

# INTERNAL REVENUE BULLETIN



## HIGHLIGHTS OF THIS ISSUE

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

### ADMINISTRATIVE, INCOME TAX

#### **Rev. Proc. 2024-21, page 1054.**

This Revenue Procedure provides issuers of qualified mortgage bonds and mortgage credit certificates with (1) the nationwide average purchase price for residences located in the United States, and (2) the average area purchase price safe harbors for residences located in statistical areas in each state, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, the Virgin Islands, and Guam.

### EMPLOYEE PLANS, EXCISE TAX

#### **Notice 2024-35, page 1051.**

This notice provides relief with respect to certain required minimum distributions (RMDs) that are not made in 2024. This relief was provided with respect to certain RMDs in 2021, 2022, and 2023, and is being extended in this notice to certain RMDs in 2024. Specifically, the notice provides that if certain requirements are met, a plan will not fail to be qualified for failing to make a specified RMD in 2024, and a taxpayer will not be assessed an excise tax for failing to take the RMD. This notice also announces that the final regulations intended to be published relating to RMDs are anticipated to apply for purposes of determining RMDs for calendar years beginning on or after January 1, 2025.

#### **T.D. 9990, page 966.**

These final rules amend the definition of short-term, limited-duration insurance for purposes of the exclusion from the

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definition of "individual health insurance coverage" in 26 CFR part 54, 29 CFR part 2590, and 45 CFR part 144. These final rules also amend the requirements for hospital indemnity and other fixed indemnity insurance to be treated as an excepted benefit in the group and individual health insurance markets.

### EXEMPT ORGANIZATIONS

#### **Announcement 2024-20, page 1069.**

Revocation of IRC 501(c)(3) Organizations for failure to meet the code section requirements. Contributions made to the organizations by individual donors are no longer deductible under IRC 170(b)(1)(A).

### INCOME TAX

#### **Rev. Proc. 2024-20, page 1053.**

Revenue Procedure 2024-20 provides domestic asset/liability percentages and domestic investment yields needed by foreign life insurance companies and foreign property and liability insurance companies to compute their minimum effectively connected net investment income under section 842(b) of the Internal Revenue Code for taxable years beginning after December 31, 2022.

#### **Rev. Rul. 2024-9, page 964.**

Federal rates; adjusted federal rates; adjusted federal long-term rate, and the long-term tax-exempt rate. For purposes of sections 382, 1274, 1288, 7872 and other sections of the Code, tables set forth the rates for May 2024.

# The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.

## Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned

against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

### **Part I.—1986 Code.**

This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

### **Part II.—Treaties and Tax Legislation.**

This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

### **Part III.—Administrative, Procedural, and Miscellaneous.**

To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

### **Part IV.—Items of General Interest.**

This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

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# Part I

## Section 1274.— Determination of Issue Price in the Case of Certain Debt Instruments Issued for Property

(Also Sections 42, 280G, 382, 467, 468, 482, 483, 1288, 7520, 7872.)

### Rev. Rul. 2024-09

This revenue ruling provides various prescribed rates for federal income

tax purposes for May 2024 (the current month). Table 1 contains the short-term, mid-term, and long-term applicable federal rates (AFR) for the current month for purposes of section 1274(d) of the Internal Revenue Code. Table 2 contains the short-term, mid-term, and long-term adjusted applicable federal rates (adjusted AFR) for the current month for purposes of section 1288(b). Table 3 sets forth the adjusted federal long-term rate and the long-term tax-exempt rate described in section 382(f). Table 4 contains the appropriate

percentages for determining the low-income housing credit described in section 42(b)(1) for buildings placed in service during the current month. However, under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, shall not be less than 9%. Finally, Table 5 contains the federal rate for determining the present value of an annuity, an interest for life or for a term of years, or a remainder or a reversionary interest for purposes of section 7520.

**REV. RUL. 2024-09 TABLE 1**  
Applicable Federal Rates (AFR) for May 2024  
*Period for Compounding*

	<i>Annual</i>	<i>Semiannual</i>	<i>Quarterly</i>	<i>Monthly</i>
		<i>Short-term</i>		
AFR	4.97%	4.91%	4.88%	4.86%
110% AFR	5.47%	5.40%	5.36%	5.34%
120% AFR	5.98%	5.89%	5.85%	5.82%
130% AFR	6.48%	6.38%	6.33%	6.30%
		<i>Mid-term</i>		
AFR	4.42%	4.37%	4.35%	4.33%
110% AFR	4.87%	4.81%	4.78%	4.76%
120% AFR	5.31%	5.24%	5.21%	5.18%
130% AFR	5.76%	5.68%	5.64%	5.61%
150% AFR	6.67%	6.56%	6.51%	6.47%
175% AFR	7.80%	7.65%	7.58%	7.53%
		<i>Long-term</i>		
AFR	4.55%	4.50%	4.47%	4.46%
110% AFR	5.01%	4.95%	4.92%	4.90%
120% AFR	5.47%	5.40%	5.36%	5.34%
130% AFR	5.94%	5.85%	5.81%	5.78%

**REV. RUL. 2024-09 TABLE 2**  
Adjusted AFR for May 2024  
*Period for Compounding*

	<i>Annual</i>	<i>Semiannual</i>	<i>Quarterly</i>	<i>Monthly</i>
Short-term adjusted AFR	3.76%	3.73%	3.71%	3.70%
Mid-term adjusted AFR	3.35%	3.32%	3.31%	3.30%
Long-term adjusted AFR	3.45%	3.42%	3.41%	3.40%

**REV. RUL. 2024-09 TABLE 3**

Rates Under Section 382 for May 2024

Adjusted federal long-term rate for the current month	3.45%
Long-term tax-exempt rate for ownership changes during the current month (the highest of the adjusted federal long-term rates for the current month and the prior two months.)	3.45%

**REV. RUL. 2024-09 TABLE 4**

Appropriate Percentages Under Section 42(b)(1) for May 2024

Note: Under section 42(b)(2), the applicable percentage for non-federally subsidized new buildings placed in service after July 30, 2008, shall not be less than 9%.

Appropriate percentage for the 70% present value low-income housing credit	8.04%
Appropriate percentage for the 30% present value low-income housing credit	3.45%

**REV. RUL. 2024-09 TABLE 5**

Rate Under Section 7520 for May 2024

Applicable federal rate for determining the present value of an annuity, an interest for life or a term of years, or a remainder or reversionary interest	5.40%
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## Section 42.—Low-Income Housing Credit

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2024. See Rev. Rul. 2024-09, page 964.

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## Section 280G.—Golden Parachute Payments

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2024. See Rev. Rul. 2024-09, page 964.

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## Section 382.—Limitation on Net Operating Loss Carryforwards and Certain Built-In Losses Following Ownership Change

The adjusted applicable federal long-term rate is set forth for the month of May 2024. See Rev. Rul. 2024-09, page 964.

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## Section 467.—Certain Payments for the Use of Property or Services

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2024. See Rev. Rul. 2024-09, page 964.

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## Section 468.—Special Rules for Mining and Solid Waste Reclamation and Closing Costs

The applicable federal short-term rates are set forth for the month of May 2024. See Rev. Rul. 2024-09, page 964.

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## Section 482.—Allocation of Income and Deductions Among Taxpayers

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2024. See Rev. Rul. 2024-09, page 964.

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## Section 483.—Interest on Certain Deferred Payments

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2024. See Rev. Rul. 2024-09, page 964.

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## Section 1288.—Treatment of Original Issue Discount on Tax-Exempt Obligations

The adjusted applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2024. See Rev. Rul. 2024-09, page 964.

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## Section 7520.—Valuation Tables

The applicable federal mid-term rates are set forth for the month of May 2024. See Rev. Rul. 2024-09, page 964.

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## Section 7872.—Treatment of Loans With Below-Market Interest Rates

The applicable federal short-term, mid-term, and long-term rates are set forth for the month of May 2024. See Rev. Rul. 2024-09, page 964.

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## T.D. 9990

### DEPARTMENT OF THE TREASURY Internal Revenue Service 26 CFR Part 54

### DEPARTMENT OF LABOR Employee Benefits Security Administration 29 CFR Part 2590

### DEPARTMENT OF HEALTH AND HUMAN SERVICES 45 CFR Parts 144, 146, and 148

### Short-Term, Limited- Duration Insurance and Independent, Noncoordinated Excepted Benefits Coverage

**AGENCY:** 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 sets forth final rules that amend the definition of short-term, limited-duration insurance, which is excluded from the definition of individual health insurance coverage under the Public Health Service Act. This document also sets forth final rules that amend the regulations regarding the requirements for hospital indemnity or

other fixed indemnity insurance to be considered an excepted benefit in the group and individual health insurance markets.

**DATES:** These regulations are effective on June 17, 2024.

**FOR FURTHER INFORMATION CONTACT:** Shannon Hysjulien or Rebecca Miller, Employee Benefits Security Administration, Department of Labor at (202) 693-8335; Jason Sandoval, Internal Revenue Service, Department of the Treasury at (202) 317-5500; Cam Clemmons, Centers for Medicare & Medicaid Services, Department of Health and Human Services at (206) 615-2338; Lisa Cuozzo, Centers for Medicare & Medicaid Services, Department of Health and Human Services at (667) 290-8537.

#### SUPPLEMENTARY INFORMATION:

##### I. Background

These final rules set forth revisions to the definition of “short-term, limited-duration insurance” (STLDI) for purposes of its exclusion from the definition of “individual health insurance coverage” in 26 CFR part 54, 29 CFR part 2590, and 45 CFR part 144. The definition of STLDI is also relevant for purposes of the disclosure and reporting requirements in section 2746 of the Public Health Service Act (the PHS Act), which require health insurance issuers offering individual health insurance coverage or STLDI to disclose to enrollees with individual health insurance or STLDI coverage, and to report annually to the Department of Health and Human Services (HHS), any direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage.

These final rules also set forth amendments to the regulations regarding the requirements for hospital indemnity and other fixed indemnity insurance to be treated as an excepted benefit in the group and individual health insurance markets

(fixed indemnity excepted benefits coverage).<sup>1</sup> As explained in greater detail later in this section of the preamble, the Department of the Treasury (Treasury Department), the Department of Labor, and HHS (collectively, the Departments) are not finalizing certain aspects of the proposed rules regarding fixed indemnity excepted benefits coverage and the Treasury Department and the Internal Revenue Service (IRS) are not finalizing the proposed amendments to Treasury Reg. § 1.105-2 at this time.

In proposed rules published on July 12, 2023, in the **Federal Register** titled “Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage;

Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance” (2023 proposed rules),<sup>2</sup> the Departments proposed revisions to define and more clearly distinguish STLDI and fixed indemnity excepted benefits coverage from comprehensive coverage. Comprehensive coverage is coverage that is subject to the Federal consumer protections and requirements established under chapter 100 of the Internal Revenue Code (Code), part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and title XXVII of the PHS Act (hereinafter referred to as the Federal consumer protections and requirements for comprehensive coverage),<sup>3</sup> such as the prohibition on exclusions for preexisting conditions, the prohibition on health status discrimination, and the requirement to cover certain preventive services without cost sharing. The Departments proposed these revisions to promote equitable access to high-quality, affordable, comprehensive coverage by increasing consumers’ understanding of their health coverage options and reducing misinformation about STLDI and fixed indemnity excepted benefits coverage, consistent with Executive Orders 14009 and 14070 as described in section I.B of this preamble. The Treasury Department and the IRS also proposed amendments to Treasury Reg. § 1.105-2 to clarify the tax treatment

<sup>1</sup> For simplicity and readability, this preamble refers to hospital indemnity or other fixed indemnity insurance that meets all requirements to be considered an excepted benefit under the Federal framework as “fixed indemnity excepted benefits coverage” to distinguish it from hospital indemnity or other fixed indemnity insurance that does not meet all such requirements.

<sup>2</sup> 88 FR 44596 (July 12, 2023).

<sup>3</sup> While STLDI is generally not subject to the Federal consumer protections and requirements for comprehensive coverage that apply to individual health insurance coverage, the agent and broker compensation disclosure and reporting requirements in section 2746 of the PHS Act apply to health insurance issuers offering individual health insurance coverage or STLDI.

of benefit payments in fixed amounts under hospital indemnity or other fixed indemnity coverage purchased on a pre-tax basis.

The Departments also solicited comments regarding coverage only for a specified disease or illness that qualifies as excepted benefits (specified disease excepted benefits coverage),<sup>4</sup> and regarding level-funded plan arrangements<sup>5</sup> to better understand the key features and characteristics of these arrangements and whether additional guidance or rulemaking is needed to clarify plan sponsors' and issuers' obligations with respect to coverage provided through these arrangements. While specified disease excepted benefits coverage and level-funded plan arrangements are not addressed in these final rules, the Departments appreciate the comments received on these topics and will take them into consideration as they determine whether additional guidance or rulemaking is warranted in the future.

#### *A. General Statutory Background*

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104-191, August 21, 1996) added chapter 100 to the Code, part 7 to ERISA, and title XXVII to the PHS Act, which set forth portability and nondiscrimination rules with respect to health coverage. These provisions of the Code, ERISA, and the PHS Act were later augmented by other laws, including the Mental Health Parity Act of 1996 (Pub. L. 104-204, September 26, 1996), the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. 110-343, October 3, 2008), the Newborns' and Mothers' Health Protection Act (Pub. L. 104-204, September 26, 1996), the Women's Health and Cancer Rights Act (Pub. L. 105-277, October 21, 1998), the Genetic Information Nondiscrimination Act of 2008 (Pub. L. 110-233, May 21, 2008), the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111-3, February 4, 2009), Michelle's Law (Pub. L. 110-381, October 9, 2008), the Patient Protection and

Affordable Care Act (Pub. L. 111-148, March 23, 2010) (as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, March 30, 2010) (collectively known as the Affordable Care Act (ACA)), and Division BB of the Consolidated Appropriations Act, 2021 (CAA, 2021) (Pub. L. 116-260, December 27, 2020), which includes the No Surprises Act.

The ACA reorganized, amended, and added 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. The ACA added section 9815 of the Code and section 715 of ERISA to incorporate the provisions of part A of title XXVII of the PHS Act, as amended or added by the ACA, into the Code and ERISA, making them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The provisions of the PHS Act incorporated into the Code and ERISA, as amended or added by the ACA, are sections 2701 through 2728.

In addition to market-wide provisions applicable to group health plans and health insurance issuers in the group and individual markets, the ACA established Health Benefit Exchanges (Exchanges) aimed at promoting access to high-quality, affordable, comprehensive coverage. Section 1401(a) of the ACA added section 36B to the Code, providing a premium tax credit (PTC) for certain individuals with annual household income that is at least 100 percent but not more than 400 percent of the Federal poverty level (FPL) who enroll in, or who have a member of their tax household enrolled in, an individual market qualified health plan (QHP) through an Exchange who are not otherwise eligible for minimum essential coverage (MEC).

