating price increases within the individual market.

Lifetime and Annual Caps

Under current law, the ban on lifetime and annual caps only applies to EHB-covered services. But under this proposal, the Departments would facilitate the proliferation of health insurance options that do not have to comply with EHB coverage requirements. The Departments acknowledge that, "[s]hort-term, limited-duration insurance policies would be unlikely to include all the elements of [ACA]-compliant

[12] 83 Fed. Reg. 7437.
[13] Blumberg LJ, Buettgens M, Wang R. Updated: 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
[14] 83 Fed. Reg. at 7443.
[15] Ibid.
[16] Ward BW, Schiller JS, Goodman RA. Multiple chronic conditions among US adults: a 2012 update. *Prev Chronic Dis.* 2014;11:E62.
[17] 83 Fed. Reg. at 7443.

plans, such as... coverage of essential health benefits without annual or lifetime dollar limits…".[18] Therefore, this proposal would once again subject patients to significant financial insecurity due to medical needs.

In 2007, more than 60 percent of all bankruptcies were the result of serious illness and medical bills.[19] Patients who undergo heart transplants, use specialty medications, have complicated pregnancies, receive a cancer diagnosis, or are diagnosed with rare and complex conditions could easily meet or exceed lifetime and annual caps within a short period of time. For example, prior to the ACA, many children with hemophilia reached the lifetime limit on coverage under both parents' insurance plans before turning 18, leaving them without coverage options.[20,21] For these reasons, we strongly urge the Departments to consider the financial implications for our patients and secure their financial wellbeing by requiring short-term plans to comply with ACA consumer protections.

Annual Out-of-Pocket Maximums

The ACA also implemented a requirement for QHPs to include an annual out-of-pocket maximum set each year by the Department of Health and Human Services (HHS). For 2018, the annual out-of-pocket limit for an individual is $7,350, and for a family plan is $14,700.[22] Similar to the ban on annual and lifetime caps, the out-of-pocket maximums only apply to EHB-covered services. If the Departments move forward with this proposed dramatic expansion of non-EHB compliant short-term plans, it will also be subjecting consumers and patients with complex and chronic conditions in these plans to unaffordable cost-sharing for medically necessary services.

Adequacy

In our third principle, we assert that healthcare coverage must be adequate, covering the services and treatments patients need, including patients with unique and complex health care needs. It is paramount that protections including EHB packages, the ban on annual and lifetime caps, and restrictions on premium rating all be preserved in all health care plans, whether they are considered short-term policies or not.

As we have already stated, we are deeply concerned that the short-term plans created by this proposed rule could offer entirely inadequate, even discriminatory, coverage to the communities we represent. Our organizations emphatically urge the Departments not to finalize the rule or, if unwilling to do so, modify the proposed rule to fully protect consumers and patients against harm by requiring that all short-term plans that are allowed to operate for longer than the currently permitted three-month limit adhere to the patient protection standards that apply to plans sold on the individual marketplace.

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[18] Ibid

[19] Himmelstein DU, Throne D, Warren E, Woolhander S, Medical bankruptcy in the United States, 2007: results of a national study. Am J Med 2009 Aug; 122(8): 741-6. Doi.

[20] Economic Costs of Hemophilia and the Impact of Prophylactic Treatment on Patient Management," AJMC (4.18.2016), http://www.ajmc.com/journals/supplement/2016/incorporating-emerging-innovation-hemophilia-ab-tailoring-prophylaxis-management-strategies-managed-care-environment/incorporating-emerging-innovation-hemophilia-ab-tailoring-prophylaxis-management-strategies-managed-care-environment-economic-costs?p=1

[21] National Hemophilia Foundation: Strategic Summit Report" (October 2012), at 11: https://www.hemophilia.org/sites/default/files/article/documents/HemophiliaSummitFinalReportOct2012.pdf

[22] Department of Health and Human Services, Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, Final Rule, 81 Fed. Reg. 94058 (Dec. 22, 2016).

Essential Health Benefits (EHBs)

One of the most troubling characteristics of short-term health insurance plans is that they are not required to comply with EHB coverage requirements that apply to health plans offered on the individual market.

The individuals we represent rely on the current law's coverage requirements for access to medically necessary care. Prior to the creation of the ten EHB categories, patients and consumers frequently found themselves enrolled in plans that failed to provide coverage for the care they routinely relied upon to maintain their health or treat illnesses. Patients with serious illnesses would discover they were not covered for new and innovative treatments, some individuals could not get coverage for emergency room services, and patients with chronic illnesses were often denied coverage for life-improving, sometimes even life-saving, medication. Many of these individuals did not realize at the time of their enrollment that they had selected a plan that did not meet their health care needs, let alone provide adequate coverage for a new diagnosis. Individuals with and without pre-existing conditions have come to rely upon the foundation that EHBs provide for adequate health insurance, and they expect those services to be covered by their insurance.

Short-term plans are allowed to categorically exclude certain benefits, such as maternity and newborn care, prescription drugs, mental health care, substance use services, and preventive services like birth control and tobacco cessation. We are very concerned that healthy individuals may enroll in a short-term health plan that they believe meets their limited needs, but then not have access to necessary and medically appropriate care, including preventive care, as well as unpredictable but necessary health services such as prescription drugs or emergency room services.

Preventive Services

Short-term plans also would not be required to cover preventive services with no cost-sharing. Current law requires most private health plans to cover preventive services without cost-sharing, including co-pays, co-insurance and deductibles. The defined preventive services are any treatment receiving an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and any immunization having a recommendation from the Advisory Committee on Immunization Practices. They include services like cancer screenings, preventive treatments for cardiovascular disease, screenings for pregnant women, and tobacco cessation. These preventive services save both money and lives and are an important component of healthcare coverage for our patients.

Specific Solicited Feedback

Under the proposed rule, the Departments also solicited specific feedback regarding commenters' perspectives on (1) the appropriate duration of short-term plans; (2)existing regulations, policies, or guidance that limit or create barriers to entry into the short-term plan market; (3) conditions under which issuers should be allowed to incorporate renewability of these plans beyond 12 months; (4) the accuracy of the Departments' estimates of the increase in both premiums and federal spending that would result from this proposal; and (5) the impact of the proposed effective date.

Duration

The Departments ask what the appropriate duration of a STLD plan should be. The proposed rule suggests that the duration should increase from three months (90 days) to under 12 months (presumably 364 days). Our organizations believe this shift is unwarranted and will threaten the accessibility, affordability, and adequacy of health care for patients, as has been previously detailed. The

short-term plans are transitional coverage for people to access some coverage between jobs or other extenuating circumstances but are not considered healthcare coverage as defined by the Affordable Care Act, the Congressional Budget Office (CBO), and our organizations. Since short-term plans are not true health insurance, our organizations believe the duration of the plans should not exceed the current three-month threshold.

Renewability

Unlike insurance plans sold on the individual market, short-term plans also do not have to offer continued coverage once the policy term expires. This means that individuals who purchase these policies and then develop a health condition almost certainly will not have the option to renew their coverage, resulting in an effective rescission of coverage due to health status. This would disproportionately affect the individuals who develop acute, chronic, and serious health conditions while enrolled in short-term plans and cause significant, potentially dangerous disruption to their care.

As such, our organizations do not believe these plans should be renewable or allowed to continue for more than three months. The renewability of plans should be reserved for health insurance that meet the definition of minimum essential coverage (MEC). Under the proposed rule, the STLD plans do not meet that definition. Further, allowing for short-term plans to be renewed will create confusion in the marketplace. Our organizations strongly object to the renewability of the short-term plans.

Effective Date

As proposed, the final rule will become effective 60 days after the publication of the final rule, and any plans sold on or after the 60th day would need to meet the definition contained in that final rule to be considered short-term, limited-duration insurance. Our groups are deeply concerned that this timeline could threaten the stability of the individual market as it will allow for plans to be sold in 2018, after the rate filing process for 2019 is well underway or even complete in some states.

Issuers, state insurance commissioners, and other stakeholders need ample time to address the significant effects that the final rule will have on the individual marketplace. Issuers are already developing rates for the 2019 plan year. The Department of Health and Human Services' guidelines indicate that issuers' deadline for submitting plans in the exchange is less than two months after comments are due.[23] Setting the effective and applicability dates just 60 days after the release of the final rule will not provide enough time to prepare for this major disruption to the health care of millions of Americans purchasing insurance in the individual marketplace.

Moreover, some state legislatures might desire to pass laws that would address the STLD plans sold in their state. As of May 31, however, at least 30 states' regular legislative sessions will have ended. The effective date denies those states the ability to consider the impact of STLD plans on their individual market and to make changes that might compensate or mitigate that effect.

Departmental Estimates

The Departments estimate that the impact of this policy would be minimal, resulting in 100,000-200,000 individuals exiting the individual insurance markets in favor of enrolling in a short-term plan. We are concerned that this estimate is excessively conservative. An analysis conducted by the Urban Institute

[23] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Proposed-Key-Dates-for-Calendar-Year-2018.pdf

estimates that more than 4 million individuals would exit the exchanges to purchase a STLD plan.[24] The significant discrepancy between these two estimates suggests that the Department's estimations may be low and should be recalculated.

Other Concerns

Guided by the real experiences and needs of people with high health care needs that we represent, many of our groups have additional concerns with the proposed rule put forward by your Departments.

Notification to Consumers

Under the proposed rule, the Departments propose modifying the notice to consumers that the plan they are purchasing is not minimum essential coverage (MEC). We appreciate the language that clarifies the plan does not meet federal standards. However, as proposed, the notice is not sufficient to inform consumers that the coverage offered by these plans is frequently inadequate or substandard. Our organizations believe the notice on short-term limited-duration plans, including all plan documents and those that advertise the plans, must clearly articulate that these plans do not meet ACA protections, including those regarding preexisting conditions and essential health benefits.

Medical Loss Ratio

Additionally, as these plans are not ACA-compliant, they are not subject to the ACA's medical loss ratio (MLR) requirements under federal law. The MLR requirement, or so-called '80-20 rule', compels individual and small group health plans to spend at least 80 percent of premium income on health care and quality improvement activities, or rebate amounts in excess of this payout requirement back to the policyholder. Since 2011, insurance companies have paid out $3.2 billion in rebates under the medical-loss-ratio requirement.[25] As such, the MLR requirement represents a major advance in the transparency and value of health insurance coverage, and places a curb on insurers' marketing and overhead expenditures.

Absent this requirement for STLD products, insurers choosing to issue them will be more likely to spend more resources on marketing short-term products and offering higher commissions to their brokers compared to comprehensive ACA-compliant plans. This creates a perverse incentive for brokers to aggressively market these plans, and consumers may purchase them without understanding what they are buying. For patients with pre-existing conditions, unintentionally signing up for a short-term plan can limit access to life-sustaining treatment or leave them with no insurance at all if they are denied coverage – and with no recourse. Without a clear explanation of the basic elements of health insurance that may not be covered by these plans, consumers may not understand the comprehensiveness (or lack thereof) of their coverage. This creates a dangerous situation for patients who may unknowingly purchase plans that do not include the providers, medications, treatments, or services that they need to manage their conditions and stay healthy. As a result, patients may end up being surprised with massive medical bills for treatment that they believed to be covered, likely when they attempt to use their plan and need care most.

[24] Blumberg, L, Buettgens, M, & Wang, R. The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending, The Urban Institute, February 2018. Available at https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf

[25] Health Insurance.org, 'Billions in ACA rebates show 80/20 Rule's impact'. online April 16, 2017.

Concerns with the Public Comment Process

Finally, our groups are concerned with the Departments' comments regarding the finalization of the rule prior to the comment period closure. In a letter to the Governor and Director of the Department of Insurance of Idaho about the enforcement of the Affordable Care Act, Administrator Verma stated that CMS believed that Idaho could modify a proposal to sell state-based plans to comply with the new short-term, limited-duration plan rule so that the state could legally offer them.[26] We are concerned that CMS and other federal agencies and departments would offer guidance to states regarding the implementation of a regulation that is not yet finalized prior to taking into account the opinions and recommendations of all stakeholders who wish to comment.

Conclusion

Our organizations represent millions of patients, individuals, caregivers, and families who need access to quality and affordable healthcare regardless of their income or geographic location. We appreciate the opportunity to provide our recommendations on the proposed rule. However, given the history of discrimination and inadequate coverage within short-term limited-duration plans, we are deeply concerned that the proposed rule could seriously undermine the key principles of access, adequacy, and affordability that are the underpinnings of current law – and put those we represent at enormous risk.

We urge the Departments to withdraw the proposed rule until the needs of our populations are met and instead, to focus on stabilizing the individual insurance markets and lowering premiums for QHPs.

As leaders in the healthcare and research communities and staunch patient and consumer advocates, we look forward to working with the Departments of the Treasury, Labor, and Health and Human Services' leadership and staff on the direction of such important public policy. Thank you for the opportunity to submit comments on this rule. If you have any questions or would like to discuss these comments further, please contact Katie Berge, American Heart Association Government Relations Manager, at katie.berge@heart.org or 202-785-7909.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
Autism Speaks
Chron's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes

[26] https://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Otter.pdf

Mended Little Hearts
NAMI
National Health Council
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocacy Foundation
National Psoriasis Foundation

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Short-Term, Limited-Duration Insurance CMS-9924-P

Document: CMS-2018-0015-8741
DC

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Organization: American College of Emergency Physicians

General Comment

On behalf of our nearly 38,000 members, the American College of Emergency Physicians (ACEP) appreciates the opportunity to comment on the proposed rule related to short-term, limited-duration insurance as it affects our practice of emergency medicine and the patients we serve. Please find our comments attached.

Attachments

ACEP Response to Short-term Limited Duration Insurance

COMMENTS to the Centers for Medicare & Medicaid Services, Department of Health and Human Services

RE: Comments on Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P)

Submitted by Community Catalyst
April 23, 2018

Community Catalyst respectfully submits the following comments to the Department of Health and Human Services (HHS) in response to the proposed changes to the definition of short-term, limited-duration insurance released on February 21, 2018.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone – especially vulnerable members of society.

We write with strong objection to the proposed rule on short-term limited-duration insurance, and recommend HHS rescind the proposed rule in its entirety.

Federal regulations can be used as a tool to implement policies to increase the affordability of comprehensive coverage and create more options for consumers to choose from, but this rule undercuts these goals. The proposed rule rescinds restrictions on short-term plans, thereby allowing insurers to offer substandard insurance policies to millions of consumers as an alternative to comprehensive coverage. These plans exclude coverage for critically important health care services; vary premium rates by gender, health status, and age; and put individuals and families at significant financial risk.

We are equally concerned about the impact of this proposed rule on the stability of the individual market. Expanding these types of plans will undermine the individual market by pulling healthy individuals away and leaving an older, sicker risk pool behind. Combined with the impact of the repeal of the individual mandate penalty, increasing premiums and a less stable market will leave many individuals who rely on comprehensive coverage – including women, older adults, and people with chronic conditions – without affordable, comprehensive options.

Short-term policies offer junk insurance that fails to meet the needs of consumers.

Short-term, limited-duration insurance is intended to provide *temporary* insurance during unexpected coverage gaps. This type of coverage is exempt from the definition of individual health insurance coverage under the Affordable Care Act (ACA) and, therefore, does not have to comply with the law's core consumer protections. The proposed rule, therefore, promotes and will increase take up of skimpy, substandard insurance coverage with minimal protections for consumers. Specifically, such coverage:

- Has high out of pocket costs,
- Limits the coverage people can receive each year and over their lifetime,
- Discriminates against individuals, and
- Excludes basic health care services.

Short-term plans discriminate against individuals based on their health status. Because short-term plans are exempt from the ACA's pre-existing condition protections, these plans commonly use medical underwriting practices to screen applicants. This means that applicants with health conditions are often denied coverage altogether or denied coverage of specific services based on health status and medical history. Some insurers go as far as defining a condition to be preexisting if a member had symptoms within the prior five years "that would cause a reasonable person to seek diagnosis, care or treatment," even if they did not receive care, and even if they were not aware of the condition.

Even healthier individuals who might pass an initial health screening, but who later develop an illness or condition, could find themselves without coverage in the middle of the plan year. Because short-term plans are not considered minimum essential coverage under federal law, the loss of such coverage does not trigger a special enrollment period to purchase marketplace coverage outside of the open enrollment period. Gaps in coverage expose consumers to serious financial liability, lead to delays in treatment and ultimately poorer health outcomes.

Short-term plans are not required to cover essential health benefits. In addition to being able to exclude coverage for pre-existing conditions, these plans are also allowed to categorically exclude certain benefits, such as routine maternity and newborn care, prescription drugs, mental health care, substance use services, and preventive services like birth control and tobacco cessation. Without these essential benefits, consumers will lack adequate coverage. Current examples of common short-term plan exclusions include:

Benefit	Exclusion Language
Emergency care	Excluded: "Charges for use of hospital emergency due to illness." (See for example UnitedHealthOne)[1]
Women's reproductive health	Excluded: "Expenses for the treatment of normal pregnancy or childbirth, except for complications of pregnancy and normal newborn care; expenses for voluntary termination of normal pregnancy or contraception; infertility treatments or sterilization." (See for example IHC Secure Lite)[2]
Gender transition-related services	Excluded "Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies." (See for example IHC Secure Lite)[3]

Mental health and substance use disorders	Excluded: "Treatment of mental health conditions, substance use disorders; and outpatient treatment of mental and nervous disorders, except as specifically covered." (See for example National General)[4]

Insurers who sell short-terms plans frequently discriminate based on gender, including charging women higher premiums. ACA protections prohibit plans from basing premiums on anything other than age (within a 3:1 ratio for adults), tobacco use, family size, and geography. Before the ACA took effect, 92 percent of best-selling plans on the individual market practiced gender rating (charging women higher premiums than men). These predatory practices cost women approximately $1 billion a year[5] and are still commonplace among insurers selling short-term plans. Health questionnaires are also often used by short-term plans to identify and deny coverage to people with preexisting conditions, like pregnancy. The application process includes explicit language excluding applicants who are pregnant or an expectant father. Short-term plans also discriminate based on gender identity by excluding coverage for transition-related services, such as surgery.

***Short-term plans impose lifetime and annual limits*.** An individual or family could quickly meet their annual and lifetime limit with expensive health care costs and treatment for a catastrophic medical emergency. The impact to individuals and families could be financially devastating and leave them without coverage. One insurer, for example, caps covered benefits, including treatment, services and supplies at just $750,000 per coverage period. At least one insurer provides per-service limits such as $1000 per day for hospital room and board, $500 per day for emergency room services, $250 per trip for ambulance, and $10,000 for AIDS treatment.[6] These limits amount to woefully inadequate coverage for consumers and their families.

Short-term plans are also not subject to out-of-pocket maximums, which can leave consumers facing major, unpredictable financial risk. The ACA limits out-of-pocket maximums to $7,350 for individual coverage for the entire year, but some short-term plans may require out-of-pocket costs in excess of $20,000 per individual per policy period.[7] In some cases, out-of-pocket maximums for short-term plans are misleading and appear to be smaller than they are because the deductible does not count toward the maximum.

Expanding the availability of short-terms plans creates an uneven playing field, which harms consumers. Due to discriminatory, predatory practices, short-term plans are able to offer low premiums and attract younger and healthier individuals, which will increase costs for consumers who need comprehensive coverage, including those with pre-existing conditions, and middle-class consumers with incomes too high to qualify for subsidies. An uneven playing field could also lead to some insurers scaling back from or leaving the ACA marketplaces, resulting in fewer plan choices for consumers shopping for comprehensive coverage.

The estimates in the fiscal impact statement on the number of people enrolled in short-term plans undercounts the individual insurance market. The NAIC report on which the estimate was based fails to include short-term plans sold by discretionary associations or similar arrangements. Recent reports have suggested enrollment in short-term plans may be closer to one million today.[8] The Urban Institute has estimated that, as a result of this proposed rule, 4.3 million people would enroll in short-term plans in 2019.[9] The Urban Institute also estimated that the effect of the proposed rule, in combination with the elimination of the individual mandate penalty, would reduce enrollment in ACA-compliant plans by 18.3 percent.[10] The American

Academy of Actuaries reaffirms the argument that short-terms plans will attract healthy individuals, causing the potential for market segmentation and adverse selection, and therefore increase premiums for comprehensive coverage.

Specific Recommendations

We recommend that the proposed rule be rescinded in its entirety, but if finalized, we offer the following recommendations.

I. Short-term limited-duration plans should not be expanded to more than three months (§54.9801-2 / §2590.701-2 / §144.103).

Short-term plans are designed to fill *temporary* gaps in coverage. These policies should not exceed three months. The proposed rule would allow short term plans to enroll individuals for as long as 364 days. Allowing extensions of these policies expands the period of time in which people may be underinsured, leaving consumers with inadequate coverage and at financial risk if they fall ill.

Yearlong short-term plans would create consumer confusion about whether the coverage is the same as would be available through ACA-compliant one-year plans. Moreover, consumers could be left with uncovered bills and/or find themselves "uninsurable." Because insurers can deny a new contract if the enrollee becomes sick or injured during the coverage term, consumers may believe they can extend or renew coverage until rejected by the issuer. If their short-term plan ends before marketplace open enrollment, their loss of coverage would not qualify for a special enrollment period, leaving a consumer to wait until the next annual open enrollment period to select a new plan. This will lead to a gap in coverage for many consumers.

Consumers seeking coverage for three months or longer can get covered through the ACA marketplaces. However, allowing short-term plans longer than three months will undermine comprehensive coverage by driving up premiums. This means that coverage for people with pre-existing condition protections will be less affordable, particularly for those that are ineligible for premium tax credits.[11]

We strongly oppose the proposed changes to the regulation at §54.9801-2 / §2590.701-2 / §144.103. The existing definition limiting the duration of short-term limited-duration insurance to "less than 3 months" should remain, as should the language "taking into account any extensions that may be elected by the policyholder with or without the issuer's consent."

II. Consumer notices should be explicit, in multiple languages, about ACA requirements that do not apply to short term plans (§54.9801-2 / §2590.701-2 / §144.103).

We support efforts in the proposed rule to help consumers who purchase short-term, limited-duration policies to understand the coverage they are purchasing. We believe notice is vital for consumers to understand the limits of short-term plans and that they are not comprehensive coverage. We appreciate the specific language that clarifies that the plan does not comply with federal requirements and that enrollees might have to wait until an open enrollment period to get other health insurance coverage.

We recommend, however, that the notice be clearer to be more easily understood by consumers and that the notice be available in multiple languages. As the preamble notes, allowing short-term plans to provide coverage for just under one year will make it more difficult for consumers to distinguish between short-term plans and plans sold on the marketplace. The notice must make clear how short-term plans differ from the comprehensive coverage sold on the marketplace. We recommend listing specific examples of ACA protections in the notice, including preexisting conditions and essential health benefits. The draft notice language also is not clear enough that loss of eligibility or coverage in a short-term plan does not trigger a special enrollment period.

Finally, we recommend that after the warnings, the notice direct consumers to the appropriate state-based marketplace or healthcare.gov for more comprehensive coverage options and possibly financial assistance. Because people might not realize that they are eligible for financial assistance, it is critical that consumers who are considering purchasing short-term plans are aware of the marketplace and the potential for more financial assistance to purchase comprehensive coverage.

The Departments should adjust the proposed notices at §54.9801-2 / §2590.701-2 / §144.103 to the following language:

> *WARNING! THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, SUCH AS COVERAGE OF PREEXISTING CONDITIONS AND ESSENTIAL HEALTH BENEFITS.* ***THIS COVERAGE MAY NOT COVER ALL OF THE HEALTH CARE YOU NEED AND LEAVE YOU WITH VERY HIGH MEDICAL BILLS****. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOES NOT COVER.* ***EXPIRATION OR LOSS OF ELIGIBILITY FOR THIS COVERAGE DOES NOT TRIGGER A SPECIAL ENROLLMENT PERIOD****, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. YOU MAY BE ABLE TO GET MORE COMPLETE INSURANCE NOW AND HELP TO PAY FOR IT AT [HEALTHCARE.GOV].*

III. The effective date of the rule should be delayed (§ 54.9833–1/§2590.736/§146.125).

We recommend that the proposed rule be rescinded in its entirety, but if finalized, insurers need time to appropriately design and price plans. Allowing expanded short-term plans to be offered in 2019 creates risk and uncertainty for health insurers in the individual market.[12] Insurers may have to build in rate increases associated with uncertainty if expanded short-term plans are allowed in 2019. Delaying implementation until 2020 will give insurers time to adjust to the insurance market without the individual mandate penalty and allow them to see which insurers are expanding or entering the short-term market. A delay would also allow states time to respond, through legislative or regulatory changes, to the impact of expanded availability of short-term plans on their markets.

We strongly oppose the proposed effective and applicability date of this rule. The effective date of the rule should be delayed until the 2020 plan year, if the rule is finalized.

Thank you for the opportunity to comment on the short-term, limited-duration insurance proposed rule (CMS-9924-P). We once again urge HHS to preserve and fully implement the Affordable Care Act as the most effective strategy to promote affordable consumer choice for health coverage. If you have any questions or concerns about our recommendations, please contact Ashley Blackburn at ablackburn@communitycatalyst.org.

Respectfully submitted,

Robert Restuccia
Executive Director
Community Catalyst

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3 The IHC Group. "Secure Lite: Short-term Medical Insurance for Individuals and Families."

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April 23, 2018

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Preston Rutledge
Assistant Secretary
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Seema Verma
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Re: **CMS-9924-P-** Short-Term, Limited-Duration Insurance

Dear Deputy Commissioner Wielobob, Assistant Secretary Rutledge, and Administrator Verma:

Thank you for this opportunity to comment on the Proposed Rule entitled "Short-Term, Limited-Duration Insurance."[1] eHealth is a publicly-traded company, operating its consumer online marketplace www.eHealthInsurance.com, and is a web-based broker that has helped enroll millions of individuals and families into coverage through its consumer-centric website over the last 20 years. As one of the largest online brokers of health insurance in the country, eHealth is

[1] 83 Fed. Reg. 7,437 (February 21, 2018).

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proud of the work it has done to enroll individuals into health insurance plans that best meet their needs and the needs of their families.

At the outset, we note that we share the Departments' goal of providing consumers more affordable choices for health insurance coverage. As the Departments note in the preamble to the proposed rule, short-term, limited-duration coverage plays an important role for many individuals either because they are unable to afford major medical insurance or are experiencing gaps in coverage. We appreciate the Departments' continued recognition of the importance of short-term coverage and share in the Departments' belief that short-term coverage offers consumers an important choice, particularly for those who are looking for more affordable health insurance coverage. In general, we support the Departments' proposal to retract the October 2016 final rule, which reduced the length of coverage under short-term, limited duration insurance from up to 364 days to three months.[2] As discussed in detail below, we encourage the Departments to provide issuers with increased flexibility so as to increase consumer choice in the health insurance marketplace.

I. eHealth Shares in the Departments' Goal of Increasing Affordable Consumer Choices

eHealth offers short-term coverage to consumers visiting eHealth's website or inquiring about their health insurance options while speaking to a licensed health insurance agent in eHealth's customer care center. eHealth is proud of the role it plays in helping individuals and families in need to secure short-term coverage, which acts as both an affordable option amidst rising insurance premiums in the individual marketplace and as a stop-gap in periods of coverage loss or financial distress. For example, COBRA premiums may not be an affordable option for a consumer, but premiums for a short-term plan may be. In other cases, COBRA may not be available at all, and short-term coverage may fulfill a key need. According to a January 2018 survey of more than 1,000 eHealth customers enrolled in short-term health plans, more than half said they would be uninsured without access to short-term coverage, and another 22% said they don't know what they would do for health insurance coverage if short-term coverage was not an option.

As the Departments work to bring more consumer choice to the marketplaces, reviving the ability of individuals to purchase short-term coverage is important. Simply put, due to the increased costs associated with major medical insurance, many financially-stressed individuals are faced with the unfortunate choice of either: (1) some coverage (i.e. short-term coverage); or (2) no coverage at all. Moreover, short-term coverage also offers consumers, in many cases, the unique advantage of an open network of providers (which is of particular importance in an era of ever-narrowing networks.)

[2] The final rule scaling back the duration of short-term coverage was published in the Federal Register on October 31, 2016 at 81 Fed. Reg. 75,316.

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In light of the rising cost of major medical insurance, we believe many individuals, by selecting a short-term policy, are making what amounts to the most rational economic choice for their families. According to a recent eHealth study, in 2018, health insurance was unaffordable for families earning less than $128,795 a year, and individuals earning less than $69,457 a year.[3] Health insurance premiums for eHealth customers rose 16% for individuals and 17% for families between 2017 and 2018 – based on a comparison of the average monthly premiums on qualified health plans selected by eHealth customers during the 2018 open enrollment period. Individual premiums jumped from an average of $378 per month in 2017 to $440 a month in 2018. For families, premiums increased from $997 per month to more than $1,168 per month. This is the fifth year in a row than consumers have faced double-digit rate increases.

These prices are unsustainable on a middle-class income, and without more affordable long-term options, an ever increasing number of middle-class families will be without affordable health insurance options.

We urge the Departments to remove the unnecessary limits placed on short-term coverage by the Obama Administration and to give issuers enhanced flexibility in offering and administering these plans. In the preamble to the proposed rule, the Departments requested comment on whether the length of short-term coverage should be something other than a maximum of 364 days. As noted above, eHealth supports maximum carrier flexibility in designing short-term coverage, as we believe such flexibility will result in the widest array of choices for consumers. In general, shorter plans (3 months) tend to be less expensive than longer plans (364 day or greater) but offer less long-term reliability. Given the vast differences in personal circumstances that today's consumers face (e.g. some consumers will benefit from a 3-month policy between jobs, while others will find value in a longer-term and affordable choice), we believe short term health insurance issuers should be permitted to design policies as short – or as long – as the market will support.

II. eHealth Supports the Availability of Issuer-Initiated Renewable Policies

The Departments also seek comment in the proposed rule on the conditions under which carriers should be able to allow short-term, limited-duration insurance to continue for 12 months or longer with the issuer's consent. At the outset, we note that we strongly support the Departments' proposal to amend the regulatory definition of "Short-term, limited-duration insurance" at 26 C.F.R. § 54.9801–2 to permit carriers, at their discretion, to offer renewable short-term policies. Consumers may need to renew a policy for a variety of reasons – including a gap in coverage that lasts longer than anticipated or simply a desire to remain in a plan that offers affordable coverage.

[3] *See* https://news.ehealthinsurance.com/news/free-obamacare-coverage-available-in-2018-for-most-subsidy-eligible-families-earning-51-000-or-less-but-its-more-unaffordable-than-ever-for-families-who-dont-get-subsidies-ehealth-report-shows.

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We believe this regulatory change (which simply reverts to the pre-2016 definition) is fully supported by the underlying language in the Public Health Services Act, which leaves to the Departments' discretion the definition of short-term insurance. Once again, eHealth believes that granting carriers reasonable flexibility here will ensure a robust offering of affordable consumer choices and enhanced market competition. In particular, we expect that given the appropriate flexibilities, carriers will be able to offer consumers two different types of products (of varying length) – renewable and non-renewable policies. The former would offer consumers the reliability and affordability of a traditional, medically underwritten individual market plan, while the latter will enable consumers to take advantage of the inherent flexibility in short-term insurance to fill gaps in coverage. The Departments may need to put an ultimate limit on the amount of time short term coverage is renewable so as not to exceed their regulatory authority. However, the ultimate limit should be significantly longer than 364 days (e.g., 5 years) to preserve the flexibility referred to above.

III. The Departments' Should Maximize Issuer Flexibility by Clarifying the Applicability of Section 1557

One concern that continues to be expressed by health insurance issuers is the burden imposed by Section 1557 of the Affordable Care Act – and in particular, the barrier that the Office of Civil Rights' regulations at 42 C.F.R. Part 92 pose to true medically-underwritten coverage. In order to offer affordable short-term policies, issuers must underwrite policies based on an individual's health status. However, carriers have expressed concerns that the existing rules under section 1557 may limit a carrier's ability to offer true medically-underwritten coverage as the underwriting process *may* have a disparate impact that results in discrimination on a basis prohibited by Section 1557. Given the Departments' clear interest in making more affordable consumer choices available, we urge the Departments to clarify that offering short-term coverage and medically underwriting those policies does not create issues under section 1557.

IV. The New Definition for Short-Term Coverage Should Become Effective as of the Date of the Publication of the Final Rule

In the proposed rule, the Departments propose that the changes to the definition of short-term coverage will take effect 60 days after the publication of the Final Rule. While we appreciate the Departments' clear goal in finalizing the rule as soon as possible in order to increase consumer choices to affordable coverage, we believe that the rule should be effective immediately upon publication of the Final Rule (which should occur well in advance of the Open Enrollment period for 2019 coverage). First, we note that issuers already have the capability to offer both 6 and 12-month renewable and non-renewable policies. They do not require any implementation time to make these new policies available, and delay only harms consumers. Second, and given the approaching Open Enrollment period in the marketplaces, we believe that consumers must be given affordable choices well in advance of being forced to make the decision of whether to enroll

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in a marketplace plan that may place their family under severe financial distress. We are concerned that, given the time it will take for the Departments to review comments and publish a Final Rule, a 60-day effective date may very well extend into the 2019 Open Enrollment period. We strongly urge the Departments to make the Final Rule effective at the date of publication – and to expedite the publication of the Final Rule.

Thank you for your attention to our comments. We would be pleased to answer any questions that you may have.

Sincerely,

John D. Desser

Fields of Opportunities

STATE OF IOWA

KIM REYNOLDS
GOVERNOR

ADAM GREGG
LT GOVERNOR

DOUG OMMEN
COMMISSIONER OF INSURANCE

April 23, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9924-P
P.O. Box 8010
Baltimore, MD 21244-8010

Dear Administrator Verma:

Thank you for the opportunity to comment on the proposed regulations on *Short-Term, Limited Duration Insurance* published in the *Federal Register* on February 21, 2018. Specifically, we write to comment on the proposed rule for 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, 129 CFR part 2590, and 45 CFR part 144.

