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DEPARTMENT OF THE TREASURY

Internal Revenue Service

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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

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 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 [**INSERT DATE THAT IS 60 DAYS FROM THE DATE OF PUBLICATION IN THE FEDERAL REGISTER**].

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 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/ccio) 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 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

¹ Public Law 104-204, 110 Stat. 2944 (September 26, 1996).

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".)

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 Departments¹⁰) 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

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.

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

¹³ Division M of the Consolidated and Further Continuing Appropriations Act, 2015, Public Law 113-235.

¹⁴ 81 FR 38019, 38033 (June 10, 2016).

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

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>.

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 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 Code¹⁷, 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

¹⁷ See Code section 5000A.

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 coverage¹⁸ 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

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.

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 to take enforcement actions against issuers with respect to such coverage sold before April 1, 2017.

B. Excepted Benefits

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.

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

²³ 26 CFR 54.9831-1(c)(3)(v), 29 CFR 2590.732(c)(3)(v), 45 CFR 146.145(b)(3)(v).

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

²⁴ PHS Act section 2722(c)(1), ERISA section 732(c)(1), Code section 9831(c)(1).

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,

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).

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 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

²⁷ Frequently Asked Questions about Affordable Care Act Implementation (Part XXIII), available at [http://www.dol.gov/ebsa/pdf/faq-Affordable Care Act23.pdf](http://www.dol.gov/ebsa/pdf/faq-Affordable%20Care%20Act23.pdf) and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/Supplemental-FAQ_2-13-15-final.pdf.

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

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).

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

²⁹ 26 CFR 57.2(h)(4).

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 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

³⁰ 80 FR 72192.

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

³¹ 26 CFR 54.9815-2711(c), 29 CFR 2590.715-2711(c), 45 CFR 147.126(c).

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

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.

small group markets. However, these FEHBP plan options³⁴ 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

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>.

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 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

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.

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

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.

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 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 website 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.

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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).

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