Section 1402 of the ACA provides for, among other things, reductions in cost sharing for essential health benefits for qualified low- and moderate-income enrollees in silver-level QHPs purchased through the individual market Exchanges. Section 1402 also provides for reductions in cost sharing for American Indians

enrolled in QHPs purchased through the individual market Exchanges at any metal level.

Section 5000A of the Code, added by section 1501(b) of the ACA, provides that individuals must maintain MEC, or make a payment known as the individual shared responsibility payment with their Federal tax return for the year in which they did not maintain MEC, if they are not otherwise exempt.<sup>6</sup> On December 22, 2017, the Tax Cuts and Jobs Act (Pub. L. 115-97) was enacted, which included a provision under which the individual shared responsibility payment under section 5000A of the Code was reduced to \$0, effective for months beginning after December 31, 2018.

The American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2) was enacted on March 11, 2021. Among other policies intended to address the health care and economic needs of the country during the coronavirus disease 2019 (COVID-19) pandemic, the ARP increased the PTC amount for individuals with annual household income at or below 400 percent of the FPL and extended PTC eligibility for the first time to individuals with annual household incomes above 400 percent of the FPL. Although the expanded PTC subsidies under the ARP were applicable only for 2021 and 2022, the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169, August 16, 2022) extended the subsidies for an additional 3 years, through December 31, 2025.

The No Surprises Act was enacted on December 27, 2020, as title I of Division BB of the CAA, 2021. The No Surprises Act added new provisions in Subchapter B of chapter 100 of the Code, part 7 of ERISA, and part D of title XXVII of the PHS Act, applicable to group health plans and health insurance issuers offering group or individual health insurance coverage. These provisions provide protections against surprise medical bills for certain out-of-network services and generally require plans, issuers, providers, and facilities to make certain disclosures regarding balance billing protections to the public and to individual participants,

<sup>4</sup> 88 FR 44596 at 44632 (July 12, 2023).

<sup>5</sup> *Id.* at 44632-34.

beneficiaries, and enrollees. In addition to the new provisions applicable to group health plans and issuers of group or individual health insurance coverage, the No Surprises Act added a new part E to title XXVII of the PHS Act, establishing corresponding requirements applicable to health care providers, facilities, and providers of air ambulance services. The CAA, 2021 also amended title XXVII of the PHS Act to, among other things, add section 2746, which requires health insurance issuers offering individual health insurance coverage or STLDI to disclose the direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in individual health insurance coverage or STLDI to the enrollees in such coverage as well as to report such compensation annually to HHS.

The Secretaries of the Treasury, Labor, and HHS have authority to issue such regulations as may be necessary or appropriate to carry out the parallel provisions under the Code, ERISA, and the PHS Act, including the definitions in section 9832 of the Code, section 733 of ERISA, and section 2791 of the PHS Act.<sup>7,8</sup>

### *B. Recent Executive Orders*

On January 28, 2021, President Biden issued Executive Order 14009, “Strengthening Medicaid and the Affordable Care Act,” which directed the Departments to review policies to ensure their consistency with the Administration’s goal of protecting and strengthening the ACA and making high-quality health care accessible and affordable for every American.<sup>9</sup> Executive Order 14009 also directed Federal agencies to examine policies or practices

that may undermine protections for people with preexisting conditions and that may reduce the affordability of coverage or financial assistance for coverage. Executive Order 14009 also revoked the previous Administration’s Executive Order 13813, “Promoting Healthcare Choice and Competition Across the United States,” which directed agencies to expand the availability of STLDI.<sup>10</sup> On April 5, 2022, President Biden issued Executive Order 14070, “Continuing to Strengthen Americans’ Access to Affordable, Quality Health Coverage,” which directed the heads of Federal agencies with responsibilities related to Americans’ access to health coverage to examine policies or practices that make it easier for all consumers to enroll in and retain coverage, understand their coverage options, and select appropriate coverage; that strengthen benefits and improve access to health care providers; that improve the comprehensiveness of coverage and protect consumers from low-quality coverage; and that help reduce the burden of medical debt on households.<sup>11</sup>

In addition, on January 21, 2021, President Biden issued Executive Order 13995, “Ensuring an Equitable Pandemic Response and Recovery,” which directed the Secretaries of Labor and HHS, and the heads of all other agencies with authorities or responsibilities relating to the COVID-19 pandemic response and recovery, to consider any barriers that have restricted access to preventive measures, treatment, and other health services for populations at high risk for COVID-19 infection, and modify policies to advance equity.<sup>12</sup>

Consistent with these executive orders, the Departments reviewed the regulatory provisions related to STLDI and fixed

indemnity excepted benefits coverage and, after carefully considering public comments received, are finalizing amendments to those provisions in these final rules.

### *C. Short-Term, Limited-Duration Insurance (STLDI)*

STLDI is a type of health insurance coverage sold by health insurance issuers that typically fills temporary gaps in coverage that may occur when an individual is transitioning from one plan or coverage to another, such as transitioning between health coverage offered by one employer to health coverage offered by another employer. Section 2791(b)(5) of the PHS Act provides that “[t]he term ‘individual health insurance coverage’ means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited duration insurance.”<sup>13</sup> The PHS Act does not, however, define the phrase “short-term, limited duration insurance.” Sections 733(b)(4) of ERISA and 2791(b)(4) of the PHS Act provide that group health insurance coverage means, “in connection with a group health plan, health insurance coverage offered in connection with such plan.” Sections 733(a)(1) of ERISA and 2791(a)(1) of the PHS Act provide that a group health plan is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents (as defined under the terms of the plan) directly, or through insurance, reimbursement, or otherwise. There is no corresponding provision excluding STLDI from the definition of group health insurance coverage. Thus,

<sup>6</sup> Section 5000A of the Code and Treasury regulations at 26 CFR 1.5000A-3 provide exemptions from the requirement to maintain MEC for the following individuals: (1) members of recognized religious sects; (2) members of health care sharing ministries; (3) exempt noncitizens; (4) incarcerated individuals; (5) individuals with no affordable coverage; (6) individuals with household income below the income tax filing threshold; (7) members of Federally recognized Indian tribes; (8) individuals who qualify for a hardship exemption certification; and (9) individuals with a short coverage gap of a continuous period of less than 3 months in which the individual is not covered under MEC. The eligibility standards for exemptions can be found at 45 CFR 155.605.

<sup>7</sup> Section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act.

<sup>8</sup> See also 64 FR 70164 (December 15, 1999).

<sup>9</sup> Executive Order 14009 of January 28, 2021, 86 FR 7793 (February 2, 2021).

<sup>10</sup> Executive Order 13813 of October 12, 2017, 82 FR 48385 (October 17, 2017).

<sup>11</sup> Executive Order 14070 of April 5, 2022, 87 FR 20689 (April 5, 2022).

<sup>12</sup> Executive Order 13995 of January 21, 2021, 86 FR 7193 (January 26, 2021).

<sup>13</sup> The definition of individual health insurance coverage (and its exclusion of STLDI) has some limited relevance with respect to certain provisions that apply to group health plans and group health insurance issuers. For example, an individual who loses coverage due to moving out of a health maintenance organization (HMO) service area in the individual market is eligible for a special enrollment period to enroll in a group health plan. See 26 CFR 54.9801-6(a)(3)(i)(B), 29 CFR 2590.701-6(a)(3)(i)(B), and 45 CFR 146.117(a)(3)(i)(B).

any health insurance that is sold in the group market and purports to be STLDI must nonetheless comply with applicable Federal group market consumer protections and requirements for comprehensive coverage, unless the coverage satisfies the requirements of one or more types of group market excepted benefits.

Because STLDI is not individual health insurance coverage, it is generally exempt from the Federal individual market consumer protections and requirements for comprehensive coverage. STLDI is not subject to PHS Act provisions that apply to individual health insurance coverage under the ACA including, for example, the prohibition of preexisting condition exclusions or other discrimination based on health status (section 2704 of the PHS Act), the prohibition on discrimination against individual participants and beneficiaries based on health status (section 2705 of the PHS Act), nondiscrimination in health care (section 2706 of the PHS Act), and the prohibition on lifetime and annual dollar limits on essential health benefits (section 2711 of the PHS Act). In addition, STLDI is not subject to the Federal consumer protections and requirements added to the PHS Act by other laws that apply to individual health insurance coverage, including MHPAEA (Pub. L. 110-343, October 3, 2008) (section 2726 of the PHS Act), and the No Surprises Act, as added by the CAA, 2021. Thus, individuals who enroll in STLDI are not guaranteed these key consumer protections under Federal law.<sup>14</sup> The lack of these key Federal consumer protections is especially problematic when the differences between STLDI and comprehensive individual health insurance coverage are not readily apparent to consumers.

In 1997, the Departments issued interim final rules implementing the portability and renewability requirements of HIPAA

(1997 HIPAA interim final rules).<sup>15</sup> Those interim final rules included definitions of individual health insurance coverage, as well as STLDI. That definition of STLDI, which was finalized in rules issued in 2004 and applied through 2016, defined “short-term, limited-duration insurance” as “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.”<sup>16</sup>

To address the issue of STLDI being sold as a type of primary coverage, as well as concerns regarding possible adverse selection impacts on the individual market risk pools that were created under the ACA,<sup>17</sup> the Departments published proposed rules on June 10, 2016, in the **Federal Register** titled “Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance” (2016 proposed rules). Those rules proposed to revise the Federal definition of STLDI by shortening the permitted duration of such coverage, and adopting a consumer notice provision.<sup>18</sup> On October 31, 2016, the Departments published final rules in the **Federal Register** titled “Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance” (2016 final rules).<sup>19</sup> The 2016 final rules amended the definition of STLDI to specify that the maximum coverage period must be less than 3 months, taking into account any extensions that may be elected by the policyholder with or without the issuer’s consent.<sup>20</sup> In addition, the 2016 final rules stated that the following notice must be prominently displayed in the contract and in any application mate-

rials provided in connection with enrollment in STLDI, in at least 14 point type:

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.<sup>21</sup>

On June 12, 2017, HHS published a request for information (RFI) in the **Federal Register** titled “Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients,”<sup>22</sup> which solicited comments about potential changes to existing regulations and guidance that could promote consumer choice, enhance affordability of coverage for individual consumers, and affirm the traditional regulatory authority of the States in regulating the business of health insurance, among other goals.<sup>23</sup> In response to this RFI, HHS received comments that recommended maintaining the definition of STLDI adopted in the 2016 final rules, and comments that recommended expanding the definition to allow for a longer period of coverage. Commenters in support of maintaining the definition adopted in the 2016 final rules expressed concern that expanding the definition could leave enrollees in STLDI at risk for significant out-of-pocket costs and cautioned that expanding the definition of STLDI could facilitate its sale to individuals as their primary form of health coverage, even though such insurance lacks key Federal consumer protections that apply to individual health insurance coverage. Commenters in favor of maintaining the definition in the 2016 final rules also suggested that amending the

<sup>14</sup> Some State laws apply some consumer protections and requirements that parallel those in the ACA to STLDI.

<sup>15</sup> 62 FR 16894 (April 8, 1997).

<sup>16</sup> 62 FR 16894 at 16928, 16942, 16958 (April 8, 1997); see also 69 FR 78720 (December 30, 2004).

<sup>17</sup> See Pub. L. 111-148, March 23, 2010, section 1312(c)(1) and 45 CFR 156.80.

<sup>18</sup> 81 FR 38019 (June 10, 2016).

<sup>19</sup> 81 FR 75316 (October 31, 2016).

<sup>20</sup> *Id.* at 75317 – 75318.

<sup>21</sup> *Id.*

<sup>22</sup> 82 FR 26885 (June 12, 2017).

<sup>23</sup> See also Executive Order 13813 of October 12, 2017, 82 FR 48385 (October 17, 2017) (directing the Secretaries of the Treasury, Labor and HHS “...to consider proposing regulations or revising guidance, consistent with law, to expand the availability of [STLDI]. To the extent permitted by law and supported by sound policy, the Secretaries should consider allowing such insurance to cover longer periods and be renewed by the consumer.”).



2016 final rules to include coverage lasting 3 months or more could have the effect of pulling healthier people out of the individual market risk pools, thereby increasing overall premium costs for enrollees in individual health insurance coverage and destabilizing the individual market.

In contrast, several other commenters stated that changes to the 2016 final rules may provide an opportunity to achieve the goals outlined in the RFI (for example, to promote consumer choice, enhance affordability, and affirm the traditional authority of the States in regulating the business of insurance). These commenters stated that shortening the permitted length of STLDI policies in the 2016 final rules had deprived individuals of affordable coverage options. One commenter explained that due to the increased costs of comprehensive coverage, many financially stressed individuals could be faced with a choice between purchasing STLDI or going without any coverage at all. One commenter highlighted the need for STLDI for individuals who are between jobs for a relatively long period and for whom enrolling in Consolidated Omnibus Budget Reconciliation Act (COBRA)<sup>24</sup> continuation coverage is financially infeasible. Another commenter noted that States have the primary responsibility to regulate STLDI and encouraged the Departments to defer to the States' authority with respect to such coverage.

On February 21, 2018, the Departments published proposed rules in the **Federal Register** titled "Short-Term, Limited-Duration Insurance" (2018 proposed rules) in which the Departments proposed changing the definition of STLDI to have a maximum coverage period of less than 12 months after the original effective date of the contract, taking into account any extensions that may be elected by the policyholder without the issuer's consent.<sup>25</sup> Among other things, the Departments solicited comments on whether the maximum length of STLDI should be less than 12 months or some

other duration and under what conditions issuers should be able to allow such coverage to continue for 12 months or longer.<sup>26</sup> In addition, the Departments proposed to revise the content of the consumer notice that must appear in the contract and any application materials provided in connection with enrollment in STLDI. The 2018 proposed rules included two variations of the consumer notice—one for policies that had a coverage start date before January 1, 2019, and the other for policies that had a coverage start date on or after January 1, 2019, the latter of which excluded language referencing the individual shared responsibility payment (which was reduced to \$0 for months beginning after December 2018).<sup>27,28</sup>

Some commenters on the 2018 proposed rules acknowledged that STLDI fills an important role by providing temporary coverage but stated that STLDI should not take the place of comprehensive coverage. These commenters expressed concern that allowing STLDI to be marketed as a viable alternative to comprehensive coverage would subject uninformed consumers to potentially severe financial risks. Commenters who opposed the proposed changes to the definition also expressed concern that such plans would siphon off healthier individuals from the market for individual health insurance coverage, thereby raising premiums for individual health insurance coverage.