We applaud the efforts to expand the availability of short-term, limited-duration health plans to consumers. In Iowa, we have seen a substantial departure of consumers from our individual Affordable Care Act (ACA)-compliant Marketplace in 2018. To date, we anticipate that up to 26,000 Iowans who were enrolled in the Marketplace in 2017 have left, in large part due to the skyrocketing premium rates faced by individuals who do not receive federal subsidies.

Given the collapse of our market, we believe that short-term limited-duration insurance can provide an option for consumers to ensure coverage. However, it will be important for these plans to be regulated at the state level to ensure that they provide comprehensive and meaningful benefits to consumers.

Duration & Disclosure

We welcome the proposal to amend the definition back to the original 1997 HIPAA rule, which would expand the potential maximum coverage period back to a period of less than 12 months. We believe that extending the permissible coverage back to a period of up to 364 days can provide consumers who are unable to afford coverage on the Marketplace an option to purchase comprehensive coverage.

We share the agency's concern that these policies may be difficult to distinguish from those offered on the Marketplace and are in favor of the proposed disclosure requirements.

State Authority

It is important for states to maintain primary regulatory authority over these plans so that we can develop a regulatory scheme appropriate for our specific market. The proposed rule contains language implying that States can impose requirements for short-term, limited duration insurance that are the same as or more restrictive than the Federal standard proposed in this proposed rule. Consistent with this sentiment, we urge that any further requirements, including but not limited to restrictions related to the sale, design, rating or duration of these plans must be left to the States so that they can address the unique conditions and needs of their respective insurance markets. For example, Iowa intends to issue regulations for the short-term limited-duration plans to require that any carrier who wants to offer those plans in our marketplace provides fulsome coverage.

As noted above, up to 26,000 Iowans left the Marketplace in 2018. The majority of these were unsubsidized individuals who cannot afford the current premium amounts. We believe enacting requirements for these plans will help prevent our Marketplace from an influx of plans offering limited coverage at rates that would destabilize what is left of our ACA-compliant Marketplace.

Section 1557 of the Affordable Care Act

The proposed rulemaking does not address the impact of Section 1557 of the ACA on a carrier's issuance of short-term, limited-duration plans. Without clarification on this issue, traditional and established health plans will be unlikely to enter this market and provide plans for Iowans desperately in need of coverage.

Pursuant to Section 1557 of the ACA, carriers who receive Federal financial assistance cannot, through any of their health plans or activities, exclude, deny benefits, or discriminate against any individual on the basis of race, color, national origin, sex, age, or disability.[1] Rules issued pursuant to Section 1557 of the ACA by the previous Administration could possibly be interpreted to mean that any underwriting, as traditionally utilized in short-term, limited-duration plans, could be construed as discriminatory.

Accordingly, a carrier who is participating in the Marketplace would be prohibited from using underwriting or more limited benefit structures to design short-term, limited-duration plans that are more cost-effective than the current ACA-compliant individual plans. In many states throughout the country, carriers are deciding whether or not to participate in the ACA-compliant marketplace, and if clarifying language is not included, carriers will be forced to choose either to offer short-term, limited duration plans or participate in the Marketplace.

Specifically, it is unclear whether or not these plans will be considered to be a "health program or activity" under 42 C.F.R. §92.4 and thus subject to the requirements of Section 1557. We ask for clarification on this issue, and specifically advise that CMS include language in the proposed definition of "short-term, limited duration insurance" providing that such insurance is "not a health program or activity as defined in 45 C.F.R. § 92.4."

[1] 42 U.S.C. §18116.

Iowa has sought clarification on this issue on several occasions. We were advised that CMS lacks the authority to issue such clarification, and were directed to the HHS Office of Civil Rights. It is unclear as to why, when finalizing the proposed rule which lays out the definition of a short-term, limited-duration plan, that HHS or CMS lacks the authority to control that definition.

Without clarification on this issue, we fear that reputable carriers who currently offer ACA-compliant products will not be able to participate in the short-term limited-duration market. Instead, we will see carriers enter the Marketplace who have no connection with our state or communities, and who see limited value in maintaining and stabilizing our entire health insurance market.

Renewability

The Departments sought comment on the potential for renewal of short-term, limited-duration plans. We believe there are benefits to consumers by requiring that a short-term limited-duration policy to be renewable for at least one 12 month period without the issuer's consent. This would allow consumers, who otherwise have no affordable access to continuous coverage, to be able to purchase coverage that does provide substantial benefits. This is critical for consumers who may experience a serious health condition during the pendency of their short-term limited-duration policy, as allowing for one "guaranteed" renewal would ensure that they have coverage until they are able to enroll via an open enrollment period for Marketplace coverage.

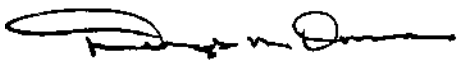
If such an automatic renewal period is not provided for in the Departments' final rule, Iowa is contemplating including such a provision in regulation for these plans.

Timing

Given the collapse of our individual market, we would recommend that the Departments allow for the rule to be effective in time for carriers to begin selling these plans in 2019.

Thank you for the opportunity to comment and for the opportunities to continue to partner in the future.

Regards,



Doug Ommen
Commissioner

A not-for-profit health and tax policy research organization

April 23, 2018

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Re: **CMS-9924-P**- Short-Term, Limited-Duration Insurance

Dear Deputy Commissioner Wielobob, Assistant Secretary Rutledge, and Administrator Verma:

Thank you for this opportunity to comment on the Proposed Rule entitled "Short-Term, Limited-Duration Insurance."[1] We, the undersigned, are writing today to provide support for the Administration's proposal to retract the October 2016 final rule, which reduced the length of coverage under short-term, limited duration insurance policies and deprived consumers of an important, affordable choice in the healthcare marketplace.[2] We applaud

[1] 83 Fed. Reg. 7,437 (February 21, 2018).

[2] The final rule scaling back the duration of short-term coverage was published in the Federal Register on October 31, 2016 at 81 Fed. Reg. 75,316.

efforts by this Administration to loosen the regulatory restrictions on the sale of short-term, limited-duration coverage in order to expand choices for individuals and their families

As you are well aware, the individual health insurance market is contracting: preliminary numbers show that the total number of people with individual policies fell from 20 million in March 2016 to 16 million in September of last year. That is a 20-percent drop in a period of just 18 months. The reasons for this precipitous drop in coverage are numerous: the 2010 Patient Protection and Affordable Care Act (PPACA) introduced wave after wave of distortions into our healthcare sector leading to skyrocketing premiums, states have been deprived of their traditional role in creating unique solutions for their individual populations, and current regulations restrict the offering of important consumer choices including association health plans and short-term, limited-duration coverage. While we believe a broad scale reform of our healthcare system is needed, we also know that granting immediate flexibility in the offering of short-term coverage is an important step in the right direction.

As discussed in detail below, outside of providing a definition for what constitutes "short-term, limited duration" coverage, the plain language of HIPAA exempts these products from federal rulemaking, leaving their regulation to the states. The previous Administration improperly assumed that it had statutory warrant to regulate non-PPACA compliant products that it feared might compete with PPACA-compliant products – but this is simply not the case. We urge the Departments to clarify that, in conformance with the statute, the regulation of short-term coverage is left to the states – and restore to issuers flexibility in designing products that best meet consumers' needs

Supporting Affordable Options for Consumers

American families are currently in the midst of a health insurance crisis. Millions of people now rely on PPACA subsidies for their health coverage, resulting in a chronic state of uncertainty for Americans facing the prospects of changing income or even a new political wind in Washington. For those not qualifying for subsidies, the prospect of obtaining affordable health insurance coverage is bleak. Health costs are rising faster than before: according to a March 2018 survey from the West Health Institute and NORC at the University of Chicago, between a third and a half of people ages 45 to 59 and a quarter of those 60+ went without needed health care in the last year due to its cost.[3] And over the period 2013 through 2017, premiums in the PPACA exchanges increased by 105 percent.

While healthcare costs continue to rise at a rapid pace, choice and competition are disappearing from the marketplace. Competition among health issuers in the PPACA exchanges has collapsed: 52 percent of U.S. counties have only one issuer in 2018.

[3] "Americans' Views of Healthcare Costs, Coverage and Policy," Issuer Brief, West Health Institute and NORC at the University of Chicago (March 2018).

Simply put, Americans now face skyrocketing costs and dwindling choices and many are facing the heartbreaking reality of going without coverage.

These government-subsidized monopolies have priced insurance out of the reach of consumers who do not qualify for premium assistance. As the President's Council of Economic Advisers recently noted:

> Issuers remaining in the individual and small group markets seem to have recently accounted for ACA regulations and an older, more costly risk pool than they expected by charging higher premiums that have largely been covered by federal government premium subsidies. Stable year-over-year enrollment, despite large premium increases suggests a distorted market that involves large transfers from taxpayers to issuers.

Issuers of PPACA-compliant policies thus tend to price their most common policies (so-called Silver-level plans) based on the assurance that the federal government will pay 100 percent of the premium increases for most enrollees through income-related premium subsidies. While these large and growing transfers from taxpayer to issuers have made many issuers profitable, they have increasingly made non-group coverage unaffordable for millions of other un-subsidized consumers.

Short-term, limited duration coverage is one important option that can give a lifeline to some individuals and families looking for either an affordable option amidst rising insurance premiums in the individual marketplace or a stop-gap in periods of coverage loss or financial distress. As this Administration works to bring consumer choice back to the marketplaces, reviving the ability of individuals to purchase short-term coverage is important. Not only would expanded short-term coverage offer many consumers a significantly more affordable option for coverage, as the Departments note in the preamble to the proposed rule, expanding short-term coverage could also offer consumers broader access to health care providers compared to the PPACA plans which are plagued by narrow-networks.

While we certainly don't think that revising the rules around short-term coverage will solve the health insurance crisis overnight, we believe this is one important and immediate step the Administration can take to inject competition and affordability into the marketplace today. We urge the Departments to remove the inappropriate limits placed on short-term coverage by the Obama Administration and restore to issuers flexibility in offering and administering these plans.

Revising the Restrictions on Short-Term Coverage is Required by Statute

Before turning to the issues of the length of contract and renewability, it is important to understand the statutory scheme that Congress has adopted for purposes of regulating short-term coverage. Of note, this scheme protects short-term, limited duration policies from federal regulation.

Congress originally created the exemption for these policies in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).[4] In HIPAA, Congress for the first time imposed certain federal requirements on non-group health insurance policies. These policies had previously been regulated almost exclusively by the states. By exempting short-term, limited duration policies from HIPAA, Congress preserved state regulation of these products and excluded federal regulation.[5]

Congress subsequently enacted the PPACA,[6] which established a far more sweeping federal regulatory regime on non-group policies. Significantly, PPACA did not amend the definition of 'individual health insurance coverage' in the Public Health Service Act and thus did not subject short-term coverage to this new federal regulatory regime. As a result, CMS saw no need to issue new regulations pertaining to short-term coverage as a result of PPACA's enactment. It did, however, issue rules that were not only not required by PPACA in late 2016[7] but, rules that, we will argue, should be rescinded, in part because they exceed the Departments' statutory authority.

The effect of the two statutes was to create a safe harbor from federal regulation for short-term coverage. Unlike insurance products sold in the non-group market, these plans are exempt from federal regulation and subject only to state regulation. The extent of CMS's statutory authority is to define what short-term coverage is; it has no legal warrant to impose regulatory burdens or limitations on these policies. To define them is to exempt them from federal regulation. The Departments must take care not to use their authority to define short-term coverage as a means of imposing federal regulation on these products or of pre-empting state regulation. The definition must allow room for states to devise regulatory schemes best suited to their respective markets.

The Departments erred in their rulemaking by subjecting these plans to new federal regulation. In their June 10, 2016 NPRM,[8] the Departments opined that short-term coverage provided "an important means for individuals to obtain health coverage when transitioning from one job to another." They no longer are needed, the Departments continued, because of PPACA's "guaranteed availability of coverage and special enrollment requirements."

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[4] Pub. L. 104-191 § 102, codified at 42 U.S.C. § 300gg-91 (adding new section 2791 to the Public Health Service Act).

[5] *See* 42 U.S.C. § 300gg-91(b)(5) ("The 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.")

[6] Pub. L. No. 111-148, 124 Stat. 119, as amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

[7] 81 Fed. Reg. 75,316 (October 31, 2016)

[8] 81 Fed. Reg. 38,020, 38,032 (July 10, 2016).

The Departments were alarmed by a *Wall Street Journal* article indicating that the policies were "being sold to address situations other than the situations that the exception was initially intended to address."[9] Some individuals, according to the Departments' interpretation of the article, "are purchasing this coverage as their primary form of health coverage." This raised concern at the Departments because short-term coverage is "exempt from market reforms, may have significant limitations, such as lifetime and annual dollar limits on EHBs and pre-existing condition exclusions, and therefore may not provide meaningful health coverage." The Departments also speculated that "healthier individuals might be targeted for this type of coverage, thus adversely impacting the risk pool for PPACA-compliant coverage."

The Departments then set out to write a rule with the express purpose of "address[ing] the issue of short-term coverage being sold as a type of primary coverage." In addition to limiting their duration to 90 days, they stipulated that such contracts could not be extended "with or without the issuer's consent." The Departments argued that this limitation was needed "to address the Departments' concern that some issuers are taking liberty with the current definition of short-term, limited duration insurance either by automatically renewing such policies or having a simplified reapplication process."

Selling a state-licensed product that is exempt from federal regulation is not "taking liberty" in any nefarious sense. The Departments, however, are inappropriately "taking liberty" with their definitional authority, transmuting it into a regulatory authority that is not authorized by statute. The regulation's intent was not to define the law's terms but to impose a revised definition that is not a definition at all, but a transparent effort to federally regulate a product that the statute exempts from federal regulation.

PPACA's combination of federal regulations and subsidies that both incentivize (and oftentimes, force) issuers to price products beyond the reach of millions of Americans has enhanced the market power of government-subsidized monopolies and duopolies throughout most of the U.S. The sale of short-term coverage threatened these anti-competitive arrangements, allowing other issuers to offer different types of coverage consumers may prefer at prices they are willing to pay. The Departments under the previous Administration sought to stamp out this competitive threat to PPACA-compliant policies through the artifice of a definitional change to short-term, limited-duration insurance.

However, the plain language of HIPAA exempts these products from federal rulemaking, leaving their regulation to the states. The Departments improperly assumed that they had statutory warrant to conduct search and destroy missions against non-PPACA compliant products that they feared might compete with PPACA-compliant products.

The Departments have no such warrant. The statutory reference to "short-term, limited duration" polices expressly prevents the federal government from regulating them. By excluding these policies from the definition of "individual health insurance coverage,"

[9] "Sale of Short-Term health Policies Surge," Anna Wilde Matthews, Wall Street Journal (April 10, 2016).

the statute preserves the pre-existing arrangement under which states, not the federal government, regulate these plans. The Department's belated discovery that these policies are exempt from HIPAA and PPACA regulation (which is both the purpose and effect of their lone mention in the United States Code) and a newspaper article suggesting that some people may rely on them "as a type of primary coverage," does not create a regulatory authority that the statute excludes.

By leaving the term undefined, the statute invites the Departments to *define* short-term coverage. It *does not* authorize the Departments to use this authority to define as a pretext to regulate. The existing regulation, by the Departments' own admission, is an effort to limit the sale of these policies, constrain consumer choice and impose federal regulations on a product whose regulation the statute reserves to the states. It is an exercise in regulatory overreach and must be amended to make it consistent with the statute.

Loosening the Restrictions on Short-Term Coverage

Given these limitations, we will turn to the three general provisions of the October 2016 rule that the Departments now proposes to revise:

1. Requiring a disclaimer that short-term, limited duration coverage does not satisfy the requirement that everyone lawfully present in the United States have "minimum essential coverage."
2. The limitation of these policies to 90 days.
3. The prohibition of extensions "with or without the issuer's consent."

Changes to the Required Disclaimer

While we find the proposed disclaimer unobjectionable, we are unaware of any legal basis for imposing it on products that are exempt from federal regulation. It is understandable that the Departments want consumers to be notified that these products are not PPACA-compliant. It is not clear that the Departments have the statutory authority to require such notification. State insurance commissioners regulate short-term policies pursuant to state law. Some ban their sale; others may impose notice requirements or otherwise provide that consumers be informed of the difference between these plans and PPACA-compliant policies. It is not clear that the Departments have the authority to require these disclaimers. If the Departments move forward with requiring such disclaimers in the final rule, they should explicitly set forth the legal basis for that requirement.

Extending the Duration of Short-Term Coverage

The Departments' proposal to change the duration of these policies from 90 days to "less than 12 months" is a good one. First, 90 days is an inadequate length of time for transitional coverage. The preamble to the June 2016 proposed regulation improperly and in a manner contrary to the statute declared that short-term limited duration policies

may only be sold for the purpose of "fill[ing] in temporary gaps in coverage when an individual is transitioning from one plan or coverage to another plan or coverage."[10] As we have seen, the Departments have no authority to limit short-term coverage in this way. In any event, limiting their duration to 90 days prevents them from fulfilling even this inappropriately narrow purpose.

In February 2018, the average duration of unemployment was 22.9 weeks (160 days), which far exceeds the arbitrary and capricious 90-day standard established in the existing regulation.[11] The unemployment rate in that month was 4.1 percent, which is low by historic standards.[12] During the most recent recession, that average at one point reached 40.7 weeks (285 days), more than three times the 90-day limitation. Moreover, even once an individual found work, the new employer could impose a waiting period of up to 90 days before allowing the employee to participate in group coverage.[13] That 90 days is in addition to the spell of unemployment.

The Obama Administration's 90-day limitation is thus inconsistent with the Departments' stated purpose which, in any event, exceeds its statutory authority.

Second, the proposed rule sets a duration limit that defines the universe of products broadly, leaving further regulatory discretion to the states, as the federal statute requires.

Third, as a matter of policy, health insurance issuers should be able to offer short-term policies with a wide variety of durations. The market will ultimately control which types of policies are demanded – and we find that by giving health issuers the flexibility to design policies that meet consumers' needs, prices will go down and options will flourish.

Permitting Renewability of Short-Term Coverage

We also strongly support the Departments' proposal to amend the regulatory definition of "Short-term, limited-duration insurance" at 26 C.F.R. § 54.9801–2 to permit carriers, at their discretion, to offer renewable short-term policies. In particular, we support the removal of the language "with or" from the definition of short-term coverage, so as to permit an issuer to option to offer renewable short-term coverage. Consumers may need to renew a policy for a variety of reasons – including a gap in other coverage that lasts longer than anticipated or simply a desire to obtain and retain coverage they can afford, rather than become uninsured.

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[10] 81 Fed. Reg. 38,025 (June 10, 2016).

[11] "Table A-12. Unemployed persons by duration of unemployment," Economic News Release, Bureau of Labor Statistics, United States Department of Labor (accessed April 6, 2018).

[12] "Unemployment rate at 4.1 percent in February 2018," TED: The Economics Daily, Bureau of Labor Statistics, United States Department of Labor (March 14, 2018).

[13] *See* 42 C.F.R. § 147.116.

The current rule exceeds the Departments' statutory authority by prohibiting extensions "with or without the issuer's consent." Congress, as we have seen, excluded these products from federal regulation. The existing rule imposes a stultifying regulatory scheme that, in effect, deprives states of the regulatory authority that the statute preserves. A policy can only last for 90 days and neither the consumer nor the issuer can extend or renew it. This is regulation designed to limit consumer choice and improperly curtail regulatory authority that the federal statute reserves to the states.

The current proposal, by contrast, would return to the pre-existing regulatory standard, which prohibits consumers from extending their coverage "without the issuer's consent."

The administration has made clear that its intent is to allow for these products to be renewed. In his executive order, the President stated:

> "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."

Consistent with the executive order, HHS Secretary Alex Azar has stated, "We'd like to see the ability to give people the option of renewability in whatever form we can have it," Azar made the statement, quoted in the March 9 issue of *Inside Health Policy*, and added that his department has solicited public comments as to his authority to allow for such renewability. It was somewhat jarring, then, to read reports that CCIIO officials have told state insurance regulators that they have already decided not to allow the plans to be renewable.

> "The response from the [CCIIO] deputy, with his boss sitting at the table with him, who last week said we could [make these plans guaranteed renewable], was 'well if we allowed you to make these guaranteed renewable they wouldn't be short term plans anymore'," a state insurance commissioner told *Inside Health Policy*, referring to Center for Consumer Information and Insurance Oversight officials.

This view is contrary to statutory and regulatory history. Under the rules in place prior to January 1, 2017, the federal government did not prohibit issuers from renewing short-term coverage. So long as the length of each contract was less than 12 months (including extensions without the issuer's consent), the policy fell within the Departments' definition. The Departments should restore the previous definition and not seek to constrain renewals for several reasons.

First, if the Departments were to decide that short-term coverage cannot be renewed, then the change they propose to the regulation would be meaningless. The current regulation

improperly prohibits extensions "with or without the issuer's consent." The proposed rule says that customers cannot renew coverage "without the issuer's consent." The unavoidable inference of that change is to permit them "with the issuer's consent." Any other reading would be nonsensical. As a result, the proposed rule can only mean that short-term policies are renewable "with the issuer's consent."

Second, it is important to understand why this phrase was needed in the original regulation. Congress had just enacted HIPAA, which for the first time established a federal requirement that issuers renew non-group policies[14] In other words, the federal government was requiring renewal of coverage at the option of the customer and "without the issuer's consent."[15] The statute, as we have seen, excluded short-term coverage from this mandate. The regulation thus properly clarified that there was no federal requirement that these policies be extended "without the issuer's consent" beyond the initial period of "less than 12 months."

But that does not mean that such policies cannot be renewed at all, much less that allowing renewals "with the issuer's consent" would somehow mean that "they wouldn't be short-term plans anymore." The length of the contract is "less than 12 months." A consumer is free to purchase a new contract from the issuer, but is subject to re-underwriting. However, nothing in the regulatory language would prevent an issuer from selling a customer a "guaranteed renewal" rider, enabling the customer to buy a new policy without being subject to medical underwriting. That separate guaranteed renewable contract or rider would not change the nature of the policy. The initial insurance contract and any of its successors still would be less than 12 months. The offering of the rider would constitute the "issuer's consent" to issue a new insurance contract once the initial one expired. The Departments have no statutory authority to prohibit or otherwise regulate such arrangements.

Other arrangements are possible so long as they are consistent with state regulation. Indeed, robust state regulation of short-term policies already exists – a clear signal of the traditional role reserved to the states in regulating these types of policies.[16] The federal government can neither impose a "guaranteed renewal" requirement on issuers nor prevent them from renewing coverage or entering into contracts with issuers that guarantee renewal without re-underwriting. The federal government lacks statutory authority to prohibit such arrangements.

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[14] Pub. L. 104-191 § 111, codified at 42 U.S.C. § 300gg-41 (adding new section 2741 to the Public Health Service Act).

[15] 69 Fed. Reg. 78,748, 78,720 (December 30, 2004).

[16] *See* Blumberg L, Buettgens M, and Wang R. "The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending," Urban Institute (February 2018). The Urban Institute study notes that six states (MA, NJ, NY, OR, VT, and WA) already have in place laws that would prevent an expansion of short-term coverage; two other states (MI and NV) have laws that would limit short-term coverage policy expansion.

We expect that given the appropriate flexibilities, carriers will be able to offer consumers two different types of products (of varying length) – (1) a traditional non-renewable short-term policy; and (2) a short-term policy with a renewability rider attached. While the latter will certainly cost a consumer more than a tradition short-term policy, it will permit consumers looking for traditional pre-PPACA coverage an important and much needed choice. Once again, we believe the offering of short-term policies with renewability riders is fully within the discretion of the Departments to implement given the wide latitude granted in defining what constitutes short-term coverage within the individual market.[17] In the final rule, we ask that the Departments clarify that health issuers are permitted to sell short-term policies with renewability waivers attached.

Providing for an Efficient Implementation

As a final note, we urge the Departments to expeditiously review the comments from this proposed rule and issue a final rule as soon as practicable, but well in advance of the 2019 Open Enrollment period. Given the approaching deadline of Open Enrollment in the PPACA exchanges, we believe that consumers must be given affordable choices well in advance of being forced to make the decision of whether to enroll in an exchange plan that may place their family under severe financial distress. We strongly urge the Departments to make the Final Rule effective at the date of publication – and to expedite the publication of the Final Rule.

Thank you for your attention to our comments. We would be pleased to answer any questions that you may have.

Rick Santorum, *Former U.S. Senator (R-PA)*

Saulius Anuzis, *60 Plus Association*

Doug Badger, *Galen Institute* and *The Heritage Foundation*

Naomi Lopez Bauman, *Goldwater Institute*

Lanhee Chen, *Hoover Institution* and *Stanford University*

Dean Clancy, *Adams Auld LLC*

Ryan Ellis, *Family Business Coalition*

Marie Fishpaw, *The Heritage Foundation*

Linda Gorman, *Independence Institute*

Beverly Gossage, *HSA Benefits Consulting* and *Independent Women's Forum*

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[17] As the Departments note in the preamble to the proposed rule, "rule, "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.*" (Emphasis added).

Ed Haislmaier, *The Heritage Foundation*
Rea Hederman, Jr., *The Buckeye Institute*
Heather R. Higgins, *Independent Women's Voice*
Dan Holler, *Heritage Action*
Phil Kerpen, *American Commitment*
Lindsay Boyd Killen, *Mackinac Center for Public Policy*
Yuval Levin, *Ethics and Public Policy Center*
Carrie Lukas, *Independent Women's Forum*
Nadine Maenza, *Patriot Voices*
James L. Martin, *60 Plus Association*
Jenny Beth Martin, *Tea Party Patriots Citizens Fund*
Thomas P. Miller, *American Enterprise Institute*
Robert E. Moffit, *The Heritage Foundation*
Derek Monson, *Sutherland Institute*
Grover Norquist, *Americans for Tax Reform*
Sal Nuzzo, *The James Madison Institute*
Dan Perrin, *HSA Coalition*
Sally Pipes, *Pacific Research Institute*
Ramesh Ponnuru, *American Enterprise Institute*
Chris Pope, *Manhattan Institute*
Kevin Roberts, *Texas Public Policy Foundation*
Charlies Sauer, *Market Institute*
Thomas Schatz, *Citizens Against Government Waste*
Jameson Taylor, *Mississippi Center for Public Policy*
Mike Thompson, *Thomas Jefferson Institute*
Grace-Marie Turner, *Galen Institute*
Dan Weber, *Association of Mature American Citizens*
Steven White, M.D., *Pulmonologist, Daytona Beach, FL*
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April 23, 2018

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RE: Comments on Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P)

Dear Secretary Azar, Administrator Verma, Acting Commissioner Kautter, and Assistant Secretary Rutledge,

The U.S. Public Interest Group (U.S. PIRG) appreciates the opportunity to comment in response to the proposed rule on short-term limited-duration insurance.

U.S. PIRG, the federation of state Public Interest Research Groups, stands up to powerful special interests on behalf of the American public, working to win concrete results for our health and our well-being.

U.S. PIRG is a voice for consumers in health care, and advocates for policies and strategies to contain costs and improve the quality of health care for Americans. We know that Americans are still spending far too much, and getting far too little in return, for our health care dollar. Despite a health care system world-renowned for developing advanced treatments, and an army of skilled and well-meaning doctors, nurses, researchers, hospital and pharmacy staff, our crazy-quilt health care system still fails to deliver an acceptable value proposition for consumers.

U.S. PIRG writes in strong opposition to the proposed rule. The proposed rule rescinds restrictions on short-term plans, thereby allowing insurers to offer low-value insurance policies to millions of consumers. These plans put individuals and families at significant financial risk and offer much less value for the consumer's dollar than a comprehensive health insurance plan. These plans are often confusing or actively misleading in their design and marketing, and consumers who purchase a short-term plan may find that their coverage is not there for them when they need it most.

In addition, expanding these types of plans will undermine the individual market by pulling healthy individuals away and leaving an older, sicker risk pool behind. This will lead to much higher premiums for individuals with pre-existing conditions and those who rely on comprehensive coverage—and since everyone is at risk of serious accident or illness, and may be in need to comprehensive coverage at any time, it will effectively raise costs for the health coverage products that all Americans may need to rely on.

Short-term policies offer low-value insurance that fails to meet the needs of consumers.

Short-term health insurance is intended to provide *temporary* insurance during unexpected coverage gaps. This type of coverage is exempt from the definition of individual health insurance coverage under the Affordable Care Act (ACA) and does not have to comply with the law's core consumer protections. By making short-term plans more widely available, the proposed rule promotes skimpy insurance coverage with minimal protections for consumers. Specifically, such coverage:

- Offers far less value for the premium dollar and lower medical loss ratios than comprehensive coverage,[1]
- Has high out of pocket costs,
- Limits the coverage people can receive each year and over their lifetime,
- Discriminates against individuals with pre-existing conditions, and
- Excludes basic health care services.

Expanding the availability of short-terms plans creates an uneven playing field. Due to discriminatory practices, short-term plans are able to offer low premiums and attract younger and healthier individuals, leaving older, sicker and costlier risk pools behind in the market for comprehensive health coverage. If healthier individuals are syphoned from the individual market, costs will increase and plan choices will decrease for individuals remaining in those markets.

Moreover, short-term plans simply offer little value because they offer scant coverage and make less efficient use of premium dollars than comprehensive health insurance. Regardless of whether these plans are made more widely available, consumers deserve better than they get from these plans. We see no legitimate reason to exempt these plans from critical consumer protections like the ACA's medical loss ratio requirements and rate review.

Specific Recommendations

I. Short-term plans should not be expanded to more than three months (§54.9801-2 / §2590.701-2 / §144.103).

Short-term plans are designed to fill temporary gaps in coverage. Even as a temporary stopgap, these plans provide little value for consumers in most situations due to their limited coverage and low loss ratios, but there is no legitimate rationale for extending the availability of these policies beyond three months.

The proposed rule would allow short term plans to enroll individuals for as long as 364 days. Yearlong short-term plans would create consumer confusion about whether the coverage is the same as comprehensive year-round coverage. Moreover, consumers could be left with uncovered bills and/or find themselves uninsurable. Because insurers can deny a new contract if the enrollee becomes sick or injured during the coverage term, consumers may believe they can extend or renew coverage until rejected by the issuer. If their short-term plan ends before Marketplace open enrollment, their loss of coverage would not qualify for a special enrollment period, forcing a consumer to wait until the next annual open enrollment period to select a new plan.

We strongly oppose the proposed changes to the regulation at §54.9801-2 / §2590.701-2 / §144.103.

II. Consumer notices should be explicit about consumer protections that do not apply to short term plans (§54.9801-2 / §2590.701-2 / §144.103).

We support efforts in the proposed rule to help consumers who purchase short-term policies to understand the coverage they are purchasing. We believe notice is vital for consumers to understand the limits of these plans. We appreciate the specific language that clarifies that these plans do not comply with federal requirements and that enrollees might have to wait until an open enrollment period to get other health insurance coverage.

However, the notice needs to be clearer to be more easily understood by consumers. As the preamble notes, allowing short-term plans to provide coverage for just under one year will make it more difficult for consumers to distinguish between short-term plans and comprehensive plans. The notice must make the differences clear. We recommend listing specific examples of consumer protections in the notice, including preexisting conditions, essential health benefits and medical loss ratio requirements. The draft notice language should also communicate clearly that loss of eligibility or coverage in a short-term plan does not trigger a special enrollment period.

III. The effective date of the rule should be delayed (§ 54.9833–1/§2590.736/§146.125).

We recommend that the proposed rule be rescinded in its entirety, but if finalized, insurers need time to appropriately design and price plans, and state regulators need time to prepare for and respond to the possibility of new entrants into state health insurance markets. Allowing expanded short-term plans to be offered in 2019 creates risk and uncertainty for health insurers in the individual market.[2] Insurers may propose higher rate increases to account for market uncertainty if expanded short-term plans are allowed in 2019.

We oppose the proposed effective and applicability date of this rule. The effective date of the rule should be delayed until the 2020 plan year if the rule is finalized.

IV. Short-term health plans should be subject to consumer protections to ensure they deliver value to consumers.

We oppose making short-term health plans more widely available not only because of their

impact on the broader health insurance system but because they simply do not provide an acceptable value proposition for consumers. One key reason for the poor value of these plans is that they are exempt from critical consumer protections like the ACA's medical loss ratio and rebate requirements, and from premium rate review. Together, these policies help ensure that premium dollars deliver value for patients. Short-term plans should be held to the same standard—whether they are made more broadly accessible or not.

Thank you for the opportunity to comment on the Short-Term, Limited-Duration Insurance Proposed Rule (CMS-9924-P). If you have any questions about our comments and recommendations, please contact Jesse O'Brien, U.S. PIRG Health Care Advocate: jesseo@pirg.org, 971-266-2463.

Sincerely,

U.S. Public Interest Research Group

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[1] "According to data from the National Association of Insurance Commissioners, the average medical loss ratio (MLR) for short-term coverage in 2016 was only 67.4 percent, and the largest insurer had an MLR of only 47.5 percent." D. Palanker, K. Lucia, and E. Curran (October 2017) New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market. Retrieved from http://www.commonwealthfund.org/publications/blog/2017/aug/short-term-health-plans

[2] Robert Wood Johnson Foundation (March 2018) Insurers Remaining in Affordable Care Act Markets Prepare for Continued Uncertainty in 2018, 2019. Retrieved from https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2018/rwjf444308

April 23, 2018

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Re: File code #CMS-9924-P

Comments submitted electronically at www.regulations.gov

Dear Secretaries Azar, Acosta, and Mnuchin:

Thank you for the opportunity to submit comments on the Department of the Treasury (Internal Revenue Service); Department of Labor (Employee Benefits Security Administration); and Department of Health and Human Services (Centers for Medicare & Medicaid Services) proposed rule on "Short-Term, Limited-Duration Insurance." My comments solely represent my personal opinions, and not those of the Federalist Society's Regulatory Transparency Project or any other organization or entity with which I am affiliated.

