February 22, 2018

Federal Regulators Propose Regulations to Promote Short-Term Health Plans

Highlights

The Departments of the Treasury, Labor, and Health and Human Services (the "Departments") have proposed regulations to promote the sale of short-term, limited-duration insurance.[1]

Short-term policies were originally marketed in the states as a stopgap solution for individuals who were between policies, and as a result were regulated by the states and not subject to much federal regulation. Because the policies are not bound to conform to the ACA's individual market reforms, they have increasingly become attractive substitutes to consumers who can pass medical underwriting and are willing to accept lesser coverage in exchange for avoiding the higher-cost, ACA-compliant individual market.

The Obama administration attempted to reverse this trend in 2016 by limiting the term of short-term policies to three months, from the former twelve. But now the current Administration is proposing to reverse that decision, allowing states to determine whether these policies should be promoted as a cheaper alternative to Marketplace policies for healthy individuals, or whether they should be banned or limited in some way to avoid rate increases for those dependent on Marketplace coverage.

The Departments estimate that under the proposal between 100,000 and 200,000 individuals would abandon ACA-compliant individual market policies, and instead switch to short-term coverage, most of them young and healthy, and only 10% of them eligible for premium subsidies. Their loss to the risk pool would raise 2019 premiums by $2 to $4 per-member per-month, and cost the federal government between $96 to $168 million annually in increased premium subsidies.

This proposal is the second major action taken by the federal government to implement President Trump's October 2017 Executive Order to "reform the United States healthcare system" and "expand choices and alternatives to Obamacare plans." In that Order, the President instructed the Department to consider ways to allow more participants to form and join Association Health Plans (AHPs), purchase short-term insurance and make better use of health reimbursement arrangements. The Department of Labor issued a proposal on AHPs this past January.

However, unlike the proposed AHP regulation, which raised the issue of federal preemption of state regulation, the short-term proposal leaves the states with full regulatory authority over

[1] 83 Fed. Reg. 7437 (Feb. 21, 2018), *available at* https://www.gpo.gov/fdsys/pkg/FR-2018-02-21/pdf/2018-03208.pdf

short-term policies. Some states effectively prohibit these policies today by prohibiting medical underwriting, which takes away their main competitive advantage. Other states limit their duration to six months, and more states are likely to consider fair marketing rules, minimum medical loss ratios, and other means of reducing the impact of these policies in increasing rates for the larger Marketplace population. Still, other states will promote short-term policies as a way to roll back the ACA. The end result will be substantial variations among states if the federal proposal is made final.

Comments on the proposed rule are due by April 23, 2018.

Background: Short-term Insurance

Short-term insurance is a form of coverage traditionally designed and sold to fill short gaps that might occur when individuals transition from one plan to another. Because Congress presumed that short-term coverage would only fill this limited niche, and by its nature would not be renewed, it exempted short-term coverage from the federal definition of "individual health insurance coverage" it adopted in 1996 when it required other individual market policies to be sold as guaranteed renewable.

Consequentially, when the ACA imposed new protections and safeguards on individual market policies, short-term coverage escaped the new requirements. For example, the ACA required that individual market health insurance be sold on a guaranteed-issue basis, cover preexisting conditions, and that the policies offer minimum benefits and actuarial value. Short-term policies, which are not considered individual market insurance, are not subject to these rules, can be medically underwritten, and have no federal standards for the benefits they cover.

There is no statutory definition of short-term insurance. Regulations adopted in 2004 defined short-term insurance as a 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 less than 12 months after the original effective date of the contract."

As the ACA's individual market reforms took hold, and individual market policy prices began to rise, some consumers saw short-term insurance as an attractive substitute for an ACA-compliant individual policy and used it as a type of permanent primary coverage, with issuers extending renewals every 12 months. This trend raised concern at the Departments. Such sales raised the potential for individuals to unwittingly buy less-regulated policies with significant benefit limitations. Because short-term policies can be medically underwritten, they attract healthier individuals who could receive better premium rates than would be available in the ACA-regulated individual market. As a consequence, growth in the short-term coverage undermines the remaining individual market, increasing premium rates.

To address the issue of short-term insurance sold as a type of primary coverage, the Departments adopted a more restrictive definition of the policies, requiring that coverage must be less than three months in duration, including any period for which the policy may be

renewed. The Departments also required a disclaimer be placed on short-term insurance, advising that it did not constitute Minimum Essential Coverage or satisfy the ACA's individual mandate. The regulation took effect for policy years beginning on or after January 1, 2017, with a transitional allowance for some policies sold before April 2017 that terminate by December 2017.

New Proposals for Short-term Insurance

Redefining Short-Term Limited Duration Insurance. The Departments are proposing to revert to a definition consistent with the 2004 definition of short-term insurance, allowing policies that offer a maximum coverage period of less than 12 months, taking into account extensions that may be elected by the policyholder without the issuer's consent.

New Disclaimers. The Departments also propose a new disclaimer to be provided with any short-term policy. The disclaimer would state:

> 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.

Additional language, used only in 2018, would advise that the coverage does not satisfy the ACA's individual mandate. Issuers could drop that clause in 2019, when the individual mandate is no longer in effect.

Extensions With the Issuer's Consent. Under the proposed rule, coverage would be considered short-term if its total term, including any renewals possible without the issuer's consent, is less than twelve months. But the issuer would be permitted to consent to renewals beyond twelve months, and could re-underwrite the policy at each renewal.

The Department seeks comment on whether it should impose conditions on with-consent renewals, or define a process for an "expedited or streamlined" reapplication process for short-term insurance, under which the policies could presumably roll over from year to year. However, it will be difficult to provide "expedited" renewal if medical underwriting is allowed, which typically includes a questionnaire and medical follow up to verify information.

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