Many of these commenters also expressed concerns about the lack of protections for consumers who purchase STLDI, stating that such policies are not a viable option for people with serious or chronic medical conditions due to potential coverage exclusions and benefit limitations in STLDI policies. These commenters further observed that STLDI policies can discriminate against individuals with serious illnesses or preexisting conditions, including individuals with mental health and substance use disorders, older consumers, women, transgender patients, persons with gender identi-

ty-related health concerns, and victims of rape and domestic violence. Many of these commenters also expressed concern about aggressive and deceptive marketing practices utilized by marketers of STLDI.

Other commenters highlighted the important role that STLDI could play in providing temporary coverage to individuals who would otherwise be uninsured. These commenters, who supported the proposed changes to the definition, also noted that such changes would allow purchasers of STLDI to obtain the coverage they want at a more affordable price for a longer period.

With respect to the maximum length of the initial contract term for STLDI, most commenters opposed extending the maximum duration beyond 3 months. Others suggested periods such as less than 6 or 8 months. However, most commenters who supported extending the maximum initial contract term beyond 3 months suggested it should be 364 days. A few commenters suggested more than 1 year. Other commenters stated the maximum length of coverage should be left to the States. Commenters who supported the 2018 proposed rules generally favored permitting renewals of STLDI policies, while those who opposed the 2018 proposed rules generally opposed permitting such renewals.

After reviewing comments and feedback received from interested parties, on August 3, 2018, the Departments published final rules in the **Federal Register** titled "Short-Term, Limited-Duration Insurance" (2018 final rules)<sup>29</sup> with some modifications from the 2018 proposed rules. Specifically, in the 2018 final rules, the Departments amended the definition of STLDI to provide that STLDI is coverage with an initial term specified in the contract that is less than 12 months after the original effective date of the contract, and taking into account renewals or extensions, has a duration of no longer than 36 months in total.<sup>30</sup> The 2018 final rules also finalized the provision that issuers of

<sup>24</sup> Pub. L. 99-272, April 7, 1986. COBRA added parallel provisions at Code section 4980B, ERISA sections 601-608, and PHS Act sections 2201-2208.

<sup>25</sup> 83 FR 7437 (February 21, 2018).

<sup>26</sup> *Id.* at 7441.

<sup>27</sup> *Id.* at 7440-7441.

<sup>28</sup> Pub. L. 115-97, December 22, 2017.

<sup>29</sup> 83 FR 38212 (August 3, 2018).

<sup>30</sup> *Id.*

STLDI must display one of two versions of a notice prominently in the contract and in any application materials provided in connection with enrollment in such coverage, in at least 14-point type. Under the 2018 final rules, the notice must read as follows (with the final two sentences omitted for policies sold on or after January 1, 2019)<sup>31</sup>:

This coverage is not required to comply with certain Federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not “minimum essential coverage.” If you don’t have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

#### *D. Independent, Noncoordinated Excepted Benefits: Hospital Indemnity or Other Fixed Indemnity Insurance*

Section 9831 of the Code, section 732 of ERISA, and sections 2722(b)-(c) and 2763 of the PHS Act provide that the respective Federal consumer protections and requirements for comprehensive coverage do not apply to any individual coverage or any group health plan (or group health insurance coverage offered in connection with a group health plan) in relation to its provision of certain types of benefits, known as “excepted benefits.” These excepted benefits are described in section 9832(c) of the Code, section 733(c) of ERISA, and section 2791(c) of the PHS Act.

HIPAA defined certain types of coverage as “excepted benefits” that were exempt from its portability requirements.<sup>32</sup> The same definitions are applied to describe benefits that are not required to comply with the ACA requirements.<sup>33</sup> There are four statutory categories of excepted benefits: independent, noncoordinated excepted benefits, which are the subject of these final rules; benefits that are excepted in all circumstances;<sup>34</sup> limited excepted benefits;<sup>35</sup> and supplemental excepted benefits.<sup>36</sup>

The category “independent, noncoordinated excepted benefits” includes 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 9831(c)(2) of the Code, section

732(c)(2) of ERISA, and section 2722(c)(2) of the PHS Act 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 an event without regard to whether benefits are provided with respect to such event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.<sup>37</sup> In addition, under existing regulations, hospital indemnity and other fixed indemnity insurance in the group market must pay a fixed dollar amount per day (or other period) of hospitalization or illness, regardless of the amount of expenses incurred, to be considered an excepted benefit.<sup>38</sup> By contrast, in the individual market, under existing regulations, hospital indemnity and other fixed indemnity insurance must also pay benefits in a fixed dollar amount, regardless of the amount of expenses incurred, to be considered an excepted benefit, but is permitted to pay on either a per period of hospitalization or illness, or a per-service basis (for example, \$100/day or \$50/visit).<sup>39,40</sup>

The amendments to the regulations regarding independent, noncoordinated excepted benefits coverage that were proposed in the 2023 proposed rules and those finalized in these final rules address

<sup>31</sup> See *id.* at 38222-38225.

<sup>32</sup> See sections 9831(b) – (c) and 9832(c) of the Code, sections 732(b) – (c) and 733(c) of ERISA, and sections 2722(b) – (c), 2763 and 2791(c) of the PHS Act.

<sup>33</sup> Section 1551 of the ACA. See also section 1563(a) and (c)(12) of the ACA. Excepted benefits are also not subject to the consumer protections and requirements added by other Federal laws that apply to comprehensive coverage, including MHPAEA, the Newborns’ and Mothers’ Health Protection Act, the Women’s Health and Cancer Rights Act, the Children’s Health Insurance Program Reauthorization Act of 2009, Michelle’s Law, and Division BB of the CAA, 2021.

<sup>34</sup> Under section 9832(c)(1) of the Code, section 733(c)(1) of ERISA, and section 2791(c)(1) of the PHS Act, this category includes, for example, accident and disability income insurance, automobile medical payment insurance, liability insurance and workers compensation, as well as “[o]ther similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.”

<sup>35</sup> Under section 9832(c)(2) of the Code, section 733(c)(2) of ERISA, and section 2791(c)(2) of the PHS Act, this category includes limited scope vision or dental benefits, benefits for long-term care, nursing home care, home health care, or community-based care, or other, similar limited benefits specified by the Departments through regulation.

<sup>36</sup> Under section 9832(c)(4) of the Code, section 733(c)(4) of ERISA, and section 2791(c)(4) of the PHS Act, this category includes Medicare supplemental health insurance (also known as Medigap), TRICARE supplemental programs, or “similar supplemental coverage provided to coverage under a group health plan.” To be considered “similar supplemental coverage” and thus an excepted benefit, the coverage, whether offered in the group or individual market, must supplement coverage provided under a group health plan. This category does not include coverage that supplements individual health insurance coverage. 26 CFR 54.9831-1(c)(5), 29 CFR 2590.732(c)(5), 45 CFR 146.145(b)(5) and 148.220(b)(7).

<sup>37</sup> See also section 2763(b) of the PHS Act (providing that “[t]he requirements of this part [related to the HIPAA individual market reforms] shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (2), (3), or (4) of section 2791(c) if the benefits are provided under a separate policy, certificate or contract of insurance.”).

<sup>38</sup> 26 CFR 54.9831-1(c)(4), 29 CFR 2590.732(c)(4), and 45 CFR 146.145(b)(4).

<sup>39</sup> 45 CFR 148.220(b)(4)(iii).

<sup>40</sup> As discussed further in section I.D.2 of this preamble, the existing individual market regulation also provides that hospital indemnity and other fixed indemnity insurance cannot coordinate between the provision of benefits and an exclusion of benefits under any health coverage to be considered an excepted benefit. See 45 CFR 148.220(b)(4)(ii).

the conditions that must be met for hospital indemnity and other fixed indemnity insurance in the group or individual markets to be considered excepted benefits under the Federal regulations.

Like other forms of excepted benefits, fixed indemnity excepted benefits coverage does not provide comprehensive coverage. Rather, its primary purpose is to provide income replacement benefits.<sup>41</sup> Benefits under this type of coverage are paid in a flat (“fixed”) cash amount following the occurrence of a health-related event, such as a period of hospitalization or illness, subject to the terms of the contract. In addition, benefits are provided at a pre-determined level regardless of any health care costs incurred by a covered individual with respect to the health-related event. Although a benefit payment may equal all or a portion of the cost of care related to an event, it is not necessarily designed to do so, and the benefit payment is made without regard to the amount of health care costs incurred.<sup>42</sup>

Traditionally, benefits under fixed indemnity excepted benefits coverage are paid directly to a policyholder, rather than to a health care provider or facility. The policyholder has discretion over how to use such benefits – including using the payment to cover non-medical expenses, such as childcare or transportation – that may or may not be related to the event that precipitated the payment.<sup>43</sup>

## 1. Group Market Regulations and Guidance

The Departments’ 1997 interim final rules implementing the portability and renewability requirements of HIPAA cod-

ified at 26 CFR 54.9831-1(c)(4), 29 CFR 2590.732(c)(4), and 45 CFR 146.145(b)(4) established requirements for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit in the group market. These requirements, which were effective until February 27, 2005, provided that coverage for hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the following conditions: (1) the benefits are provided under a separate policy, certificate or contract of insurance; (2) there is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.<sup>44</sup>

The Departments’ group market regulations for fixed indemnity excepted benefits coverage were first amended in the 2004 HIPAA group market final rules. Those amendments added language to further clarify that to be hospital indemnity or other fixed indemnity insurance that is an excepted benefit, the insurance must pay a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses incurred.<sup>45</sup> An example was also added as part of these amendments illustrating that a policy providing benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum amount per day does not qualify as an excepted benefit.<sup>46</sup> As explained in the 2004 HIPAA group market final rules, the result is the same even if, in

practice, the policy pays the maximum for every day of hospitalization.<sup>47</sup>

The Departments later released Frequently Asked Questions (FAQ) on January 24, 2013, to offer additional guidance on the types of hospital indemnity or other fixed indemnity insurance that meet the criteria for fixed indemnity excepted benefits coverage.<sup>48</sup> The Departments issued the FAQ in response to reports that policies were being advertised as fixed indemnity coverage, but were paying a fixed amount on a per-service basis (for example, per doctor visit or surgical procedure) rather than a fixed amount per period (for example, per day or per week). The FAQ affirmed that, under the 2004 HIPAA group market final rules, to qualify as fixed indemnity excepted benefits coverage, the policy must pay benefits on a per-period basis as opposed to on a per-service basis.<sup>49</sup> The FAQ also affirmed that group health insurance coverage that provides benefits in varying amounts based on the type of procedure or item, such as the type of surgery actually performed or prescription drug provided, does not qualify as fixed indemnity excepted benefits coverage because it does not meet the condition that benefits be provided on a per-period basis, regardless of the amount of expenses incurred.<sup>50</sup>

The Departments proposed amendments to the group market regulations for fixed indemnity excepted benefits coverage in the 2016 proposed rules.<sup>51</sup> As explained in those proposed rules, the Departments were concerned that some individuals may mistake these policies for comprehensive coverage that would be considered MEC.<sup>52</sup> To address this confusion, the Departments proposed to adopt

<sup>41</sup> The original version of HIPAA that the House Ways & Means Committee referred to the House floor referred to hospital indemnity or other fixed indemnity insurance as a “hospital or fixed indemnity *income-protection policy*” (emphasis added). See H.R. Rep. No. 104-496 part I, at 32 (1996), available at: <https://www.govinfo.gov/content/pkg/CRPT-104hrpt496/pdf/CRPT-104hrpt496-pt1.pdf>. See also 79 FR 15818 (March 21, 2014) (“The primary reason fixed indemnity insurance is considered to be an excepted benefit... is that its primary purpose is not to provide major medical coverage but to provide a cash-replacement benefit for those individuals with other health coverage.”).

<sup>42</sup> Jost, Timothy (2017). “ACA Round-Up: Market Stabilization, Fixed Indemnity Plans, Cost Sharing Reductions, and Penalty Updates,” *Health Affairs*, available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20170208.058674/full>. (“Fixed indemnity coverage is excepted benefit coverage that pays a fixed amount per-service or per-time period of service without regard to the cost of the service or the type of items or services provided.”).

<sup>43</sup> America’s Health Insurance Plans (2019). “Supplemental Health Insurance: Hospital or Other Fixed Indemnity, Accident-Only, Critical Illness,” available at: <https://www.ahip.org/documents/Supplemental-Health-Insurance-Fast-Facts.pdf>.

<sup>44</sup> 62 FR 16894 at 16903, 16939 through 16940, 16954, and 16971 (April 8, 1997).

<sup>45</sup> 69 FR 78720 at 78735, 78762, 78780, and 78798 – 78799 (December 30, 2004).

<sup>46</sup> *Id.* See also 26 CFR 54.9831-1(c)(4)(iii), 29 CFR 2590.732(c)(4)(iii), and 45 CFR 146.145(b)(4)(iii).

<sup>47</sup> *Id.*

<sup>48</sup> Frequently Asked Questions about Affordable Care Act Implementation (Part XI) (Jan. 24, 2013), Q7, available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xi.pdf> and [https://www.cms.gov/CCHIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs11](https://www.cms.gov/CCHIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11).

<sup>49</sup> *Id.*

<sup>50</sup> *Id.*

<sup>51</sup> 81 FR 38019 at 38031-38032, 38038, 38042-38043, and 38045-38046 (June 10, 2016).

<sup>52</sup> *Id.* at 38031-38032.

a notice provision to inform enrollees and potential enrollees that the coverage is a supplement to, rather than a substitute for, comprehensive coverage, and also proposed to add two illustrative examples to further clarify the condition that benefits must be provided on a per-period basis.<sup>53</sup> The Departments also requested comments on whether to more substantively align the rules for hospital indemnity or other fixed indemnity insurance in the group and individual markets.<sup>54</sup> After consideration of comments, the Departments did not finalize the proposed changes to the group market regulation but noted their intention to address hospital indemnity and other fixed indemnity insurance in future rulemaking.<sup>55</sup>

## 2. Individual Market Regulations and Guidance

HHS also issued an interim final rule in 1997 establishing the regulatory framework for the HIPAA individual market Federal requirements and addressing the requirements for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit in the individual market.<sup>56</sup> The initial HIPAA individual market fixed indemnity excepted benefits coverage regulation, which was effective until July 27, 2014, provided an exemption from the Federal individual market consumer protections and requirements for comprehensive coverage if the hospital indemnity or other fixed indemnity insurance provided benefits under a separate policy, certificate, or contract of insurance and met the noncoordination-of-benefits requirements outlined in the HHS group market excepted benefits regulations.<sup>57</sup>

Following issuance of the Departments' January 24, 2013 FAQ,<sup>58</sup> State insurance

regulators and industry groups representing health insurance issuers expressed concerns that prohibiting hospital indemnity and other fixed indemnity insurance from payment on a per-service basis to qualify as an excepted benefit could limit consumer access to an important supplemental coverage option.<sup>59</sup> Based on this feedback, HHS announced in an FAQ released in January 2014 that it intended to propose amendments to the individual market fixed indemnity excepted benefits coverage regulation to allow hospital indemnity or other fixed indemnity insurance sold in the individual market to be considered an excepted benefit if four conditions were met.<sup>60</sup> First, such coverage would be sold only to individuals who have other health coverage that is MEC, within the meaning of section 5000A(f) of the Code. Second, no coordination between the provision of benefits and an exclusion of benefits under any other health coverage would be permitted. Third, benefits would be paid in a fixed dollar amount regardless of the amount of expenses incurred and without regard to whether benefits are provided with respect to an event or service under any other health insurance coverage. Finally, a notice would have to be prominently displayed to inform policyholders that the coverage is not MEC and would not satisfy the individual shared responsibility requirements of section 5000A of the Code. HHS explained that if these proposed revisions were implemented, hospital indemnity or other fixed indemnity insurance in the individual market would no longer have to pay benefits solely on a per-period basis to qualify as an excepted benefit.