I. Introduction

As a physician, attorney, and Health Policy Expert with the Federalist Society's Regulatory Transparency Project, I applaud your proposal to restore the maximum period of short-term, limited-duration health insurance to its historical duration of twelve months. In addition, I support renewability of these policies as described subsequently.

Short-term limited duration insurance products played a vital role in the health insurance marketplace for nearly 20 years, providing excellent value for consumers, particularly those who were between jobs or self-employed. Following full implementation of the Patient Protection and Affordable Care Act in 2014, these policies also were important for individuals who missed the open enrollment period, could not afford Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, are ineligible for premium tax credits and/or who cannot otherwise afford the extremely expensive, high deductible coverage offered on the Affordable Care Act exchanges. Importantly, short-term, limited duration insurance has been the sole means by which individuals who frequently travel can obtain coverage outside their local areas.

However, in 2016 the Departments of Treasury, Labor and Health and Human Services published its final rule entitled, "Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance," which mandated contract terms of no greater than three months. This restriction greatly limited the usefulness of short-term, limited duration policies, severely disadvantaging millions of patients and consumers in the process.

II. Value of Short-Term Limited Duration Health Plans

Short-term, limited duration plans, many of which are provided by the United States' largest health insurance companies, often offer a broad range of deductible and copay options. Importantly, many short-term limited duration plans provide a high level of coverage for essentially all serious medical problems that most applicants are likely to encounter. Moreover, the large networks utilized by these plans have typically contracted with substantial numbers of high-quality physicians, hospitals and other providers often on a nationwide basis, the latter of which is important for self-employed individuals who travel frequently. Finally, they are often

very reasonably priced given the high-quality of their offerings, and are for many consumers a far better and safer option than shared ministry plans or no coverage at all.

III. Length of Short-Term Limited Duration Health Plans

Shortening the allowable term of short-term limited duration health plans to 3 months was an unfair and even cruel decision that put at risk the financial security of individuals who must rely on this insurance. Reducing the maximum coverage period to 3 months caused deductibles and co-payments associated with these policies to reset every quarter. This results in significant increases in costs for people who accrue significant medical expenditures during the insurance contract. More important, it created the substantial risk that anybody who develops a serious illness will no longer be able to obtain coverage in the subsequent quarter, generating the spectre of a prolonged period without health insurance during which a patient could incur hundreds of thousands of dollars in medical bills.

For many people, the Departments of Treasury, Labor and Health and Human Services imposed these burdens at the worst possible time, for example after job loss. Imagine a woman or man in the prime of life, who loses her or his job, signs up for the short-term limited duration plan that she or he can afford, who is then afflicted with breast cancer, colon cancer, or a brain tumor. Government regulations, as currently constituted, prevent this person from obtaining insurance that will cover the lengthy and expensive treatment required to save her or his life.

Consider a middle-aged man who has a serious injury or burn requiring months of care, and who should be entirely focused on survival, but must persist with the knowledge that he no longer has health insurance. Extending the allowable duration of short-term, limited duration

insurance to 12 months guarantees that these people, and all others who must obtain short-term limited duration health policies will be covered until the next open enrollment period. This noble and common-sense objective is entirely consistent with the Affordable Care Act, which has insurance coverage of all Americans as its stated goal.

Lastly, given the limited number of insurance options on many exchanges, the lack of coverage for individuals who travel, and the exorbitant cost of Affordable Care Act policies, insurers should be permitted to offer renewable short-term limited duration insurance policies to those who need them.

IV. Authority

As discussed in the proposed rule, Section 2971(b)(5) of the Public Health Services Act, explicitly excludes short-term limited duration insurance from the definition of individual health insurance coverage. However, the Statute does not define the term "short-term limited duration insurance". Therefore, Congress has delegated authority to draw the line between short-term limited duration insurance and individual health insurance coverage to the relevant federal agencies. Further, the broad general terms in which legislation has been written suggest that Congress intended that the agencies have maximal flexibility in defining and promulgating rules under the law to effectively meet current exigencies.

As a practical matter, distinguishing individual health insurance coverage and short-term limited duration insurance is a simple matter of specifying the contract terms that apply to each type of insurance without overlap or ambiguity. The law only requires that this is done in a reasonable manner. Allowing insurance companies to offer consumers renewable, 12 month

short-term limited duration health insurance contracts is not only reasonable, it is the proper and morally correct policy to pursue.

Respectfully Yours,

Roger D. Klein

COMMISSIONER OF SECURITIES & INSURANCE

MATTHEW M. ROSENDALE, SR.
COMMISSIONER

OFFICE OF THE MONTANA
STATE AUDITOR

April 23, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-9924-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Short-Term, Limited-Duration Insurance, RIN 0938-AT48

To Whom It May Concern

To enhance options for consumers, we support the rule as proposed to eliminate the 3-month limitation on short-term insurance and allow a coverage period of "less than 12 months". Any additional requirements, such as rating, renewability or duration of the policies, should be left to the states.

The education of consumers on short-term coverage is important and we support the expansion of the disclosure requirements.

The ability of carriers to offer short-term plans and participate in other coverages should not be limited, as it impacts choices for consumers. We urge clarification in the rules so that carriers can offer coverage such as ACA compliant coverage in addition to short-term coverage.

We support the effective and applicability dates as proposed.

Thank you for the opportunity to comment on the proposed regulations on Short-Term, Limited Duration Insurance.

Sincerely,

Matthew M. Rosendale, Sr.
Montana Commissioner of Securities and Insurance

Phone: 1-800-332-6148 / (406) 444-2040 / Main Fax: (406) 444-3497
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NAIC National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

April 23, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9924-P
P.O. Box 8010
Baltimore, MD 21244-8010.

Re: Short-Term, Limited-Duration Insurance CMS-9924-P

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed regulations on *Short-Term, Limited Duration Insurance* published in the *Federal Register* on February 21, 2018. These comments are submitted on behalf of the members of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators in the 50 states, the District of Columbia, and the 5 United States territories.

As state insurance regulators we have the primary responsibility of regulating our insurance markets and ensuring consumers are protected and the markets are competitive. As we stated in our comments on the current short-term, limited duration regulation, "Federal interference can, and often does, have unintended consequences and may not be effective in addressing the underlying issues." We argued that the arbitrary 3-month limitation set by the Federal government could harm some consumers and limit choices. Returning the Federal definition to "less than 12 months," as proposed, is consistent not only with longstanding federal law but also with how this term has been long defined by most states.

In the analysis of Economic Impact and Paperwork Burden related to federalism, the proposed rule states:

> *Federal officials have discussed the issue of the term length of short-term, limited duration insurance with State regulatory officials. This proposed 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 proposed in this proposed rule. States may continue to apply such State law requirements.*

Consistent with this statement, any further requirements, including but not limited to restrictions related to the sale, design, rating or duration of these plans, must be left to the States, which have the primary authority under our federal system to regulate the business of insurance, so that they can address the unique conditions and needs of their respective insurance markets. It is critical that state regulators maintain the flexibility to determine whether, and under what conditions, these plans are appropriate for their state. We urge continued state flexibility on this issue.

We also agree that educating consumers and ensuring that they are aware of the limitations of these plans is paramount. Some of these plans may provide significantly less coverage and consumer protections than comprehensive plans. We supported the disclosure requirements in the current regulations and support the expansions in this proposed rule.

States have received several consumer complaints about confusion and misinformation regarding their short-term or excepted benefit plans. Because of the real risk that consumers may confuse short-term policies with comprehensive health insurance that complies with the Affordable Care Act (ACA), it is important that they be

made aware of any limitations to these policies during the sales process. We are pleased that the proposed rule retains these important disclosure requirements and adds valuable additional disclosures.

As drafted, this rulemaking does not address the impact of Section 1557 of the ACA on the issuance of short-term, limited duration plans. Specifically, it is unclear whether or not these plans will be considered to be a "health program or activity" under 45 C.F.R. §92.4. This distinction is critical.

If these plans are not exempt from the definition of "health plan or activity," the implication would be that carriers could not offer these plans and also participate on the Marketplace, Medicare, or Medicaid. In many states throughout the country, carriers are deciding whether or not to participate in the ACA-compliant marketplace, and if clarifying language is not included carriers will be forced to choose either to offer short-term, limited duration plans or participate in the Exchange. We would ask for clarification on this issue, and specifically advise that CMS include language in the proposed definition of "short-term, limited duration insurance" providing that such insurance is "not a health program or activity as defined in 45 C.F.R. § 92.4."

As to the issue of renewability, the members of the NAIC concur that any decision over whether and when these plans should be renewable should be left up to the States, not dictated by the Federal government.

Finally, states are concerned about the timing of this rule, and some states may want to modify existing laws and regulations to protect consumers and state markets. Therefore, we recommend that the final regulation allow states, if they so choose, to begin enforcing the new rules in 2020, thus giving them time to review their rules and seek statutory or regulatory changes to facilitate a smooth transition.

Thank you for this opportunity to comment. We are available to discuss these or other issues as the Short-Term, Limited Duration Proposed Rule is finalized.

Sincerely,

Julie Mix McPeak
NAIC President
Commissioner
Tennessee Department of
Commerce & Insurance

Eric A. Cioppa
NAIC President-Elect
Superintendent
Maine Bureau of Insurance

Raymond G. Farmer
NAIC Vice President
Director
South Carolina Department of Insurance

Gordon I. Ito
NAIC Secretary-Treasurer
Commissioner
Insurance Division
Hawaii Department of Commerce
and Consumer Affairs

CATO INSTITUTE

April 23, 2018

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services

Preston Rutledge
Assistant Secretary
Employee Benefits Security Administration
U.S. Department of Labor

Kirsten B. Wielobob
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
Department of Treasury

Re: Comments on Short-Term, Limited Duration Insurance - CMS-9924-P

Dear Administrator Verma, Assistant Secretary Rutledge, and Deputy Commissioner Wielobob:

Thank you for the opportunity to comment on the proposed rule, "Short-Term, Limited Duration Insurance."

The Cato Institute is a 501(c)(3) educational foundation dedicated to the principles of individual liberty, limited government, free markets, and peace. Its scholars conduct independent, nonpartisan research on a wide range of policy issues. To maintain its independence, the Cato Institute accepts no government funding. Cato receives approximately 80 percent of its funding through tax-deductible contributions from individuals. The remainder of its support comes from foundations, corporations, and the sale of books and publications.

On October 12, 2017, President Donald J. Trump signed Executive Order 13813, directing the Departments to reduce regulations and expand consumer choice in health insurance. Specifically, the president urged: "To the extent permitted by law and supported by sound policy, the Secretaries should consider allowing [short-term limited duration] insurance to cover longer periods and be renewed by the consumer."[1] On March 8, 2018, Secretary of Health and Human Services Alex Azar publicly lent his support to allowing short-term plans to offer renewal guarantees: "We'd like to see the ability to give people the option of renewability in whatever form we can have it."[2]

On February 21, 2018, the Departments issued the proposed rule, "Short-Term, Limited-Duration Insurance," which proposes two principal changes to federal regulation of these products: increasing the maximum contract term for short-term limited duration insurance plans to 12 months (from the 3-month limit imposed by regulation in 2016); and allowing short-term plans to offer "renewal guarantees" that allow enrollees who develop expensive medical conditions to continue paying the same premiums as healthy enrollees.[3]

These changes are necessary to protect consumers and consistent with federal law. In brief, these comments make the following points.

- Consumers need relief from the Patient Protection and Affordable Care Act (ACA), which is not working as Congress intended. Allowing short-term plans to offer 12-month contract terms and renewal guarantees would provide protection and relief to millions of consumers struggling with the cost of coverage under the ACA.

- Guaranteed-renewable individual-market plans provide coverage for patients with high-cost medical conditions that is equally or more secure than employer-sponsored coverage.[4]

- Allowing short-term plans to offer 12-month contract terms and renewal guarantees is a reasonable interpretation of the Public Health Service Act (PHSA). Congress and administrations of both political parties accepted 12-month contract terms as a reasonable interpretation for more than 20 years. It is likewise a reasonable interpretation that the PHSA allows short-term plans to offer renewal guarantees, which are a distinct type of insurance that lie outside the definition of "health insurance coverage" the statute authorizes the Departments to regulate.

- Allowing these consumer protections in short-term plans is consistent with the purposes of the PHSA and the ACA, both of which seek to protect consumers from medical underwriting. It would not conflict with or prevent the operation of the ACA or any other federal law. Every provision in the ACA and the PHSA would continue to apply to the plans they regulate.

- The 2016 final rule that blocks these consumer protections exceeds the Departments' authority.

- It is an economic fallacy to claim that allowing these consumer protections in short-term plans would increase the cost of ACA plans. On the contrary, it would reduce the problem of preexisting conditions and lessen the burden the ACA imposes on taxpayers.

I urge you to allow short-term plans to offer longer contract terms and renewal guarantees that protect enrollees from re-underwriting. Swift action enabling these consumer protections could allow short-term plans to provide a more affordable, a more viable health-insurance option to millions of Americans before the end of this year. The remainder of this comment expands upon the above points.

The Affordable Care Act: Consumers Need Relief

Congress' primary goal when enacting the ACA was to create "Affordable Choices of Health Benefit Plans"[5] and "Affordable Coverage Choices for All Americans,"[6] with various standards and requirements specifying that "Coverage Must Be Affordable"[7]—and, notably, providing relief for "Individuals Who Cannot Afford Coverage."[8] Additional goals included ensuring "Consumer Choices and Insurance Competition Through Health Benefit Exchanges"[9] and ensuring "Quality Health Insurance Coverage for All Americans"[10] by "Rewarding Quality through Market-Based Incentives."[11]

The ACA is not working as Congress intended, and consumers need relief. Rather than deliver an array of quality health-insurance products at reasonable premiums, the ACA is delivering skyrocketing premiums, restricting insurance choices, and eroding the quality of coverage for the sick. Shrinking enrollment in the law's health-insurance Exchanges are further evidence of the law's failure to deliver on its promise, and of the need for relief.

Skyrocketing Premiums

In Executive Order 13813, President Donald J. Trump found the ACA is neither expanding choices nor making coverage more affordable:

> The Patient Protection and Affordable Care Act (ACA), however, has severely limited the choice of healthcare options available to many Americans and has produced large premium increases in many State individual markets for health insurance. The average exchange premium in the 39 States that are using www.healthcare.gov in 2017 is more than double [105 percent] the average overall individual market premium recorded in 2013. The ACA has also largely failed to provide meaningful choice or competition between insurers, resulting in one-third of America's counties having only one insurer offering coverage on their applicable government-run exchange in 2017.[12]

The Department of Health and Human Services (HHS) reports premiums for benchmark plans increased an additional 37 percent in 2018.[13] California's health-insurance Exchange estimates "the statewide average premium increases in 2019 could range from 12 to 32 percent — with some carriers in certain states having even higher rate increases, depending on state factors."[14]

A report prepared for HHS found the ACA's preexisting-conditions provisions are the driving force behind these premium increases.[15] While those provisions were supposed to protect women from discrimination in health insurance, research indicates they increased premiums for older women more than anyone else:

> Total expected premiums and out of pocket expenses rose by 50 percent for women age 55 to 64 — a much larger increase than for any other group — for policies on the federal exchanges relative to prices that individuals who bought individual insurance before health care reform went into effect…

> Premiums for the second-lowest silver policy are 67 percent higher for a 55 to 64-year-old woman than they were pre-ACA.[16]

The fact that most Exchange enrollees receive federal subsidies (nominally, tax credits) toward their premiums merely shifts those rising costs to taxpayers. Those subsidies are also increasing at an accelerating rate. By 2018, the cost to taxpayers of those subsidies increased by 45 percent over 2017, and by 114 percent since 2014.[17]

Increasingly Less Choice

HHS reports the ACA's Exchanges are likewise offering consumers increasingly fewer choices: "Eight states in [2018] will have only one issuer: Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina, and Wyoming…29% of current enrollees will have only one issuer to choose from, up from 20% in [2017]."[18]

This exodus of insurers from the Exchanges is consistent with an adverse selection death spiral. While no Exchange has completely collapsed (yet), there have been periodic and growing fears that in some counties, there will be no Exchange coverage at all.[19]

Eroding Quality

Economic research indicates that in addition to driving up premiums, the ACA's preexisting-conditions provisions penalize high-quality coverage for the sick and have caused Exchange coverage to grow increasingly worse for patients with multiple sclerosis, opioid addiction, and other expensive conditions—a side effect that turns public opinion against those provisions.[20]

Former President Bill Clinton captured the ACA's effects on both premiums and coverage quality when he remarked in 2016: "The people who are out there busting it, sometimes 60 hours a week, wind up with their premiums doubled and their coverage cut in half. It's the craziest thing in the world."[21]

Falling Enrollment

Skyrocketing premiums and eroding coverage are affecting Exchange enrollment, which has consistently failed to meet expectations, and is now falling. Plan selections fell by 4 percent from 2016 to 2017, and by 3 percent in 2018.[22]

And while plan selections numbered 11.8 million for 2018, actual enrollment—i.e., consumers who both select a plan and pay their premiums—will likely prove substantially less. There were originally 12.2 million plan selections for 2017, but 16 percent of those individuals never made a premium payment, reducing actual enrollment to 10.3 million.[23] If that trend persists, peak Exchange enrollment could fall below 10 million in 2018, a lower number than any year since 2014.[24]

The Benefits and Promise of Short-Term Limited Duration Insurance

In the PHSA, however, Congress explicitly exempts "short-term limited duration insurance" from the costly regulations (including ACA regulations) it imposes on other individual-market coverage.[25] As a result, short-term plans have been providing relief for a growing number of consumers.

Premiums for short-term plans are often 70 percent lower than Exchange premiums,[26] and have not been subject to the same (or any) premium inflation that Exchange coverage has.[27] This is due in part to the fact that federal law allows underwriting in short-term plans, but also to the fact that consumers may select on those benefits they want. If researchers are correct that women age 55-64 have seen the largest premium increases under the ACA,[28] short-term plans would offer the greatest premium savings to women in this age group. Unlike Exchange coverage, consumers can enroll in short-term plans at any time of year—an option that a majority of voters support.[29] Access to providers is often broader than in Exchange plans.[30] Due to these factors, consumers have sought relief from the ACA in short-term plans, demand for which has been growing.[31]

Relief for Victims of the ACA

With longer contract terms and renewal guarantees, short-term plans could provide relief to potentially millions more consumers and reduce the burden the ACA imposes on taxpayers. The National Association of Insurance Commissioners (NAIC) explains the current 3-month maximum contract term exposes consumers to "the risk of losing their coverage after three months if they become sick."[32] By contrast, a 12-month contract term would give short-term plan enrollees the additional peace of mind that comes from knowing their current plan will cover them, and protect them from medical underwriting, for an entire year.

Renewal Guarantees Can Increase Health Security, Reduce the Burden of the ACA

Renewal guarantees, as offered in the individual market prior to the ACA (and under existing "grandmothered" plans[33]) offer even greater protection. They guarantee both that enrollees may renew their coverage at the end of the contract term (i.e., when they form a new contract with the issuer) *and* that the issuer will not subject the enrollee to re-underwriting at renewal. A renewal guarantee thus guarantees that if a consumer develops an expensive medical condition, she will continue to pay the same premium as healthy enrollees. Research indicates renewal guarantees create sustainable, incentive-compatible insurance pools that offer more secure coverage to patients with high-cost conditions than even employer-sponsored plans.[34]

Allowing short-term plans to offer renewal guarantees could reduce the problem of preexisting conditions, and thus reduce the burden the ACA places on taxpayers, by providing greater protection to both the uninsured and individuals with employer-sponsored insurance.

Here's how. While renewal guarantees are insurance, they are distinct from health insurance and insure against a distinct risk. Health insurance—i.e., insurance that pays one's medical bills—insures against the risk that one will need expensive medical services during the contract term. Renewal guarantees insure consumers against the risk that *developing an expensive medical condition* during the contract term will increase their premiums.[35] Since renewal guarantees insure against a distinct risk, insurers can sell them as a separate product that protects consumers

against the risk that developing an expensive medical condition will leave them with an uninsurable preexisting condition.

Indeed, one insurer has sold renewal guarantees as a separate product. In 2009, UnitedHealth Group received regulatory approval from 25 states to offer renewal guarantees as a standalone product.[36] Consumers could purchase the guarantees for an annual premium equal to 20 percent of the cost of a guaranteed-renewable health insurance policy. Purchasing the standalone renewal guarantee—what we might call "preexisting-conditions insurance"—gave consumers the right to enrolling in a health insurance policy, at a healthy-person premium, no matter how sick they became in the meantime. UnitedHealth had planned to offer this product, which reduced the cost of insurance protection by *80 percent*, in an additional 15 states. Yet the ACA made the products economically unviable everywhere but the short-term market.

Allowing short-term plans to offer renewal guarantees would allow insurers to offer them once again as standalone products to both the uninsured and individuals with employer-sponsored insurance. This approach would make coverage more secure for workers by building on an approach that is already proven to make coverage equally or more secure for patients with high-cost conditions than employer-sponsored insurance does.[37]

It would also reduce the burden the ACA imposes on taxpayers by enabling individuals with expensive medical conditions, even if they lose employer-sponsored coverage, to obtain secure coverage that does not depend on taxpayer subsidies. By contrast, prohibiting short-term plans from offering renewal guarantees effectively forces short-term plan enrollees who fall ill, the uninsured who fall ill, and workers who fall ill and lose their employer-sponsored coverage, to enroll in Exchange plans where they become a burden on taxpayers.

Unfortunately, ill-conceived federal rules are blocking these consumer protections.

The 2016 Rule Blocks Consumer Protections

Though health-insurance regulation has traditionally been the responsibility of states, in 1996 Congress imposed a set of federal regulations on the individual market. At the same time, it exempted "short-term limited duration insurance" from those regulations. The rules governing short-term plans were settled for two decades before the Departments issued an ill-advised rule that misread federal law and congressional intent, and arbitrarily blocked important consumer protections in that market.

From 1996 to 2016, interim and final rules 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.[38]

In 2010, the ACA imposed significant new regulations on health insurance markets, but did not alter the exemption for short-term plans or the Departments' rules interpreting that exemption.

The 2016 Rule

In 2016, however, the Departments finalized a rule that imposed arbitrary limits on short-term plans.[39] In relevant part, the 2016 rule redefined "short-term limited duration insurance" as (changes in *italics*):

> health insurance coverage provided pursuant to a contract with an issuer that [h]as an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder *with or* without the issuer's consent) that is less than *3 months* after the original effective date of the contract…

The new language shortened the maximum duration of short-term plan contracts from 12 months to 3 months and prohibited short-term plans from offering renewal guarantees. The stated reason for the changes was that "the Departments are concerned that these policies may have significant limitations…may not provide meaningful health coverage…[and may] adversely impact[] the risk pool for Affordable Care Act-compliant coverage."[40] The stated purpose of the changes was "to address the Departments' concern that some issuers are taking liberty with the current definition…either by automatically renewing such policies or having a simplified reapplication process with the result being that such coverage…lasts longer than 12 months and serves as an individual's primary health coverage."[41] In reality, the changes were arbitrary, exceeded the Departments' authority, and harmed consumers by stripping important consumer protections from short-term plan enrollees.

Since the PHSA does not define the phrase "short-term limited duration," it falls to the Departments to define that term.[42] That task requires only that the Departments fix a period of time within which a health insurance contract must expire in order to qualify for this exemption. The PHSA grants the Departments no authority to decide that consumers are purchasing short-term plans in the wrong quantities or for the wrong reasons—much less to alter the established maximum contract term to prevent consumers from entering these contracts in quantities and for reasons that Congress never declared to be wrong. If Congress wanted to restrict the availability of short-term plans, it could have done so in the ACA or other bills it passed before or since. It did not, and the Departments lacked the authority to do so.

Just as these changes are unsupported by the statute, they are unsupported by data, and are harming consumers rather than helping them. As the NAIC explained in comments on the proposed 2016 rule:

> The proposed rule provides no data to support the premise that a three-month limit would protect consumers or markets.
>
> In fact, state regulators believe the arbitrary limit proposed in the rule could harm some consumers. For example, if an individual misses the open enrollment period and applies for short-term, limited duration coverage in February, a 3-month policy would not provide coverage until the next policy year (which will start on January 1). The only option would be to buy another short-term policy at the end of the three months, but since

> the short-term health plans nearly always exclude pre-existing conditions, if the person develops a new condition while covered under the first policy, the condition would be denied as a preexisting condition under the next short-term policy.[43]

In other words, the 3-month limit reduces consumer protections by exposing enrollees who develop expensive illnesses to medical underwriting and cancelled coverage. The NAIC further explained the 3-month limit would not make the ACA's risk pools healthier and could even make them sicker:

> [W]e do not believe this proposal will actually solve the problem it is intended to address. If the concern is that healthy individuals will stay out of the general pool by buying short-term, limited duration coverage there is nothing in this proposal that would stop that. If consumers are healthy they can continue buying a new policy every three months. Only those who become unhealthy will be unable to afford care, and that is not good for the risk pools in the long run.[44]

The 2016 rule exceeds the Departments' authority because the changes are not supported or required by statute, and indeed run counter to congressional intent. Congress has never enacted or sought any such restrictions on short-term plans. At no time before or after it enacted the ACA in 2010 has Congress given any indication it wished to restrict the ability to purchase short-term plans under the rules that had been in place since 1996. With the ACA, Congress created a regulatory scheme it hoped would "improve health insurance markets, not…destroy them."[45] Yet it left consumers the choice of enrolling in short-term plans under the rules that existed at the time.

As the NAIC's comments highlight, the Departments' rationale for the 2016 rule rests on a perverse and counter-historical interpretation of congressional intent. Congress has never, in any health-insurance market, sought to block renewal guarantees or expose consumers to medical underwriting. On the contrary, at every turn, Congress has sought to expand renewal guarantees—even to the point of mandating them[46]—and to shield consumers from medical underwriting.

The 2016 rule flouts congressional intent by blocking these consumer protections and exposing short-term plan enrollees to medical underwriting—even after they fall ill. Just as a 12-month maximum contract term gives enrollees the additional peace of mind that comes from knowing their current plan will cover them, and protect them from medical underwriting, for an entire year, renewal guarantees further protect enrollees who develop an expensive medical condition by guaranteeing their premiums will not spike when they enroll in a new plan. The 2016 rule, and those who wish to preserve it,[47] are literally blocking valuable consumer protections.

Recent congressional action provides further evidence that the 2016 rule's interpretation of federal law and congressional intent is flawed. The 2016 rule inadvertently contradicts itself when it complains "individuals are purchasing this coverage as their primary form of health coverage" even as it explains the ACA's "individual shared responsibility provision…provides sufficient incentive to discourage consumers from purchasing multiple successive short-term, limited-duration insurance policies."[48]

Despite the contradiction, the Departments apparently believed that Congress intended the individual mandate to discourage consumers from purchasing multiple successive short-term plans. It is therefore significant that earlier this year, Congress eliminated that disincentive by eliminating the penalty for failing to purchase minimum essential coverage beginning in 2019.[49] The fact that Congress enacted legislation facilitating consumers' ability to use short-term plans in a manner the 2016 rule assumes is counter to congressional intent casts doubt on that rule's claim that it effectuates congressional intent.

Agencies Have Repeatedly Reinterpreted the ACA to Provide Relief to Consumers

Fortunately, there is ample precedent for reversing the 2016 rule. On several occasions, the Departments have altered their interpretation of the PHSA and the ACA to provide relief to victims of the latter. Relief efforts have included delaying provisions limiting out-of-pocket exposure in health plans; multiple delays in implementing the employer mandate; and allowing consumers to remain in non-ACA-compliant "grandmothered" health plans for four years (and counting[50]) after the ACA prohibited them.[51]

Since 2013, HHS has allowed hundreds of thousands of consumers to remain in so-called "grandmothered" plans that neither comply with, nor qualify for exemptions from, the ACA's health-insurance regulations.[52] As one ACA supporter describes the policy, HHS "prospectively licens[ed] large groups of people to violate a congressional statute."[53] Under this policy, HHS has allowed these non-compliant plans to continue offering renewal guarantees that protect enrollees from re-underwriting at renewal.[54] If HHS can allow renewal guarantees in health insurance plans federal law clearly forbids, it can certainly allow renewal guarantees where federal law does not forbid them.

Most analogous to the current situation is HHS's decision to reinterpret the ACA to exempt U.S. territories from the law's core regulations. From 2010 through 2013, HHS maintained "that the insurance market reforms in title XXVIII of the Public Health Service Act (PHS Act), as amended by title I of the Affordable Care Act, apply to health insurance issuers in the territories because the definition of 'State' in the PHS Act includes territories."[55] In 2013, the NAIC described the likely impact of that interpretation and those regulations on U.S. territories:

> Without some action to prevent a cycle of adverse selection in the territories, implementation of the ACA's market reforms is likely to lead to a result that is the opposite of what the ACA intended—higher premiums, less competition, and more Americans without health insurance coverage.[56]

After being confronted with the consequences of its interpretation, HHS reversed its interpretation in 2014:

> We have been informed by representatives of the territories that this interpretation is undermining the stability of the territories' health insurance markets. After a careful review of this situation and the relevant statutory language, HHS has determined that the new provisions of the PHS Act enacted in title I are appropriately governed by the

definition of "state" set forth in that title, and therefore that these new provisions do not apply to the territories.[57]

HHS reversed its interpretation of the ACA to provide relief from unintended harms that law caused—i.e., higher premiums, less competition, and a destabilized health-insurance market.

On the mainland, consumers are suffering those very harms with no relief in sight. Reversing the Departments' interpretation of federal law with respect to short-term plans can provide relief to millions of those consumers. As explained below, unlike delays in the employer mandate and exemptions for "grandmothered" plans, allowing short-term plans to offer longer contract terms and renewal guarantees is consistent with federal law.

Legal Analysis: A Reasonable Interpretation of the PHSA

Even if one considers the 2016 rule a reasonable interpretation of the PHSA, it is not the only reasonable interpretation. It is clearly reasonable to interpret the PHSA to allow short-term plans to offer contract terms of up to 12 months. That rule was in place for 20 years, accepted by administrations of both political parties, and has never been altered by Congress. It is likewise reasonable to interpret the PHSA as allowing short-term plans to offer renewal guarantees.

The undefined phrase "short-term, limited duration" allows the Secretary to define the length of time within which short-term plan contracts must expire. It creates no authority for the Secretary to limit how many such contracts consumers enter. Nor does it create any authority for the Secretary to regulate renewal guarantees.

On the contrary, renewal guarantees are a form of insurance that lies completely outside those that the PHSA authorizes the Secretary to regulate. The PHSA authorizes the Secretary to regulate "health insurance coverage," including "individual health insurance coverage," but exempts "short-term limited duration insurance" from regulation.

The proposed rule is incorrect when it states, "The PHS Act does not define short-term, limited-duration insurance."[58] The statute does indeed fail to define the phrase *short-term, limited duration*. The task of defining that ambiguous term therefore falls to the Secretary. As noted above, this ambiguity authorizes the Departments to do no more than to fix a period of time within which health insurance contracts must expire to qualify for this exemption.

Yet the PHSA does define *insurance* as used that phrase. The PHSA specifies[59] and the Departments affirm[60] that the word *insurance* in the phrase *short-term, limited duration insurance* means "health insurance coverage," which the statute defines as a "policy or certificate [or] contract" that provides "benefits consisting of medical care."[61] To qualify for this exemption, therefore, a policy/certificate/contract must provide benefits consisting of medical care and must expire within the timeframe specified in regulation.

Renewal Guarantees Are Not "Health Insurance Coverage"

Importantly, renewal guarantees are not "health insurance coverage." They provide no benefits consisting of items and services paid for as medical care. They are a form of insurance, but a different one that protects against a different risk (the risk of one's health insurance premiums increasing due to a change in health status) and provide a different benefit (lower premiums). As evidence that renewal guarantees are a separate and distinct product from health insurance coverage, in 2009, 25 states had approved renewal guarantees for sale as a standalone product, separate from health insurance and providing no medical benefits. [62]

When the PHSA creates an exemption from regulation for short-term limited duration *insurance* and specifies that only *insurance* of limited duration qualifies for that exemption, it creates no authority for the Departments to regulate or prohibit something that does not meet the definition of *insurance*. The only authority the PHSA creates for the Secretary to deny the "short-term, limited duration insurance" exemption to health insurance contracts is if those contracts fail to expire within the specified time period. It creates no authority to prohibit short-term plans from offering renewal guarantees that govern the relationships between issuers and consumers when they renew—i.e., form a new short-term health insurance contract. In sum, the Secretary has no authority to interpret "short-term limited duration insurance" in a manner that regulates insurance products whose benefits do not consist of medical care. In this way, renewal guarantees are akin to the "excepted benefits" insurance products the PHSA exempts from many of the same regulations.[63]

Since renewal guarantees are not "health insurance coverage," it is reasonable to interpret the statute as not counting renewal guarantees against the time limit HHS sets for the legally relevant contract for medical benefits. Even if there are other reasonable interpretations of the statute, it is implausible to argue the law precludes HHS from adopting this one. This interpretation is sufficiently reasonable that the 2016 rule could prompt a legal challenge from insurers and/or consumers who would wish to buy and sell short-term plans with renewal guarantees.

