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Publications

Tri-Agencies Issue Proposed Rule on Short-Term, Limited-Duration Insurance, Excepted Benefits, and Level-Funded Plans

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On July 7, the Departments of Labor, Treasury, and Health and Human Services (the "Tri-Agencies") published a long-anticipated proposed rule ("Proposed Rule") that:

- reinterprets short-term, limited-duration insurance ("STLDI");
- changes the requirements for fixed indemnity and hospital indemnity excepted benefits;
- solicits comments on requirements for specified disease or illness excepted benefits;
- solicits information about the use of level-funded premium plans in the small group market; and
- clarifies the tax treatment under Code section 105 of fixed amounts received through employment-based accident or health insurance that are paid regardless of the amount of medical expenses incurred (see our separate alert here regarding this part of the Proposed Rule).

A White House published fact sheet on the Proposed Rule is available here. Overall, the Proposed Rule seems focused on the effects of various coverage options on the stability of the risk pools (and premiums) in the individual and small group markets and consumer protection against deceptive or misleading marketing, which is consistent with the Biden Administration's January 28, 2021 Executive Order directing federal agencies to protect and strengthen the Affordable Care Act.

STLDI

As expected, the Proposed Rule would reinterpret the phrase "short-term" to mean no more than 3 months—consistent with how that phrase was interpreted prior to the Trump Administration's 2018 STLDI rulemaking. STLDI coverage would be required to have an expiration date specified in the policy/certificate/contract that is no more than 3 months after the original effective date. The Tri-Agencies requested comments on this interpretation, including whether the duration should be some other period of time.

The Proposed Rule also would reinterpret "limited-duration" to mean that the maximum duration for STLDI, including renewals and extensions, is no longer than 4 months in total within 12 months of the original effective date. For example, an STLDI policy could be issued for an initial term of 3 months and then renewed for 1 month within 12 months of the original effective date. That is a significant change from the 3 years

under the Trump Administration rule. For purposes of the maximum duration for STLDI, renewals or extensions includes a new STLDI policy issued by the same issuer to the same policyholder within 12 months of the original effective date. The Tri-Agencies requested comments on whether to extend the limitation on stacking to include issuers that are members of the same controlled group and whether there should be circumstances where issuers may extend the policies beyond 4 months in total in a 12-month period.

The new interpretations of "short-term" and "limited-duration" would apply to policies sold on or after the effective date of the final rule. Existing policies in effect or issued before the effective date—including subsequent renewals or extensions—could have up to a 12-month contract term and renewals for up to 3 years (subject to any state law limitations). The Tri-Agencies request comment on whether to end all existing STLDI policies on the effective date of the final rule, some other date, or to provide a longer transition period.

The Proposed Rule cites concerns about aggressive and deceptive sales and marketing of STLDI, but stops short of express proposals. Instead, the Tri-Agencies solicit comments on "ways to help consumers distinguish between STLDI and comprehensive coverage," including ways to prevent or mitigate direct competition between STLDI and comprehensive coverage—such as prohibitions on STLDI sales during open enrollment, which some states have enacted. The Tri-Agencies also request comment on how to support state efforts to protect consumers from misleading/deceptive marketing and sales of STLDI.

The Proposed Rule also would make some formatting and content changes to the consumer notice required for STLDI, including information about where and how consumers could enroll in comprehensive coverage. The notice must be "prominently displayed" (reasonably noticeable to a typical consumer within the context of the page on which it is displayed, *e.g.* in a font that contrasts with the background color) in at least 14-pt font and included on the first page of any marketing materials used in enrollment or reenrollment for STLDI.

The Tri-Agencies seek comment on whether to include additional information in the notice, such as the maximum length of enrollment/renewal of STLDI. The Tri-Agencies also request comment on (1) whether to include language that the notice is required by federal law and (2) any suggested revisions to content or formatting for the notice to make it more consumer-friendly.

The Tri-Agencies also request comments on how to support state oversight of STLDI sold through associations.

GROOM INSIGHT: The Proposed Rule represents the third time in the last decade that the fundamental structures of STLDI coverage has been modified.[1] While the proposed changes are consistent with the first modification to STLDI under the Obama Administration, the interplay of the new definitions of "short-term" and "limited duration" are likely to create material disruptions for issuers and enrollees who are currently covered by STLDI under the Trump Administration rules.

Excepted Benefits

The Proposed Rule would implement several changes intended to further differentiate fixed indemnity and hospital indemnity excepted benefits ("Fixed Indemnity") from comprehensive coverage to reduce consumers' confusion regarding their health coverage options and so they can make more informed decisions in purchasing health coverage. The Proposed Rule also seeks to align Fixed Indemnity coverage across individual and group markets "when practical and appropriate" and clarify what conditions apply to such coverage.