In the proposed rule, titled "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards

for 2015 and Beyond" (2014 proposed rule), HHS proposed to amend the criteria in 45 CFR 148.220 for fixed indemnity insurance to be treated as an excepted benefit in the individual market.<sup>61</sup> Consistent with the framework outlined in the January 2014 FAQ, the amendments proposed to eliminate the requirement that individual market fixed indemnity excepted benefits coverage must pay benefits only on a per-period basis (as opposed to a per-service basis) and instead proposed to require, among other things, that it be sold only as secondary to other health coverage that is MEC to qualify as an excepted benefit.<sup>62</sup>

On July 28, 2014, in the rule titled "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond" (2014 final rule), HHS finalized the proposed amendments to 45 CFR 148.220(b)(4) with some modifications. Pursuant to the finalized amendments, hospital indemnity or other fixed indemnity insurance in the individual market may qualify as fixed indemnity excepted benefits coverage if payments are made on a per-period and/or per-service basis subject to several additional requirements that do not apply to fixed indemnity excepted benefits coverage in the group market.<sup>63</sup> Under 45 CFR 148.220(b)(4)(i), to qualify as excepted benefits coverage, benefits under an individual market hospital indemnity or other fixed indemnity insurance policy may only be provided to individuals who attest in their application that they have other health coverage that is MEC within the meaning of section 5000A(f) of the Code, or that they are treated as having MEC due to their status as a bona fide resident of any possession of the United States pursuant to section 5000A(f)(4)(B) of the

<sup>53</sup> *Id.* at 38031-38032, 38038, 38042-38043, and 38045-38046.

<sup>54</sup> As described in section I.D.2 of this preamble, HHS amended the individual market fixed indemnity excepted benefits coverage regulation to provide additional flexibility, subject to several additional requirements that do not apply in the group market. 79 FR 30239 (May 27, 2014).

<sup>55</sup> 81 FR 75316 at 75317 (October 31, 2016).

<sup>56</sup> 62 FR 16985 at 16992 and 17004 (April 8, 1997).

<sup>57</sup> *Id.*; 45 CFR 146.145(b)(4)(ii)(B) and (C).

<sup>58</sup> Frequently Asked Questions about Affordable Care Act Implementation (Part XI) (Jan. 24, 2013), available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xi.pdf> and [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs11](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11).

<sup>59</sup> While the FAQ only addressed fixed indemnity insurance sold in the group market, the same statutory framework and legal analysis also applies to hospital indemnity and fixed indemnity insurance sold in the individual market.

<sup>60</sup> Frequently Asked Questions about Affordable Care Act Implementation (Part XXVIII) and Mental Health Parity Implementation (Jan. 9, 2014), Q11, available at: <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xxviii.pdf> and [https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca\\_implementation\\_faqs18](https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18).

<sup>61</sup> 79 FR 15807 at 15818-15820, 15869 (March 21, 2014).

<sup>62</sup> *Id.*

<sup>63</sup> 79 FR 30239 (May 27, 2014).

Code.<sup>64</sup> Further, to qualify as an excepted benefit, 45 CFR 148.220(b)(4)(iv) outlines specific notice language that must be prominently displayed in the application materials for individual market hospital indemnity or other fixed indemnity insurance. Finally, consistent with the group market fixed indemnity excepted benefits coverage regulations, 45 CFR 148.220(b)(4)(ii) implements the statutory noncoordination standard and requires that there is no coordination between the provision of benefits under the individual market fixed indemnity excepted benefits insurance policy and an exclusion of benefits under any other health coverage.

HHS made these changes in the 2014 final rule for two reasons. First, as stated previously, interested parties, including State insurance regulators and industry groups representing health insurance issuers, communicated to HHS that fixed indemnity plans that paid benefits on a per-service basis were widely available as a complement to comprehensive coverage in the group and individual markets. The National Association of Insurance Commissioners (NAIC) also expressed that State insurance regulators believed fixed indemnity plans that paid benefits on a per-service basis provided consumers an important supplemental coverage option by helping consumers that purchase MEC pay for out-of-pocket costs.<sup>65</sup> Second, beginning in 2014, most consumers were required to have MEC to avoid being subject to an individual shared responsibility payment under section 5000A of the Code. HHS adopted the MEC attestation requirement to prevent fixed indemnity excepted benefits coverage in the individual market from being offered as a substitute for comprehensive coverage

while also accommodating the concerns of interested parties who supported allowing fixed indemnity excepted benefits coverage in the individual market to pay benefits on a per-service basis, rather than only on a per-period basis.<sup>66</sup> However, in its 2016 decision in *Central United Life Insurance Company v. Burwell*, the U.S. Court of Appeals for the District of Columbia invalidated the requirement at 45 CFR 148.220(b)(4)(i) that an individual must attest to having MEC prior to purchasing fixed indemnity excepted benefits coverage in the individual market.<sup>67</sup> The Court did not engage in a severability analysis to determine whether HHS would have intended to leave the remaining provisions of the regulation in place, and left intact the language permitting fixed indemnity excepted benefits coverage in the individual market to provide benefits on a per-service basis.

#### *E. Tax Treatment and Substantiation Requirements for Amounts Received from Fixed Indemnity Insurance and Certain Other Arrangements*

As part of the 2023 proposed rules, the Treasury Department and the IRS proposed amendments to 26 CFR 1.105-2. For the reasons that follow, the Treasury Department and the IRS are not finalizing the proposed amendments at this time.

Hospital indemnity or other fixed indemnity insurance, as well as coverage only for a specified disease or illness, generally are considered “accident or health insurance” under sections 104, 105, and 106 of the Code, regardless of whether they are “excepted benefits” as defined in section 9832(c) of the Code. Premiums paid by an employer (including by salary

reduction pursuant to section 125 of the Code) for accident or health insurance are excluded from an employee’s gross income under section 106(a) of the Code. The Treasury Department and the IRS also have recognized the ability of employers and employees to agree to include them in employees’ gross income notwithstanding section 106(a) of the Code.<sup>68</sup>

Amounts received through accident or health insurance are excluded from an employee’s gross income under section 104(a)(3) of the Code if the premiums were paid on an after-tax basis. However, amounts received are included in an employee’s gross income if the amounts are attributable to contributions by an employer that were excluded from the employee’s gross income under section 106(a) of the Code. Whether amounts received by an employee through accident or health insurance are excluded from an employee’s gross income where the premiums or contributions were paid on a pre-tax basis is determined under section 105. Section 105(a) of the Code provides that such amounts are included in gross income except as otherwise provided in section 105 of the Code. Section 105(b) of the Code excludes such amounts from gross income amounts if they are paid to reimburse the employee’s expenses for medical care (as defined in section 213(d) of the Code). Under 26 CFR 1.105-2, this means the exclusion “applies only to amounts which are paid specifically to reimburse the taxpayer for expenses incurred by him for the prescribed medical care.”<sup>69</sup>

The 2023 proposed amendments to 26 CFR 1.105-2 would provide that the exclusion from gross income under section 105(b) of the Code does not apply to

<sup>64</sup> As discussed later in this section and in section III.B.2 of this preamble, the U.S. Court of Appeals for the District of Columbia vacated the requirement at 45 CFR 148.220(b)(4)(i) that an individual attest to having MEC prior to purchasing a hospital indemnity or other fixed indemnity policy in order for the policy to qualify as an excepted benefit. *Central United Life Insurance Company v. Burwell*, 827 F.3d 70 (D.C. Cir. 2016).

<sup>65</sup> National Association of Insurance Commissioners (2013). “Letter to Secretaries of Labor, Treasury, and Health and Human Services,” available at: <https://naic.soutronglobal.net/Portal/Public/en-GB/RecordView/Index/23541>. (“State regulators believe hospital and other fixed indemnity coverage with variable fixed amounts based on service type could provide important options for consumers as supplemental coverage. Consumers who purchase comprehensive coverage that meets the definition of ‘minimum essential coverage’ may still wish to buy fixed indemnity coverage to help meet out-of-pocket medical and other costs.”).

<sup>66</sup> 79 FR 30239 at 30255 (May 27, 2014).

<sup>67</sup> 827 F.3d 70 (D.C. Cir. July 1, 2016).

<sup>68</sup> See, for example, IRS Rev. Rul. 2004-55, which concludes that long-term disability benefits received by an employee who has irrevocably elected, prior to the beginning of the plan year, to have the coverage paid by the employer on an after-tax basis for the plan year in which the employee becomes disabled are attributable solely to after-tax employee contributions and are excludable from the employee’s gross income under section 104(a)(3) of the Code.

<sup>69</sup> Additionally, an employer-provided accident or health insurance policy or plan that reimburses an employee for any expenses incurred for medical care is a group health plan subject to section 4980B of the Code, regardless of whether the reimbursements are included in an employee’s income under section 105(a) of the Code or excluded under section 104(a)(3) or 105(b) of the Code. In contrast, a policy or plan that does not reimburse an employee for any expenses incurred for medical care is not a group health plan subject to section 4980B of the Code (and section 105(b) of the Code cannot apply to it).

amounts that are paid without regard to the amount of incurred medical expenses as defined in section 213(d) of the Code. The proposed amendments also would clarify that, consistent with guidance issued by the Treasury Department and the IRS relating to certain specific types of health plans, the substantiation requirements for qualified medical expenses apply to reimbursements under all types of accident and health plans.<sup>70</sup> Finally, the proposed amendments would update several cross-references in 26 CFR 1.105-2 to reflect statutory changes since the rules were issued in 1956.<sup>71</sup>

The Treasury Department and the IRS issued the proposed amendments because uncertainty regarding the exclusion under section 105(b) of the Code has resulted in inconsistent treatment by taxpayers of benefits under different types of accident and health plans and has encouraged some taxpayers to apply the exclusion to situations where the amount or even the existence of medical expenses is doubtful. The Treasury Department and the IRS also are concerned that uncertainty regarding the related Federal Insurance Contributions Act (FICA)<sup>72</sup> and Federal Unemployment Tax Act (FUTA)<sup>73</sup> exclusions, and the Federal income tax withholding rules,<sup>74</sup> has resulted in instances where no FICA, FUTA, or Federal income taxes are withheld from or paid with respect to taxable benefits from accident and health plans and policies by either employers or payors. Although these issues are not limited to fixed indemnity plans and policies, the Treasury Department's and the IRS's concerns have recently escalated after identifying an increasing number of arrangements, some involving fixed indemnity plans and policies, that distribute cash benefit payments, purportedly for medical expenses, even if any expenses incurred may already have been reimbursed through other coverage, or participants do not incur any medical expenses within the

meaning of section 213(d) of the Code. In some cases, no medical expenses are incurred and participants simply complete certain health-related activities. Benefit payments from such accident and health plans that are not made on account of medical expenses incurred generally would not qualify for exclusion from gross income, FICA, FUTA, or Federal income tax withholding.

The Treasury Department and the IRS received comments in support of and in opposition to the proposed amendments to 26 CFR 1.105-2. Commenters who opposed the proposed amendments primarily argued that the exclusion under section 105(b) of the Code should apply with respect to the amount of any medical expenses associated with the health-related event that precipitates payments under accident or health insurance, even if the amount paid is determined without regard to the amount of actual medical expenses incurred (as is required for hospital indemnity or other fixed indemnity insurance to be considered an excepted benefit). These commenters generally argued that only the amount in excess of the medical expenses associated with the health-related event should be included in gross income.

The preamble to the 2023 proposed rules noted that, if the proposed amendments to 26 CFR 1.105-2 were finalized, taxpayers would need to consider the impact the proposal would have on determinations of whether amounts received under accident and health plans constitute wages for employment tax and income tax withholding purposes. Many commenters responded that the proposed amendments would, if finalized, prompt the need for additional guidance regarding collecting and paying employment taxes on some or all of the amounts paid through accident or health insurance that are not excluded from gross income, and proper reporting of such amounts on the employee's Form

W-2. Commenters also requested further clarification on how incurred medical expenses must be substantiated.

The Treasury Department and the IRS intend to address these issues in more detail in future guidance. Accordingly, to provide more time to study the issues and concerns raised by commenters, the Treasury Department and the IRS are not finalizing the proposed amendments to 26 CFR 1.105-2 at this time. No inference should be drawn regarding whether or the extent to which the Treasury Department or the IRS agree with any comments on the scope of section 105(b) of the Code based on this decision.

IRS compliance efforts regarding the exclusion from gross income under section 105(b) of the Code will continue to assist taxpayers to satisfy their existing tax responsibilities. Employers are reminded that amounts received through accident or health insurance are not taxable if premiums for the coverage are paid on an after-tax basis, thereby avoiding many of the practical concerns relating to benefits that do not meet the criteria to be excluded from gross income. The Treasury Department and IRS understand that is how most premiums for hospital indemnity or other fixed indemnity insurance are paid.

## II. Promoting Access to High-Quality, Affordable, and Comprehensive Coverage

The Departments recognize that STLDI can provide temporary health coverage for individuals who are experiencing brief periods without comprehensive coverage (for example, due to application of a waiting period for employer coverage). They also recognize that fixed indemnity excepted benefits coverage can provide consumers with income replacement that can be used to cover out-of-pocket expenses not covered by comprehensive coverage or to defray

<sup>70</sup> See, for example, 84 FR 28888, 28917 (June 20, 2019) (describing substantiation requirements for employer-sponsored health reimbursement arrangements); see also Q44-55 of IRS Notice 2017-67, 2017-47 IRB 517; Prop. Treas. Reg. § 1.125-6(b)(4) (2007); IRS Notice 2002-45, 2002-2 CB 93.