Finally, ending the ban would not conflict with or prevent the operation of any federal law. Congress never prohibited renewal guarantees. Every provision in the PHSA and the ACA would continue to apply to the plans they regulate.

Economic Impacts of Allowing Consumer Protections

The proposed rule and various observers miscategorize the economic impact of these changes. Allowing these consumer protections would not increase the cost of Exchange coverage by one penny. If anything, they would reduce the cost of Exchange coverage. Nor would they transfer resources from the sick to the healthy.

Revealing the Full Cost of the ACA

The proposed rule estimates these consumer protections could induce as many as 200,000 low-risk individuals to leave Exchange plans for short-term plans in 2019, and that their exit could increase nominal Exchange premiums by less than 1 percent, which would cause spending on Exchange subsidies to rise by up to $168 million.[64] Other estimates predict greater impacts. The Urban Institute projects as many as 2.1 million people could leave Exchange plans, which when

combined with the effect of eliminating the individual-mandate penalty, could increase nominal ACA premiums by 18 percent.[65]

While the proposed consumer protections would make short-term plans differentially attractive to healthy consumers who would otherwise enroll in Exchange plans, and while this dynamic could cause *nominal* Exchange premiums to rise, it would not cause *actual* Exchange premiums to rise. The full or actual premium for Exchange coverage is equal to the total cost of the coverage the ACA requires participating insurers to provide. When adverse selection causes nominal Exchange premiums to rise, it means those nominal premiums are more closely reflecting the actual cost of the coverage the ACA requires participating insurers to provide. When those higher nominal premiums cause federal spending on Exchange subsidies to rise, it is because the ACA is replacing *hidden* transfers (from low-risk Exchange enrollees in the form of higher premiums) with *explicit, on-budget* transfers (from taxpayers). Making those transfers explicit is desirable because it increases transparency in government and provides voters and policymakers with better information about the cost of the ACA.

Enhancing Short-Term Plans Could Reduce Exchange Spending

Allowing short-term plans to offer longer contract periods and renewal guarantees could reduce the cost of the ACA. As noted above, guaranteed-renewable individual coverage can provide sustainable access to care for people who develop expensive conditions without taxpayer subsidies. It can do so not only for consumers who are currently in (or sitting out) the individual market. It can also do so for workers in employer-sponsored plans through innovations like standalone renewal guarantees (i.e., preexisting-conditions insurance).

Every individual who develops and expensive condition and would have enrolled in Exchange coverage but instead obtains secure coverage through a short-term plan with a renewal guarantee reduces the cost of the ACA both to taxpayers and to other Exchange enrollees. Given the ACA's current struggles, supporters should reconsider their opposition to allowing these consumer protections in short-term plans.

It Is Not a "Transfer" When You Get to Keep Your Own Money

The proposed rule further miscategorizes the economic effects of these consumer protections when it claims they would "transfer [resources] from enrollees in individual market plans who experience increase in premiums to individuals who switch to lower premium short-term, limited-duration insurance."[66]

As noted above, the ACA currently effects hidden transfers from healthy people to sick people by increasing premiums on low-risk Exchange enrollees (a hidden tax) in order to reduce premiums for high-risk enrollees (a hidden subsidy). When healthy Exchange enrollees switch to short-term plans with lower premiums, the money they save is not a *transfer* that they receive from sick consumers. The money they save was theirs in the first place. It is not a transfer when consumers get to keep their own money. Allowing greater consumer protections in short-term plans no more transfers resources from sick to healthy than the ACA itself does when its skyrocketing premiums spur healthy consumers to withdraw from the market.

Concerns with the Rulemaking Process

With the caveat that one ought not to believe everything one reads, in late March the health-policy trade press recently attributed the following troubling comments to HHS officials:

> The Trump administration told state insurance commissioners and officials that they will not include guaranteed renewability in the final version of short-term plans, according to insurance officials exiting a closed door meeting…
>
> "The response from the deputy, with his boss sitting at the table with him, who last week said we could [make these plans guaranteed renewable], was 'well if we allowed you to make these guaranteed renewable they wouldn't be short term plans anymore'," a state insurance commissioner told Inside Health Policy, referring to Center for Consumer Information and Insurance Oversight officials.
>
> Three additional meeting attendees confirmed that CCIIO officials declared that short-term plans and guaranteed renewability are incompatible.[67]

Such reports raise concerns about the rulemaking process. First, these remarks are not consistent with a careful understanding of the authority Congress has granted the Departments. Second, they suggest agency officials are not asking the right questions. The question is not, "Do the Departments have the authority to *permit* guaranteed renewability?" It is, "Do the Departments have the authority to *prohibit* guaranteed renewability?" As detailed here, that authority is lacking.

Most troubling, these remarks suggest agency officials have made their decision prior to reviewing public comments. If so, there would be little point to soliciting public comments. I trust instead agency officials will approach public comments with an open mind.

Conclusion

Consumers need immediate relief from the ACA's skyrocketing premiums, dwindling choices, and eroding coverage. Allowing short-term plans to offer 12-month contract terms and renewal guarantees can provide that relief. It is consistent with federal law, and with Congress' manifest support for renewal guarantees and desire to shield patients from medical underwriting. The 2016 rule that bars these consumer protections is a clear example of executive overreach. Commenters who defend the 2016 rule or ask the Departments to "withdraw the proposed rule in its entirety" are quite literally asking the Departments to deny consumer protections to individuals seeking relief from the ACA.[68] If the Departments act swiftly, they can provide that relief before the ACA's next open enrollment season.

I am happy to answer any questions the Departments may have.

Sincerely,

Michael F. Cannon
Director of Health Policy Studies

[1] Executive Order No. 13813, 82 FED. REG. 48,385 (Oct. 12, 2017), https://www.federalregister.gov/documents/2017/10/17/2017-22677/promoting-healthcare-choice-and-competition-across-the-united-states.
[2] Ariel Cohen, tweet, March 8, 2017, https://twitter.com/ArielCohen37/status/971843452861321217 (".@SecAzar answers my ? about short-term plan renewability being decided in HHS vs on the hill: 'we'd like to see the ability to give people the option of renewability in whatever form we can have it...'").
[3] Short-Term, Limited-Duration Insurance, 83 FED. REG. 7437 (Feb. 21, 2018), https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-03208.pdf.
[4] Mark V. Pauly and Robert D. Lieberthal, *How Risky Is Individual Health Insurance?* 27 HEALTH AFF. 3, May-June 2008, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.27.3.w242.
[5] ACA, Section 1311.
[6] ACA, Title I, Subtitle E.
[7] IRC, 36B(c)(2)(C)(i).
[8] IRC, Section 5000A(e)(1).
[9] ACA, Title I, Subtitle D, Part 2.
[10] ACA, Title I, Subtitle C.
[11] ACA, Section 1311(g).
[12] https://www.federalregister.gov/documents/2017/10/17/2017-22677/promoting-healthcare-choice-and-competition-across-the-united-states.
[13] https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf.
[14] http://hbex.coveredca.com/data-research/library/CoveredCA_High_Premium_Increases_3-8-18.pdf.
[15] https://www.ronjohnson.senate.gov/public/_cache/files/2c915f24-f868-4207-85ed-4d0d319c45e8/johnson-and-lee-dear-colleague-july-19a.pdf.
[16] Joann Weiner, "Older Women Bear the Brunt of Higher Insurance Costs under Obamacare," *Washington Post*, June 24, 2014, https://www.washingtonpost.com/blogs/she-the-people/wp/2014/06/24/older-women-bear-the-brunt-of-higher-insurance-costs-under-obamacare/ ("I asked one of the author's [sic] of the study, Mark Pauly, why it seems that older women are bearing the brunt. 'It's likely because they are being averaged in with younger women who have much higher expenses associated with childbearing and with older men who didn't take care of themselves. Community rating redistributes against the relatively healthy,' he explained.").
[17] https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf.
[18] https://aspe.hhs.gov/system/files/pdf/258456/Landscape_Master2018_1.pdf.
[19] https://www.kff.org/interactive/counties-at-risk-of-having-no-insurer-on-the-marketplace-exchange-in-2018/.
[20] See https://www.healthaffairs.org/do/10.1377/hblog20180103.261091/full/; and https://www.healthaffairs.org/action/showDoPubSecure?doi=10.1377/hblog20180103.932096&format=full. See also http://www.nber.org/papers/w22832.
[21] Fox 10 Phoenix, "FNN: Bill Clinton Campaigns in Flint, Michigan," October 3, 2016, https://www.youtube.com/watch?v=Rva2kLSBAWY (at 25:43)
[22] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html.
[23] https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf
[24] https://data.cms.gov/Marketplace-Qualified-Health-Plan-QHP-/Total-Effectuated-Enrollment-and-Financial-Assista/v9jz-riug/data.
[25] 42 U.S.C. §300gg–91(b)(5), https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/html/USCODE-2016-title42-chap6A-subchapXXV-partC-sec300gg-91.htm.
[26] Michelle Andrews, "Sales Of Short-Term Insurance Plans Could Surge If Health Law Is Relaxed," NPR.org, January 31, 2017, https://www.npr.org/sections/health-shots/2017/01/31/512518502/sales-of-short-term-insurance-plans-could-surge-if-health-law-is-relaxed ("In the fourth quarter of 2016, the average monthly premium a shopper would pay for a short-term plan sold through eHealth.com was $124, compared with $393 for someone who bought a regular Obamacare plan and didn't qualify for premium subsidies.").

[27] eHealth, *Short-Term Health Insurance: Value, Benefits and Cost*, March 2018, https://news.ehealthinsurance.com/_ir/68/20182/Short-Term%20Health%20Insurance%20-%20Value%20Benefits%20and%20Cost.pdf ("The average premium for individual short-term coverage in 2017 was unchanged from 2016 ($110 per month) and decreased by 3 percent for families during the same period (from $276 to $267 per month), a stark contrast to the premium inflation seen among major medical plans.").

[28] Joann Weiner, "Older Women Bear the Brunt of Higher Insurance Costs under Obamacare," *Washington Post*, June 24, 2014, https://www.washingtonpost.com/blogs/she-the-people/wp/2014/06/24/older-women-bear-the-brunt-of-higher-insurance-costs-under-obamacare/.

[29] Foundation for Government Accountability, "34-State Poll Confirms Voters Don't Want State-Run Obamacare Exchanges," March 26th, 2015, https://thefga.org/news/for-immediate-release-34-state-poll-confirms-voters-dont-want-state-run-obamacare-exchanges/ ("77 percent of voters want to buy health insurance coverage at any time during the year, not just during 3-month windows of open enrollment").

[30] Anna Wilde Mathews, "Sales of Short-Term Health Policies Surge," *Wall Street Journal*, April 10, 2016, https://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539 ("A recent promotional email to insurance brokers from UnitedHealth Group Inc. touted its short-term policies' broad access to doctors, compared with limits found in 'most major medical plans.'").

[31] eHealth, *Short-Term Health Insurance: Value, Benefits and Cost*, March 2018, https://news.ehealthinsurance.com/_ir/68/20182/Short-Term%20Health%20Insurance%20-%20Value%20Benefits%20and%20Cost.pdf.

[32] National Association of Insurance Commissioners & the Center for Insurance Policy Research, comments on the proposed rule *Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, published in the Federal Register on June 10, 2016*, August 9, 2016, http://www.naic.org/documents/government_relations_160809_hhs_reg_short_term_dur_plans.pdf.

[33] "individuals in transitional plans did not undergo underwriting." http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-S rt-Term-Limited-Duration-Plans-Report.pdf.

[34] See Bradley Herring & Mark V. Pauly, "Incentive-Compatible Guaranteed Renewable Health Insurance Premiums," *Journal of Health Economics*, Volume 25, Issue 3, May 2006, pp. 395-417, http://www.nber.org/papers/w9888.pdf; and Mark V. Pauly & Robert D. Lieberthal, "How Risky Is Individual Health Insurance?", *Health Affairs*, Vol. 27, No. 3, May/June 2008, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.27.3.w242.

[35] See generally John H. Cochrane, Health-Status Insurance: How Markets Can Provide Real Health Security, Cato Institute Policy Analysis no. 633, February 18, 2009, https://object.cato.org/sites/cato.org/files/pubs/pdf/pa-633.pdf.

[36] Reed Abelson, "UnitedHealth to Insure the Right to Insurance," *New York Times*, Dec. 2, 2008, https://www.nytimes.com/2008/12/03/business/03insure.html.

[37] Mark V. Pauly and Robert D. Lieberthal, "How Risky Is Individual Health Insurance?", *Health Affairs*, Vol. 27, No. 3, May/June 2008, https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.27.3.w242.

[38] See https://www.cms.gov/Regulations-and-Guidance/Health-Insurance-Reform/HealthInsReformforConsume/downloads/InterimRulesforHIPAA.pdf; and https://www.gpo.gov/fdsys/pkg/FR-2004-12-30/pdf/04-28112.pdf.

[39] "Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance," 81 FR 75316, October 31, 2016, https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance.

[40] "Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance," 81 FR 75316, October 31, 2016, p. 75317-75318, https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance.

[41] "Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance," 81 FR 75316, October 31, 2016, p. 75318, https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance.

[42] The PHSA does define the term "insurance," which undercuts the 2016 rule's prohibition on renewal guarantees (see below).

[43] National Association of Insurance Commissioners & the Center for Insurance Policy Research, comments on the proposed rule *Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, published in the Federal Register on June 10, 2016*, August 9, 2016, p. 1, http://www.naic.org/documents/government_relations_160809_hhs_reg_short_term_dur_plans.pdf.

[44] National Association of Insurance Commissioners & the Center for Insurance Policy Research, comments on the proposed rule *Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, published in the Federal Register on June 10, 2016*, August 9, 2016, p. 1, http://www.naic.org/documents/government_relations_160809_hhs_reg_short_term_dur_plans.pdf.
[45] *King v. Burwell*, 576 U.S. ___ (2015), p. 21, https://www.supremecourt.gov/opinions/14pdf/14-114_qol1.pdf.
[46] Since 1996, Congress has mandated that all issuers of health insurance in the individual or group market "must renew or continue in force such coverage at the option of the plan sponsor or the individual." Many issuers in the individual market offered stronger consumer protections than the law required, including renewal guarantees that protected enrollees from underwriting after initial enrollment. 42 U.S.C. §300gg–2, https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/html/USCODE-2016-title42-chap6A-subchapXXV-partA-subpartI-sec300gg-2.htm.
[47] See https://democrats-energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/HHS.2018.4.11.%20Short%20Term%20Plans%20proposed%20rule%20comment.%20HE.pdf
[48] Page 75318, https://www.federalregister.gov/documents/2016/10/31/2016-26162/excepted-benefits-lifetime-and-annual-limits-and-short-term-limited-duration-insurance#citation-17-p75318.
[49] Public Law 115-97, 131 Stat. 2054
[50] https://www.healthaffairs.org/do/10.1377/hblog20170223.058912/full/; https://www.healthinsurance.org/obamacare-enrollment-guide/should-i-keep-my-grandmothered-health-plan/.
[51] Nicholas Bagley, "Legal Limits and the Implementation of the Affordable Care Act," 164 *U. Pa. L. Rev.* 1715 (2016), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=9550&context=penn_law_review.
[52] https://www.healthaffairs.org/do/10.1377/hblog20170223.058912/full/; https://www.healthinsurance.org/obamacare-enrollment-guide/should-i-keep-my-grandmothered-health-plan/. On the legality of "grandmothered" plans, see Nicholas Bagley, "The Legality of Delaying Key Elements of the ACA," *New England Journal of Medicine*, May 22, 2014, 370:1967-1969, http://www.nejm.org/doi/full/10.1056/NEJMp1402641
[53] Nicholas Bagley, "Legal Limits and the Implementation of the Affordable Care Act," 164 *U. Pa. L. Rev.* 1715 (2016), p. 1723, https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=9550&context=penn_law_review.
[54] "individuals in transitional plans did not undergo underwriting." http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf.
[55] https://www.doi.gov/sites/doi.gov/files/migrated/oia/igia/upload/12-3-HHS-CMS-CNMI-Letter-igisomar7-12-13.pdf.
[56] Health Insurance and Managed Care (B) Committee, National Association of Insurance Commissioners, *Implementation of the Affordable Care Act in the U.S. Territories*, October 7, 2013, p. 9, http://www.naic.org/documents/index_health_reform_comments_140501_naic_letter_us_territories_paper_final.pdf
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[57] https://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Francis.pdf.
[58] Short-Term, Limited-Duration Insurance, 83 FED. REG. 7437 (Feb. 21, 2018), https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-03208.pdf
[59] 42 U.S.C. §300gg–91(b)(1), https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/html/USCODE-2016-title42-chap6A-subchapXXV-partC-sec300gg-91.htm ("The term 'health insurance coverage' means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.").
[60] See, e.g., p. 78747, 2nd column, https://www.gpo.gov/fdsys/pkg/FR-2004-12-30/pdf/04-28112.pdf ("*Health insurance coverage* means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and short-term, limited-duration insurance. However, benefits described in § 54.9831(c)(2) are not treated as benefits consisting of medical care.").
[61] 42 U.S.C. §300gg–91(b)(1), https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/html/USCODE-2016-title42-chap6A-subchapXXV-partC-sec300gg-91.htm. Emphasis added.
[62] Reed Abelson, "UnitedHealth to Insure the Right to Insurance," *New York Times*, Dec. 2, 2008, https://www.nytimes.com/2008/12/03/business/03insure.html.

[63] 42 U.S.C. §300gg–21(b)-(c), https://www.gpo.gov/fdsys/pkg/USCODE-2016-title42/html/USCODE-2016-title42-chap6A-subchapXXV-partA-subpart2-sec300gg-21.htm.
[64] Short-Term, Limited-Duration Insurance, 83 FED. REG. 7437 (Feb. 21, 2018), https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-03208.pdf.
[65] Linda Blumberg et al., *The Potential Impact of Short-Term Limited-Duration Policies on Insurance Coverage, Premiums, and Federal Spending*, URBAN INST. (2018), https://www.urban.org/sites/default/files/publication/96781/stld_draft_0226_finalized_0.pdf. See also Letter from Ryan Shultz, Oliver Wyman, to Mila Kofman, Executive Director, DC Health Benefit Exchange Authority, (Apr. 11, 2018) (on file with the DC Health Benefit Exchange Authority), 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; and Michael Cohen et al., *Effects of Short-term Limited Duration Plans on the ACA-Compliant Individual Market* WAKELY CONSULTING GRP., (2018), http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf.
[66] Short-Term, Limited-Duration Insurance, 83 FED. REG. 7437 (Feb. 21, 2018), https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-03208.pdf.
[67] Ariel Cohen, "Sources: CMS Will Not Allow Guaranteed Renewability In Short-Term Plans," *Inside Health Policy*, March 26, 2018.
[68] See https://democrats-energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/HHS.2018.4.11.%20Short%20Term%20Plans%20proposed%20rule%20comment.%20HE.pdf.

THE STATE of ALASKA
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April 23, 2018

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9924-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Comments on Proposed Revision of Federal Regulations
Short-Term, Limited-Duration Insurance
26 CFR Part 54 – RIN 1545-BO41
29 CFR Part 2590 - RIN 1210-AB86
45 CFR Parts 144, 146, and 148 – RIN 0938-AT48

To Whom It May Concern:

The Alaska Division of Insurance appreciates the opportunity to comment on the proposed regulations on *Short-Term, Limited Duration Insurance* (*Federal Register,* February 21, 2018).

The State of Alaska supports the removal of the three-month limitation on short-term limited duration plans. This will allow plans to provide continuous coverage of up to 12-months, which is more consistent with existing federal Health Insurance Portability and Accountability Act and historical state interpretations. The three-month limitation has resulted in negative consequences for Alaskan consumers whose coverage was disallowed under this arbitrary, unnecessarily restrictive federal rule.

As with all other states, Alaska maintains vigilant oversight of health insurance markets to ensure adequate access to affordable coverage. Through insurance industry regulatory primacy granted by longstanding federal law, states like Alaska are in the best position to address unique market conditions and provide careful monitoring and guidance to protect and benefit consumer interests. For these reasons, we appreciate the federal recognition that short-term limited duration plan requirements, including but not limited to restrictions related to the sale, design, rating, duration or renewability of these plans must be left to the States.

Alaska is also in agreement with the proposed expansion of consumer disclosure and education provisions for short-term limited duration plans. Consumers must be made aware of plan limitations and exclusions to avoid confusion with more comprehensive ACA-compliant plans.

In evaluating the proposal, a potential problem has emerged related to the impact of Section 1557 of the ACA. If short term limited duration plans are considered a "health program or activity" as described in 45 CFR §92.4, insurers would be prohibited from offering such plans if they participate in the Federally-facilitated Marketplace or in Medicare or Medicaid programs. This could unnecessarily restrict health insurance market insurer participation and should be remedied by clarifying that a short-term limited duration plan is not to be construed as a "health program or activity" under 45 CFR § 92.4.

Thank you for your consideration of these comments.

Sincerely,

Lori Wing-Heier
Director

Congressional Budget Office

NOVEMBER 2017

Repealing the Individual Health Insurance Mandate: An Updated Estimate

The Affordable Care Act (ACA) includes a provision, generally called the individual mandate, that requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance meeting specified standards and that imposes penalties on those without an exemption who do not comply. In response to interest from Members of Congress, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) have updated their estimate of the effects of repealing that mandate. As part of repealing the mandate, the policy analyzed would eliminate the penalty that people who have no health insurance and who are not exempt from the mandate must pay under current law.

The analysis underlying this estimate incorporates revised projections—of enrollment in health insurance, premiums, and other factors—made as part of the usual process CBO follows to update its baseline projections. This report updates a budget option published in December 2016 and is not based on specific legislative language.[1]

The Results of CBO and JCT's Analysis

CBO and JCT estimate that repealing that mandate starting in 2019—and making no other changes to current law—would have the following effects:

- Federal budget deficits would be reduced by about $338 billion between 2018 and 2027 (see Table 1).
- The number of people with health insurance would decrease by 4 million in 2019 and 13 million in 2027 (see Table 2).
- Nongroup insurance markets would continue to be stable in almost all areas of the country throughout the coming decade.
- Average premiums in the nongroup market would increase by about 10 percent in most years of the decade (with no changes in the ages of people purchasing insurance accounted for) relative to CBO's baseline projections.

Those effects would occur mainly because healthier people would be less likely to obtain insurance and because, especially in the nongroup market, the resulting increases in premiums would cause more people to not purchase insurance.

If the individual mandate penalty was eliminated but the mandate itself was not repealed, the results would be very similar to those presented in this report. In CBO and JCT's estimation, with no penalty at all, only a small number of people who enroll in insurance because of the mandate under current law would continue to do so solely because of a willingness to comply with the law. If eliminating the mandate was accompanied by changes to tax rates or premium tax credits or by other significant changes, then the policy analyzed here would interact with those changes and have different effects.

For this analysis, CBO and JCT have measured the budgetary effects relative to CBO's summer 2017 baseline, which underlies the Concurrent Resolution on the Budget for Fiscal Year 2018.[2] In that baseline, the ACA's other provisions, including premium tax credits and

1 See Congressional Budget Office, *Options for Reducing the Deficit: 2017 to 2026* (December 2016), www.cbo.gov/publication/52142.

2 See Congressional Budget Office, *An Update to the Budget and Economic Outlook: 2017 to 2027* (June 2017), www.cbo.gov/publication/52801. For additional information about the baseline presented in that report, see *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027* (September 2017), www.cbo.gov/publication/53091.

Table 1.

Estimate of the Net Budgetary Effects of Repealing the Individual Mandate

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	Total, 2018–2027
Change in Subsidies for Coverage Through Marketplaces and Related Spending and Revenues[a,b]	0	-4	-9	-19	-23	-24	-25	-26	-27	-28	-185
Medicaid	0	-5	-9	-16	-20	-22	-24	-26	-28	-29	-179
Change in Small-Employer Tax Credits[b,c]	0	*	*	*	*	*	*	*	*	*	*
Change in Penalty Payments by Employers[c]	0	0	0	*	*	*	*	*	*	*	1
Change in Penalty Payments by Uninsured People	0	*	5	5	5	5	5	6	6	6	43
Medicare[d]	0	1	2	4	5	5	5	6	7	7	44
Other Effects on Revenues and Outlays[e]	0	*	-2	-6	-8	-8	-9	-9	-10	-10	-62
Total Effect on the Deficit	**0**	**-8**	**-13**	**-33**	**-40**	**-44**	**-47**	**-49**	**-51**	**-54**	**-338**
Memorandum:											
Total Change in Direct Spending	0	-7	-14	-30	-36	-40	-42	-44	-46	-49	-307
Total Change in Revenues[f]	0	1	-2	3	4	4	5	5	6	6	31

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

Estimates are based on CBO's summer 2017 baseline.

Changes in budget authority would equal the changes in outlays shown.

Except as noted, positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

Numbers may not add up to totals because of rounding.

* = between -$500 million and $500 million.

a. "Related spending and revenues" includes spending for the Basic Health Program and net spending and revenues for risk adjustment.

b. Includes effects on both outlays and revenues.

c. Effects on the deficit include the associated effects that changes in taxable compensation would have on revenues.

d. Effects arise mostly from changes in payments to hospitals that treat a disproportionate share of uninsured or low-income patients.

e. Consists mainly of the effects that changes in taxable compensation would have on revenues.

f. Positive numbers indicate an increase in revenues; negative numbers indicate a decrease in revenues.

Table 2.

Effects of Repealing the Individual Mandate on Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027
Change in Coverage Under the Policy										
Medicaid[a]	0	-1	-2	-4	-4	-4	-4	-5	-5	-5
Nongroup coverage, including marketplaces	0	-3	-4	-5	-5	-5	-5	-5	-5	-5
Employment-based coverage	0	*	-1	-2	-2	-3	-3	-3	-2	-2
Other coverage[b]	0	*	*	*	*	*	*	*	*	*
Uninsured	0	4	7	12	12	12	12	13	13	13

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

Estimates are based on CBO's summer 2017 baseline. They reflect average enrollment over the course of a year among noninstitutionalized civilian residents of the 50 states and the District of Columbia who are under age 65, and they include spouses and dependents covered under family policies.

For these estimates, CBO and the staff of the Joint Committee on Taxation consider individuals to be uninsured if they would not be enrolled in a policy that provides financial protection from major medical risks.

Numbers may not add up to totals because of rounding.

* = between -500,000 and zero.

a. Includes noninstitutionalized enrollees with full Medicaid benefits.

b. Includes coverage under the Basic Health Program, which allows states to establish a coverage program primarily for people whose income is between 138 percent and 200 percent of the federal poverty level. To subsidize that coverage, the federal government provides states with funding that is equal to 95 percent of the subsidies for which those people would otherwise have been eligible.

cost-sharing reduction (CSR) subsidies in the marketplaces that the legislation established, are assumed to remain in place.[3]

In the budget option presented last year, CBO and JCT examined the same policy starting a year earlier and relative to CBO's March 2016 baseline: They estimated that the policy would reduce federal budget deficits by $416 billion between 2018 and 2026 and increase the number of uninsured people by 16 million in 2026.

The differences between the budgetary effects shown here and those estimated in December 2016 stem from several sources. The current estimate relies on updated baseline projections related to the federal costs of subsidizing health insurance. This estimate also incorporates CBO and JCT's expectation that individuals' and employers' full reaction to the elimination of the individual mandate would phase in more slowly than the agencies previously projected. (The agencies have incorporated that expectation in all estimates for legislative proposals related to the mandate that they have prepared after the 2017 budget reconciliation process ended in September.) And this estimate includes an interaction with Medicare, whose "disproportionate share hospital" payments to facilities that serve a higher percentage of uninsured patients would be affected.[4]

In addition to updates to the baseline, which occur on a regular cycle, CBO and JCT sometimes make major

3. After consultation with the Budget Committees, CBO has not changed its baseline to reflect the Administration's announcement on October 12, 2017, that it would stop making payments for CSRs. The Balanced Budget and Emergency Deficit Control Act of 1985, which specifies construction of the baseline, requires that CBO assume full funding of entitlement authority. CBO has long viewed the cost-sharing subsidies as a form of entitlement authority—that is, legal authority for federal agencies to incur obligations and to make payments out of the Treasury for specified purposes. On that basis, in the agencies' initial cost estimate for the ACA and in all subsequent baseline projections, they have recorded the CSR payments as direct spending (that is, spending that does not require appropriation action). For a related discussion, see Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions* (August 2017), www.cbo.gov/publication/53009.

4. That interaction, which would add costs totaling $44 billion over the 2018–2027 period, was not included in the December 2016 estimate because, as is often the case with budget options, it followed a simplified method. However, during 2017, the interaction with Medicare has been included in estimates of the effects of major changes to policies affecting health insurance.

methodological changes to improve their estimates. Accordingly, the agencies have undertaken considerable work to revise their methods to estimate the effects of repealing the individual mandate. CBO's Panel of Health Advisers and experts at the American Enterprise Institute, the Office of the Actuary in the Centers for Medicare & Medicaid Services, the RAND Corporation, and the Urban Institute, along with other sources, have provided valuable information during that process.[5] However, the evidence available to inform CBO and JCT's work on that issue is limited. Because that work is not complete and significant changes to the individual mandate are being considered as part of the budget reconciliation process, the agencies are publishing this update now without incorporating major changes to their analytical methods.

However, the preliminary results of analysis using revised methods indicates that the estimated effects on the budget and health insurance coverage would probably be smaller than the numbers reported in this document. The agencies are continuing to work on those methods, and they expect to complete and publish an estimate including and explaining the revisions at some point after the current budget reconciliation process is complete or along with a future update to the baseline.

Uncertainty Surrounding the Estimates

CBO and JCT's estimates of this policy are inherently imprecise because the ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other affected parties would respond to it are all difficult to predict. The responses by individuals in the short term to a policy that would repeal the mandate are uncertain, for example.

The policy's nonfinancial effects—changes in people's tendency to comply with laws and attitudes about health insurance and their greater responsiveness to penalties than to subsidies—amplify its financial effects in CBO and JCT's analysis. The amplification from those nonfinancial effects is harder to project. In large part because of the difficulty in projecting that amplification, different organizations' estimates of the effects of repealing the mandate have varied. The effects could be smaller than those presented here: Some organizations have recently published such smaller estimates that appear to ascribe lesser effects to nonfinancial factors.[6] Alternatively, the nonfinancial effects of the mandate might grow over time—as the effects of many provisions of the tax code appear to have done after their implementation and as could occur if awareness and enforcement of the mandate changed. Under that circumstance, the effects of repealing the mandate could be larger over time.

CBO and JCT's baseline projections are also uncertain, and revisions to them would alter interactions and change the estimates of the effects of eliminating the mandate. For example, if there are no payments for CSRs, premiums in the marketplaces would probably be higher than projected in the baseline. (The Administration has halted those payments, but the baseline projections used in this estimate incorporated the assumption that they would continue.) Premiums that are higher than those in the baseline projections would tend to boost the budgetary savings under this policy by increasing the estimated per-person savings from people no longer enrolling in nongroup coverage. As another example, subsidized enrollment in the marketplaces might be lower than projected in the baseline, which would tend to decrease the budgetary savings under this policy.

Despite the uncertainty, some effects of this policy are clear: For instance, the federal deficit would be many billions of dollars lower than under current law, and the number of uninsured people would be millions higher.

5 For additional information, see Alexandra Minicozzi, Unit Chief, Health Insurance Modeling Unit, Congressional Budget Office, *Modeling the Effect of the Individual Mandate on Health Insurance Coverage* (presentation to CBO's Panel of Health Advisers, Washington, D.C., September 15, 2017), www.cbo.gov/publication/53105; and Congressional Budget Office, "Panel of Health Advisers" (accessed November 7, 2017), www.cbo.gov/about/processes/panel-health-advisers.

6 Those estimates were for the early years of policies that would have initially repealed the individual mandate and later made many other changes. See Office of the Chief Actuary, Centers for Medicare & Medicaid Services, *Estimated Financial Effect of the "American Health Care Act of 2017"* (June 2017), https://go.usa.gov/xnTzU; and Linda Blumberg, Matthew Buettgens, and John Holahan, *Implications of Partial Repeal of the ACA Through Reconciliation* (Urban Institute, December 2016), http://tinyurl.com/y6vkugs4.

This report updates CBO and JCT's estimate of the effects of a budget option that CBO published in December 2016. Susan Yeh Beyer, Kate Fritzsche, Jeffrey Kling, Sarah Masi, Kevin McNellis, Eamon Molloy, Allison Percy, Lisa Ramirez-Branum, and Robert Stewart prepared the report with guidance from Jessica Banthin, Chad Chirico, Holly Harvey, and Alexandra Minicozzi and with contributions from Ezra Porter and the staff of the Joint Committee on Taxation. Theresa Gullo, Mark Hadley, Robert Sunshine, and David Weaver reviewed the document; John Skeen edited it; and Casey Labrack prepared it for publication.

