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Final Regulations Regarding Short-Term Limited-Duration Insurance, Excepted Benefits, and Lifetime/Annual Limits

On October 31, 2016, the U.S. Department of the Treasury, Department of Labor (DOL), and Department of Health and Human Services (HHS) (collectively the Departments) issued final regulations regarding the definition of short-term, limited-duration insurance, standards for travel insurance and supplemental health insurance coverage to be considered excepted benefits, and an amendment relating to the prohibition on lifetime and annual dollar limits.

Effective Date and Applicability Date

These final regulations are effective on December 30, 2016. These final regulations apply beginning on the first day of the first plan or policy year beginning on or after January 1, 2017.

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 exempt from Public Health Service Act (PHS Act) requirements because it is not individual health insurance coverage. 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.

On June 10, 2016, the Departments proposed regulations to address the issue of short-term, limited-duration insurance being sold as a type of primary coverage.

The Departments have finalized the proposed regulations without change. The final regulations define 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 permitted coverage period takes into account extensions made by the policyholder "with or without the issuer's consent." 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.

The revised definition of short-term, limited-duration insurance applies for policy years beginning on or after January 1, 2017.

Because 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, 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. States may also elect not to take enforcement actions against issuers with respect to such coverage sold before April 1, 2017.

Excepted Benefits

Earlier this year, the Departments proposed regulations regarding excepted benefits, specifically similar supplemental coverage and travel insurance.

The Departments have finalized the regulations on similar supplemental coverage without substantive change. The final regulations indicate that 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 essential health benefit (EHB), as defined under the Patient Protection and Affordable Care Act (ACA), in the state in which the coverage is issued.

Practically speaking, 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 regulations. Further, 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 regulations, provided all other criteria are met.

The Departments have also finalized regulations on travel insurance without change. The regulations identify travel insurance as an excepted benefit and define travel insurance consistently with the Treasury's and the IRS' definition of travel insurance.

The regulations define 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.

Definition of EHB for Purposes of the Prohibition on Lifetime and Annual Limits

Section 2711 of the PHS Act, as added by the ACA, generally prohibits group health plans and health insurance issuers offering group or individual health insurance coverage from imposing lifetime and annual dollar limits on EHBs, as defined under Section 1302(b) of the ACA. 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 ACA, self-insured group health plans, large group market health plans, and grandfathered health plans are not required to offer EHBs, but they generally cannot place lifetime or annual dollar limits on services they cover that are considered EHBs.

On November 18, 2015, the Departments issued final regulations implementing section 2711 of the PHS Act.

The Departments have finalized the clarification to the lifetime and annual limit regulations without change. The regulation defines EHBs for plans that are not required to cover EHBs as:

- Any EHBs covered by an EHB-benchmark plan in any state, including state-mandated benefits that qualify as EHBs, or
- Benefits under one of the three largest Federal Employees Health Benefit Program plans, including any benefits added to meet EHB regulatory requirements.

These final regulations are applicable for plan years (or, in the individual market, policy years) beginning on or after January 1, 2017.

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Our access to ACA Advisor resources can help you clear up ACA questions and better craft your company's benefit strategy for the future.