<sup>71</sup> The current rules reference section 105(d) of the Code, which has been repealed. The rules also reference the definition of a dependent in section 152(f) of the Code which may, in some circumstances, not include children up to the age of 26 that must be eligible to enroll in a group health plan or group or individual health insurance coverage under section 2714 of the PHS Act (which is incorporated by reference in section 9815 of the Code) if the plan or coverage makes available dependent coverage of children.

<sup>72</sup> Subtitle C, chapter 21 of the Code.

<sup>73</sup> Subtitle C, chapter 23 of the Code.

<sup>74</sup> Subtitle C, chapter 24 of the Code.

non-medical expenses (for example, mortgage or rent) upon the occurrence of a health-related event. Both STLDI and fixed indemnity excepted benefits coverage generally provide limited benefits at lower premiums than comprehensive coverage,<sup>75</sup> and enrollment is typically available at any time (sometimes subject to medical underwriting) rather than being restricted to open and special enrollment periods. However, the Departments are concerned about the financial and health risks that consumers face if they use either form of coverage as a substitute for comprehensive coverage, particularly as a long-term substitute. Consumers who do not understand key differences between STLDI, fixed indemnity excepted benefits coverage, and comprehensive coverage may unknowingly take on significant financial and health risks if they purchase STLDI or fixed indemnity excepted benefits coverage under the misapprehension that such products provide comprehensive coverage. Consumer confusion can be exacerbated when the products are designed in ways that resemble comprehensive coverage. As discussed further in this section II of this preamble, given significant changes in the legal landscape and market conditions since the Departments last addressed STLDI and fixed indemnity excepted benefits coverage, and the low value that STLDI and fixed indemnity excepted benefits coverage provide to some consumers when used as a substitute for comprehensive coverage, the Departments have determined that it is necessary and appropriate to amend the existing Federal regulations governing both types

of coverage to more clearly distinguish them from comprehensive coverage and increase consumer awareness of coverage options that include the full range of Federal consumer protections and requirements.

#### *A. Access to Affordable Coverage*

In the preamble to the 2018 final rules, the Departments explained the decision to amend the definition of STLDI to expand the initial term and total duration of such policies by citing STLDI as an important means to provide more affordable coverage options and more choices for consumers.<sup>76</sup> The Departments cited a 21 percent increase in individual health insurance coverage premiums between 2016 and 2017, and a 20 percent decrease in average monthly enrollment for individuals who did not receive PTC, along with a 10 percent overall decrease in monthly enrollment during the same period.<sup>77</sup> Additionally, the Departments noted that in 2018 about 26 percent of enrollees (living in 52 percent of counties) had access to just one issuer on the Exchange.<sup>78</sup>

Since the publication of the 2018 final rules, comprehensive coverage for individuals has generally become more accessible and affordable. For example, a study examining issuer participation trends from 2014 to 2021 in every county in the United States found that the number of consumers with multiple issuer options for individual health insurance coverage on the Exchanges has grown consistently since 2018. In 2021, 78 percent of enrollees (living in 46 percent of counties) had

a choice of three or more health insurance issuers, up from 67 percent of enrollees in 2020, 58 percent of enrollees in 2019, and 46 percent of enrollees in 2018. Only 3 percent of enrollees (residing in 10 percent of counties) resided in single-issuer counties in 2021 – down from 26 percent of enrollees (residing in 52 percent of counties) in 2018.<sup>79</sup> Issuer participation in the Exchanges has continued to trend positively in recent years, with the average number of issuers offering individual health insurance coverage on the Exchanges per State increasing from 5 in 2021 to 6 in 2024.<sup>80</sup> The Centers for Medicare & Medicaid Services (CMS) reported that a record 21.3 million people enrolled in Exchange coverage during the 2024 Open Enrollment Period, including 5 million consumers (approximately 24 percent of total enrollments) who were new to Exchanges in 2024, and 16.3 million returning customers.<sup>81</sup> Nearly 5 million more consumers signed up for coverage during the 2024 Open Enrollment Period compared to the same period in 2023 (an increase of more than 30 percent). This follows an increase of approximately 13 percent in 2023 and an increase of approximately 21 percent in 2022.<sup>82</sup> The enrollment gains in recent years were influenced by the expansion of PTC subsidies, as first provided under the ARP and then extended through 2025 under the IRA, as discussed in section I.A of this preamble.<sup>83</sup> In an analysis prior to the passage of the IRA, the Congressional Budget Office stated that if the ARP subsidies were made permanent, they would attract 4.8 million new people to the Exchanges each

<sup>75</sup> Although it is typically true that the unsubsidized premium price for comprehensive coverage is greater than STLDI or fixed indemnity excepted benefits coverage, consistent with the greater level of benefits provided under comprehensive coverage, *see* the additional discussion in this section II of this preamble regarding the availability of financial subsidies for eligible individuals to reduce the premium and out-of-pocket costs for comprehensive coverage purchased on an Exchange.

<sup>76</sup> 83 FR 38212 at 38217 (October 2, 2018).

<sup>77</sup> *Id.* at 38214 (citing CMS (2018). “Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment,” available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-2.pdf>).

<sup>78</sup> *Id.* (citing KFF (2017). “Insurer Participation on ACA Marketplaces, 2014-2018,” now available at: <https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/>).

<sup>79</sup> McDermott, Daniel and Cynthia Cox (2020). “Insurer Participation on the ACA Marketplaces, 2014-2021,” KFF, available at: <https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021>.

<sup>80</sup> *See* KFF (2024). “Number of Issuers Participating in the Individual Health Insurance Marketplaces, 2014-2024,” available at: <https://www.kff.org/other/state-indicator/number-of-issuers-participating-in-the-individual-health-insurance-marketplace>.

<sup>81</sup> *See* CMS (2024). “Marketplace 2024 Open Enrollment Period Report: Final National Snapshot,” available at: <https://www.cms.gov/newsroom/fact-sheets/marketplace-2024-open-enrollment-period-report-final-national-snapshot>.

<sup>82</sup> *See* CMS (2023). “Health Insurance Marketplaces, 2023 Open Enrollment Report,” available at: <https://www.cms.gov/files/document/health-insurance-exchanges-2023-open-enrollment-report-final.pdf>.

<sup>83</sup> Although unsubsidized premiums for 2023 increased on average between 2.2 percent and 4.7 percent compared to the previous year, after 4 years of declines, the expanded PTC subsidies under the IRA largely shielded many consumers from these premium increases. *See* Ortaliza, Jared, Justin Lo, Krutika Amin, and Cynthia Cox (2022). “How ACA Marketplace Premiums Are Changing By County in 2023,” KFF, available at: <https://www.kff.org/private-insurance/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2023>.

year, and that 2.2 million fewer individuals would be without health insurance, on average, over the period from 2023 through 2032.<sup>84</sup>

Additionally, on October 13, 2022, the Treasury Department and the IRS issued final regulations under section 36B of the Code to provide that affordability of employer-sponsored MEC for family members of an employee is determined based on the employee's share of the cost of covering the employee and those family members, not the cost of covering only the employee (2022 affordability rule).<sup>85</sup> It was estimated that this rule change, aimed at addressing the issue often called the "family glitch," would increase the number of individuals with PTC-subsidized Exchange coverage by approximately 1 million per year for the next 10 years.<sup>86</sup>

These recent and projected enrollment trends and the availability of the enhanced subsidies lessen the accessibility and affordability concerns expressed by the Departments in the preamble to the 2018 final rules regarding the availability of affordable options for comprehensive coverage, and offer further support for the provisions in these final rules, which are aimed at helping consumers differentiate between comprehensive coverage and other forms of more limited health coverage to decide which option is best for them.

Although access to affordable comprehensive coverage has improved in recent years, the Departments recognize that affordability concerns continue to persist among consumers, including among consumers who are enrolled in comprehensive coverage. A 2022 national survey conducted by the Commonwealth Fund found that 29 percent of people with employer-sponsored coverage and 44 per-

cent of those with coverage purchased in the individual market (including coverage purchased through an Exchange) were underinsured, meaning that their coverage did not provide them with affordable access to health care.<sup>87</sup> As benchmarks for affordability, the study considered whether out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 10 percent or more of household income; out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 5 percent or more of household income for individuals living under 200 percent of the FPL (\$27,180 for an individual or \$55,500 for a family of four in 2022); or the deductible constituted 5 percent or more of household income. The performance of STLDI products along these affordability dimensions has been proven worse, often to striking degree, as discussed in section II.B of this preamble.

The Departments also recognize that these affordability concerns could be exacerbated when the expanded PTC subsidies under the IRA end in 2025 or if health expenditures (and therefore premiums) continue to grow at a relatively high rate.<sup>88</sup> The Departments are of the view that it is important to ensure consumers have access to a wide range of products that can support access to affordable health care. However, neither STLDI nor fixed indemnity excepted benefits coverage represent a complete solution to larger issues of affordable access to health care and health coverage, and current marketing practices and benefit designs that mimic comprehensive coverage exacerbates affordability and accessibility concerns. Consumers who enroll in these plans as a substitute for comprehensive coverage or under the misapprehension that STLDI and fixed indemnity excepted benefits coverage are

a lower-cost equivalent to comprehensive coverage are at risk of being exposed to significant financial liability in the event of a costly or unexpected health event, often without knowledge of the risk associated with such coverage.

### *B. Risks to Consumers*

As noted in the introduction to this section II of this preamble, the limitations on benefits and coverage under STLDI or fixed indemnity excepted benefits coverage may allow some issuers to offer such coverage at lower monthly premiums than comprehensive coverage. The Departments are concerned about additional costs to consumers who enroll in STLDI or fixed indemnity excepted benefits coverage and incur medical expenses that are not covered by such coverage. The typical limits on coverage provided by STLDI and fixed indemnity excepted benefits coverage can lead to more and higher uncovered medical bills than consumers enrolled in comprehensive coverage would incur, exposing consumers with STLDI or fixed indemnity excepted benefits coverage to greater financial risk.<sup>89</sup> Healthy consumers who enroll in STLDI or fixed indemnity excepted benefits coverage as an alternative to comprehensive coverage may not realize their STLDI or fixed indemnity excepted benefits coverage excludes or limits coverage for pre-existing conditions (including conditions the consumer did not know about when they enrolled), or conditions contracted after enrollment,<sup>90</sup> such as COVID-19, as discussed in this section and in section V.B.2.a.

Additionally, a consumer enrolled in STLDI may discover that a newly-diagnosed medical condition is categorized

<sup>84</sup> Congressional Budget Office (2022). "Letter from Phillip L. Swagel to Rep. Mike Crapo, "Re: Health Insurance Policies," available at: [https://www.cbo.gov/system/files?file=2022-07/58313-Crapo\\_letter.pdf](https://www.cbo.gov/system/files?file=2022-07/58313-Crapo_letter.pdf).

<sup>85</sup> 87 FR 61979 (October 13, 2022).

<sup>86</sup> *Id.* at 61999.

<sup>87</sup> Collins, Sara, Lauren Haynes, and Relebohile Masitha (2022). "The State of U.S. Health Insurance in 2022: Findings from the Commonwealth Fund Biennial Health Insurance Survey," Commonwealth Fund, available at: <https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey>.

<sup>88</sup> Regarding trends in national health expenditure, see CMS (2023). "NHE Fact Sheet," available at: <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>.

<sup>89</sup> Palanker, Dania, JoAnn Volk, and Kevin Lucia (2018). "Short-Term Health Plan Gaps and Limits Leave People at Risk," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2018/short-term-health-plan-gaps-and-limits-leave-people-risk>. (Describing STLDI marketing materials that list coverage limits that would fall far short of typical costs to a consumer, including \$1,000 a day for hospital room and board coverage, \$1,250 a day for the intensive care unit, \$50 a day for doctor visits while in the hospital, \$100 a day for inpatient substance abuse treatment, and \$250 for ambulance transport).

<sup>90</sup> See Williams, Jackson (2022). "Addressing Low-Value Insurance Products With Improved Consumer Information: The Case of Ancillary Health Products," National Association of Insurance Commissioners, *Journal of Insurance Regulation*, available at: <https://content.naic.org/sites/default/files/cipr-jir-2022-9.pdf>.



as a preexisting condition, and related medical expenses will not be covered by, or will be only partially covered by, their STLDI policy.<sup>91</sup> For example, a consumer in Illinois who was diagnosed with Stage IV cancer a month *after* enrolling in STLDI was denied coverage for treatment by the STLDI issuer, both for treatments that led to his successful remission and for a potentially life-saving bone marrow transplant. In his case, the issuer of his STLDI policy determined that his cancer was a preexisting condition because he had disclosed experiencing back pain of undiagnosed cause to the broker who sold him his STLDI policy – leaving him with \$800,000 of medical debt and without meaningful health coverage as he continued to fight his illness.<sup>92</sup>

The financial risk for consumers enrolled in STLDI increases with the length of their policy, as the longer consumers are enrolled in STLDI, the more likely they are to incur costs that are not covered. This is especially the case for consumers who encounter newly diagnosed conditions or have a significant medical event while enrolled in STLDI. Researchers found that the maximum out-of-pocket health care spending limit for STLDI was on average nearly three times that of comprehensive coverage in 2020.<sup>93</sup> A 2020 report found that over 60 percent of the STLDI policies surveyed had a maximum out-of-pocket limit greater than the \$7,900 limit that was permitted for self-only comprehensive coverage in 2019, and 15 percent had limits in excess of \$15,000; as is typical for STLDI, these

limits apply only to the coverage period, which in some cases was only 6 months, compared to the annual limits required under the ACA for comprehensive coverage.<sup>94</sup> Consumers enrolled in STLDI who ultimately require medical care are more likely to incur higher out-of-pocket costs than if they had enrolled in comprehensive coverage.<sup>95</sup> Refer to section V.B.2.c of this preamble for additional discussion of the financial risks to consumers.

As noted in section I.D of this preamble, consumers who enroll in fixed indemnity excepted benefits coverage as an alternative to comprehensive coverage bear similar risk and exposure to significant out-of-pocket expenses due to their health care costs exceeding the fixed cash benefit to which they may be entitled, if benefits are even provided at all for their illness or injury. Comments received in response to the 2023 proposed rules affirmed the Departments' concerns by offering several examples of consumer risk and exposure resulting from enrollment in fixed indemnity insurance. For example, one commenter described a fixed indemnity plan that advertised that it would pay \$25 for a doctor visit, \$100 for a diagnostic exam, and \$300 for neonatal intensive care, and contrasted those benefits to one hospital's pricing schedule for NICU service, Level 4. The commenter observed that a consumer with such fixed indemnity insurance alone could still face \$8,500 daily for NICU services. Another commenter stated that indemnity plans that are structured to pay various dollar amounts for different services appear very

similar to comprehensive insurance, even though they offer much less coverage.