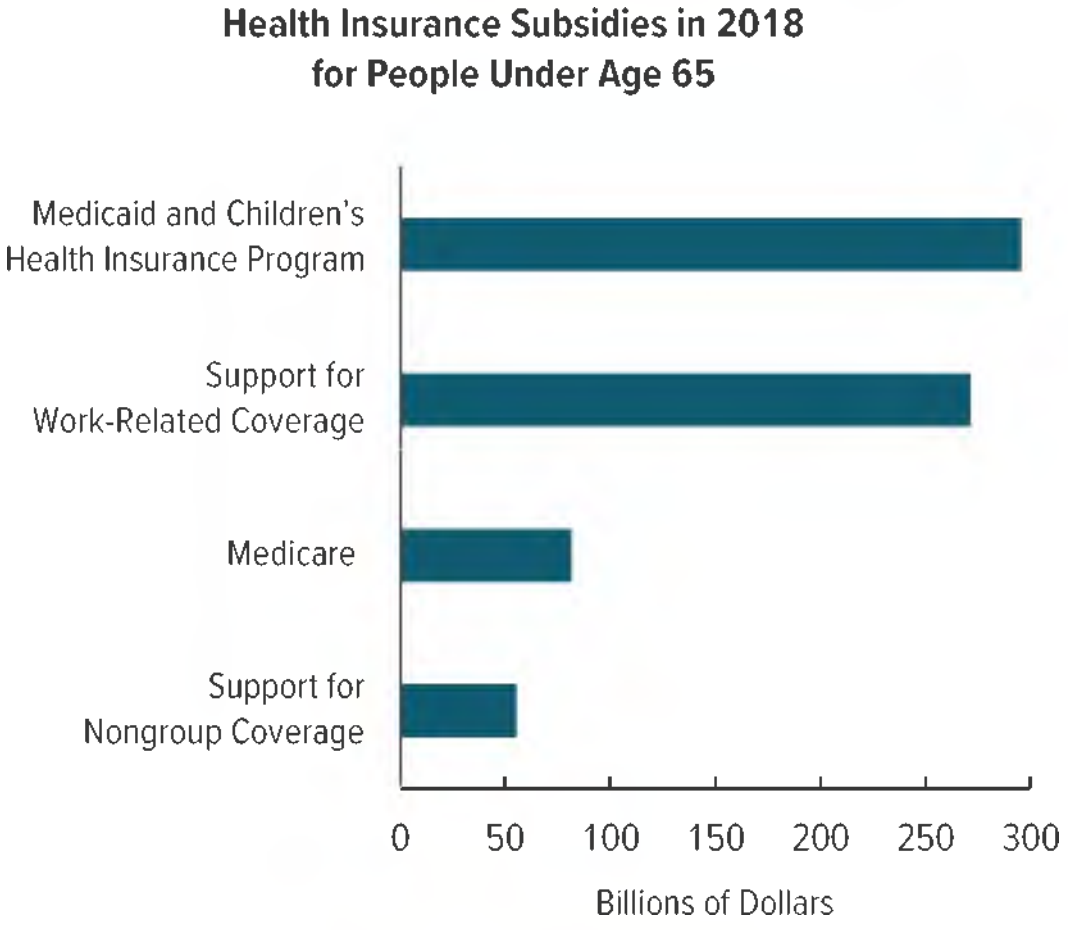
An electronic version is available on CBO's website (www.cbo.gov/publication/53300).

Keith Hall
Director

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028



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At a Glance

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. This report updates CBO's baseline, providing estimates for the 2018–2028 period of the number of noninstitutionalized people under age 65 with health insurance and the federal costs associated with each kind of subsidy.

- In an average month in 2018, about 244 million of those people will have health insurance, and about 29 million will not. By 2028, about 243 million are projected to have health insurance and 35 million to lack it.
- Net federal subsidies for insured people in 2018 will total $685 billion. That amount is projected to reach $1.2 trillion in 2028. Medicaid and the Children's Health Insurance Program account for about 40 percent of that total, as do subsidies in the form of tax benefits for work-related insurance. Medicare accounts for about 10 percent, as do subsidies for coverage obtained through the marketplaces established by the Affordable Care Act or through the Basic Health Program.
- The market for nongroup health insurance (that is, insurance bought individually rather than through an employer) is expected to be stable in most areas of the country over the decade. Premiums for benchmark plans, which are the basis for determining subsidies in that market, are projected to increase by about 15 percent from 2018 to 2019 and by about 7 percent per year between 2019 and 2028.
- Since CBO's most recent report comparable to this one was published in September 2017, the projection of the number of people with subsidized coverage through the marketplaces in 2027 has fallen by 3 million, and the projection of the number of uninsured people in that year has risen by 5 million. Projected net federal subsidies for health insurance from 2018 to 2027 have fallen by 5 percent.

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Notes

As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148), the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

Numbers in the tables and figures may not add up to totals because of rounding.

Unless the report indicates otherwise, all years referred to in describing estimates of spending and revenues are federal fiscal years, which run from October 1 to September 30 and are designated by the calendar year in which they end.

Estimates of health insurance coverage reflect average monthly enrollment during a calendar year and include spouses and dependents covered under family policies. Those estimates are for the noninstitutionalized civilian population under age 65.

Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2018 to 2028

Summary

The federal government subsidizes health insurance for most Americans through a variety of programs and tax provisions. In 2018, net subsidies for noninstitutionalized people under age 65 will total $685 billion, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) estimate. That amount includes the cost of preferential tax treatment for work-related insurance coverage, the cost of Medicaid and Medicare coverage for people under age 65, and government payments for other kinds of health insurance coverage—such as plans purchased through the marketplaces established under the Affordable Care Act (ACA).

This report describes the basis for CBO's baseline projections of the federal costs for those subsidies under current law for the 2018–2028 period. Those projections of costs are built upon estimates of the number of people with health insurance of various kinds. During the coming year, CBO and JCT will use the projections presented here as the benchmark for assessing proposed legislation's effects on the subsidies.

How Many People Under Age 65 Are Projected to Have Health Insurance?

According to CBO and JCT's estimates, a monthly average of about 244 million noninstitutionalized civilians under age 65 will have health insurance in 2018. About two-thirds of the insured population under 65 will have coverage through an employer, and roughly a quarter will be enrolled in Medicaid or the Children's Health Insurance Program (CHIP). A smaller number will have nongroup coverage, coverage provided by Medicare, or coverage obtained from various other sources. For example, about 4 percent, or 9 million people, are projected to obtain coverage through the marketplaces.

On average throughout the year, about 29 million people—11 percent of all noninstitutionalized civilians younger than 65—will be uninsured in 2018, CBO and JCT estimate (see Figure 1).[1] Between 2018 and 2019, in the agencies' projections, the number of uninsured people rises by 3 million, mainly because the penalty associated with the individual mandate will be eliminated and premiums in the nongroup market will be higher.[2] The elimination of the penalty was enacted as part of Public Law 115-97 (originally called the Tax Cuts and Jobs Act and referred to as the 2017 tax act in this report).

From 2019 through 2028, the number of people with insurance coverage is projected to rise, from 241 million to 243 million, under current law. The number of uninsured people is also projected to grow, from 32 million to 35 million, increasing the share of the under-65 population without insurance to 13 percent.

How Large Are the Projected Federal Subsidies, Taxes, and Penalties Associated With Health Insurance?

The estimated $685 billion in net federal subsidies in 2018 for health insurance coverage for people under age 65 (reflecting the combined effects of subsidies and taxes and penalties) would equal 3.4 percent of gross domestic product (GDP) (see Figure 2). That amount is projected to rise at an average annual rate of about 6 percent between 2018 and 2028, reaching $1.2 trillion, or 3.9 percent of GDP, in 2028. The estimates of subsidies are intended to be in the middle of the distribution of potential outcomes but are uncertain.

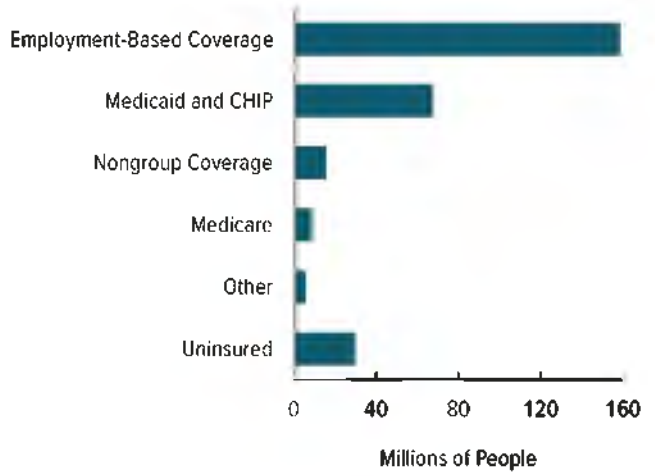
For the 2019–2028 period, projected net subsidies amount to $9.3 trillion. Two types of costs account for most of that total:

1 See Congressional Budget Office, *How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65* (May 2018), www.cbo.gov/publication/53822.

2 The individual mandate is a provision of law that requires most U.S. citizens and noncitizens who lawfully reside in the country to have health insurance meeting specified standards and that imposes penalties on those without an exemption who do not comply.

Figure 1.

Health Insurance Coverage in 2018 for People Under Age 65



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

CHIP = Children's Health Insurance Program.

- Federal spending for people under age 65 with full Medicaid and CHIP benefits (excluding people who reside in a nursing home or another institution) is projected to amount to $4.0 trillion. That amount includes $842 billion for people made eligible for Medicaid by the ACA and $143 billion for CHIP enrollees.

- Federal subsidies for work-related coverage for people under age 65, which stem mainly from the exclusion of most premiums for such coverage from income and payroll taxes, are projected to amount to $3.7 trillion.

Other subsidy costs are smaller:

- Medicare benefits for noninstitutionalized beneficiaries under age 65 (net of their payments for premiums and other offsetting receipts) are projected to amount to $1.0 trillion. Such spending is primarily for people who are disabled.

- Subsidies for coverage obtained through the marketplaces or through the Basic Health Program are estimated to total about $0.8 trillion.

In the agencies' projections, the total cost of federal subsidies is offset to a small extent, $0.3 trillion, by taxes and penalties collected from health insurance providers, employers, and uninsured people.

How Stable Is the Nongroup Health Insurance Market Projected to Be?

The nongroup health insurance market is stable in most areas of the country over the next decade in CBO and JCT's projections—but that stability may be fragile in some places. In 2018, insurers are offering coverage in all areas, but about one-quarter of enrollees have access to only one insurer's plans. Stability would be threatened if more insurers exited markets with limited participation than entered them.

Although premiums have been increasing, most subsidized enrollees buying health insurance through the marketplaces are insulated from those increases. Out-of-pocket payments for premiums are based on a percentage of subsidized enrollees' income; the federal government pays the difference between that percentage and the premium for the benchmark plan used as the basis for determining subsidies. Those subsidies are anticipated to result in demand for insurance by enough people, including people with low health care expenditures, for the number of insurers in the marketplaces to be stable in most areas.

How Rapidly Are Premiums in the Nongroup Health Insurance Market Projected to Grow?

In 2018, the average premium for a benchmark plan—the gross amount not including any premium tax credits—is about 34 percent higher than it was in 2017. By CBO and JCT's estimates, in addition to rising health care costs per person, the increase was caused by three primary factors: First, insurers are no longer reimbursed for the costs of cost-sharing reductions (CSRs) through a direct payment; second, a larger percentage of the population lives in areas with only one insurer in the marketplace; and third, some insurers expected less enforcement of the individual mandate in 2018 (which would probably induce some healthier enrollees to leave the market).

CBO and JCT expect premiums for benchmark plans to increase by about 15 percent from 2018 to 2019, an increase that exceeds projected growth in overall spending for private health insurance. (That outcome includes the expected increase in nongroup premiums resulting from healthier people being less likely to obtain insurance after the elimination of the penalty related to the individual mandate.) The agencies expect premiums

for benchmark plans to increase by an average of about 7 percent per year between 2019 and 2028.

Many people who enroll in coverage through the marketplaces receive federal subsidies in the form of premium tax credits, and the premiums they pay net of those tax credits are often substantially lower than the gross premiums. The net premiums those people face are projected to decline or to grow more slowly than the premiums in the nongroup market for people with higher income who are ineligible for subsidies.

How Do These Projections Compare With Previous Ones?

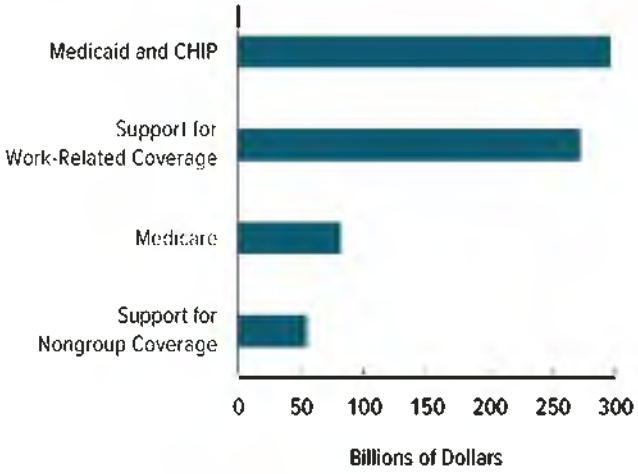
These projections update the preliminary projections of subsidies for insurance purchased through the marketplaces established under the ACA as well as revenues related to health insurance coverage for people under age 65 that were published in *The Budget and Economic Outlook* last month.[3] Compared with those preliminary estimates, federal spending for subsidizing health insurance marketplaces is now projected to be $4 billion lower in 2018 and $6 billion lower over the 2019–2028 period, and federal revenues associated with marketplace subsidies, work-related coverage, the excise tax on high-premium insurance plans, and penalties imposed on employers and uninsured people are projected to be $1 billion higher in 2018 and $24 billion higher over the 2019–2028 period, on net.

CBO's most recent report comparable to this one was published in September 2017.[4] For 2027 (the last year covered by that report and this one), CBO and JCT's projection of the number of people obtaining subsidized coverage through the marketplaces is now 3 million lower, and the projection of the number of uninsured people is now 5 million larger, than they were in that earlier report. The projection of net federal subsidies for health insurance from 2018 to 2027 is $481 billion (or 5 percent) lower. The largest contributors to that decrease are a $389 billion decline in projected subsidies for work-related coverage and a $202 billion decline in projected spending for Medicaid and CHIP.

Figure 2.

Health Insurance Subsidies in 2018 for People Under Age 65

Net federal subsidies for the year total $685 billion.



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

CHIP = Children's Health Insurance Program.

Projected Health Insurance Coverage

CBO broadly defines private health insurance coverage as a policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals. Such coverage is often referred to as comprehensive major medical coverage.

CBO and JCT project that, on average during 2018, 89 percent of the noninstitutionalized civilian population under age 65 will have health insurance, mostly from employment-based plans and Medicaid. Other major sources of coverage include CHIP, nongroup policies, and Medicare. Over the 2019–2028 period, a slightly smaller percentage of that population is projected to be insured. CBO and JCT's projections of insurance coverage are inherently uncertain and represent the agencies' central estimates.

Employment-Based Coverage

The most common source of health insurance for the noninstitutionalized civilian population under age 65 is a current or former employer—either one's own or a family member's. CBO and JCT estimate that in 2018, a monthly average of about 158 million people (or about

3 See Congressional Budget Office, *The Budget and Economic Outlook: 2018 to 2028* (April 2018), www.cbo.gov/publication/53651. The updated projections are incorporated in the adjustments to CBO's baseline budget projections that will be released later this week as part of the agency's analysis of the President's budget. See Congressional Budget Office, *An Analysis of the President's 2018 Budget* (forthcoming).

4 See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2017 to 2027* (September 2017), www.cbo.gov/publication/53091.

Table 1.

Health Insurance Coverage for People Under Age 65

Millions of People, by Calendar Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028
Total Population Under Age 65	273	273	274	275	275	276	276	276	277	277	278
Employment-Based Coverage	158	159	159	157	156	155	154	154	154	154	154
Medicaid and CHIP[a]											
Made eligible for Medicaid by the ACA	12	12	12	12	13	13	13	14	14	14	14
Otherwise eligible for Medicaid	49	48	48	49	49	49	50	50	50	50	50
CHIP	6	6	6	6	6	6	6	6	6	6	6
Subtotal	67	66	66	67	68	69	69	70	70	70	70
Nongroup Coverage and the Basic Health Program											
Nongroup coverage purchased through marketplaces[b]											
Subsidized	8	7	7	7	7	7	7	7	6	6	6
Unsubsidized	2	2	2	2	2	2	2	2	2	2	2
Subtotal	9	9	9	9	9	9	9	9	9	8	8
Nongroup coverage purchased outside marketplaces	5	4	4	4	4	4	4	4	4	4	4
Total, nongroup coverage	15	12	12	12	13	13	13	13	12	12	12
Coverage through the Basic Health Program[c]	1	1	1	1	1	1	1	1	1	1	1
Medicare[d]	8	8	8	8	8	8	8	8	9	9	9
Other Coverage[e]	5	5	5	5	5	5	5	5	6	6	6
Uninsured[f]	29	32	34	35	35	35	35	35	35	35	35
Memorandum:											
Number of Insured People	244	241	241	240	240	241	241	241	242	242	243
Insured as a Percentage of the Population											
Including all U.S. residents	89	88	88	87	87	87	87	87	87	87	87
Excluding unauthorized immigrants	91	90	90	89	89	89	89	89	89	90	90

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

Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in most years, 10 million people (or 4 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid.

Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation.

a. Includes noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.

b. Under the ACA, many people can purchase subsidized health insurance coverage through marketplaces, which are operated by the federal government, state governments, or partnerships between the federal and state governments.

c. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

d. Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

e. Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

f. Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

58 percent of the population under age 65) will have employment-based coverage (see Table 1 on page 4). That number is projected to decline to 154 million, or about 55 percent of the population under age 65, in 2028.

Roughly half of the projected reduction in employment-based coverage over the next decade is attributable to the elimination of the penalty associated with the individual mandate, which CBO and JCT estimate will lead to 2 million fewer people enrolling in employment-based coverage in most years after 2018. In addition, the agencies estimate that health insurance premiums that are rising faster than wages will exert downward pressure on enrollment in employment-based coverage. However, an increase in employment over the next two years resulting from changes in the government's fiscal policy is estimated to mitigate the negative effect of the growth in premiums in the near term.

Medicaid and CHIP

The next-largest source of coverage among people under age 65 is Medicaid. In 2018, CBO estimates, a monthly average of 61 million noninstitutionalized people will receive full Medicaid benefits.[5] By 2028, that number is projected to grow to 64 million people (14 million made eligible through the ACA's expansion of Medicaid coverage at states' option, and 50 million eligible otherwise). CBO estimates that 6 million people, mostly children but also some pregnant women, will be enrolled in CHIP in 2018, on average. Together, Medicaid and CHIP are projected to provide insurance coverage for one-quarter of the population under age 65 in 2028.

CBO's estimates of Medicaid enrollment over the next decade reflect the agency's expectation that, if current federal laws remained in place, additional states would expand eligibility for the program and that more people would enroll in the program in states that have already done so. Most of the increase in enrollment during that period would stem from additional states expanding eligibility for the program, CBO estimates. Under the ACA, states are permitted to expand eligibility for Medicaid to adults under age 65 whose income is no more than 138 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL). The federal government pays a larger share of the costs for those people than it pays for those who are eligible otherwise. Currently, about 55 percent of people who meet the eligibility criteria established under the ACA live in states that expanded Medicaid. CBO anticipates that share would increase annually at a rate based on the historical pace of expansion since 2014. By 2028, about two-thirds of the people who meet the new eligibility criteria are projected to be in states that have expanded Medicaid coverage.

Nongroup Coverage and the Basic Health Program

Nongroup insurance covers a much smaller share of the population under age 65 than employment-based policies and Medicaid do. In 2018, a monthly average of about 15 million people under age 65 are expected to have such coverage, 9 million of whom will have purchased it through the marketplaces established under the ACA.[6] That number is a decline from 2017, when an estimated monthly average of 10 million people purchased nongroup coverage through the marketplaces. (Nongroup policies can be purchased either through the marketplaces—with or without government subsidies—or elsewhere.) An additional 1 million people are estimated to be participating in the Basic Health Program, which allows states to offer subsidized health coverage to certain low-income people outside the marketplaces.

Nongroup Coverage. Between 2018 and 2019, the number of people enrolled in health insurance through the nongroup market is projected to fall by 3 million, mainly because the penalty associated with the individual mandate will be eliminated and premiums faced by people who are ineligible for subsidies in the nongroup market will be higher. Enrollment in the nongroup market is then projected to remain between 12 million and 13 million in each year between 2019 and 2028. The

5 Some enrollees receive only partial benefits from Medicaid. They include Medicare enrollees who receive only assistance from Medicaid with out-of-pocket payments and premiums for Medicare, people who receive only family planning services, and unauthorized immigrants who receive only emergency services. Spending for enrollees who receive partial benefits is excluded from the estimates.

6 A total of 12 million people selected plans through the marketplaces by the close of the open-enrollment period established by the ACA. However, CBO and JCT estimate that the average monthly enrollment during the year will be lower than the total number of people who will have coverage at some point during the year because some people are covered for only part of the year: Those who experience a qualifying life event (such as a change in income or family size or the loss of employment-based insurance) are allowed to purchase coverage later in the year, and some people stop paying the premiums or leave their marketplace-based coverage as they become eligible for insurance through other sources.

agencies estimate that between 6 million and 7 million of those people will receive subsidies.

The stability in estimated enrollment over the 2019–2028 period is the net result of offsetting effects. On the one hand, CBO and JCT expect the following factors to put downward pressure on enrollment between 2019 and 2028:

- Some additional people will forgo health insurance in years after 2019 as the reaction to the elimination of the individual mandate penalty reaches its full effect, and
- More states are expected to expand eligibility for Medicaid, reducing the number of people projected to obtain coverage through the marketplaces, because people who are eligible for Medicaid are not permitted to receive subsidies for marketplace coverage.

On the other hand, the agencies expect the following effects to increase nongroup enrollment between 2019 and 2028:

- More people will purchase subsidized coverage because they will be eligible for larger tax credits that cover a greater share of premiums for certain plans offered through the marketplaces. Those higher tax credits are based on the higher premiums brought about by the fact that insurers are no longer reimbursed for the costs of CSRs through a direct payment (see Box 1).
- More uninsured people will purchase short-term, limited-duration insurance (STLDI) offered in the nongroup market outside the marketplaces, reflecting a probability that a proposed regulation expanding such coverage takes effect (see Box 2 on page 10).

Stability in the Marketplaces. Decisions about offering and purchasing health insurance depend on the stability of the health insurance market—that is, on the proportion of people who live in areas with participating insurers and on the likelihood that premiums will not rise in an unsustainable spiral. In the marketplaces, where premiums cannot be based on individual enrollees' health status, the market for insurance would be unstable if, for example, the people who wanted to buy coverage at any offered price would have average health care expenditures so high that offering the insurance would be unprofitable for insurers.

In CBO and JCT's projections, the marketplaces are stable in most areas in large part because most enrollees purchasing subsidized health insurance there are insulated from increases in premiums. The subsidies—combined with the rules requiring insurers to offer coverage for preexisting medical conditions, the relative ease of comparison shopping in the marketplaces, and the effects of other requirements—are anticipated to produce sufficient demand for nongroup insurance, including among people with low health care expenditures, to attract at least one insurer almost everywhere.

Moreover, data about insurers' profitability in 2017 provide some indication that the market is stable in most areas of the country.[7] Insurers' profitability, as measured by the share of premiums that goes toward their administrative costs and profits rather than paying for claims, increased in 2017, moving close to pre-ACA levels. That evidence suggests that the premium increases in 2017 were sufficient to account for the underlying health risk of the nongroup population.

Nevertheless, about 26 percent of the population lives in counties with only one insurer in the marketplace in 2018, up from 19 percent in 2017.[8] Several factors may have led insurers to withdraw from those markets, including low enrollment (both in the marketplaces and outside them) in part because of increases in premiums paid by people without subsidies; uncertainty about the enforcement of the individual mandate; and uncertainty about the federal policies affecting the nongroup market, including how preliminary regulations that would allow a wider range of insurance products to be sold might affect the nongroup market if they are finalized. Additional withdrawals are possible in 2019—in response to lower anticipated enrollment stemming from repeal of the penalty related to the individual mandate. Still, with steady demand for insurance in the marketplaces, CBO and JCT expect the number of insurers in

7 See Cynthia Cox, Ashley Semanskee, and Larry Levitt, *Individual Insurance Market Performance in 2017* (Kaiser Family Foundation, May 2018), http://tinyurl.com/yd3z5tm9.

8 Calculations based on data from Ashley Semanskee and others, *Insurer Participation on ACA Marketplaces, 2014–2018* (Kaiser Family Foundation, November 10, 2017), https://tinyurl.com/y75j4mn7.

the marketplaces to stabilize thereafter in most areas of the country.

Substantial uncertainty continues to exist about federal policies affecting the nongroup market and about the effects of eliminating the penalty related to the individual mandate. That uncertainty may affect insurers' decisions to participate in the nongroup market in future years, and such withdrawals could threaten market stability in some areas of the country.

Gross Premiums for Benchmark Plans in the Marketplaces. Premiums for benchmark silver plans in the marketplaces—which are key drivers of subsidy amounts—increased by an average of 34 percent from 2017 to 2018. That increase occurred for three main reasons:

- *CSRs.* CBO and JCT estimate that gross premiums for silver plans offered through the marketplaces are, on average, 10 percent higher in 2018 than they would have been without the announcement in October 2017 that the Administration would no longer reimburse insurers for the cost of CSRs through a direct payment without an appropriation for that purpose. Because insurers are required to provide lower cost-sharing for enrollees in silver plans purchased through the marketplaces even in the absence of a federal payment, most insurers increased gross premiums for those plans to cover the costs of CSRs. CBO and JCT estimate that the effects of the lack of a direct payment for CSRs will continue to phase in over the next few years, putting upward pressure on premiums for silver plans offered through the marketplaces.

- *Limited Competition.* The increase in the percentage of the population that lives in a county with only one insurer in the marketplace between 2017 and 2018 probably contributed to the growth in national average benchmark premiums in 2018, because areas where only one insurer offers coverage through the marketplace tend to have higher benchmark premiums than areas where multiple insurers compete against one another to offer coverage.

- *Uncertainty.* CBO and JCT also estimate that some of the increase in benchmark premiums from 2017 to 2018 was related to insurers' uncertainty about whether the individual mandate would be enforced. Such a reduction in enforcement would probably cause some healthier enrollees to leave the market.

The agencies expect insurers to raise premiums for benchmark plans offered through the marketplaces in 2019 by an average of roughly 15 percent over the premiums charged in 2018. Part of that increase is projected to occur because plans are expected to have a less healthy mix of enrollees after the penalty related to the individual mandate is no longer levied beginning on January 1, 2019. In total, CBO and JCT expect, premiums for nongroup health insurance will be about 10 percent higher in 2019 than they would have been if the individual mandate penalty remained in place and was enforced. The lack of a direct payment for CSRs and the rising costs of health care per person are also anticipated to contribute to the overall increase.

After a few years, average premiums for benchmark plans will rise largely with growth in health care spending per person, CBO and JCT expect.[9] As a result, average benchmark premiums in the marketplaces are projected to increase by an average of close to 10 percent per year over the 2019–2023 period and then by an average of roughly 5 percent per year over the 2024–2028 period, after the effects of the elimination of the individual mandate penalty and of the lack of a direct payment for CSRs are expected to be fully phased in. Overall, between 2018 and 2028, the average benchmark premium is projected to grow by an average of about 7 percent per year. Those growth rates are about 2 percentage points lower in real terms (after the effects of inflation are removed).

Gross Premiums by Tier and Age. In addition to the key role that gross premiums for benchmark silver plans play in determining subsidies, gross premiums for all tiers of plans—including bronze and gold, for example—reflect the amounts paid by people without subsidies. Gross premiums, which differ by age, geographic area, and smoking status, affect the number of people with different types of health insurance coverage.

Although premiums for benchmark silver plans increased by an average of 34 percent from 2017 to 2018, the premiums for the lowest-cost bronze and gold plans increased by 17 percent and 18 percent, respectively. Insurers' increasing silver plan premiums to cover the cost of CSRs contributed to that difference. Most

9 For discussion of how CBO and JCT project premiums, see Congressional Budget Office, *Private Health Insurance Premiums and Federal Policy* (February 2016), pp. 9–11, www.cbo.gov/publication/51130.

Box 1.

Cost-Sharing Reductions in the Congressional Budget Office's Spring 2018 Baseline

Background

The Affordable Care Act (ACA), in section 1402, requires insurers who participate in the marketplaces established under that act to offer cost-sharing reductions (CSRs) to eligible people. CSRs reduce deductibles and other out-of-pocket expenses like copayments.

To qualify for CSRs, people must generally purchase a silver plan through a marketplace and have income between 100 percent and 250 percent of the federal poverty guidelines (also known as the federal poverty level, or FPL).[1] The size of the subsidy varies with income. For example, in 2017, by the Congressional Budget Office's estimates, the average deductible for a single policyholder (for medical and drug expenses combined) with a silver plan varied according to income in the following way:

Income as a Percentage of the FPL	Approximate Deductible (Dollars)
Above 250 (Without CSRs)	3,600
Between 200 and 250	2,900
Between 150 and 200	800
Between 100 and 150	300

Before October 12, 2017, the federal government reimbursed insurers for the cost of CSRs through a direct payment. However, on that date, the Administration announced that, without an appropriation for that purpose, it would no longer make such payments to insurers. Because insurers are still required to offer CSRs and to bear their costs even without a direct payment from the government, most have covered those costs by explicitly increasing premiums for silver plans offered through the marketplaces for the 2018 plan year, and CBO expects all insurers to do so beginning in 2019.[2] (For the most part, insurers did not increase premiums for other plans to cover the cost of CSRs because the requirement for CSRs does not generally apply to those plans.)

Budgetary Treatment

CBO and the staff of the Joint Committee on Taxation (JCT) have long viewed the requirement that the federal government compensate insurers for CSRs as a form of entitlement authority. Section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985, which specifies rules for constructing CBO's baseline, requires that the agency assume full funding of entitlement authority.[3] On that basis, CBO included the CSR payments as direct spending (that is, spending that does not require appropriation action) in the agency's June 2017 baseline.

For the spring 2018 baseline, CBO and JCT project that the entitlement for subsidies for CSRs is being funded through higher premiums and larger premium tax credit subsidies instead of a direct payment. The projection reflects the way insurers are currently reimbursed for the cost of providing CSRs to eligible enrollees in light of the Administration's change in policy in October 2017.

1 In most marketplaces, people can choose among plans—such as bronze, silver, and gold—for which the portion of covered medical expenses paid by the insurer differs. The average percentage of covered expenses paid by the insurer is called the actuarial value of the plan. Silver plans differ from other plans because they must provide CSRs to eligible enrollees. For people at most income levels, the actuarial value of a silver plan is 70 percent. People who qualify for CSRs are eligible for silver plans with higher actuarial values: 73 percent for people with income between 200 percent and 250 percent of the FPL; 87 percent for people with income between 150 percent and 200 percent of the FPL; and 94 percent for people with income between 100 percent and 150 percent of the FPL. The actuarial values of bronze and gold plans are 60 percent and 80 percent, respectively.

Individuals with income generally between 100 percent and 400 percent of the FPL are also eligible for tax credits to help cover a portion of their premiums. The size of those premium tax credits varies with income and premiums.

2 In 2018, in a few states, insurers did not explicitly increase premiums for silver plans in the marketplaces to account for CSRs because state regulators did not allow them to do so. Some insurers nevertheless raised premiums substantially for reasons that were not fully specified; in constructing its baseline, CBO attributed part of such increases to CSRs. Other insurers in those states did not raise premiums by much or at all, but, on the basis of information provided by those insurers, CBO projected that those premiums were sufficient to cover the cost of CSRs. Together, those situations involved fewer than 3 percent of subsidized enrollees in 2018, CBO estimates. For more information, see Sabrina Corlette, Kevin Lucia, and Maanasa Kona, *States Step Up to Protect Consumers in Wake of Cuts to ACA Cost-Sharing Reduction Payments* (The Commonwealth Fund, October 2017), https://tinyurl.com/y728ro2y.

3 2 U.S.C. §907(b)(1) (2012). Entitlement authority is the authority for federal agencies to incur obligations to make payments to entities that meet the eligibility criteria set in law.

Continued

Box 1. Continued

Cost-Sharing Reductions in the Congressional Budget Office's Spring 2018 Baseline

That approach complies with section 257 of the Deficit Control Act because the CSR entitlement is assumed to be fully funded. CBO adopted that revised baseline treatment of the financing of CSRs after consulting with the House and Senate Budget Committees. On the basis of an analysis of insurers' rate filings, CBO and JCT estimate that gross premiums for silver plans offered through the marketplaces are, on average, about 10 percent higher in 2018 than they would have been if CSRs were funded through a direct payment. The agencies project that the amount will grow to roughly 20 percent by 2021.

Effect on the Baseline

The size of premium tax credits is linked to the premiums for the second-lowest-cost silver plans offered through the marketplaces: Out-of-pocket payments for premiums for enrollees who are eligible for subsidies are based on a percentage of their income, and the government pays the difference through the premium tax credits. As a result, in CBO's projections, higher gross premiums for silver plans increase the amount of tax credits paid by the federal government, thereby covering insurers' costs for CSRs. Higher gross premiums for silver plans do not significantly affect the out-of-pocket payments that subsidized enrollees make for premiums for silver plans offered through the marketplaces because the structure of the premium tax credit largely insulates them from those increases.

For plans besides silver ones, insurers in most states have not increased gross premiums much, if at all, to cover the costs of CSRs. Because the premium tax credits are primarily based on the income of enrollees and not the nature of the plan they choose, enrollees could use those credits to cover a greater share of premiums for plans other than silver ones in those states. For example, more people are able to use their higher premium tax credits to obtain bronze plans, which cover a smaller share of benefits than silver plans, for free or for very low out-of-pocket payments for premiums. Also, some people with income between 200 percent and 400 percent of the FPL can purchase gold plans, which cover a greater share of benefits than do silver plans, with similar or lower premiums after tax credits. As a result of those changes, in most years, between 2 million and 3 million more people are estimated to purchase subsidized plans in the marketplaces than would have if the federal government had directly reimbursed insurers for the costs of CSRs.