First, the Proposed Rule would reinstate a condition that Fixed Indemnity coverage in the individual market only provide benefits on a per-period basis and not allow benefits on a per-service basis. This would align the individual market rules with the group market rules. HHS seeks comment on how this change to Fixed Indemnity coverage in the individual market may affect consumers' ability to make informed choice on coverage options, how it would impact affordability, and how it would impact access to care and coverage.

Second, the Tri-Agencies propose to adopt new standards governing the payment of fixed benefits in the individual and group markets. Under the Proposed Rule, Fixed Indemnity insurance would be required to pay benefits without regard to services or items received, actual or estimated amount of expenses incurred, the severity of the illness or injury, or other characteristics particular to a course of treatment. The Tri-Agencies request comments on all aspects of the proposed standards, including how the fixed payment standards may interact with other proposed changes, such as the per-period-only requirement.

Third, the Tri-Agencies noted their awareness that some Fixed Indemnity coverage pays benefits directly to providers, rather than to the participant. Although the Proposed Rule does not include policy or regulatory changes specific to this, the Tri-Agencies do seek comment on whether additional guidance or rulemaking is needed in this area.

Fourth, the Proposed Rule would require that plans and issuers provide a notice to consumers for Fixed Indemnity in the group market, similar to the notice requirement in the individual market. HHS also proposes changes to the individual market notice to align it with the content and formatting requirements proposed for the group market notice. The Tri-Agencies seek comment on the content and level of detail for the proposed notice and any burdens associated with requiring plans and issuers to provide state-specific contact information.

The Tri-Agencies also solicit comments on whether any changes are needed for specified disease excepted benefits coverage in the group and individual markets, but do not propose changes to the current regulations on such coverage.

GROOM INSIGHT: The proposed modifications to the fixed indemnity and hospital indemnity provisions could require significant changes in benefit structures for fixed indemnity policies in the individual market, particularly if the policy pays a fixed amount per service (e.g., $50 for a blood test), which the Tri-Agencies call out as being impermissible. Coupled with the proposed tax modifications discussed in our other alert, these proposed changes would likely materially limit the marketability of fixed indemnity products in the individual market.

Some employers offer "skinny plans" that consist of preventive care plus a bundle of fixed indemnity coverage that pays when the individual receives medical care. The Proposed Rule calls into question whether employers would be able to continue to offer these plans because the Proposed Rule prohibits fixed indemnity policies to pay based on the individual's actual receipt of a medical service. This change could significantly change the structure of many policies and benefit packages of employers seeking to control their benefit costs.

Level-Funded Plan Arrangements

The Proposed Rule cites concerns raised by "interested parties" that level-funded plans are not required to comply with federal or state consumer protection and insurance regulations—particularly if the arrangement uses "stop-loss coverage that has low attachment points." For example, the Tri-Agencies raise whether stop-loss coverage would deny a claim because of an annual or lifetime dollar limit that would not be permissible in the group insurance market. Likewise, the Tri-Agencies note that self-funded small group plans would not be subject to "various essential health benefits and consumer protections such as those included in MHPAEA." But the Proposed Rule does not address that state insurance laws regulate the stop-loss attachment point, thereby largely obviating the concern about low attachment points.

The Tri-Agencies also recognized the interested parties' concerns whether level-funded plan sponsors' contributions are not properly segregated from other funds held by their service providers and whether the service providers "might inadvertently be establishing multiple employer welfare arrangements," thereby subjecting the plans to state insurance regulation and additional ERISA obligations. Although the Tri-Agencies acknowledged these concerns, it is not clear that they endorsed them. Rather, they provide a basis for further investigation.

Stopping short of proposing any particular regulations or actions regarding level-funded plans, the Tri-Agencies solicit a wide array of information on the use and prevalence of level-funded plans, particularly in the small group market, such as:

- How prevalent are level-funded plans by: private or public employer, state or other geographic area, and number of individuals are covered?
- What types of benefits typically are and are not offered by level-funded plans? How comprehensive are the benefits offered? How do the benefit packages differ from fully-insured plans?
- How is the stop-loss coverage attachment point determined, what factors are considered, and by whom?
- What consumer protections apply, particularly if a claim is reimbursed through stop-loss insurance?
- What are the effects of level-funded plans on the small group market?

GROOM INSIGHT: The Tri-Agencies request for comments on level-funded plans and their concern that stop-loss coverage with low attachment points could be viewed as health insurance coverage mirrors efforts in a small number of states to limit the sale of stop-loss coverage to small employers. If the Tri-Agencies adopt rules akin to the efforts in certain states, then the ability of small employers to self-fund their benefits could be materially limited, if not impossible.

The Proposed Rule is scheduled to be published on July 12. Comments are due by September 11, 2023.