Consumers who enroll in STLDI and fixed indemnity excepted benefits coverage and do not also have comprehensive coverage may experience financial hardship when their medical bills are unaffordable.<sup>96</sup> Notably, the protections against balance billing and out-of-network cost sharing for certain out-of-network services established under the No Surprises Act, which are intended to shield consumers from surprise bills that can result in medical debt,<sup>97</sup> do not apply to STLDI or fixed indemnity excepted benefits coverage.<sup>98</sup> Because STLDI is typically subject to medical underwriting and is not guaranteed renewable, consumers enrolled in STLDI in lieu of comprehensive coverage may be unable to renew their STLDI policy at the end of the coverage period. These consumers therefore face the risk of being uninsured until they are eligible to purchase comprehensive coverage in the individual market during an open enrollment or when a special enrollment period occurs. It is therefore critical for consumers to understand, prior to purchase, that STLDI serves better as a bridge between different sources of comprehensive coverage than as an alternative to comprehensive coverage, and that choosing to substitute STLDI for comprehensive coverage may reduce access to coverage. Similarly, as noted in section I.D of this preamble, consumers need to understand, prior to purchase, that fixed indemnity excepted benefit coverage serves best as an income replacement policy<sup>99</sup> that supplements

<sup>91</sup> See Lueck, Sarah (2018). "Key Flaws of Short-Term Health Plans Pose Risks to Consumers," Center on Budget and Policy Priorities, available at: <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers>. See also Hall, Mark and Michael McCue (2022). "Short-Term Health Insurance and the ACA Market," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2022/short-term-health-insurance-and-aca-market>. See also Partnership to Protect Coverage (2021). "Under-Covered: How 'Insurance-Like' Products are Leaving Patients Exposed," available at: [https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Undercovered\\_Report\\_03252021.pdf](https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Undercovered_Report_03252021.pdf).

<sup>92</sup> Partnership to Protect Coverage (2021). "Under-Covered: How 'Insurance-Like' Products are Leaving Patients Exposed," available at: [https://www.nami.org/NAMI/media/NAMIMedia/Public%20Policy/Undercovered\\_Report\\_03252021.pdf](https://www.nami.org/NAMI/media/NAMIMedia/Public%20Policy/Undercovered_Report_03252021.pdf).

<sup>93</sup> Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-term Limited-duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>94</sup> *Id.* See also Palanker, Dania, Kevin Lucia, and Emily Curran (2017). "New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2017/new-executive-order-expanding-access-short-term-health-plans-bad-consumers-and-individual>. ("When considering the deductible, the best-selling plans have out-of-pocket maximums ranging from \$7,000 to \$20,000 for just three months of coverage. In comparison, the ACA limits out-of-pocket maximums to \$7,150 for the entire [2017 calendar] year.")

<sup>95</sup> *Id.*

<sup>96</sup> Unaffordable medical debt increasingly impacts members of disadvantaged and marginalized communities. See Lopes, Lunna, Audrey Kearney, Alex Montero, Liz Hamel, and Mollyann Brodie (2022). "Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills," KFF, available at: <https://www.kff.org/health-costs/report/kff-health-care-debt-survey>. See also Himmelstein, David, Samuel Dickman, Danny McCormick, David Bor, Adam Gaffney, and Steffie Woolhandler (2022). "Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US," *JAMA Network Open*, Volume 5, Issue 9, available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796358>.

<sup>97</sup> Families USA (2019). "Surprise Medical Bills, Results from a National Survey," available at: <https://familiesusa.org/wp-content/uploads/2019/11/Surprise-Billing-National-Poll-Report-FINAL.pdf>.

<sup>98</sup> See 26 CFR 54.9816-2T, 29 CFR 2590.716-2(b), and 45 CFR 149.20(b).

<sup>99</sup> As an income replacement policy, the policyholder of a fixed indemnity excepted benefits coverage plan typically has broad discretion in how to use the fixed cash benefits provided, including but not limited to payment for medical expenses not covered by comprehensive coverage (for example, deductibles, coinsurance, copays) or to defray non-medical costs (for example, mortgage or rent).

comprehensive coverage by providing financial assistance, rather than serving as an alternative to comprehensive coverage.

In the preamble to the 2018 final rules, the Departments stated that individuals who purchased STLDI would potentially experience improved health outcomes and have greater protection from catastrophic health care expenses than if those individuals were uninsured.<sup>100</sup> However, experience with the COVID-19 public health emergency (PHE)<sup>101</sup> has prompted the Departments to reassess the degree of protection generally afforded by STLDI and fixed indemnity excepted benefits coverage, and to reassess the value of a framework that instead encourages uninsured individuals to purchase comprehensive coverage. Enrollees in STLDI with COVID-19 typically face significant limitations on coverage for COVID-19 related treatments, and high out-of-pocket expenses.<sup>102</sup> In addition, neither STLDI nor fixed indemnity excepted benefits coverage was subject to requirements under section 6001 of the Families First Coronavirus Response Act (Pub. L. 116-

127, March 18, 2020), as amended by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, March 27, 2020), to cover COVID-19 diagnostic testing, without cost sharing, furnished during the COVID-19 PHE; or the requirement under section 3203 of the CARES Act to cover qualifying coronavirus preventive services, including COVID-19 vaccines, without cost sharing.<sup>103</sup> Instead, both of these important coverage expansions enacted by Congress as part of the nation's response to the COVID-19 PHE applied only to comprehensive coverage. Any coverage by STLDI of (or, with respect to fixed indemnity excepted benefits coverage, benefits provided related to) COVID-19 diagnostic testing or vaccines was subject to the discretion of individual issuers of these policies and applicable State law. Notably, the Health Resources and Services Administration's COVID-19 Coverage Assistance Fund, which reimbursed eligible health care providers for providing COVID-19 vaccines to underinsured individuals, included enrollees in STLDI

and excepted benefits coverage within the definition of underinsured.<sup>104</sup> The CARES Act also amended the definition of "uninsured individual" in Social Security Act section 1902(ss) to include individuals enrolled only in STLDI. Even individuals enrolled in STLDI or fixed indemnity excepted benefits coverage who are generally healthy are at risk of needing health care, and thus at risk of incurring unaffordable medical bills at any time. The COVID-19 PHE underscored the unpredictability of when the need for medical care will arise, and the importance of encouraging individuals to enroll in comprehensive coverage.

The Departments have also become aware of potentially deceptive or aggressive marketing of STLDI and fixed indemnity excepted benefits coverage to consumers who may be unaware of the coverage limits of these plans or the availability of Federal subsidies that could reduce the costs of premiums and out-of-pocket health care expenditures for comprehensive coverage purchased through an Exchange.<sup>105</sup> A recent study that engaged

<sup>100</sup> 83 FR 38212, 38229 (October 2, 2018).

<sup>101</sup> On January 31, 2020, HHS Secretary Alex M. Azar II declared that as of January 27, 2020, a nationwide public health emergency exists as a result of the 2019 novel coronavirus (COVID-19). See HHS Administration for Strategic Preparedness and Response (January 31, 2020). "Determination That A Public Health Emergency Exists," available at: <https://aspr.hhs.gov/legal/PHE/Pages/2019-nCoV.aspx>. This declaration was last renewed by HHS Secretary Xavier Becerra on October 13, 2022, following previous renewals on April 21, 2020, July 23, 2020, October 2, 2020, January 7, 2021, April 15, 2021, July 20, 2021, October 18, 2021, January 14, 2022, April 12, 2022, and July 15, 2022. See "HHS Administration for Strategic Preparedness and Response, Renewal of Determination That A Public Health Emergency Exists," available at: <https://aspr.hhs.gov/legal/PHE/Pages/covid19-13Oct2022.aspx>. On January 30, 2023, and February 9, 2023, the Biden-Harris Administration announced that it intended to end the PHE at the end of the day on May 11, 2023. See Executive Office of the President, Office of Management and Budget (January 30, 2023). "Statement of Administration Policy: H.R. 382 and H.J. Res. 7," available at: <https://www.whitehouse.gov/wp-content/uploads/2023/01/SAP-H.R.-382-H.J.-Res.-7.pdf>; HHS Secretary Xavier Becerra (February 9, 2023). "Letter to U.S. Governors from HHS Secretary Xavier Becerra on renewing COVID-19 Public Health Emergency (PHE)," available at: <https://www.hhs.gov/about/news/2023/02/09/letter-us-governors-hhs-secretary-xavier-becerra-renewing-covid-19-public-health-emergency.html>. The PHE ended at the end of the day on May 11, 2023.

<sup>102</sup> See, for example, Curran, Emily, Kevin Lucia, JoAnn Volk, and Dania Palanker (2020). "In the Age of COVID-19, Short-Term Plans Fall Short for Consumers," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2020/age-of-covid-19-short-term-plans-fall-short-consumers>. This study found that STLDI policies provide less financial protection than comprehensive coverage if an enrollee needs treatment for COVID-19. The study found that among the 12 brochures reviewed for STLDI policies being sold in Georgia, Louisiana, and Ohio, 11 excluded nearly all coverage for prescription drugs, with some providing limited coverage of inpatient drugs. The study further found that STLDI imposed high cost sharing, with deductibles ranging from \$10,000 to \$12,500 (which did not count toward the enrollees' maximum out-of-pocket costs) and that enrollees may be required to meet separate deductibles for emergency room treatment, forcing some enrollees to face out-of-pocket costs of more than \$30,000 over a 6-month period. Additionally, the study found that STLDI did not cover services related to pre-existing conditions.

<sup>103</sup> Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 FR 71142, 71173 (Nov. 6, 2020); See also Departments of the Treasury, Labor, and Health and Human Services. "FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42, Q1," (April 11, 2020), available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf> and <https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf> (FAQs Part 42); "FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 50," (October 4, 2021), available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-50.pdf> and <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/faqs-part-50.pdf> (FAQs Part 50); "FAQs about Affordable Care Act Implementation Part 51, Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation," (Jan. 10, 2022), available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-51.pdf> (FAQs Part 51); "FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 52" (February 4, 2022), available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-52.pdf> and <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/faqs-part-52.pdf> (FAQs Part 52); and "FAQs about Families First Coronavirus Response Act, Coronavirus Aid, Relief, and Economic Security Act and Health Insurance Portability and Accountability Act Implementation Part 58" (March 29, 2023), available at: <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-58> and <https://www.cms.gov/ccio/resources/fact-sheets-and-faqs/downloads/faqs-part-58.pdf> (FAQs Part 58). Note that the COVID-19 PHE ended on May 11, 2023.

<sup>104</sup> Underinsured individuals are defined for this purpose as having a health plan that either does not include COVID-19 vaccine administration as a covered benefit or covers COVID-19 vaccine administration but with cost sharing. See Health Resources and Services Administration. "FAQs for The HRSA COVID-19 Coverage Assistance Fund," available at: <https://www.hrsa.gov/provider-relief/about/covid-19-coverage-assistance/faq>.

<sup>105</sup> Palanker, Dania and Kevin Lucia (2021). "Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk>. (Noting that fixed indemnity insurance may be "bundled" with other non-comprehensive insurance products in such a way that "the plans look like comprehensive coverage" while still offering limited benefits). See also Palanker, Dania, JoAnn Volk, and Maanasa Kona (2019). "Seeing Fraud and Misleading Marketing, States Warn Consumers About Alternative Health Insurance Products," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2019/seeing-fraud-and-misleading-marketing-states-warn-consumers-about-alternative-health>.

in covert testing of health insurance sales representatives found evidence of deceptive marketing practices by agents and brokers who omitted or misrepresented information about the products they were selling.<sup>106</sup> For example, during a phone transaction, a sales representative told the consumer that they were purchasing a comprehensive health insurance plan, but instead sold the consumer two limited benefit insurance plans. During the exchange, the consumer repeatedly informed the sales representative that they had diabetes and had recently been seeking treatment for the condition. However, the application filled out by the sales representative on the consumer's behalf stated that consumer had not been treated for or diagnosed with diabetes for the past 5 years. In another phone transaction, the sales representative enrolled the consumer in a benefit association offering a limited benefit indemnity insurance plan. The representative would not provide the consumer with documentation describing the plan prior to enrollment and stated that the consumer had to purchase the plan on the day of the call if they wanted to be guaranteed the quoted price. The Departments note that these concerns are not limited to individual market consumers considering STLDI or fixed indemnity excepted benefits coverage. Reports that employers are increasingly offering fixed indemnity coverage alongside a plan that offers only a very limited set of primary or preventive care benefits (or in some cases, as the only form of health coverage) have also raised concerns with respect to consumers who obtain this health coverage through their employers.<sup>107</sup>

Consumers who are unaware of the coverage limitations of these arrangements, or who are employed by employers

who are similarly unaware, can face overwhelming medical costs if they require items and services that are not covered by the very limited group health plan. This is because the fixed indemnity excepted benefits coverage generally provides only fixed cash benefits that may be far lower than the costs of medical services, rather than coverage intended to cover most of the costs of the medical services themselves. For example, a Texas consumer who was enrolled in two forms of health insurance through his employer received a \$67,000 hospital bill after he experienced a heart attack. Although he believed he had comprehensive coverage, he learned that his coverage was provided through a group health plan that covered only preventive services and prescription drugs and a fixed indemnity excepted benefits coverage policy that provided a cash benefit of less than \$200 per day of hospitalization.<sup>108</sup> Additionally, employers may incur penalties if they erroneously treat fixed indemnity policies as excepted benefits when the policies do not meet the requirements for excepted benefits (for example, when they are not offered as independent, noncoordinated benefits) and fail to comply with applicable group market Federal consumer protections and requirements for comprehensive coverage, such as the requirement to provide participants, beneficiaries, and enrollees with a summary of benefits and coverage that meets applicable content requirements or the prohibition on lifetime and annual dollar limits on essential health benefits.<sup>109</sup>

In light of research revealing significant disparities in health insurance literacy among certain underserved racial and ethnic groups and people with incomes below the FPL,<sup>110</sup> and as further discussed in sections III.A.1 and V.B.2.g of this

preamble, the Departments are also concerned that underserved populations may be particularly vulnerable to misleading or aggressive sales and marketing tactics that obscure the differences between comprehensive coverage and STLDI or fixed indemnity excepted benefits coverage, exposing these populations to higher levels of health and financial risks. As noted in Executive Order 13995, the COVID-19 pandemic has “exposed and exacerbated severe and pervasive health and social inequities in America,” highlighting the urgency with which such inequities must be addressed.<sup>111</sup> These concerns continue during the time frame when States are unwinding from the Medicaid continuous enrollment condition under the Families First Coronavirus Response Act (FFCRA), which expired on March 31, 2023, under amendments made by the Consolidated Appropriations Act, 2023. Across the country, State agencies are currently in the process of resuming regular eligibility and enrollment operations, which includes conducting full Medicaid and CHIP renewals and terminating coverage for individuals who are no longer eligible.<sup>112</sup> As a result, individuals may have to transition between coverage programs, leaving them vulnerable.<sup>113</sup> The Departments are concerned that those transitioning out of Medicaid coverage may be susceptible to aggressive or deceptive marketing and sales tactics, and might therefore mistakenly enroll in STLDI or fixed indemnity excepted benefits coverage in lieu of comprehensive coverage.