Higher gross premiums for silver plans affect premiums for people who are not eligible for premium tax credits (most of whom have income above 400 percent of the FPL). However, many of those enrollees have options for purchasing other plans to avoid paying the premium increases resulting from the October 2017 policy change regarding the government's payments for CSRs. Just as insurers in most states have not appreciably increased premiums for plans other than silver ones to cover the costs of CSRs, insurers in many states have not increased the premiums of silver plans sold outside the marketplaces to cover the costs of CSRs either. Therefore, many people who are not eligible for subsidies are able to select a plan besides a silver one or a silver plan sold outside the marketplaces and avoid paying the premium increases stemming from the lack of a direct appropriation for CSRs.

Future Cost Estimates

In recent cost estimates for legislation that would appropriate funding for the payments to cover the costs of providing CSRs, CBO and JCT estimated that the appropriation would not affect direct spending or revenues because such payments were already incorporated in CBO's baseline projections.[4] After consulting with the budget committees about the baseline and about cost estimates relative to that baseline, CBO will continue that practice.

For legislation that would change the means of funding the CSR entitlement, CBO will estimate that enactment would not affect the federal deficit—because the obligations stemming from the entitlement can be fully satisfied through a direct payment or higher premiums and larger premium tax credit subsidies. However, if legislation was enacted that appropriated funds for direct payments for CSRs, the agency would update its baseline projections to incorporate those appropriations and to lower its projections of premium tax credits and other effects—because insurers would no longer increase gross premiums for silver plans offered through the marketplaces to cover the costs of providing CSRs.

4. See Congressional Budget Office, cost estimate for the Bipartisan Health Care Stabilization Act of 2018 (March 19, 2018), www.cbo.gov/publication/53666, and letter to the Honorable Lamar Alexander on the appropriation of cost-sharing reduction subsidies (March 19, 2018), www.cbo.gov/publication/53664.

Box 2.

Association Health Plans and Short-Term, Limited-Duration Insurance

The baseline presented in this report incorporates estimates from the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) of two recent regulations proposed by the Administration. The first regulation—published on January 5, 2018—would make it easier for business associations and other entities to offer health insurance through what are termed association health plans (AHPs) and multiple employer welfare associations, which are legal arrangements that allow business associations or unrelated employers to jointly offer health insurance and other fringe benefits to their members or employees. The second regulation—published on February 21, 2018—would expand the maximum policy length of short-term, limited-duration insurance (STLDI) plans from 3 months to 364 days. In accordance with CBO's standard practice for incorporating the effects of proposed rules, the baseline incorporates an assumption reflecting a 50 percent chance that the final issued rules will be the same as the proposed ones and a 50 percent chance that no new rules like the proposed ones will be issued.[1] The effects described here represent the agencies' estimates if the rules were implemented as proposed.

Estimated Effects of the Proposed Regulations

The agencies expect that the regulations would affect the small-group and nongroup insurance markets by allowing the sale of insurance products that do not comply with many current insurance regulations governing those markets. For example, insurers could offer plans that do not meet the minimum standards for benefits that insurers in the small-group and nongroup markets must provide, and insurers could also vary premiums on the basis of sex, occupation, and other personal characteristics. Both employers with healthier workforces and individuals who are relatively healthy and have income too high to qualify for premium tax credits for health insurance would find such plans appealing because the premiums would be lower than those for insurance products that comply with the current rules governing the small group and nongroup markets.

By CBO and JCT's estimates, starting in 2023 (when the effects of both rules are estimated to be fully phased in), roughly 6 million additional people would enroll in either an AHP or STLDI plan as a result of the proposed rules, with about 4 million in AHPs and about 2 million in STLDI plans. (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.)[2] The agencies estimate that the rules would decrease the number of uninsured people by roughly 1 million in 2023 and each year thereafter, with the majority of the previously uninsured enrolling in STLDI plans.

In 2023 and later years, about 90 percent of the 4 million people purchasing AHPs and 65 percent of the 2 million purchasing STLDI plans would have been insured in the absence of the proposed rules, CBO and JCT estimate. Because the people newly enrolled in AHPs or STLDI plans are projected to be healthier than those enrolled in small-group or nongroup plans that comply with the current regulations governing those markets, their departures would increase average premiums for those remaining in other small-group and nongroup plans. As a result, premiums are projected to be 2 percent to 3 percent higher in those markets in most years.

1 See Congressional Budget Office, letter to the Honorable John M. Spratt Jr. about how CBO reflects anticipated administrative actions in its baseline projections (May 2, 2007), www.cbo.gov/publication/18615. If final versions of the rules are promulgated, CBO and JCT will account for any changes from the regulations and will include estimates of the full effects of the final rules in subsequent cost estimates and in future baseline projections of health insurance coverage and federal subsidies for it.

2 In developing those estimates, CBO and JCT consulted with numerous policy and legal experts, industry associations, insurers, and state insurance regulators. On the basis of those conversations, the agencies expect that if the proposed STLDI regulation was finalized, a range of new STLDI insurance products would be sold. A small percentage of those plans would resemble current STLDI plans, which do not meet CBO's definition of health insurance coverage. In addition to those plans, insurers would, CBO expects, offer new types of short-term products resembling nongroup insurance products sold before the implementation of the Affordable Care Act. Those new products would probably limit benefits, be priced on the basis of individuals' health status, and impose lifetime and annual spending limits, and insurers could reject applicants on the basis of their health and any preexisting conditions. The majority of those plans would probably meet CBO's definition of private health insurance because they would still provide financial protection against high-cost, low-probability medical events.

Continued

Box 2. Continued

Association Health Plans and Short-Term, Limited-Duration Insurance

CBO and JCT estimate that the proposed rules would reduce the federal deficit by roughly $1 billion over the 2019–2028 period if implemented as proposed (and simultaneously, as assumed). 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 nongroup market. 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.

Comparison With Other Estimates

CBO and JCT's assessment of the effects of the AHP and STLDI rules is in line with other published analyses, although comparing results is difficult because the policy scenarios evaluated are different. One outcome that is straightforward to compare is the effect of the rules on premiums for the small-group and nongroup plans that comply with the current regulations governing those markets. For that measure, CBO's estimate of a 2 percent to 3 percent increase in premiums accords with most other published estimates but is lower than the 6 percent increase estimated by the Chief Actuary for the Centers for Medicare & Medicaid Services (CMS).[3] Similarly, CBO's estimate of 4 million enrollees in AHPs is similar to other estimates.[4]

For the STLDI regulation, different analyses have reported very different measures, but most have reported the number of people leaving nongroup plans that comply with the current regulations governing that market. On that measure, CBO and JCT's estimate is significantly higher than the Administration's estimate contained in the proposed rule but lower than estimates in other published analyses.[5] Specifically, the Administration estimates in the proposed rule that fewer than 0.2 million people will leave the nongroup plans for STLDI plans, and other analyses show a range of 1.1 million to 2.2 million—compared with the agencies' estimate of almost 1 million departures in most years for both AHPs and STLDI plans (most of those for the latter).

3. For an analysis of how both rules would affect premiums for small-group and nongroup plans that comply with the regulations governing those markets, see 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), Table 1, https://tinyurl.com/yb5bpc2y. For an analysis of how AHPs would affect premiums for nongroup plans, see Sabrina Corlette, Josh Hammerquist, and Pete Nakahata, "New Rules to Expand Association Health Plans," *The Actuary Magazine* (web exclusive, May 2018), https://tinyurl.com/yavdxagj. For CMS's analysis of the STLDI rule, see Centers for Medicare & Medicaid Services, "Estimated Impact of STLD Proposed Rule (2018)" (April 6, 2018), https://go.usa.gov/xQPpj.

4. For an analysis of expected enrollment in AHPs, see Dan Mendelson, Chris Sloan, and Chad Brooker, "Association Health Plans Projected to Enroll 3.2 Million Individuals," *Avalere* (press release, February 28, 2018), Table 2, https://tinyurl.com/yb6pkqdh.

5. For the estimate in the proposed rule, see Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 7437, 7441 (proposed February 21, 2018), https://go.usa.gov/xQPY5. See also Centers for Medicare & Medicaid Services, "Estimated Impact of STLD Proposed Rule (2018)" (April 6, 2018), https://go.usa.gov/xQPpj. For a summary of other assessments, see Christopher Pope, "Evaluating Assessments of Short-Term Insurance Deregulation," *Health Affairs Blog* (blog entry, May 9, 2018) Exhibit 1, https://tinyurl.com/y9xbps6k. One of the assessments cited assumes that the individual mandate remains in place, so comparing its estimates with those of other assessments is difficult. The more comparable assessments are Michael Cohen, Michelle Anderson, and Ross Winkelman, "Effects of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market" (prepared by Wakely Consulting Group for the Association for Community Affiliated Plans, 2018), Table 1, https://tinyurl.com/y7ccesj7; and Linda J. Blumberg, Matthew Buettgens, and Robin Wang, *Updated: The Potential Impact of Short-Term Limited Duration Policies on Insurance Coverage, Premiums, and Federal Spending* (Urban Institute, March 14, 2018), https://tinyurl.com/yc37zx3o.

insurers did not increase premiums for plans in other tiers to cover the cost of CSRs because the requirement to offer CSRs does not generally apply to those plans.

After 2018, growth in gross premiums is projected to be slightly slower for bronze than for silver plans mainly because premiums for silver plans are expected to absorb more of the costs for CSRs during the next few years. Such growth for gold plans is projected to be slower than for silver or bronze plans mainly because the fast growth in premiums for silver plans in the marketplaces is expected to cause some people to choose gold plans instead of silver plans and the health of those people is anticipated to reduce the average costs borne by gold plans. The fast premium growth of silver plans is projected to make those plans increasingly unattractive over time to people not eligible for subsidies. By the end of the coming decade, gross premiums for gold plans are projected to be lower than gross premiums for silver plans, and the gold plans will provide more generous benefits for people not eligible for CSRs.

Increases in gross premiums for a particular tier are the same across age groups in percentage terms, but gross premium amounts themselves differ substantially by age. For people without subsidies, premiums are estimated to be slightly less than three times higher for a 64-year-old than a 21-year-old, on average, after accounting for regulations in different states. For example, CBO and JCT estimate average premiums for a 21-year-old, a 45-year-old, and a 64-year-old who buy the lowest-cost gold plans through the marketplaces to be about $8,800, $12,600, and $25,700, respectively, in 2028 (see Figure 3). Those estimates represent a national average of premiums excluding any premium tax credits, reflecting the geographic distribution of people who have coverage through the marketplaces.

Net Premiums for People Eligible for Subsidies. Because many people who enroll in coverage through the marketplaces receive federal subsidies in the form of premium tax credits, the net premiums that enrollees pay are often substantially lower than the gross premiums discussed above. In 2017, the average gross premium for subsidized enrollees in all states that use the federally facilitated marketplace platform healthcare.gov was about $5,850, but the average net premium paid after subsidies was about $1,250 (see Figure 4). In 2018, gross premiums in those states grew substantially, to an average of about $7,650 for subsidized enrollees. Although people not receiving subsidies paid the gross amount, net premiums for subsidized people fell to an average of about $1,050 because average tax credits increased substantially.[10] Average tax credits increased because the average premium for a benchmark silver plan rose. Those tax credits can be used to buy a plan in any tier. Because the tax credits grew so much more than premiums for bronze and gold plans, enrollees receiving subsidies often saw a significant reduction in their net premiums for those plans from 2017 to 2018.

The net premiums faced by people eligible for subsidies in the nongroup market, whose income is less than 400 percent of the FPL, vary substantially by income as well as by tier and by age. However, the general trends over time for such people can be illustrated by the premiums for people with income at 225 percent of the FPL (see Figure 5).

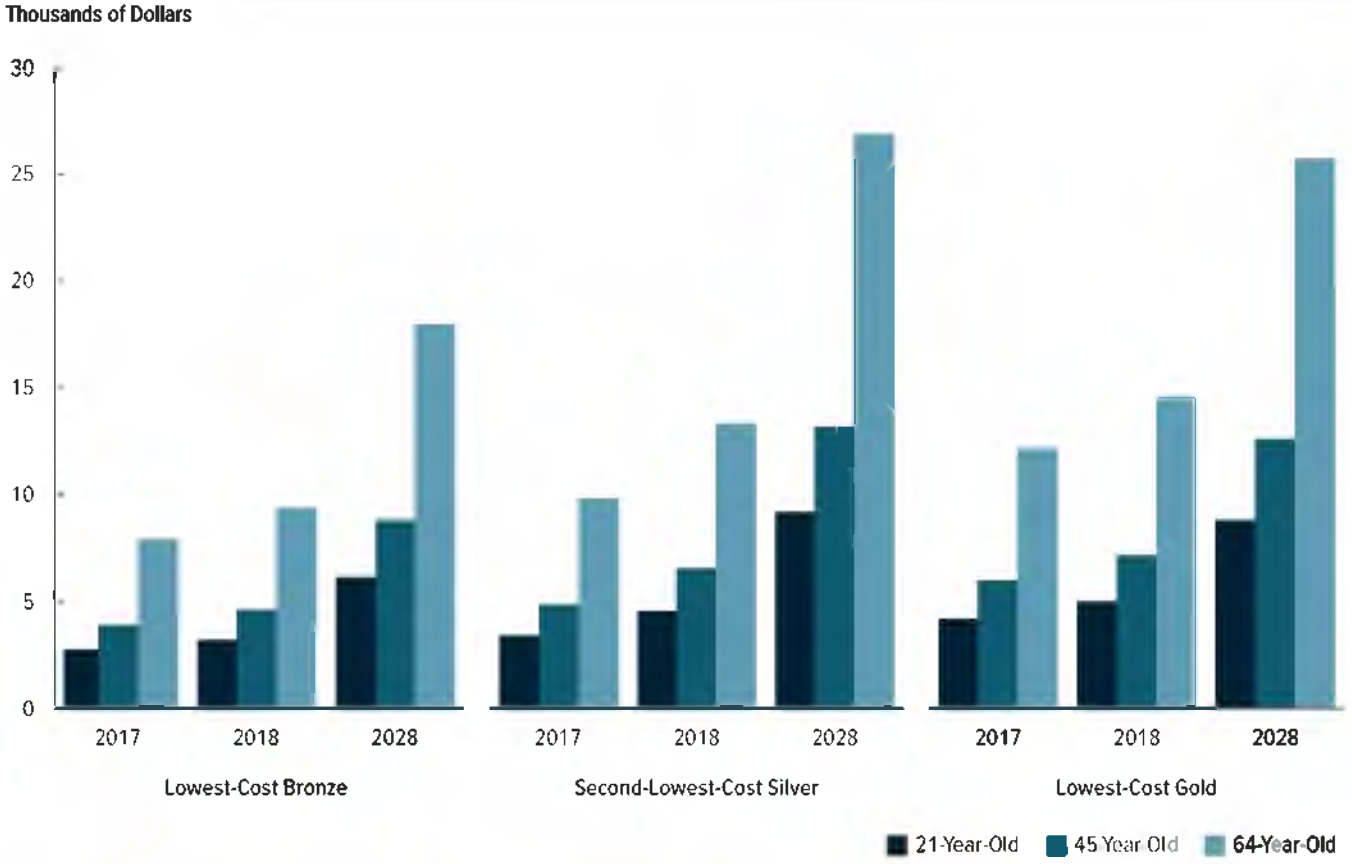
For silver plans, growth in net premiums for people with that amount of income—and for many other people eligible for subsidies—is estimated to be about 5 percent per year between 2018 and 2028 in nominal terms and 3 percent in real terms. That growth is limited by several factors that apply equally across age groups. For example, net premiums are limited to be no more than a certain percentage of people's income.

For bronze and gold plans, growth in net premiums in CBO's projections is heavily influenced by premium tax credit amounts, which are linked to the second-lowest-cost silver plan in the marketplaces. Because the gross premiums for those silver plans rose so much in 2018, the net premiums for bronze and gold plans for people eligible for tax credits in 2017 fell substantially in percentage terms between 2017 and 2018 for people with income at 225 percent of the FPL and for many other people eligible for subsidies (if the 2017 net premiums were greater than zero). Between 2018 and 2028, the projected nominal growth in those premiums varies significantly by age and tier as well as income. However, after the effects of inflation are removed, net premiums for bronze and gold plans for many people eligible for subsidies are generally projected to decline over that period.

10. CBO's calculations are based on data on plans selected during the open-enrollment period for each year. See Centers for Medicare & Medicaid Services, "2017 Marketplace Open Enrollment Period Public Use Files," https://go.usa.gov/xQ5ba, and "2018 Marketplace Open Enrollment Period Public Use Files," https://go.usa.gov/xQ5bC.

Figure 3.

Illustrative Examples, for Single Individuals, of Gross Premiums for Health Insurance Purchased Through the Marketplaces



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

Dollar amounts have been rounded to the nearest $50.

CBO and the staff of the Joint Committee on Taxation projected the average national gross premiums for a 21-year-old, a 45-year-old, and a 64-year-old in the nongroup health insurance market, taking into account the different age-rating methodology used in each state. The benchmark premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which a person resides. For bronze and gold plans, the premiums displayed in the figure are for the lowest-cost plan available in the marketplace in the area in which a person resides.

The actuarial value of a plan—the percentage of costs for covered services that the plan pays on average—differs by income. Bronze plans and gold plans have actuarial values of 60 percent and 80 percent, respectively. For people whose income is greater than 250 percent of the FPL, a silver plan has a standard 70 percent actuarial value.

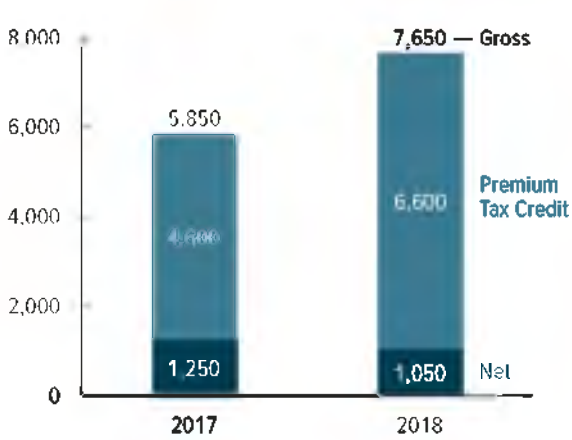
FPL = federal poverty level.

Basic Health Program. Under the ACA, states have the option to establish a Basic Health Program, which is primarily for people whose income is between 138 percent and 200 percent of the FPL. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would have been eligible through a marketplace. States can use those funds, in addition to funds from other sources, to offer health insurance that covers a broader set of benefits or requires smaller out-of-pocket payments than coverage in the marketplaces does.[11] So far, Minnesota and New York have created a Basic Health Program. In total, about 1 million people are projected to be enrolled in such a plan in each year from 2018 through 2028.

11. For more information about the Basic Health Program, see Centers for Medicare & Medicaid Services, "Basic Health Program" (accessed May 1, 2017), www.medicaid.gov/basic-health-program/index.html.

Figure 4.

Gross and Net Premiums for Subsidized Enrollees in States Using Healthcare.gov



Source: Congressional Budget Office, using data from the Centers for Medicare & Medicaid Services.

Data are for enrollees receiving advanced payments of premium tax credits in states that use the federally facilitated marketplace platform healthcare.gov. The data are based on the plans selected during the open-enrollment period for each year.

Medicare and Other Coverage

Although Medicare is best known for providing coverage for people age 65 or older, it also covers some people who are under age 65. Many of those younger enrollees receive that coverage because they have qualified for benefits from the Social Security Disability Insurance program. (In general, people become eligible for Medicare two years after they qualify for disability insurance.) Between 8 million and 9 million people under age 65 are projected to be covered by Medicare in 2018 and in each year over the 2019–2028 period.

Other miscellaneous sources of coverage account for 5 million to 6 million people each year from 2018 to 2028. Those sources include student health plans, the Indian Health Service, and foreign sources.

Uninsured

An average of 29 million people under age 65 are projected to be uninsured in 2018. (In this report, CBO and JCT consider people uninsured if they are not covered by a plan or are not enrolled in a government program that provides financial protection from major medical risks.)

The number of uninsured people is projected to rise by 3 million in 2019, mainly because of the elimination of the penalty associated with the individual mandate and the higher premiums resulting from that change. That number rises by another 3 million over the following two years, on net, as more people adjust to the fact that they no longer face the mandate penalty. The effects of the penalty's elimination more than offset downward pressure on the number of uninsured people, which strengthens from 2019 to 2021. That pressure stems from higher premium tax credits caused by the lack of a direct appropriation for CSRs and from proposed regulations that would expand the use of association health plans (AHPs) and STLDI plans.

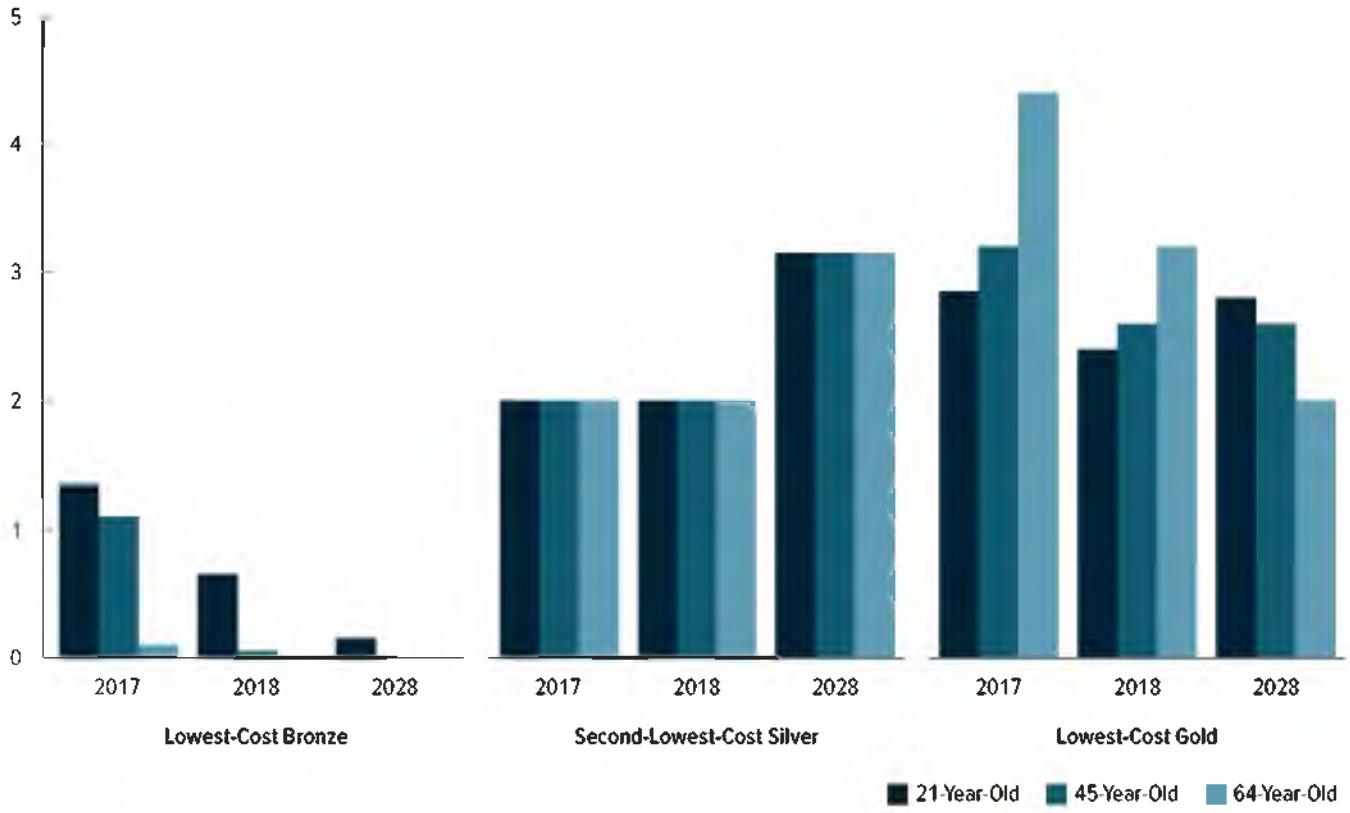
In most years over the next decade, and at the end of that period, about 13 percent of people under age 65 are projected to be uninsured, leaving about 35 million people uninsured in 2028.[12] In that year, according to CBO and JCT's estimates, about 20 percent of those uninsured people would be unauthorized immigrants and thus ineligible for subsidies through a marketplace or for most Medicaid benefits; about 10 percent would be ineligible for Medicaid because they live in a state that had not expanded coverage; about 20 percent would be eligible for Medicaid but would not enroll; and the remaining 50 percent would not purchase insurance to which they had access through an employer, through the marketplaces, or directly from insurers.

12. The sum of the estimates of the number of people enrolled in health insurance plans and the number of people who are uninsured exceeds CBO and JCT's estimate of the total population under age 65 by 10 million in most years, because some people will have multiple sources of coverage. A common example is people who report having both employment-based coverage and Medicaid. To arrive at the estimates given here, CBO and JCT did not assign a primary source of coverage to people who reported multiple sources; the resulting amounts align better with estimates of spending as well as with information about health insurance coverage from household surveys. (By contrast, when CBO and JCT have estimated changes in the sources of insurance coverage stemming from proposed legislation, the agencies have used only people's primary source of coverage to count them, an approach that has generally proved more useful for that purpose.)

Figure 5.

Illustrative Examples, for Single Individuals With Income at 225 Percent of the FPL, of Net Premiums for Health Insurance Purchased Through the Marketplaces

Thousands of Dollars



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

Dollar amounts have been rounded to the nearest $50.

CBO and the staff of the Joint Committee on Taxation projected the average national gross premiums for a 21-year-old, a 45-year-old, and a 64-year-old in the nongroup health insurance market, taking into account the different age-rating methodology used in each state. Net premiums equal gross premiums minus the projected premium tax credits for which a person is eligible. Premium tax credits are calculated as the difference between the benchmark premium and a specified percentage of income for a person with income at a given percentage of the FPL. That specified percentage generally grows over time. For the purpose of determining the premium tax credits, eligibility is based on the most recently published FPL as of the first day of the annual open-enrollment period for coverage for that year. The benchmark premium is the premium for the second-lowest-cost silver plan available in the marketplace in the area in which a person resides. For bronze and gold plans, the premiums displayed in the figure are for the lowest-cost plan available in the marketplace in the area in which a person resides.

The actuarial value of a plan—the percentage of costs for covered services that the plan pays on average—differs by income. Bronze plans and gold plans have actuarial values of 60 percent and 80 percent, respectively. For people whose income is greater than 250 percent of the FPL, a silver plan has a standard 70 percent actuarial value. The cost-sharing amounts (out-of-pocket payments required under insurance policies) are reduced for covered people whose income is generally between 100 percent and 250 percent of the FPL. Those cost-sharing reductions generally have the effect of increasing the actuarial value of a typical silver plan from 70 percent to 94 percent for people whose income is at least 100 percent of the FPL and not more than 150 percent; to 87 percent for people with income greater than 150 percent of the FPL and not more than 200 percent; and to 73 percent for people with income greater than 200 percent of the FPL and not more than 250 percent.

Income levels reflect modified adjusted gross income, which equals adjusted gross income plus untaxed Social Security benefits, foreign earned income that is excluded from adjusted gross income, tax-exempt interest, and income of dependent filers. A modified adjusted gross income at 225 percent of the FPL equaled $27,150 in 2017 and $27,300 in 2018; the amount is projected to be $34,550 in 2028.

FPL = federal poverty level.

Projected Subsidies for Health Insurance Coverage

The federal government encourages people to obtain health insurance by making it less expensive than it would be otherwise. For people under age 65, the government subsidizes health insurance coverage in four main ways:

- Giving tax benefits for work-related coverage,
- Providing roughly three-fifths of all funding for Medicaid (while requiring states to provide the remainder),
- Offering tax credits to eligible people who purchase coverage through the health insurance marketplaces, and
- Providing coverage through the Medicare program to people under age 65 who receive benefits from the Social Security Disability Insurance program or who meet certain other criteria.

The costs of those subsidies are partly offset by related taxes and penalties that the federal government collects. They include excise taxes on providers of health insurance and penalty payments from large employers that do not offer health insurance that meets certain standards.

If current laws did not change, the net federal subsidy for health insurance coverage for people under age 65—that is, the cost of all the subsidies minus the taxes and penalties—would be about $685 billion in 2018 and would total $9.3 trillion over the 2019–2028 period, CBO and JCT estimate (see Table 2). Those sums reflect projections by the agencies about choices that people would make about obtaining health insurance and are subject to considerable uncertainty.

Work-Related Coverage

Health insurance that people receive from employers is the most common source of subsidized coverage for people under age 65. Employers' payments for workers' health insurance coverage are a form of compensation, but unlike cash compensation, those payments are excluded from income and payroll taxes. In most cases, the amounts paid by workers themselves for their share of the cost of employment-based coverage are also excluded from income and payroll taxes. Another work-related subsidy is the income tax deduction for health insurance premiums that can be used by self-employed people, including sole proprietors and workers in partnerships (who may purchase insurance individually or as part of a group). In addition, some small employers that provide health insurance to their employees are eligible to receive a tax credit of up to 50 percent of the cost of that insurance.

JCT estimates that subsidies for work-related coverage for people under age 65 will total about $272 billion in 2018.[13] That amount is estimated to grow to $489 billion in 2028 and to total $3.7 trillion over the 2019–2028 period. The amount of the tax subsidy for work-related coverage is very large because the number of people with such coverage is large. (It is important to note that the estimated subsidies are not equal to the tax revenues that would be collected if those subsidies were eliminated, because in that event, many people would adjust their behavior to reduce the tax liability created by the change.)

Medicaid and CHIP

Outlays for all noninstitutionalized Medicaid and CHIP enrollees under age 65 who receive full benefits are estimated to amount to $296 billion in 2018. Over the 2019–2028 period, estimated outlays total $4 trillion: $842 billion (or 21 percent of the total) for people made eligible for Medicaid by the ACA and $3.2 trillion (or 79 percent) for people eligible for Medicaid or CHIP otherwise. Medicaid spending for the noninstitutionalized population under age 65 accounts for roughly 80 percent of total projected Medicaid spending for medical services over the 2019–2028 period.

Nongroup Coverage and the Basic Health Program

In 2018, subsidies for nongroup coverage obtained through the marketplaces, related spending and revenues (that is, premium tax credits, net spending and revenues related to risk adjustment and reinsurance, and grants to states), and payments for the Basic Health Program will total $55 billion, CBO and JCT estimate. Over the 2019–2028 period, such costs are projected to total $760 billion and to consist of the following main components:

13. That estimate excludes federal spending on medical benefits provided by the Department of Veterans Affairs and on the Defense Department's TRICARE program. For more information about those programs, see Congressional Budget Office, "Military and Veterans' Health Care," www.cbo.gov/topics/health-care/military-and-veterans-health-care.

- Outlays of $624 billion and a reduction in revenues of $79 billion for premium tax credits, totaling $703 billion (those tax credits cover a portion of eligible people's health insurance premiums and, because they are refundable, they can reduce individuals' tax liability below zero, resulting in outlays);
- Outlays of $57 billion for the Basic Health Program; and
- Outlays of $70 billion and revenues of roughly the same amount related to payments and collections for risk adjustment and reinsurance.

The third component of those subsidies is projected to have no net costs over time. The risk-adjustment and reinsurance programs were established under the ACA to stabilize premiums in the nongroup and small-group insurance markets by reducing the likelihood that particular insurers with a disproportionate share of less healthy enrollees would bear especially high costs.[14] The programs, which were implemented in 2014, make payments to insurers with less healthy enrollees; those payments are financed by collecting funds from insurers with healthier enrollees in the case of risk adjustment and by an assessment on a broad range of insurers in the case of reinsurance. The payments under the risk-adjustment and reinsurance programs are recorded in the budget as mandatory outlays, and the collections are recorded as revenues. In CBO's projections for the 2019–2028 period, risk-adjustment and reinsurance payments and collections total about $70 billion; almost all of that amount is for risk adjustment, as the last claims eligible for the reinsurance program are from plan year 2016. (Collections and payments ultimately offset each other exactly, but because of differences in the timing of collections and payments, slight discrepancies between the two will occur in any given period.)

Subsidies for insurance obtained through the marketplaces and outlays for the Basic Health Program depend on the number of people who purchase such coverage; the premiums for benchmark plans; and certain characteristics of enrollees, such as age, family size, and income. Combined, those subsidies and outlays for the Basic Health Program are projected to average $6,300 per subsidized enrollee in calendar year 2018 and to rise to about $12,440 in 2028.

Medicare

Net outlays for Medicare coverage for noninstitutionalized people under age 65 are projected to be $82 billion in 2018 and to total $1 trillion over the 2019–2028 period. That amount is about one-eighth of total projected net spending for the Medicare program.

Taxes and Penalties

Taxes and penalties related to health insurance coverage are expected to reduce the total amount of federal subsidies for such coverage by $21 billion in 2018. Under current law, those taxes and penalties would total $313 billion over the 2019–2028 period, CBO and JCT estimate—mostly from a tax on health insurance providers and from penalties imposed on some employers for not offering to their employees health insurance that meets specified standards.

Excise Tax on High-Premium Insurance Plans. An excise tax on certain high-cost employment-based coverage is scheduled to be imposed beginning in 2022. The tax was originally supposed to take effect in 2018, but lawmakers have delayed its implementation until 2022.[15] In CBO and JCT's projections, collections of that tax total $47 billion over the 2019–2028 period.

The excise tax is expected to cause some employers and workers to shift to health plans with lower premiums in order to entirely avoid paying the tax or to reduce their tax liability. Those shifts will generally increase income tax revenues, CBO and JCT estimate, because affected workers will receive less of their income in nontaxable health benefits and more in taxable wages. Including those increases in income tax revenues, JCT estimates receipts stemming from the imposition of the excise tax to total $168 billion over the coming decade.[16]

14. The small-group insurance market is for health insurance generally purchased by or through employers with up to 50 employees; starting in 2016, states could expand the definition to include employers with up to 100 employees.

