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LEGAL ADVICE FOR HEALTH PLANS

HEALTH LAW ALERT
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Short-Term, Limited Duration Insurance Expanded
Duration of Coverage Changed from 3 to 36 Months

Today, the Departments of Health and Human Services, Labor, and the Treasury (the Agencies) formally[1] published final rules revising the definition of "short-term, limited duration insurance" to extend the permitted length of coverage from three months to a total of 36 months (including renewals and extensions). The Agencies argued that the changes were made "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." Moreover, the Agencies emphasized that federal rules should not be seen as an impediment to "consumers . . . stringing together coverage under separate [short-term, limited duration insurance] policies offered by the same or different [health insurance] issuers, for total coverage periods that would exceed 36 months."

The final rule goes into effect on October 2, 2018. It is published at 83 *Federal Register* 38212 (click here). Click here for my compilation of Selected Federal Health Insurance Provisions incorporating the amendments into previously-published rules (*see* Volume I of "Federal Insurance Rules" under "Compiled Rules") (or see the "Resources" page at tbixbylaw.com). the revised definition of "short-term, limited duration insurance is on pages 10-11 of Volume I.

Short-term, limited duration insurance coverage is not subject to requirements imposed on individual insurance coverage by the Affordable Care Act and HIPAA, such as limitations on preexisting conditions, lifetime and annual limits, coverage of children through age 26, and the right to an external review of claim denials. Nor are such policies required to cover benefits that must be provided in individual policies, such as preventive care services with no out-of-pocket costs, mental health and substance use disorder benefits, and other essential health benefits (emergency services, hospitalization, maternity care, prescription drugs, etc.). Under federal law, short-term, limited duration insurance is not required to be guaranteed renewable and denial of coverage for pre-existing conditions

[1] The Department informally published the Rules and released them to the public on August 1 when they were filed with the Office of the Federal Register.

would be permitted. State law will still apply to such policies, however, and States may impose various restrictions on short-term, limited duration insurance.

In order to qualify as short-term, limited duration insurance, policies and any application material must "prominently" display a notice that explains that such coverage is not subject to the types of requirements described above. Specifically, the notice[2] must state:

> "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."

As part of implementing insurance market reforms arising out of HIPAA in 1997, the Agencies defined "short-term, limited duration insurance" to mean a health insurance policy "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." After the Affordable Care Act went into effect, the maximum term for the policy (including any "extension") was shortened to 3 months to address concerns about adverse selection.

In the Rule published today, the Agencies changed the maximum term for such insurance to "less than 12 months after the original effective date of the contract," similar to the original 1997 version of the Rule. But, the Agencies now permit "renewals or extensions" to go beyond the initial 12 months, so that a policy could have "a duration of no longer than 36 months in total." To arrive at this conclusion, the Agencies explained that the "less than 12 months" limitation addressed the "short-term" aspect of the coverage and the permitted renewals of up to 36 months addressed the "limited duration" aspect of the coverage. Thus, the phrase is "short-term [*i.e.*, term of less than 12-months], limited duration [*i.e.*, total duration after permitted renewals not to exceed 36 months] insurance."

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[2] For policies with an effective date prior to January 1, 2019, the notice must also explain that the coverage is not "minimum essential coverage" and the policyholder may therefore be required to pay a tax penalty for any month in 2018 during which the short-term, limited duration coverage is in effect.

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