### C. Impact on Risk Pools

At the time the 2018 final rules were issued, the Departments acknowledged that expanding access to STLDI could

<sup>106</sup> Government Accountability Office (2020). “Private Health Coverage: Results of Covert Testing for Selected Offerings,” available at: <https://www.gao.gov/products/gao-20-634r>.

<sup>107</sup> Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Coverage is a Problematic Form of “Junk” Insurance,” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>.

<sup>108</sup> Avila, Jaie (2019). “Show Me Your Bill Helps Wipe Out \$70K in Charges After Heart Attack,” News 4 San Antonio, available at: <https://news4sanantonio.com/news/trouble-shooters/show-me-your-bill-helps-wipe-out-70k-in-charges-after-heart-attack>.

<sup>109</sup> See 26 CFR 54.9815-2715(e); 29 CFR 2590.715-2715(e); 45 CFR 147.200(e). See also section 2711 of the PHS Act and section 4980D of the Code.

<sup>110</sup> Edward, Jean, Amanda Wiggins, Malea Hoepf Young, Mary Kay Rayens (2019). “Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform,” *Health Literacy Research and Practice*, available at: <https://pubmed.ncbi.nlm.nih.gov/31768496>. See also Villagra, Victor and Bhumika Bhuvra (2019). “Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference,” *The American Journal of Managed Care*, available at: <https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference>.

<sup>111</sup> 86 FR 7193 (January 26, 2021).

<sup>112</sup> See CMS, Center for Medicaid & CHIP Services (January 5, 2023). Key Dates Related to the Medicaid Continuous Enrollment Condition Provisions in the Consolidated Appropriations Act, 2023, available at: [https://www.medicare.gov/sites/default/files/2023-01/cib010523\\_1.pdf](https://www.medicare.gov/sites/default/files/2023-01/cib010523_1.pdf). As a condition of receiving a temporary Federal Medical Assistance Percentage (FMAP) increase under section 6008 of the FFCRA, States were required to maintain enrollment of nearly all Medicaid enrollees. This “continuous enrollment condition” expired on March 31, 2023, under amendments made by the Consolidated Appropriations Act, 2023. States adopted other flexibilities in CHIP and BHP that impacted renewals in those programs during this time.

have potential negative effects on the risk pools for individual health insurance coverage and on individuals who find themselves insufficiently protected by the typically limited benefits of an STLDI policy.<sup>114</sup> However, the Departments were of the view that the affordability and access challenges facing consumers at that time outweighed those potential negative effects and necessitated action to increase access to STLDI to provide an alternative option for individuals who were unable or disinclined to purchase comprehensive coverage.

As discussed earlier in section II.A of this preamble, access to affordable comprehensive coverage has significantly improved since the 2018 final rules were published. However, research based on individual market data for plan year 2020 has substantiated concerns about the negative impact that the shift of healthier individuals from comprehensive coverage to STLDI has on individuals remaining in the risk pools for individual health insurance coverage.<sup>115</sup> Because healthier individuals are more likely to enroll in STLDI than individuals with known medical needs, the extended contract terms and renewal periods of STLDI under the current Federal regulations result in healthier consumers leaving (or opting out of) the risk pools for individual health insurance coverage for extended periods of time. This has resulted in increased premiums for individuals seeking to purchase individual health insurance coverage.<sup>116</sup> For unsubsidized individuals, the costs are borne directly by the consumer, and for subsidized individuals, the costs are borne largely by the Federal Government in the form of increased per capita PTC spending associated with increased individual health

insurance coverage premiums. Likewise, reports of fixed indemnity excepted benefits coverage being marketed and sold as an alternative to comprehensive coverage, as discussed in section V.B.2.a of this preamble, raise concerns about the potential for such practices having a similar impact on the risk pools for individual health insurance coverage.

Another study looking at States that have adopted policies that restrict STLDI to shorter durations than allowed under the current Federal regulations found that, from 2018 to 2020, States that restricted or prohibited the sale of STLDI saw fewer consumers enroll in such insurance, were able to keep more healthy people in the individual health insurance coverage market risk pool, and saw a greater decline in average medical costs for enrollees in individual health insurance coverage.<sup>117</sup> The study reported that, as a result, the risk score – a measurement of the relative medical costs expected for the populations covered by comprehensive coverage in each State, both on- and off-Exchange – decreased by 40 percent more in States with more regulation of STLDI than States with less regulation.<sup>118</sup>

In addition to ensuring that consumers can clearly distinguish STLDI from comprehensive coverage, this new evidence provides an additional basis for the Departments' conclusion that it is important to amend the Federal definition of STLDI.

#### *D. Need for Rulemaking*

For the reasons described in this section II of this preamble, the Departments are of the view that it is necessary and appropriate to amend the Federal defi-

nition of STLDI to ensure that consumers can clearly distinguish STLDI from comprehensive coverage, protect the risk pools and stabilize premiums for individual health insurance coverage, and promote access to affordable comprehensive coverage.

With respect to individual market fixed indemnity excepted benefits coverage, the decision in *Central United Life Ins. Co. v. Burwell*, which invalidated the requirement that an individual must attest to having MEC prior to purchasing fixed indemnity excepted benefits coverage in the individual market, and the passage of the Tax Cuts and Jobs Act, which reduced the individual shared responsibility payment to \$0 for months beginning after December 31, 2018, increase the likelihood that individuals would purchase fixed indemnity excepted benefits coverage as a substitute for comprehensive coverage. HHS is of the view that these changes necessitate rulemaking with respect to individual market fixed indemnity excepted benefits coverage. Further, while the Departments did not finalize the proposed amendments to the group market fixed indemnity excepted benefits coverage regulations outlined in the 2016 proposed rules, the Departments noted their intention to address fixed indemnity excepted benefits coverage in future rulemaking.<sup>119</sup> The Departments have continued to monitor the impact of these coverage options and remain concerned about the negative impacts of fixed indemnity excepted benefits coverage on consumers when such products are sold as an alternative to comprehensive coverage.

In light of the Departments' ongoing concerns about the numerous negative impacts of STLDI and fixed indemnity

<sup>113</sup> See CMS, Center for Medicaid & CHIP Services (January 27, 2023). "Letter to State Health Officials from Deputy Administrator and Director Daniel Tsai RE: Medicaid Continuous Enrollment Condition Changes, Conditions for Receiving the FFCRA Temporary FMAP Increase, Reporting Requirements, and Enforcement Provisions in the Consolidated Appropriations Act, 2023," available at: <https://www.medicare.gov/sites/default/files/2023-08/sho23002.pdf>.

<sup>114</sup> 83 FR 38212 at 38218 (August 3, 2018).

<sup>115</sup> See Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-term Limited-duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>116</sup> *Id.* ("Carrier expectations for the impact of [regulatory actions including the expansion of short-term, limited-duration insurance policies and other loosely regulated insurance and the repeal of the Federal individual shared responsibility payment being reduced to \$0] on premiums in the ACA individual market for 2020 are approximately 4 percent in [S]tates that have not restricted the sale or duration of STLD policies ... Among the [S]tates that have limited the impact of loosely regulated insurance through reinstating an individual mandate or by restricting STLD expansion, carriers have assumed an average premium impact in 2020 due to regulatory actions that is about 5 percent lower than other [S]tates.") As noted in section V.B.2.e of this preamble, this study also found that the few issuers that explicitly included a premium adjustment because of the adoption of the revised Federal definition of STLDI in the 2018 final rules increased premiums by between 0.5 percent and 2 percent in 2020.

<sup>117</sup> See Hall, Mark and Michael McCue (2022). "Short-Term Health Insurance and the ACA Market," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2022/short-term-health-insurance-and-aca-market>.

<sup>118</sup> *Id.*

<sup>119</sup> 81 FR 75316 at 75317 (October 31, 2016).

excepted benefits coverage being offered as an alternative to comprehensive coverage, as well as the significant changes in market conditions and in the legal landscape since the Departments’ last regulatory actions addressing these products, and in consideration of the comments on the 2023 proposed rules received by the Departments, the Departments are finalizing changes to the Federal regulations governing STLDI and addressing notice requirements in the individual and group market regulations related to fixed indemnity excepted benefits coverage. HHS is also finalizing the technical amendments to the individual market fixed indemnity excepted benefits coverage regulation to remove the MEC attestation requirement currently codified at 45 CFR 148.220(b)(4)(i). As further explained in section III.B of this preamble, the Departments are not finalizing the proposed payment standards and noncoordination provisions regarding fixed indemnity excepted benefits coverage at this time. The Departments remain concerned about the issues addressed by these proposals, and intend to address these issues in future rulemaking, after additional study and consideration of the concerns raised in comments.

**III. Overview of the Final Regulations – The Departments of the Treasury, Labor, and Health and Human Services**

*A. Short-Term, Limited-Duration Insurance*

After considering the public comments, the Departments are finalizing the proposed amendments to the Federal definition of STLDI with some modifications. Under the definition in these final rules, STLDI means health insurance coverage provided pursuant to a policy, certificate, or contract of insurance that has an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date of the policy, certificate, or contract of insurance, and taking into account any renewals or extensions, has a duration no longer than 4 months in total. For purposes of this definition, a renewal or extension includes the term of a new STLDI policy, certificate, or contract of insurance issued by the same issuer to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certifi-

cate, or contract of insurance. As explained in section III.A.2 of this preamble, in response to comments, the Departments are specifying that for purposes of this definition, if the issuer is a member of a controlled group, a renewal or extension also includes the term of a new STLDI policy, certificate, or contract of insurance issued by any other issuer that is a member of such controlled group. As used in this context, the term “controlled group” means any group treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Code, as amended.

These final rules also retain the requirement that STLDI issuers display a notice on the first page (in either paper or electronic form, including on a website) of the policy, certificate, or contract of insurance, and in any marketing, application, and enrollment materials (including reenrollment materials) provided to individuals at or before the time an individual has the opportunity to enroll (or reenroll) in the coverage, in at least 14-point font. As finalized in these final rules, STLDI issuers must use the following updated language for the STLDI consumer disclosure notice:

**IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage**

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov.

<b>This policy</b>	<b>Insurance on HealthCare.gov</b>
<b>Might not cover you</b> due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can’t deny you coverage due to preexisting health conditions
<b>Might not cover</b> things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have <b>no limit on what you pay</b> ut-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You <b>won’t qualify</b> for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
<b>Doesn’t have to meet</b> Federal standards for comprehensive health coverage	All plans must meet Federal standards

**Looking for comprehensive health insurance?**

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member’s job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners’ website ([naic.org](https://www.naic.org)) under “Insurance Departments.”

As explained in section III.A.4 of this preamble, in response to comments, the notice adopted in these final rules contains additional specificity, including that STLDI does not have to meet Federal standards for comprehensive coverage and information about finding contact information for State departments of insurance on the NAIC website (naic.org).

In response to comments, the Departments are finalizing modified applicability dates. These final rules apply to new STLDI policies sold or issued on or after September 1, 2024. The provisions of the 2018 final rules continue to apply to STLDI policies sold or issued before September 1, 2024, except that the updated notice provision adopted in these final rules applies to such policies for coverage periods beginning on or after September 1, 2024. As was proposed in the 2023 proposed rules, these final rules are effective 75 days after publication in the **Federal Register**.

#### 1. In General

The Departments received comments generally in support of and generally opposed to the adoption of the STLDI proposals in the 2023 proposed rules. The Departments summarize and respond to comments about the STLDI proposals in the 2023 proposed rules later in this section of the preamble.

Some commenters stated that the 2023 proposed rules were an overreach of the Departments' authority because Congress did not provide an explicit delegation of authority to define the terms "short-term" and "limited-duration." Some commenters expressed concern that the 2023 proposed rules are contrary to congressional intent because Congress specifically determined that certain types of insurance would not be subject to the requirements of the ACA,

including STLDI, which is excepted from the definition of individual health insurance coverage. Commenters suggested that the Departments' interpretation is unreasonable because it conflicts with and undermines Congress's express goals for consumers to have access to STLDI plans that are exempt from Federal regulation, to reduce gaps in health insurance and the number of uninsured. One commenter also expressed concern that the Departments' interpretation will increase medical underwriting frequency to every 3 to 4 months leading to more consumers losing coverage. One commenter stated that the Departments' interpretation is unreasonable because it pressures consumers into enrolling in comprehensive coverage to avoid greater financial exposure. Several commenters stated that there is no statutory basis for the Departments to regulate consumer behavior and the Departments have no legal authority to impose burdens or limitations on STLDI, such as a consumer notice. One commenter argued that the Departments lack the authority to implement a shorter maximum allowed length because the proposals are overly broad and will unduly harm consumers. Several commenters stated that the proposed rules are arbitrary, capricious, and not in accordance with law because the Departments rely on factors to justify the new definition that were not relevant to Congress's considerations.

The Departments are not persuaded by these comments. As explained in greater detail in this section III.A.1 of this preamble, these final rules revise the definition for the term "short-term, limited-duration insurance," and set standards to more clearly distinguish STLDI from individual health insurance coverage. These final rules do not regulate consumer behavior. Consumers will continue to have access to STLDI plans that are generally exempt

from the Federal consumer protections and requirements for comprehensive coverage that apply to individual health insurance coverage.<sup>120</sup> As detailed later in this section of this preamble, the Departments have clear authority to promulgate regulations to define STLDI and to pursue the current amendments. The Departments also disagree that the definition in the proposed rules, and as finalized in these rules, is unreasonable, inconsistent with the law, or arbitrary and capricious.

Other commenters stated that the Departments have clear statutory authority under the PHS Act to interpret undefined terms in the PHS Act, ERISA, and the Code,<sup>121</sup> and to promulgate regulations that interpret (or reinterpret) the meaning of "short-term, limited-duration," so long as their interpretation is reasonable. These commenters observed that Congress did not define the term "short-term, limited-duration insurance," and primarily only included a reference to STLDI as an exclusion from individual health insurance coverage.<sup>122, 123</sup> These commenters explained that the Departments must give meaning to the term short-term, limited-duration insurance to distinguish it from individual health insurance coverage.

The Departments disagree with the commenters who questioned the Departments' legal authority to promulgate Federal regulations to define STLDI and distinguish it from individual health insurance coverage. As explained in the preamble to the 2018 final rules,<sup>124</sup> the Departments have clear statutory authority under the Code, ERISA, and the PHS Act to implement those statutes.<sup>125</sup> To determine what is and is not individual health insurance coverage, which is essential to ensure that the Code, ERISA, and the PHS Act function as Congress intended, and to allow enforcement of the rules that apply to individual health insurance coverage,

<sup>120</sup> Neither the proposed rules nor these final rules seek to extend the Federal consumer protections and requirements for comprehensive individual health insurance coverage to STLDI.