15. See section 101 of Div. P of the Consolidated Appropriations Act, 2016, P.L. 114-113, 129 Stat. 2242, 3037, and section 4002 of an act making further continuing appropriations for the fiscal year ending September 30, 2018, and for other purposes, P.L. 115-120, 132 Stat. 28, 29.

16. That amount is shown as a memorandum item in Table 2. If workers' wages were instead held constant, their total compensation would be reduced by the amount of the change in premiums. Their employers would have smaller deductions for compensation costs and hence more taxable income—and the resulting total revenues would be similar.

Table 2.

Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	Total, 2019–2028
Work-Related Coverage												
Tax exclusion for employment-based coverage[a,b]	266	276	293	310	326	343	361	380	426	458	480	3,653
Income tax deduction for self-employment health insurance[c]	5	5	5	5	6	6	7	7	7	8	8	64
Small-employer tax credits[b]	1	1	1	1	1	1	1	1	1	1	1	8
Subtotal	272	282	299	316	332	350	368	387	434	466	489	3,725
Medicaid and CHIP[d]												
Made eligible for Medicaid by the ACA	59	62	63	68	74	80	87	93	99	105	111	842
Otherwise eligible for Medicaid	221	233	245	260	276	293	311	329	348	368	388	3,049
CHIP	16	16	14	13	13	13	14	14	15	15	16	143
Subtotal	296	310	323	340	363	386	411	436	462	488	514	4,034
Nongroup Coverage and the Basic Health Program												
Premium tax credit outlays	43	47	51	57	64	66	67	68	67	68	70	624
Premium tax credit revenue reductions	6	6	6	6	7	7	8	8	10	11	11	79
Subtotal, premium tax credits	49	53	57	63	71	73	74	75	76	78	81	703
Cost-sharing outlays	0	0	0	0	0	0	0	0	0	0	0	0
Outlays for the Basic Health Program	4	4	4	5	5	6	6	6	7	7	8	57
Collections for risk adjustment and reinsurance	-5	5	-6	6	-7	7	-7	8	-8	8	-9	-71
Payments for risk adjustment and reinsurance	7	5	6	6	6	7	7	8	8	8	9	70
Marketplace grants to states	*	0	0	0	0	0	0	0	0	0	0	0
Subtotal	55	57	61	68	76	79	80	82	83	85	89	760
Medicare[e]	82	84	88	93	97	102	106	111	116	122	129	1,049
Taxes and Penalties Related to Coverage												
Gross collections of excise tax on high-premium insurance plans[f]	0	0	0	0	-1	-5	-5	-6	-8	-11	-12	-47
Penalty payments by uninsured people	-4	-3	0	0	0	0	0	0	0	0	0	-3
Net receipts from tax on health insurance providers[g]	-13	0	-14	-15	-16	-17	-18	-19	-20	-21	-22	-161
Gross collections of employer penalties[i]	-4	-8	-10	-11	-8	-9	-10	-10	-11	-12	-12	-101
Subtotal	-21	-11	-24	-26	-26	-31	-33	-35	-38	-43	-45	-313
Net Subsidies	**685**	**723**	**747**	**791**	**843**	**886**	**933**	**981**	**1,057**	**1,118**	**1,176**	**9,255**

Continued

Tax on Health Insurance Providers. Health insurers are subject to an excise tax (though legislation eliminated it for calendar year 2019). The law specifies the total amount of tax to be assessed, and that total is divided among insurers according to their share of total applicable premiums charged in the previous year. Some health insurers, such as firms operating self-insured plans and certain state government entities and tax-exempt providers, are fully or partly exempt from the tax.[17] Net revenues from the tax will be $13 billion in 2018 and under current law would increase to about $22 billion by 2028, for a total of $161 billion over the decade, CBO and JCT estimate.

17. A self-insured firm essentially acts as its own insurer and bears much of the financial risk of providing coverage to its workers.

Table 2. Continued

Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65

Billions of Dollars, by Fiscal Year

	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	Total, 2019–2028
Memorandum:												
Average Subsidy per Subsidized Marketplace or Basic Health Program Enrollee (Dollars)	6,300	7,210	8,010	9,330	9,970	10,200	10,740	11,050	11,440	11,940	12,440	n.a.
Collections of Excise Tax on High-Premium Insurance Plans, Including the Associated Effects on Revenues of Changes in Taxable Compensation	0	0	0	0	-8	-16	-20	-24	-28	-34	-39	-168

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

Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

This table excludes outlays made by the federal government in its capacity as an employer.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; n.a. = not applicable; * = between zero and $500 million.

a. Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and penalty payments by employers. JCT made this projection; it differs from JCT's estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are excluded here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

b. Includes increases in outlays and reductions in revenues.

c. JCT made this projection; it does not include effects stemming from the deduction for people over age 65.

d. For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits. Also, the federal government covers a larger share of costs for Medicaid enrollees whom the ACA made eligible for the program than for people otherwise eligible for Medicaid; the government therefore tracks those groups separately.

e. For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

f. The excise tax is scheduled to go into effect in 2022. Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance. If those effects were included, net revenues stemming from the excise tax would total $168 billion over the 2019–2028 period, and revenues from penalty payments by employers would total $79 billion over that 10-year period.

g. Net receipts include effects of the excise tax on individual and corporate tax receipts. The tax is suspended in 2019.

Penalties on Employers. Some large employers that do not offer health insurance coverage that meets certain standards under the ACA will owe a penalty if they have any full-time employees who receive a subsidy through a health insurance marketplace.[18] The requirement generally applies to employers with at least 50 full-time-equivalent employees. In CBO and JCT's projections, payments of those penalties total $101 billion over the 2019–2028 period. However, the increased costs for employers that pay the penalties are projected to reduce other revenues by $22 billion, because employers would generally be expected to shift the costs of the penalties to workers by lowering taxable wages. Once that shift is taken into account, the net reduction in the deficit is $79 billion.

Uncertainty Surrounding the Estimates

The ways in which federal agencies, states, insurers, employers, individuals, doctors, hospitals, and other parties will behave in the future are all difficult to predict, so the estimates in this report are uncertain. CBO and JCT have endeavored to develop budgetary estimates that are in the middle of the distribution of potential outcomes.

18. To meet the standards, the cost to employees for self-only coverage must not exceed a specified share of their income (which is 9.56 percent in 2018 and is scheduled to grow over time), and the plan must pay at least 60 percent of the cost of covered benefits.

The actual distribution of health insurance coverage in future years could differ from the projections presented in this report for a variety of reasons. If national economic trends diverge from CBO's economic forecast, for example, that would alter the number of people offered insurance by their employers, as well as the number of people eligible for Medicaid or coverage through the marketplaces. Additionally, changes in laws or regulations would affect health insurance markets. For example, if proposed regulations take effect, AHPs and STLDI plans may have smaller or larger effects on enrollment and premiums in the small-group and nongroup insurance markets than projected in this report. Depending on how state insurance commissioners regulate those plans, those markets may expand, shrink, or, in some areas of the country, become unstable. Furthermore, such economic and regulatory factors may interact with one another in a variety of ways to bring about outcomes that differ from the projections presented here.

Many other factors will also affect federal subsidies for health care. One important factor is the extent to which the emergence and adoption of health care technology will raise or lower costs. New and less expensive medical procedures or treatments could prove effective in helping patients, which could lower costs. But other beneficial procedures and treatments might be more expensive. Other factors that could affect health care costs are changes in the structure of payment systems and innovations in the delivery of health care. Those changes could encourage providers to supply more cost-effective treatments and reduce costs per enrollee. Other changes could reach previously underserved populations and raise costs per enrollee.

Changes in the Estimates of Insurance Coverage and Subsidies Since September 2017

In CBO and JCT's current projections for the 2018–2027 period (the span covered by both last year's projections and the current ones), about 3 million more people are uninsured, on average, than the agencies estimated in September 2017. The agencies have decreased their estimate of the net federal subsidies associated with health insurance coverage for people under age 65 from $9.2 trillion to $8.8 trillion for that period (see Table 3).

Changes in the Estimates of Insurance Coverage

In most years of the 2018–2027 period, CBO and JCT have changed their projections in the following ways:

- The number of uninsured people is higher;
- Enrollment in subsidized and unsubsidized nongroup coverage is lower;
- Enrollment in Medicaid is lower; and
- Enrollment in employment-based coverage is higher.

Uninsured. In CBO and JCT's current projections, an average of 3 million more people are uninsured between 2018 and 2027 than the agencies estimated last September. However, the change in the number of uninsured people varies significantly over that 10-year period: In 2018, 1 million fewer people are projected to be uninsured, and in 2027, 5 million more people are projected to be uninsured.

Effects of Eliminating the Individual Mandate Penalty. The primary reason for the increase in the projected number of uninsured people in most years is the elimination of the penalty related to the individual mandate beginning in 2019. Without a penalty for not having insurance, fewer people are projected to enroll in health insurance because some people would have enrolled to avoid paying the penalty and because some people are expected to forgo insurance in response to the resulting higher premiums in the nongroup market.

The projections explained in this report incorporate revised methods for estimating the effects of eliminating the penalty. Using those updated methods, CBO and JCT estimate the reduction in health insurance coverage is about one-third smaller than the agencies previously estimated.[19]

The update was prompted by a reassessment of the decline in the number of uninsured people since 2012 and the reasons for it. CBO and JCT have long attributed only part of the decline to financial factors that reduced the cost of obtaining coverage or increased the cost of being uninsured: the expansion of publicly financed coverage by Medicaid, the availability of subsidies for insurance obtained through the marketplaces, and the financial effect of the individual mandate penalty. The agencies have attributed the remainder to nonfinancial factors that lowered barriers to obtaining

19. For information on the agencies' prior estimate, see Congressional Budget Office, *Repealing the Individual Health Insurance Mandate: An Updated Estimate* (November 2017), www.cbo.gov/publication/53300.

coverage, including simplified procedures for participating in Medicaid, the existence of the marketplaces, outreach and advertising, and market rules having the effect of broadening coverage.[20] Other nonfinancial factors are related to the individual mandate, including people's tendency to comply with laws, widespread and growing expectations that most people should have coverage, and people's greater responsiveness to penalties than to subsidies.[21]

In CBO and JCT's current projections, compared with earlier ones:

- The total effect of all nonfinancial factors is smaller;
- The nonfinancial factors associated with the mandate explain a smaller share of the total effect of all nonfinancial factors; and
- The mandate has been in place for an additional year (five years in total), and people's expectations about whether one should have coverage are more established and, in CBO's current judgment, less sensitive to repealing the legal mandate.

Each of those revisions reduced the agencies' estimates of the effects of eliminating the mandate penalty, which include eliminating the effects of the financial penalty and almost all of the nonfinancial effects of the individual mandate.

Those revisions were based in part on CBO's analysis of data from the National Health Interview Survey (NHIS) to discern changes over time in the number of uninsured people. Whereas CBO and JCT previously relied more heavily on estimates from the Medical Expenditure Panel Survey—Household Component, the agencies now use the NHIS as their primary benchmark for information on the number of uninsured people because it is the earliest available source each year and provides more reliable estimates derived from a larger sample.[22] The revisions also took into account information from analysts at other organizations.[23]

Effects of Other Factors. Partially offsetting those changes to methods are some changes that would, all else being equal, tend to lower the estimated number of uninsured people:

- CBO and JCT have updated their projections of premiums in the nongroup market to account for how insurers and state insurance commissioners reacted to the lack of a direct appropriation for CSRs. As a result of that change in funding, about 2 million more people are estimated to purchase coverage through the nongroup market in most years than would have if the federal government had continued to directly reimburse insurers for the cost of CSRs; some of those people would otherwise have been uninsured.
- CBO and JCT have incorporated the effects of two proposed regulations that would expand AHPs and STLDI plans. In particular, following the usual procedures for incorporating the effects of proposed rules, the agencies have incorporated a 50 percent chance that the final issued rules will be the same as the proposed ones and a 50 percent chance that no new rules like the proposed ones will be issued. Accordingly, the number of uninsured people in the baseline is projected to be between 500,000 and 1 million lower in most years than it would otherwise have been.

20. Those market rules include prohibiting insurers from denying coverage or varying premiums because of an enrollee's health status, or limiting coverage because of preexisting medical conditions; they allow insurers to vary premiums only on the basis of age, tobacco use, and geographic location. In addition, the market rules require that nongroup plans cover certain categories of benefits defined as essential.

21. For additional information, see Alexandra Minicozzi, Unit Chief, Health Insurance Modeling Unit, Congressional Budget Office, *Modeling the Effect of the Individual Mandate on Health Insurance Coverage* (presentation to CBO's Panel of Health Advisers, Washington, D.C., September 15, 2017), www.cbo.gov/publication/53105.

22. For a discussion of the data that CBO and JCT use, see Congressional Budget Office, *How CBO Defines and Estimates Health Insurance Coverage for People Under Age 65* (May 2018), www.cbo.gov/publication/53822.

23. See Ashley Kirzinger and others, *Kaiser Health Tracking Poll—March 2018: Non-Group Enrollees* (April 3, 2018), https://tinyurl.com/y9osz5pm; John Hsu and others, "Eliminating the Individual Mandate Penalty in California: Harmful but Non-Fatal Changes in Enrollment and Premiums," *Health Affairs Blog* (blog entry, March 1, 2018), https://tinyurl.com/ybmbbob9; S&P Global Ratings, "U.S. Tax Reform: Repeal of the Health Insurance Mandate Will Save Less Than Expected, and Will Not Support the Current Insurance Market" (November 16, 2017); Paul Spitalnic, *Estimated Financial Effect of the "American Health Care Act of 2017"* (Centers for Medicare & Medicaid Services, Office of the Actuary, June 13, 2017), https://go.usa.gov/xQDfG; and Linda J. Blumberg, Matthew Buettgens, and John Holahan, *Implications of Partial Repeal of the ACA Through Reconciliation* (Urban Institute, December 2016), https://tinyurl.com/y6vkugs4.

Table 3.

Comparison of Current and Previous Projections of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65

	2018			2018–2027		
	September 2017 Projection	Spring 2018 Projection[a]	Difference	September 2017 Projection	Spring 2018 Projection[a]	Difference
	Insurance Coverage During the Year[b] (Millions of people)			Average Insurance Coverage Over the Period[b] (Millions of people)		
Total Population	273	273	*	275	275	*
Employment-Based Coverage	157	158	1	153	156	3
Medicaid and CHIP[c]						
Made eligible for Medicaid by the ACA	13	12	*	15	13	-2
Otherwise eligible for Medicaid or CHIP	56	55	-1	55	55	*
Total	68	67	-1	70	68	-1
Nongroup Coverage and the Basic Health Program						
Subsidized nongroup	9	8	-2	10	7	-3
Unsubsidized nongroup	6	7	1	7	6	-2
Total	16	15	-1	18	13	-5
Coverage through the Basic Health Program[d]	1	1	*	1	1	*
Medicare[e]	8	8	*	9	8	*
Other Coverage[f]	5	5	*	5	5	*
Uninsured[g]	30	29	-1	31	34	3
	Effects on the Federal Deficit[h] (Billions of dollars)			Effects on the Cumulative Federal Deficit Over the Period[h] (Billions of dollars)		
Work-Related Coverage						
Tax exclusion for employment-based coverage[i]	297	266	-31	3,796	3,439	-357
Income tax deduction for self-employment health insurance[k]	7	5	-2	91	61	-30
Small-employer tax credits[l]	1	8	7	10	8	-2
Subtotal	306	279	-26	3,897	3,508	-389
Medicaid and CHIP[j]						
Made eligible for Medicaid by the ACA	76	59	-17	1,036	791	-245
Otherwise eligible for Medicaid or CHIP	238	237	-2	2,981	3,025	44
Subtotal	315	296	-19	4,017	3,815	-202
Nongroup Coverage and the Basic Health Program						
Premium tax credits	47	49	2	605	671	66
Cost-sharing outlays	9	0	-9	99	0	-99
Outlays for the Basic Health Program	5	4	-1	69	54	-15
Subtotal	62	55	-7	773	725	-48
Medicare[m]	81	82	2	1,011	1,003	-8
Taxes and Penalties Related to Coverage						
Gross collections of excise tax on high-premium insurance plans[n]	0	0	0	-29	-36	-7
Penalty payments by uninsured people	-4	-4	--	-51	-7	44
Net receipts from tax on health insurance providers[o]	-13	-13	0	-166	-152	13
Gross collections of employer penalties[p]	-12	-4	7	-207	-93	114
Subtotal	-28	-21	7	-453	-289	165
Net Subsidies[q]	**735**	**685**	**-50**	**9,245**	**8,764**	**-481**

Continued

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

Estimates of insurance coverage apply to calendar years, and estimates of the effect on the federal deficit apply to fiscal years.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; * = between -500,000 and 500,000; ** = between zero and $500 million.

a Estimates are from CBO's adjusted April 2018 baseline. The adjustment reflects updates to the preliminary projections (contained in *The Budget and Economic Outlook: 2018 to 2028*, released on April 9, 2018) for subsidies for insurance purchased through the marketplaces established under the ACA as well as for revenues related to health care.

b. Estimates include noninstitutionalized civilian residents of the 50 states and the District of Columbia who are younger than 65. The components do not sum to the total population because some people report multiple sources of coverage. CBO and JCT estimate that in most years, 10 million people (or 4 percent of insured people) have multiple sources of coverage, such as employment-based coverage and Medicaid. Estimates reflect average monthly enrollment over the course of a year and include spouses and dependents covered under family policies.

c Includes noninstitutionalized enrollees with full Medicaid benefits. Estimates are adjusted to account for people enrolled in more than one state.

d. The Basic Health Program, created under the ACA, allows states to establish a coverage program primarily for people with income between 138 percent and 200 percent of the federal poverty guidelines. To subsidize that coverage, the federal government provides states with funding equal to 95 percent of the subsidies for which those people would otherwise have been eligible through a marketplace.

e Includes noninstitutionalized Medicare enrollees under age 65. Most Medicare-eligible people under age 65 qualify for Medicare because they participate in the Social Security Disability Insurance program.

f Includes people with other kinds of insurance, such as student health plans, coverage provided by the Indian Health Service, and coverage from foreign sources.

g. Includes unauthorized immigrants, who are ineligible either for marketplace subsidies or for most Medicaid benefits; people ineligible for Medicaid because they live in a state that has not expanded coverage; people eligible for Medicaid who do not enroll; and people who do not purchase insurance available through an employer, through the marketplaces, or directly from an insurer.

h Positive numbers indicate an increase in the deficit, and negative numbers indicate a decrease in the deficit.

i Includes the effect on tax revenues of the exclusion of premiums for people under age 65 with employment-based insurance from federal income and payroll taxes and includes the effects on taxable wages of the excise tax on high-cost plans and penalty payments by employers. JCT made this projection; it differs from JCT's estimate of the tax expenditure for the exclusion of employer-paid health insurance because effects stemming from the exclusion for people over age 65 are excluded here and because the Federal Insurance Contributions Act tax exclusion for employer-paid health insurance is included here.

j Includes increases in outlays and reductions in revenues.

k. JCT made this projection; it does not include effects stemming from the deduction for people over age 65.

l For Medicaid, the outlays reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits. Also, the federal government covers a larger share of costs for Medicaid enrollees whom the ACA made eligible for the program than for people otherwise eligible for Medicaid; the government therefore tracks those groups separately.

m For Medicare, the outlays are for benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

n Excludes the associated effects on revenues of changes in taxable compensation, which are included in the estimate of the tax exclusion for employment-based insurance.

o Net receipts include the effects of the excise tax on individual and corporate tax receipts. The tax is suspended in 2019.

- CBO and JCT have updated their estimates to include the recently enacted extension of funding for CHIP from 2018 to 2027. Because some people who will gain coverage through CHIP would otherwise have gone uninsured, its extension reduces projections of the number of uninsured people by fewer than 500,000 in each year.

Nongroup Coverage and the Basic Health Program. Average monthly enrollment in the nongroup market is now projected to be 1 million lower in 2018 and 5 million lower, on average, between 2018 and 2027 than estimated in September 2017. On average, over the 10-year period, subsidized enrollment is lower by 3 million people, and unsubsidized enrollment is lower by 2 million. Projections of enrollment in the Basic Health Program are not noticeably different.

The 2017 tax act's elimination of the individual mandate penalty accounts for most of the reduction in the projections of nongroup enrollment: Fewer people are expected to enroll in coverage through the nongroup market as a consequence. In addition, the extension of CHIP funding from 2018 through 2027 reduced estimates of enrollment in the nongroup market because some people

who will gain coverage through CHIP would otherwise have obtained nongroup coverage.

Those reductions in nongroup coverage are somewhat offset by the lack of direct federal funding for CSR payments. As discussed above, CBO and JCT estimate that funding CSRs through higher gross premiums and therefore higher premium tax credits will result in about 2 million more people purchasing coverage through the nongroup market in most years than would have if the federal government had continued to directly reimburse insurers for the cost of CSRs. In addition, CBO and JCT estimate that the proposed regulations that would expand STLDI plans would increase the number of people enrolled in nongroup coverage by fewer than 500,000 people. (That estimate reflects a 50 percent probability that the regulations will be finalized as proposed.)

Medicaid and CHIP. Relative to the September 2017 estimates, current estimates of enrollment in Medicaid and CHIP are 1 million lower for most years over the 2018–2027 period. The elimination of the individual mandate penalty was the largest factor reducing projected enrollment. In CBO's estimation, the penalty for not having insurance encouraged more people to enroll in Medicaid than would otherwise have been the case. For example, some people applied for coverage in the marketplaces as a result of the penalty and turned out to be eligible for Medicaid, and some Medicaid-eligible adults and children would have had to pay a penalty if they did not obtain insurance. As a result, when the penalty is eliminated, beginning in 2019, fewer people will enroll in Medicaid, CBO expects.

Partially offsetting that effect is additional estimated enrollment in CHIP stemming from the extension of funding for that program from 2018 through 2027.

Employment-Based Coverage. CBO and JCT increased last year's projections of enrollment in employment-based insurance coverage by 1 million people in 2018 and by an average of 3 million people between 2018 and 2027. Those net increases are the result of three main factors. First, the upward revision reflects an updated assessment of administrative data and data from household and employer surveys, which has led CBO and JCT to increase their estimate of the total number of people with employment-based coverage before 2018. Second, in its latest economic forecast, CBO projects that more people will be employed in most years over the coming decade than previously estimated, which boosts projected enrollment in employment-based coverage. Finally, partly on the basis of actual premiums for 2018, the agencies increased their projections of gross premiums for plans offered through the nongroup market, thereby increasing projected enrollment in employment-based coverage. (Because alternative sources of coverage would be more expensive, more employers are expected to offer insurance to their employees.)

Partially offsetting those factors increasing employment-based coverage is the elimination of the individual mandate penalty beginning in 2019. That factor has led CBO and JCT to lower their estimates of the number of people with employment-based coverage by 2 million in most years after 2018, relative to the September 2017 projections.

Changes in the Estimates of Subsidies, Penalties, and Taxes

In CBO and JCT's current projections, the net cost to the federal government of subsidizing health insurance coverage is $50 billion lower in 2018 and $481 billion (or about 5 percent) lower over the 2018–2027 period than it was in the agencies' September 2017 projections. Reduced estimates of the net cost of the tax exclusion for employment-based coverage and of Medicaid spending explain most of that decrease.

Tax Exclusion for Employment-Based Coverage. Estimates of the net cost of the tax exclusion for employment-based coverage are now $31 billion lower in 2018 and $357 billion lower over the 2018–2027 period. The cost of the exclusion depends on the number of people with employment-based coverage, the marginal tax rates of people enrolled in that coverage, and premiums for employment-based coverage. Although total enrollment in employment-based coverage is now projected to be higher than the September estimate, two other changes more than offset that effect: As a result of changes enacted in the 2017 tax act, marginal tax rates are estimated to be lower through 2025, and on the basis of new information available from the Internal Revenue Service about premiums in 2015, average premiums for employment-based coverage are, on net, estimated to be lower.

Medicaid and CHIP. CBO has reduced its projections of outlays for Medicaid and CHIP by $19 billion in 2018 and by $202 billion over the 2018–2027 period. Lower spending for Medicaid accounts for $280 billion of that net reduction, mostly because the elimination

of the individual mandate penalty is expected to lower enrollment in the program. In addition, the extension of funding for CHIP from 2018 through 2027 is estimated to generate savings for Medicaid because CBO had expected that, in the absence of extended funding for CHIP, states would switch some children who had been enrolled in CHIP to Medicaid.

CBO also has made technical revisions that have reduced its projections of Medicaid spending over the next decade. That reduction stems largely from lower-than-anticipated per capita costs in 2017 for people made eligible for Medicaid under the ACA and lower projections of cost growth for those enrollees.

As a result of the extension of funding for CHIP, CBO's current projection of outlays for the program over the 2018–2027 period is $78 billion higher than the September 2017 estimate.

Subsidies for Nongroup Coverage and the Basic Health Program. CBO and JCT's estimates of the net cost of subsidies for coverage through the marketplaces, along with estimates of related spending and revenues, are now $7 billion lower for 2018 and $48 billion lower for the 2018–2027 period. That net reduction results from the agencies' lower projections of subsidized enrollment through the marketplaces, partly offset by an increase in the estimated per-person cost of that coverage. The elimination of the individual mandate penalty accounts for most of the reduction in nongroup enrollment.

The estimated per-person cost of subsidized nongroup coverage is higher in the current projections for two main reasons. The lack of direct funding for CSRs increased average gross premiums for benchmark plans, which results in higher average subsidies. In addition, the elimination of the individual mandate penalty is expected to result in a less healthy mix of enrollees, thereby increasing projected average gross premiums and, therefore, subsidies.

Penalties and Taxes Related to Coverage. CBO and JCT have lowered their estimates of collections of penalty payments by individuals who do not purchase health insurance coverage meeting the ACA's standards by less than $500,000 in 2018 and by $44 billion over the 2018–2027 period. That reduction stems almost entirely from the 2017 tax act and its elimination of the penalty associated with the individual mandate beginning in 2019. As a result, CBO and JCT expect that no such penalties will be collected from people who are uninsured in 2019 or later years.

In addition, CBO and JCT have reduced their estimate of collections of penalty payments from employers that do not offer coverage meeting the ACA's standards by $7 billion in 2018 and by $114 billion over the 2018–2027 period as a result of new data from the Treasury Department showing less reported penalty liability than previously projected.

Comparisons of CBO and JCT's Projections With Actual Coverage and Subsidies

In order to improve CBO and JCT's baseline projections, the agencies compare their projections of health insurance coverage and federal subsidies for people under age 65 with actual enrollment and costs reported by the Administration, state governments, and surveys whenever possible. This report compares projections for 2017 published in March 2016 and September 2017 with actual amounts for 2017 (see Table 4).

Nongroup Coverage and the Basic Health Program

CBO and JCT's March 2016 projection of subsidies for nongroup coverage obtained through the marketplaces, related spending and revenues, and payments for the Basic Health Program accounted for the largest estimating error for 2017. The agency estimated that those subsidies would total $55 billion in 2017—about $11 billion, or about 25 percent, more than the actual amount reported by the Administration for 2017.

CBO and JCT overestimated costs to the federal government because they overestimated the number of people who would enroll through the marketplaces, and receive subsidies, in 2017. In March 2016, CBO and JCT estimated that 12 million people would enroll in subsidized coverage through the marketplaces—about 4 million, or 50 percent, more than the actual number. At the time, CBO and JCT expected enrollment to grow from 2016 to 2017 as more people gained experience with the marketplaces and more employers responded to the availability of subsidies by declining to offer insurance to their employees. However, enrollment through the marketplaces changed little in 2017. As a result, in their September 2017 projections, CBO and JCT significantly reduced their estimates of enrollment through the marketplaces in 2017 and later years.

The effect on subsidies of overestimating enrollment in the March 2016 projection was partially offset by

Table 4.

Selected Estimates of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65 in CBO's March 2016 and September 2017 Projections Compared With Actual Coverage and Subsidies in 2017

	March 2016 Baseline	September 2017 Projection	Actual	Difference, March 2016–Actual	Difference, September 2017–Actual
	Selected Categories of Health Insurance Coverage for People Under Age 65 (Millions of people, calendar year 2017)				
Nongroup Coverage Purchased Through the Health Insurance Marketplaces[a]					
Subsidized	12	8	8	4	*
Unsubsidized	3	2	2	1	*
Total	15	10	10	5	*
Basic Health Program[b]	1	1	1	*	*
Uninsured[c]	26	28	28	-2	*
	Selected Categories of Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65 (Billions of dollars, fiscal year 2017)				
Medicaid and CHIP[d]					
Medicaid[e]	279	280	276	3	5
CHIP	13	16	16	-3	-1
Total	292	296	292	-1	4
Nongroup Coverage and the Basic Health Program					
Premium tax credits[f]	43	34	35	8	-1
Cost-sharing outlays[f]	9	7	6	3	1
Outlays for the Basic Health Program[f]	4	5	4	1	**
Collections for risk adjustment and reinsurance[g]	-11	-9	-10	-1	1
Payments for risk adjustment and reinsurance[g]	10	9	9	2	*
Total	55	45	45	11	*

Continued

underestimating the average costs per subsidized enrollee.[24] In March 2016, CBO and JCT's estimate of average costs per subsidized marketplace or Basic Health Program enrollee was too low—by about 10 percent. Using information from the beginning of 2017, CBO and JCT increased their estimates of average costs in that year and later years in their September 2017 projection. All told, the agencies' September 2017 projection of subsidies for nongroup coverage obtained through the marketplaces, related spending and revenues, and Basic Health Program payments for 2017 turned out to be $1 billion higher than the actual amount for that fiscal year.[25]

Other Subsidies and Revenues

For all other categories of subsidies, taxes, and penalties related to coverage for people under age 65 for which actual information for 2017 is available, CBO and JCT's March 2016 and September 2017 projections for 2017 differed by less than 5 percent from the actual amounts. For example, CBO estimated in March 2016 that outlays for noninstitutionalized Medicaid and CHIP enrollees under age 65 who receive full benefits would be $292 billion and in September 2017, $296 billion. Actual spending in 2017 was $292 billion.

24. See Congressional Budget Office, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2016* (March 2016), www.cbo.gov/publication/51385.

25. For calendar year 2017, the overestimate of total spending that could be calculated by multiplying CBO's September 2017 projection of enrollment by its projection of average costs is substantially larger than the overestimate for total spending in fiscal year 2017 mostly because the Administration stopped the payment of CSRs in October 2017 and those payments had been projected to continue in CBO's baseline.

Table 4. Continued

Selected Estimates of Health Insurance Coverage and Net Federal Subsidies for People Under Age 65 in CBO's March 2016 and September 2017 Projections Compared With Actual Coverage and Subsidies in 2017

	March 2016 Baseline	September 2017 Projection	Actual	Difference, March 2016–Actual	Difference, September 2017–Actual
	Selected Categories of Net Federal Subsidies Associated With Health Insurance Coverage for People Under Age 65 (Billions of dollars, fiscal year 2017)				
Medicare[d,h]	81	80	82	1	-2
Penalty Payments by Uninsured People[i]	-3	-3	-3	**	**
Memorandum:					
Average Subsidy per Subsidized Marketplace or Basic Health Program Enrollee (Dollars, calendar year 2017)[j]	4,550	5,550	5,010	-460	540

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation; and additional sources listed below.

Comparisons are shown only for categories of health insurance and net federal subsidies associated with people under age 65 for which actual values are publicly available for at least part of 2017.

CHIP = Children's Health Insurance Program; JCT = Joint Committee on Taxation; * = between -500,000 and 500,000; ** = between -$500 million and $500 million.

a. Actual value based on data published by the Centers for Medicare & Medicaid Services. See Centers for Medicare & Medicaid Services, "2017 Effectuated Enrollment Snapshot" (accessed April 25, 2018), https://go.usa.gov/xR7j7 (PDF, 489 KB) and "First Half of 2017 Average Effectuated Enrollment Report" (accessed April 25, 2018), https://go.usa.gov/xQmaM.

b. Actual value based on information published by the state governments of Minnesota and New York, which are the only states that have used the program. See Randall Chun, MinnesotaCare (Minnesota House of Representatives, House Research Department, updated December 2017) www.house.leg.state.mn.us/hrd/pubs/mncare.pdf (104 KB); and New York State Department of Health, "2017 Open Enrollment Report," https://go.usa.gov/xQm9U.

c. Actual value reflects the number of uninsured people reported by the National Health Interview Survey adjusted downward to exclude people with Indian Health Service coverage, which CBO and JCT consider to be health insurance coverage. See Robin A. Cohen, Emily P. Zammitti, and Michael E. Martinez, *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017* (National Center for Health Statistics, May 2018), https://go.usa.gov/xQmKM (PDF, 530 KB)

d. See Department of the Treasury, "Final Monthly Treasury Statement of Receipts and Outlays of the United States Government for Fiscal Year 2017 Through September 30, 2017, and Other Periods" (October 2017), https://go.usa.gov/xQmsd.

e. Actual value reported by the Department of the Treasury adjusted to reflect only medical services for noninstitutionalized enrollees under age 65 who have full Medicaid benefits.

f. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of the Treasury" (February 2018), p. 956, https://go.usa.gov/xR7Dc.

g. Office of Management and Budget, *Budget of the U.S. Government: Appendix*, "Detailed Budget Estimates by Agency: Department of Health and Human Services" (February 2018), pp. 449–450, https://go.usa.gov/xR7Dc.

h. Actual value reported by the Department of the Treasury adjusted to reflect benefits net of offsetting receipts for noninstitutionalized Medicare beneficiaries under age 65.

i. Actual value based on preliminary data from the Internal Revenue Service. See Internal Revenue Service, "SOI Tax Stats—Individual Income Tax Returns," Preliminary Data, Statistical Tables, Table 1—Individual Income Tax Returns: Selected Income and Tax Items (accessed April 19, 2018), https://go.usa.gov/xQm9k.

j. Estimates of actual costs per person are the ratios of costs to subsidized enrollment through the health insurance marketplaces or the Basic Health Program in a calendar year.

List of Tables and Figures

Tables

Figures

[redacted]

About This Document

Each year, the Congressional Budget Office issues a series of publications describing its projections of the federal budget. This report provides background information that helps explain some of the projections in the most recent of those publications and also provides updated estimates. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations.

Kate Fritzsche and Kevin McNellis prepared the report with contributions from Sarah Masi. Susan Yeh Beyer, Alice Burns, Philippa Haven, Ben Hopkins, Sean Lyons, Eamon Molloy, Romain Parsad, Allison Percy, Ezra Porter, Lisa Ramirez-Branum, Robert Stewart, Chris Zogby, and the staff of the Joint Committee on Taxation contributed to the analysis. Jessica Banthin, Chad Chirico, Theresa Gullo, Leo Lex, Alexandra Minicozzi, and David Weaver provided guidance and helpful comments.

Mark Hadley, Jeffrey Kling, and Robert Sunshine reviewed the report; John Skeen edited it; and Casey Labrack prepared it for publication. The report is available on the agency's website (www.cbo.gov/publication/53826).

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REPORT
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What Is the Impact on Enrollment and Premiums if the Duration of Short-Term Health Insurance Plans Is Increased?

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ABSTRACT

ISSUE: Short-term health insurance policies are inexpensive, limited-duration plans that provide few consumer protections. Two factors — a 2018 federal rule to extend the terms of these plans from three months to up to 12 months, and the repeal of the individual mandate penalty — could cause healthy people to leave the ACA-compliant market and premiums in that marketplace to increase.

GOAL: To determine the effects of these policy changes on health insurance enrollment and premiums.

METHODS: Using the RAND COMPARE microsimulation model to analyze the effect of extending short-term plans and repealing the individual mandate, both individually and in combination.

FINDINGS AND CONCLUSIONS: Extending the duration of short-term plans has little effect on premiums and enrollment alone. Repealing the individual mandate in addition to extending the duration of short-term plans leads to fewer young people enrolled in ACA-compliant plans; overall, it reduces enrollment in minimum essential insurance coverage by 6 million and leads to a 0.9 percent increase in ACA marketplace premiums. However, when behavioral factors (e.g., lack of consumer awareness of short-term plans, hassle of enrolling, desire to comply with law) are removed, we estimate that 5 million people will enroll in short-term plans, and ACA-compliant premiums will increase by 3.6 percent.

KEY TAKEAWAYS

- Changing only the duration of short-term health insurance plans — from the current three-month term to 12 months — would have minimal effects on enrollment and premiums.
- Removing the individual mandate penalty, eliminating behavioral barriers (e.g., increasing awareness of plans), and increasing the duration to 12 months would decrease enrollment in plans with minimal essential coverage by 9 million and increase premiums in silver-tier marketplace plans by 3.6 percent.
- People insured in short-term plans may face high out-of-pocket costs and coverage limitations, possibly making their health care unaffordable in the event of illness or injury.

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INTRODUCTION

In February 2018, the U.S. Departments of Treasury, Labor, and Health and Human Services proposed a rule that would expand health insurers' ability to sell short-term plans. These are limited-duration policies that do not comply with requirements of the Affordable Care Act.[1] Under current law, such plans may be sold only for three-month terms; the federal rule proposes that insurers be allowed to sell them for terms of up to 12 months. Short-term plans are less comprehensive and often cheaper than ACA-compliant policies, and therefore potentially attractive to young, healthy people who do not expect to need insurance. However, if healthy, low-cost people leave the ACA's insurance risk pool to enroll in short-term plans, premiums for ACA-compliant policies may increase.

Short-term plans have been available since before the ACA took effect, but uptake of these plans has been low; just over 160,000 people were enrolled in such plans in 2016.[2] There are likely several factors responsible. First, short-term plans are intended to cover temporary gaps rather than serving as the primary source of coverage. Second, such plans typically have limited coverage compared to standard health insurance plans, and thus are less appealing to many individuals. Third, there may be behavioral factors that affect enrollment, such as lack of awareness that these plans exist, the time and hassle associated with enrolling, and choice overload resulting from multiple plan options. Finally, after the ACA was enacted, individuals carrying short-term plans were subject to the individual mandate penalty unless they had another source of coverage.

Shortly before the proposed federal rule to extend the duration of short-term plans, Congress passed the Tax Cut and Jobs Act of 2017, which repealed the ACA's individual mandate penalty. Estimates from the Congressional Budget Office (CBO) suggest that repealing the individual mandate will reduce health insurance enrollment and increase premiums for plans purchased on the individual market.[3]

Various factors — plans' limited duration, the fact they do not satisfy the individual mandate, hassle of enrolling — may have caused some individuals to rule them out. But repeal of the mandate and extension of short-term plans' may motivate insurers to market short-term plans more aggressively or take steps to simplify enrollment. The expansion of short-term plan duration to 12 months also will allow those who enroll in 12-month short-term plans to switch to the ACA-compliant market during open enrollment if they experience a change in health status, without facing any penalties and without fear of a gap in coverage. This could lead to increased enrollment in short-term plans by young, healthy individuals who may nonetheless be risk averse.

MODELING

In this report, we use the RAND COMPARE microsimulation model to analyze the impact of extending short-term plans as a standalone policy and in combination with individual mandate repeal. To model short-term plan enrollment, we take into account a "behavioral barriers" parameter to account for factors not directly related to plan characteristics, including lack of awareness and hassle of enrolling. These factors may have previously led to low enrollment in these plans (see the Appendix for complete study methods). These barriers may be reduced, however, as a result of the new federal rule, the repeal of the individual mandate penalty, and changes in insurer behavior (like increased marketing) and consumer attitudes. We analyze the effects of five policy scenarios, projected to the year 2020:

1. **Current law.** In this scenario the individual mandate penalty is in effect and applies to short-term plan holders; consumers have access to three-month-duration short-term plans. This scenario resembles the current state of the insurance market.

2. **Twelve-month short-term plans.** The individual mandate penalty is in effect and applies to short-term plan holders; consumers have access to 12-month-duration short-term plans in states that do not restrict such plans. We model this scenario to isolate the effect of loosening restrictions on short-term plans.

3 **No individual mandate, three-month short-term plans.** The individual mandate penalty is repealed and consumers have access to three-month duration short-term plans. We model this scenario to isolate the effect of eliminating the individual mandate.

4 **No individual mandate, 12-month short-term plans.** The individual mandate penalty is repealed and consumers have access to 12-month short-term plans in states that do not restrict such plans. This scenario reflects the effect of the administration's planned changes, assuming behavioral barriers to enrollment in short-term plans remain the same.

5 **No individual mandate, 12 month short-term plans, behavioral barriers removed.** The individual mandate penalty is repealed, consumers have access to 12-month short-term plans in states that do not restrict such plans, and there are no behavioral barriers to enrollment in short-term plans. This scenario reflects the effect of the administration's planned changes, assuming behavioral barriers to enrollment in short-term plans are reduced.

OVERVIEW OF SHORT-TERM PLANS

Short-term/limited duration health insurance policies are plans that are issued for a period of less than 365 days. Such plans have been available since before the enactment of the ACA. Their original purpose was to cover short-term gaps in health insurance coverage, rather than being a sole source of coverage. Because these plans do not have to comply with ACA insurance regulations, insurers can deny or fail to renew short-term plans for people with preexisting conditions, exclude coverage of essential health benefits and preventive care, and charge higher cost-sharing than permitted in the ACA-compliant market.[4] Because of these exclusions and limitations, short-term plans often have lower premiums than ACA-compliant plans. As a result, they may be attractive to young and healthy individuals, particularly those who are ineligible for the ACA's tax credits. Because short-term plans do not meet the ACA's minimum essential coverage requirements, individuals enrolled in them without another source of coverage were subject to the individual mandate penalty in 2014 through 2017 and will continue to be subject to this penalty for the 2018 calendar year. Short-term plans are ineligible for the ACA's tax credits and cost-sharing reductions, meaning that enrollees in such plans must pay the full premium and any cost-sharing without federal financial assistance.

In April 2017, a new regulation — issued under the Obama administration — took effect, limiting the duration of short-term plans to less than three months. Previously, these plans could be issued for periods of less than 12 months, meaning they could be issued for up to 364 days, effectively a full year of coverage despite being considered "short-term." New changes put forth by the February 2018 federal rule propose to reverse this regulation, allowing short-term plans to again be issued for up to 12 months. However, states may impose stricter regulations; some do not allow the sale of short-term plans and others restrict duration to a maximum of six months. Historically, enrollment in short-term plans has been low — just over 160,000 in 2016 — perhaps because enrollees were still subject to the individual mandate penalty.[5] If short-term plans are expanded to 12 months, some people may find it advantageous to enroll, switching to the ACA's regulated market only if they become sick.

Removing the individual mandate penalty could increase enrollment in short-term plans. If this increase comes from young, healthy people moving out of marketplace plans, there could be serious implications for premiums on the ACA market as their populations become older and sicker. An analysis of the individual mandate by the CBO and the Joint Committee on Taxation predicts that repealing the individual mandate would increase the number of uninsured by 7 million individuals by 2020 and would increase average premiums in the nongroup market by 10 percent, not accounting for any changes in the ages of people purchasing insurance.[6] However, the CBO also points out that because of assumptions made about how people may respond to a change in the law, the

premium estimates may be high.[7] The CBO analysis does not directly address short-term plans; furthermore, CBO previously clarified that it considers people who are not enrolled in policies that provide "financial protection from major medical risks" to be uninsured.[8]

The Urban Institute recently released a report on the effects of short-term plan expansion, individual mandate repeal, and other recent policy changes, and found an increase of 6.4 million in the number of uninsured and an 18 percent increase in average premiums.[9] The changes reported by the Urban Institute are not directly comparable to our estimates because of differences in assumptions around cost-sharing reduction (CSR) payments, reporting of premiums (mean vs. age-specific), and other policy changes considered in the model.

RESULTS

Enrollment

Relative to current law (i.e., individual mandate penalty in effect and short-term plans restricted to three months), the consequence of increasing the duration of short-term plans to 12 months is that the overall number of nonelderly individuals with insurance that provides minimum essential coverage stays constant at 250 million. Removing the individual mandate penalty in both scenarios (three-month and 12-month short-term plans) reduces that number to 244 million, a decrease of 6 million people (Exhibit 1). This aligns with estimates from the CBO, which finds an additional 7 million uninsured people by 2020,[10] and by the Urban Institute, which finds 6.4 million

Exhibit 1. Estimated Enrollment in Health Insurance Plans, Individuals Under Age 65, in Millions

Scenario		Total enrolled in minimum essential coverage (in millions)	Enrolled in ACA-compliant nongroup plan (in millions)	Enrolled in short-term plan (in millions)
1	Current law Individual mandate penalty in effect Short-term plan duration limited to 3 months Behavioral barriers to short-term plan enrollment	250	18.9	0.2
2	Individual mandate penalty in effect Short-term plan duration expanded to 12 months Behavioral barriers to short-term plan enrollment	250	18.9	0.2
3	Individual mandate penalty repealed Short-term plan duration limited to 3 months Behavioral barriers to short-term plan enrollment	244	15.5	0.2
4	Individual mandate penalty repealed Short-term plan duration expanded to 12 months Behavioral barriers to short-term plan enrollment	244	15.5	0.3
5	Individual mandate penalty repealed Short-term plan duration expanded to 12 months No behavioral barriers to short-term plan enrollment	241	14.2	5.2

Data: Analysis based on the RAND COMPARE microsimulation model.
Notes: In scenarios in which the individual mandate penalty is still in effect, short-term plan holders are subject to the penalty. Minimum essential coverage does not include short-term plans.

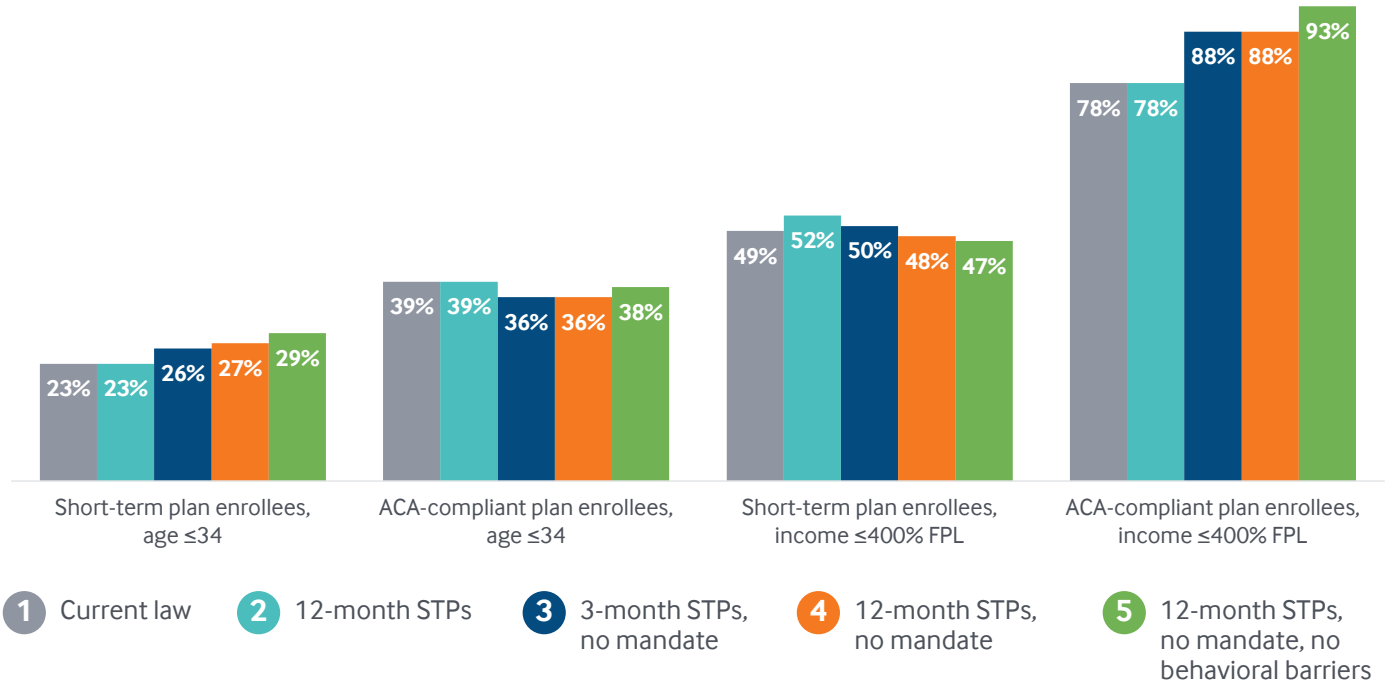
additional uninsured people by 2019.[11] When we assume the elimination of behavioral barriers to enrollment in short-term plans, the number of people in insurance that provides minimum essential coverage declines by 9 million to 241 million. This is largely the result of an estimated 5 million people enrolling in short-term plans, with others dropping insurance coverage entirely.

In the ACA-compliant nongroup market, enrollment stays constant when 12-month short-term plans are available, relative to current law, and falls by 3.4 million people when the mandate is repealed. It falls by a further 1.3 million when we remove behavioral barriers to enrollment in short-term plans. Enrollment in short-term plans is relatively low (200,000 to 300,000) in all scenarios except when behavioral barriers are removed, in which case enrollment jumps to 5.2 million. These results suggest that by themselves the repeal of the individual mandate and the increase in duration of short-term plans may have relatively small effects on short-term plan enrollment. But if these two changes together are accompanied by reductions in behavior barriers to enrollment (e.g., increased marketing of plans to increase awareness, streamlining the application process, lack of concern over facing the mandate penalty), there could be a substantial effect.

Age and Poverty Level of Nongroup Enrollees

Under current law — short-term plans available for up to three months and the individual mandate penalty still in effect — the share of short-term plan enrollees age 34 or younger is 23 percent. This remains constant when the term is increased to 12 months. The shares increase to 26 percent and 27 percent under the three-month and 12-month plans, respectively, when the mandate is repealed. The share increases to 29 percent when behavioral barriers are removed (Exhibit 2). Conversely,

Exhibit 2. Enrollment in Short-Term and ACA-Compliant Nongroup Plans, Enrollees Age 34 or Younger, Incomes at or Less Than 400% FPL



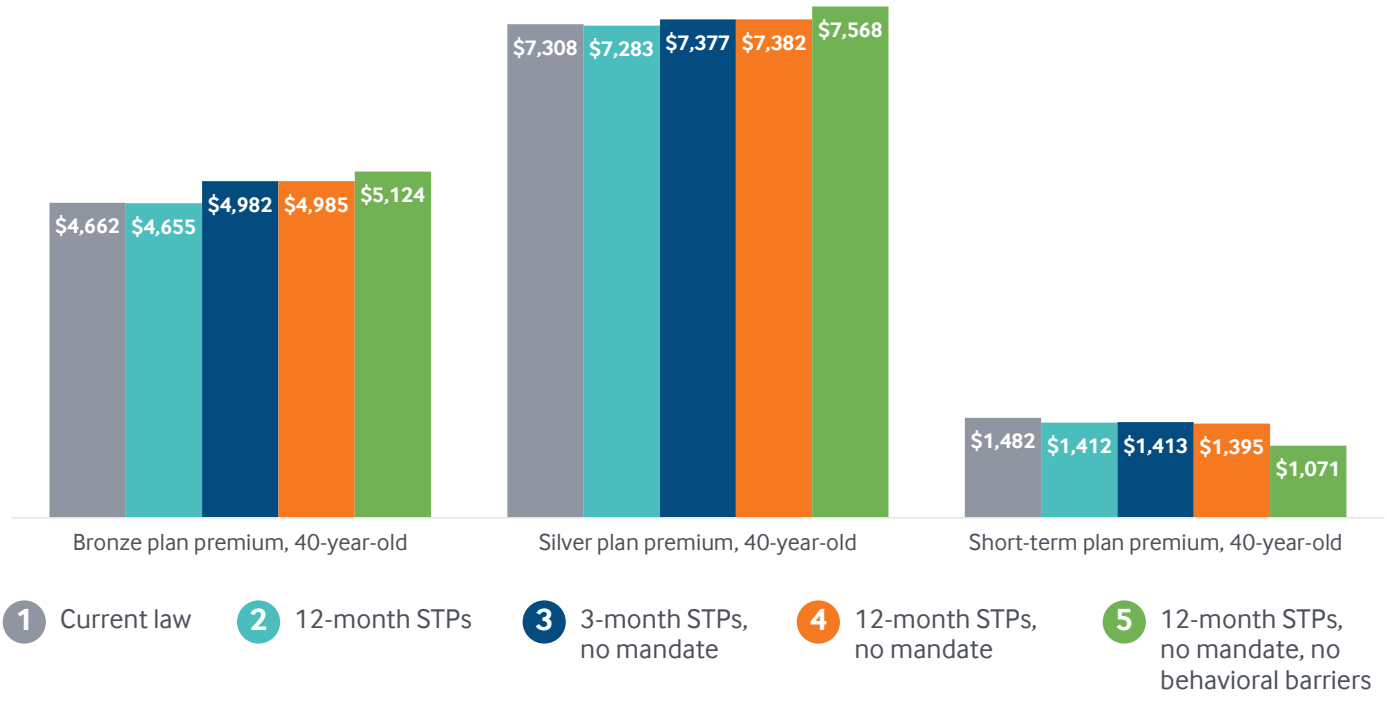
Data: Analysis based on the RAND COMPARE microsimulation model.
Notes: Absolute numbers of short-term plan and ACA-compliant nongroup plan enrollees are presented in Exhibit 1. FPL = federal poverty level. STP = short-term plan.

eliminating the mandate reduces the proportion of people age 34 or younger in ACA-compliant nongroup plans. These findings are consistent with concerns that repealing the individual mandate would cause young, healthy individuals to leave marketplace plans, leading to increases in premiums. The proportions of short-term plan enrollees with incomes under 400 percent of the federal poverty level (just over $48,000 for an individual) is 49 percent under current law and 52 percent when plan duration is increased to 12 months. The proportion of enrollees with incomes under 400 percent of poverty in the ACA-compliant market is 78 percent under current law and 88 percent when the mandate penalty is lifted. This effect is largely because of high-income individuals leaving the ACA-compliant market when the mandate is lifted and either becoming uninsured or moving to short-term plans.

Premiums

Premiums for ACA-compliant plans are relatively constant across the first two scenarios, when the individual mandate is in effect. However, the age-specific premium for an ACA-compliant 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 (Exhibit 3). We find higher increases in premiums in bronze plans — 6.9 percent when the mandate is lifted (from $4,662 to $4,982), 9.9 percent (from $4,662 to $5,124) when behavioral barriers are removed. The difference is driven by the loading of CSR subsidies onto silver-tiered plans. (For additional discussion of this, see the Appendix.) These estimates are somewhat lower than the CBO's estimate that age-specific premiums will increase by roughly 10 percent if the individual mandate is lifted. CBO has said, however, that these estimates are preliminary and revised estimates "would likely be smaller."[12] The Urban Institute predicts much higher increases in premiums (approximately 18%) following repeal of the individual mandate and expansion of short-term plans.[13] These estimates reflect average changes in premiums, as opposed to age- and metal-tier-specific premiums. These results may also reflect Urban Institute's taking into account

Exhibit 3. Estimated Changes in Premiums



Data: Analysis based on the RAND COMPARE microsimulation model.
Notes: Absolute numbers of short-term plan and ACA-compliant nongroup plan enrollees are presented in Exhibit 1. STP = short-term plan.

other concurrent policy changes, such as the shortened open enrollment periods on the ACA-compliant market and reduced federal funding for outreach and assistance. In contrast, our analyses isolate the effects of the short-term plan expansion and the individual mandate repeal. Further, our analyses take into account the Trump administration's intent to halt CSR subsidy payments to insurers. We assume that insurers load such costs onto their silver-tier plans in all scenarios; the Urban Institute's analysis does not assume CSR payments are halted in their baseline scenario.

Premiums for short-term plans fall, relative to current law, in the 12-month short-term plan scenario without the mandate, particularly when we assume changes in insurer behavior and consumer attitudes. This is consistent with the hypothesis that younger, healthier individuals would leave the ACA-compliant market and enroll in short-term plans if the mandate were lifted, reducing premiums for short-term policies while causing premiums to rise in ACA-compliant plans.

CONCLUSION

Our analysis suggests that in isolation, the changes to short-term plan duration put forth in the recent proposed federal rule would have minimal effects on enrollment in short-term plans, enrollment in ACA-compliant insurance policies, and premiums on the ACA-compliant market. Enrollment in short-term plans has been very low historically, and without an assumption of changes in insurer behavior and consumer attitudes, simply extending their duration will not affect enrollment substantially.

In contrast, eliminating the individual mandate, alone or in combination with expanding short-term plan duration, has a considerable impact on enrollment and other outcomes. Repealing the individual mandate increases the number of individuals without minimum essential coverage relative to current law, mainly because those people will leave their individual market coverage and employer-sponsored insurance plans. Premiums for ACA-compliant silver marketplace plans increase, largely because of younger and healthier individuals dropping coverage.

Without making additional assumptions, combining the extension of short-term plans with the individual mandate repeal has little additional effect beyond individual mandate repeal alone. However, the combination of expanded short-term plan duration and the mandate repeal may lead to changes in insurer behavior and consumer attitudes, ultimately reducing behavioral barriers to short-term plan enrollment. When we assume such barriers are eliminated along with the mandate repeal, we estimate substantially higher enrollment in short-term plans: slightly more than 5 million enrollees compared with roughly 200,000 if behavioral barriers continue. This scenario causes a decrease in the total enrollment in insurance plans that provide minimum essential coverage of 3 million (relative to the scenario of mandate repeal but including behavioral barriers), resulting in 9 million fewer people with minimum essential coverage. Those insured via short-term plans may face high out-of-pocket costs and coverage limitations, which may make their care unaffordable in the event of illness or injury. Simultaneously, we estimate that premiums for ACA-compliant silver plans would increase by 0.9 percent to 3.6 percent relative to the "current law" scenario.

We think there are credible reasons to believe that combining short-term plan expansion and individual mandate repeal could reduce behavioral barriers to enrolling in short-term plans. The fact that short-term plan holders were subject to the individual mandate could have made these policies a nonstarter for some consumers, regardless of their cost. Similarly, the limited duration of short-term plans could have caused some consumers to rule out these policies without seriously considering the costs and benefits. However, with the elimination of the ACA's individual mandate and resulting premium increases, people may be looking for low-cost insurance options. Insurers, in turn, may increase marketing of short-term plans and take other steps to reduce hassle or choice overload associated with enrolling in these policies. Particularly important is the fact that those who enroll in 12-month short-term plans will be able to switch to the ACA-compliant market during open enrollment if they experience a change in health status, without facing any penalties and without fear of a gap in coverage. This could encourage young, healthy individuals to enroll in short-term plans.

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5. NAIC, *2016 Accident and Health,* 2017.

6. CBO, *Repealing the Individual,* 2017

7. CBO, *Repealing the Individual,* 2017.

8. Jared Maeda and Susan Yeh Beyer, "How Does CBO Define and Estimate Health Insurance Coverage for People Under Age 65?" *Congressional Budget Office Blog,* Dec. 20, 2016, https://www.cbo.gov/publication/52352. While CBO lists several plan types that fail to meet these criteria, short-term plans are not included. In our analyses, we present the number of individuals with insurance that provides minimum essential coverage, a category that does not include short-term plans, and separately report the number of individuals enrolled in short-term plans.

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10. CBO, *Repealing the Individual,* 2017.

11. Blumberg, Buettgens, and Wang, *Potential Impact of Short-Term,* 2018.

12. CBO, *Repealing the Individual,* 2017.

13. Blumberg, Buettgens, and Wang, *Potential Impact of Short-Term,* 2018.

APPENDIX. STUDY METHODS

We estimated the effects of the expansion of short-term plan duration using RAND's COMPARE model, which uses economic theory and data to estimate the impacts of different health care reforms.[a] We used our national model, which uses data from the April 2010 wave of the 2008 Survey of Income and Program Participation, to create our population of individuals and families, and data from the 2009 Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits Survey to create our population of firms. Health care expenditures in COMPARE are derived from the 2010–2011 Medical Expenditures Panel Survey, the Centers for Medicare and Medicaid Services National Health Expenditure Accounts, and the Society of Actuaries. While our data sources predate the implementation of the ACA, we updated them to reflect population growth (using factors reported by the U.S. Census Bureau) and to reflect health care cost growth (using the CMS National Health Expenditure Accounts).

In October 2017, the Trump administration announced its intention to halt cost-sharing reduction (CSR) subsidy payments to insurers; such payments serve to reduce out-of-pocket expenses to low-income individuals. However, even without federal funding for CSRs, insurers are required to provide reduced cost-sharing for low-income individuals in silver-tier plans. In anticipation of this executive action, many insurers built the costs of the CSR payments into premiums for their silver plans. The second-lowest-cost silver plan is used to calculate tax credits provided to low-income individuals to purchase health insurance, so by increasing silver-plan premiums, insurers can effectively recoup CSR payments. Given that insurers in most states did load CSR payments onto silver-plan premiums,[b] we take this into account in COMPARE by eliminating CSR payments by the federal government and loading the costs of CSRs onto the premiums of silver nongroup market plans. In general, this change increases premiums for silver plans and increases advanced premium tax credit payments by the federal government (while reducing federal CSR payments to 0).

To incorporate short-term plans into COMPARE, we considered several features:

- **Benefit design.** Short-term plans generally do not cover preexisting conditions and are not required to adhere to ACA regulations on the actuarial value of insurance plans. Therefore, we modeled short-term plans to have an actuarial value of 50 percent, or 10 percent lower than the actuarial value of bronze-tier plans. This is consistent with estimates of the actuarial value of individual plans sold prior to the ACA.[c] In addition, we account for the possibility that since short-term plans are typically not guaranteed issue, some individuals may be denied coverage.

- **Increased risk.** We account for the fact that limited duration (e.g., three-month) short-term plans expose individuals to the possibility of being denied coverage later in the year. For example, if an individual is issued a three-month plan at the start of the year, he or she faces the risk of uninsurance because of denial at the beginning of each subsequent quarter of the year. We model this risk of uninsurance based on the age- and gender-based risk of transitioning to a poor health state each quarter.[d] Since COMPARE is an annual model, and the probabilities of health status transitions were annual, this was done by annualizing the risk of being denied coverage each quarter. We assume that unless an individual is denied coverage in any quarter, they continue enrolling in three-month plans for the full year. We note that while there is anecdotal evidence that insurers may attempt to circumvent the three-month limitation on short-term plan duration,[e] there are no estimates of the extent to which this is happening. Therefore, we assume in the model that the three-month limitation on plan duration does in fact expose enrollees to the risk of uninsurance at every subsequent quarter in which they may seek insurance coverage via an additional three-month short-term plan.

- **State variation in regulations.** Despite the proposed federal rule, some states have stricter regulations on short-term plans. Details of state regulations on short-term plans have been published elsewhere.[f] In particular, short-term plans are not available in some states, and are restricted in others. In states with restrictions on short-term plans, the most common restriction is a six-month duration restriction with renewals not permitted. We model these state policies either by making short-term plans unavailable in states where they are not sold or by accounting for the fact that enrollees in six-month plans face risk of denial midway through the year.

- **Behavioral barriers.** Finally, we considered that despite the consistent availability of short-term plans both prior to and following the enactment of the ACA, enrollment has historically been very low. We assumed that this low enrollment is at least partially because of features not directly related to plan characteristics: lack of knowledge of the existence of such plans, the time and hassle costs of applying for such plans, the uncertainty associated with

whether one will receive coverage, choice overload given the abundance of plan options, confusion regarding plan costs and benefits, and other factors.[g] Since we cannot distinguish between factors or account for them in COMPARE based on plan features alone, we predicted enrollment that is an order of magnitude larger than actual enrollment for the years for which data are most recently available.[h] Therefore, we introduced a "behavioral barriers" parameter to more accurately predict enrollment in short-term plans. This is done by taking a random sample of those who would otherwise choose a short-term plan and removing short-term plan coverage as an insurance option; these individuals would then choose the insurance option with the next-highest utility that is available to them.

To simulate the effects of repealing the individual mandate, we eliminated the financial penalty for those who remain uninsured in the model. RAND had previously conducted such an analysis.[i] Our current estimates of the increases in premiums on the nongroup market of 5 percent are somewhat lower than the 2015 results (8% increase) for several reasons:

- To account for noncompliance and nonenforcement of the individual mandate penalty, we downweighted the effect of the penalty by 20 percent.[j]
- Because of the publicity of the ACA and enrollment outreach efforts, we added a "welcome-mat" effect to the model, which increased Medicaid enrollment among previously eligible individuals after Medicaid expansion in 2014.
- We also accounted for states that have expanded Medicaid since 2015 (Louisiana, North Carolina, and Alaska), which has implications for marketplace enrollment and premiums, since those with incomes between 100 percent and 138 percent of the federal poverty level became eligible for Medicaid in those states.

Additionally, we made three recent upgrades to COMPARE to better match actual experience. First, we incorporated an adjustment factor to ensure that the model more accurately matches the distribution of tax-credit-eligible and -ineligible enrollees in the ACA-compliant market. The factor reduces uptake of tax-credit-eligible plans, reflecting the possibility that some individuals may be unaware of their eligibility, or prefer nonmarketplace coverage. Second, we made adjustments to the income distribution of individuals over 400 percent of poverty who pay the individual mandate tax penalty to better match data reported by the IRS.[k] Finally, we allowed for geographic variation in premium levels. These adjustments are explained in more detail in the Technical Appendix.

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a. Amado Cordova et al., "The COMPARE Microsimulation Model and the U.S. Affordable Care Act," *International Journal of Microsimulation* 6, no. 3 (Winter 2013): 78–117, http://www.microsimulation.org/IJM/V6_3/5_IJM_6_3_2013_Cordova.pdf.

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e. Julie Appleby, "Desperate for Coverage: Are Short-Term Plans Better Than None at All?" *Kaiser Health News,* Dec. 1, 2017, https://khn.org/news/desperate-for-coverage-are-short-term-plans-better-than-none-at-all/.

f. Kevin Lucia et al., *State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market* (Commonwealth Fund, Mar. 2018), http://www.commonwealthfund.org/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-aca.

g. Katherine Baicker, William J. Congdon, and Sendhil Mullainathan, "Health Insurance Coverage and Take-Up: Lessons from Behavioral Economics," *Milbank Quarterly* 90, no. 1 (March 2012): 107–34, https://www.milbank.org/quarterly/articles/health-insurance-coverage-and-take-up-lessons-from-behavioral-economics/.

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k. Internal Revenue Service, "SOI Tax Stats — Individual Statistical Tables by Size of Adjusted Gross Income, 2015" (IRS, last updated Apr. 4, 2018), https://www.irs.gov/statistics/soi-tax-stats-individual-statistical-tables-by-size-of-adjusted-gross-income.

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Sarah A. Nowak, Ph.D., is a physical scientist at the RAND Corporation, specializing in mathematical modeling. Much of Dr. Nowak's recent work has focused on using the RAND COMPARE microsimulation model to evaluate health insurance reforms including assessing the impact of the Affordable Care Act on individual and family spending, and how alternatives to current Affordable Care Act provisions would impact health insurance coverage and enrollment, government spending, and families' health care spending. Dr. Nowak holds a Ph.D. in biomathematics from the University of California, Los Angeles, and a bachelor's degree in physics from the Massachusetts Institute of Technology.

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