<sup>121</sup> See section 715 of ERISA and section 9815 of the Code, which incorporate 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. See also section 104 of HIPAA. See also sections 505 and 734 of ERISA, sections 2761 and 2792 of the PHS Act, section 1321(a)(1) and (c) of ACA and section 7805 of the Code.

<sup>122</sup> See section 2791(b)(5) of the PHS Act (defining "individual health insurance coverage").

<sup>123</sup> While STLDI is generally not subject to the Federal consumer protections and requirements for comprehensive coverage that apply to individual health insurance coverage, the agent and broker compensation disclosure and reporting requirements in section 2746 of the PHS Act apply to health insurance issuers offering individual health insurance coverage or STLDI.

<sup>124</sup> 83 FR 38212 at 38215 (August 3, 2018).

<sup>125</sup> See section 9815 of the Code and section 715 of ERISA, which incorporate provisions of Part A of title XVIII of the PHS Act (generally, sections 2701 through 2728 of the PHS Act) into the Code and ERISA. See also section 104 of HIPAA. See also section 7805 of the Code, sections 505 and 734 of ERISA, sections 2761 and 2792 of the PHS Act, and section 1321(a)(1) and (c) of the ACA. See also *Ass'n for Community Affiliated Plans v. U.S. Department of the Treasury*, 966 F.3d 782 (D.C. Cir. 2020).

the Departments must give meaning to the term STLDI.<sup>126</sup>

The 2023 proposed rules are faithful to Congress’s intent because Congress wanted STLDI to be an option but did not intend STLDI to be a substitute for comprehensive coverage or to pass as comprehensive coverage while avoiding ACA requirements and other Federal consumer protections applicable to comprehensive coverage. Finally, the 2023 proposed rules and these final rules are not designed to limit access to STLDI or pressure consumers into enrolling in comprehensive coverage. Rather, they are designed to, among other things, ensure that consumers can distinguish between STLDI and comprehensive coverage. Congress provided the Secretaries of the Treasury, Labor, and HHS with explicit authority to promulgate regulations as may be necessary or appropriate to carry out the provisions of the Code, ERISA, and the PHS Act.<sup>127</sup> This includes the authority to issue regulations on STLDI to define it and set standards to distinguish it from individual health insurance coverage.

The Departments’ authority to issue regulations that define STLDI and set standards to distinguish it from individual health insurance coverage was also recently affirmed in the D.C. Circuit.<sup>128</sup> In 2020, the D.C. Circuit explicitly considered the Departments’ authority to define STLDI as finalized in the 2018 final rules and affirmed the Departments’ authority to promulgate such regulations.<sup>129</sup> The D.C. Circuit stated:

“Without further guidance from Congress, we will not place amorphous restrictions on the Departments’ authority to define such an open-ended term. It suffices to say that the Departments have the discretion to define STLDI to include policies shorter than the standard policy term.”<sup>130</sup>

Furthermore, the decision made clear that Congress gave the Departments “wide latitude” to define STLDI, which includes the flexibility to narrow the definition of STLDI in the future, provided the Departments provide a reasoned explanation for the change.<sup>131</sup> Both the 2023 proposed rules and these final rules provide the Departments’ reasoned explanations for the changes to the Federal definition of STLDI. These final rules adopt a revised Federal definition of the term STLDI and set standards to more clearly distinguish STLDI from individual health insurance coverage without placing unreasonable burdens on issuers of STLDI.

The Departments acknowledge that the final rules may be associated with some consumers being subject to medical underwriting more frequently. For example, a consumer who prefers STLDI coverage and chooses to reenroll in STLDI coverage with a different issuer every 4 months may be subject to medical underwriting each time they enroll or renew coverage, whereas under the current rules they could stay in one STLDI policy for a longer duration. However, in the Departments’ view, this possibility does not outweigh other potential benefits to consumers of the revised definition of STLDI, in part because consumers face a similar risk under the current rules. Even when enrolled in STLDI coverage that complies with the 2018 final rules, a consumer can be subject to post-claims underwriting and their STLDI coverage may not cover certain health conditions that develop unexpectedly or over time. Yet because the STLDI coverage has a longer maximum duration under current rules, a consumer who remains in STLDI coverage might go without necessary benefits for a longer period of time, forcing the consumer to choose between necessary medical care and high out-of-pocket expenses. Consumers may avoid the potential consequences of more frequent medical under-

writing by enrolling in comprehensive coverage subject to Federal consumer protections and requirements.

The definition and standards, as proposed and finalized, apply to health insurance issuers that elect to offer STLDI, and they do not regulate consumer behavior. Issuers will not be prohibited from selling STLDI and consumers may continue to choose to purchase it. The changes to the Federal definition and standards for STLDI will help consumers make more informed purchasing decisions and mitigate the risk that consumers will mistakenly enroll in STLDI as a substitute for comprehensive coverage.

The Departments disagree that the revised Federal definition of STLDI is unreasonable or arbitrary and capricious. As explained in the preamble to the 2023 proposed rules<sup>132</sup> and in the introduction to this section III.A of this preamble, the Federal definition established in these final rules clearly distinguishes STLDI from individual health insurance coverage that is subject to the Federal consumer protections and requirements for comprehensive coverage. Further, the statute does not explicitly denote a required length for STLDI or to what extent the definition of STLDI must vary from the definition of individual health insurance coverage, so the Departments are interpreting and implementing the statute in a manner that distinguishes between STLDI and individual health insurance coverage. Over the last two decades, the Departments have used this discretion to both shorten and lengthen the duration of STLDI as the Departments have deemed appropriate and necessary given the market conditions and legal landscape they were then facing. Beginning in 1997, the Departments defined STLDI as coverage of less than 12 months to accommodate 12-month preexisting condition exclusion periods imposed by group health plans and group health insurance issuers when a

<sup>126</sup> As discussed in footnote 13, the definition of STLDI also has some relevance with respect to certain provisions that apply to group health plans and group health insurance issuers over which the Departments of Labor and the Treasury have jurisdiction.

<sup>127</sup> See section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act.

<sup>128</sup> *Ass’n for Community Affiliated Plans v. U.S. Department of the Treasury*, 966 F.3d 782 (D.C. Cir. 2020), *aff’d* 966 F.3d 782 (D.C. Cir. 2020).

<sup>129</sup> *Ass’n for Community Affiliated Plans v. U.S. Department of the Treasury*, 966 F.3d 782 (D.C. Cir. 2020).

<sup>130</sup> *Id.* at 789.

<sup>131</sup> *Id.* at 789 and 792 (citing to *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016)).

<sup>132</sup> See, for example, 88 FR 44596 at 44610, 44612, 44614-44618 (July 12, 2023) (discussing how the proposed changes to definitions of “short-term” and “limited-duration” and the proposed modifications to the required consumer notice would allow consumers to better distinguish between STLDI and comprehensive coverage).

new hire did not have 12 months of creditable coverage that ended no more than 63 days prior to the enrollment date in the plan or coverage.<sup>133</sup> Once preexisting condition exclusions were prohibited and the Departments implemented a limit on employee waiting periods of up to 90 days plus a 1-month reasonable and bona fide employment-based orientation period (as defined in section 9801(b)(4) of the Code, section 701(b)(4) of ERISA, and 2704(b)(4) of the PHS Act),<sup>134</sup> and comprehensive coverage in the individual market was guaranteed available to individuals through or outside of the Exchanges, the Departments determined that a shorter duration for STLDI was more appropriate and revised the definition in the 2016 final rules.<sup>135</sup> Subsequently, when the Departments were concerned about the availability of affordable health insurance options, the Departments lengthened the initial contract term to less than 12 months with a maximum allowed duration of 36 months (including renewals and extensions) in the 2018 final rules.<sup>136, 137</sup>

The definition of STLDI in the 2023 proposed rules, and that the Departments are finalizing in these final rules, is consistent with applicable Federal law (for example, the Code, ERISA, and the PHS Act). The 2023 proposed rules proposed a revised Federal definition that set standards for STLDI that clearly distinguish it from individual health insurance coverage that is subject to the Federal consumer protections and requirements. This proposal and the definition finalized in these rules is consistent with Congress maintaining the exclusion of STLDI from the PHS Act definition of individual health insurance coverage. Further, as noted by commenters and discussed in section III.A.2 of this preamble, the new definition gives reason-

able meaning to the terms “short-term” and “limited-duration” since they reflect periods of time that are brief in comparison to the length of comprehensive coverage sold with an initial term of 12 months, on a guaranteed renewable basis.<sup>138</sup> The definition of STLDI in the 2023 proposed rules and these final rules is consistent with the original intent of HIPAA, as reinforced by the ACA, to provide temporary, stopgap coverage for individuals transitioning between comprehensive coverage.

Some commenters suggested that the Departments failed to provide sufficient justification, or lacked sufficient data or analysis, to support the proposed changes to the Federal definition of STLDI, particularly with respect to the changes to limit the initial duration of STLDI policies to 3 months, and the maximum duration to 4 months including renewals and extensions. In addition, one commenter expressed concern that an abrupt change to the maximum duration of STLDI may have unintended consequences on overall health care coverage and consumer choices, as occurred when the Departments increased the maximum duration of STLDI from less than 3 months to less than 12 months in the 2018 final rules. Some commenters suggested that the 2023 proposed rules would impose a market-disrupting change in the duration of STLDI without providing evidence to support this change.

As the Supreme Court stated in *Encino Motorcars v. Navarro*,<sup>139</sup> and the D.C. Circuit Court repeated in *Association for Community Affiliated Plans v. U.S. Department of the Treasury*,<sup>140</sup> “[a]gencies are free to change their existing policies as long as they provide a reasoned explanation for the change.” The Departments satisfy this requirement; the pro-

posed rules and these final rules provide a reasoned explanation of the changes to the Federal definition of STLDI. As explained in section III.A.2 of this preamble, the Departments determined that it is necessary and appropriate to amend the Federal definition of STLDI to ensure that consumers can clearly distinguish STLDI from individual health insurance coverage, protect the risk pools and stabilize premiums for individual health insurance coverage, and promote access to affordable comprehensive coverage. While the Departments acknowledge that they have limited data on enrollment in STLDI, the Departments have sufficient information and evidence to conclude that the changes to the definition finalized in these rules are appropriate and justified.

The Departments are of the view that these final rules are necessary and appropriate to combat deceptive marketing practices, distinguish STLDI from individual health insurance coverage, and address the changes in the legal landscape and market conditions from 2018 to 2024. Further, as discussed in section II.A of this preamble, since the publication of the 2018 final rules, comprehensive coverage for individuals has generally become more accessible and affordable, and while affordability concerns persist among consumers, STLDI is an inadequate substitute for comprehensive coverage.

Aggressive, deceptive marketing practices are an ongoing challenge for consumers shopping for coverage. As discussed in section II.B and section III.A.3 of this preamble, recent secret shopper studies have detailed ongoing practices by sellers of STLDI that do not inform consumers of eligibility for less expensive Exchange plans or that provide misleading information about STLDI with limited benefits.<sup>141</sup>

<sup>133</sup> 62 FR 16894 (April 8, 1997). See also 69 FR 78,720 (December 30, 2004) (finalizing the definition of STLDI in the 1997 HIPAA interim final rules).

<sup>134</sup> 26 CFR 54.9815-2708, 29 CFR 2590.715-2708, and 45 CFR 147.116.

<sup>135</sup> 81 FR 75316 at 75317, 75318 (October 31, 2016)

<sup>136</sup> As noted previously, the Departments’ authority to issue the 2018 final rules was challenged and upheld in *Ass’n for Community Affiliated Plans v. U.S. Department of the Treasury*, 966 F.3d 782 (D.C. Cir. 2020). See also *Ass’n for Community Affiliated Plans v. U.S. Department of the Treasury*, 392 F.Supp.3d 22 (D.D.C. 2019).

<sup>137</sup> 83 FR 38212 at 38218 (August 3, 2018)

<sup>138</sup> As the court noted in *Ass’n for Community Affiliated Plans v. U.S. Department of the Treasury* regarding the STLDI definition adopted in the 2018 final rules, “(u)nder the Departments’ definition, ‘short-term’ refers to the initial contract term, while ‘limited-duration’ refers to the policy’s total length, including renewals. This reasonable reading gives independent meaning to each term.” 966 F.3d at 789. The Departments are applying the same general framework to establish the new definition adopted in these final rules, with “short-term” referring to the initial contract term and the term “limited-duration” referring to the policy’s total length, including extensions and renewals.

<sup>139</sup> 136 S. Ct. 2117, 2125 (2016).

<sup>140</sup> 966 F.3d at 792.

<sup>141</sup> Schwab, R., & Volk, J. (August 28, 2023). “The Perfect Storm: Misleading Marketing of Limited Benefit Products Continues as Millions Losing Medicaid Search for New Coverage.” Center on Health Insurance Reforms, available at: <https://chirblog.org/the-perfect-storm-misleading-marketing-of-limited-benefit-products-continues-as-millions-losing-medicaid-search-for-new-coverage>.



Deceptive marketing practices can have devastating financial implications for consumers that purchased STLDI without fully understanding its limitations and later encounter unexpected and expensive medical events that are not covered by their insurance.<sup>142</sup> In addition, as explained in section III.A.2 of this preamble and the preamble to the 2023 proposed rules, the Federal definition for STLDI in these final rules is consistent with the group market rules regarding the 90-day waiting period provision under the ACA and with STLDI's traditional role of serving as temporary coverage for individuals transitioning between other types of comprehensive coverage. The definition is also similar to the less-than-3-month maximum term for STLDI under the 2016 final rules and under a number of State laws and aligns with the goal of Executive Order 14009 to support protections for people with preexisting conditions. The Departments have weighed the potential benefits and costs to consumers when developing the proposed rules and these final rules and concluded the changes will not unduly harm consumers.<sup>143</sup>

While the Departments are of the view that the changes to the Federal definition of STLDI finalized in these rules are critical, these final rules take steps to limit the potential of the rules having an abrupt, disruptive effect, particularly with respect to consumers currently enrolled in STLDI coverage, and to address the potential reliance interests of both issuers offering STLDI and consumers enrolled in STLDI under the 2018 final rules. As discussed in section III.A.6 of this preamble, with the exception of the notice provision, these final rules will not be applicable to STLDI policies sold or issued before September 1, 2024. This will result in a phased-in approach that limits the potential for market disrupting impact by

allowing individuals currently enrolled in STLDI to maintain coverage that meets the standards in the 2018 final rules through the duration of their current policy. In addition, this phased-in approach does not require issuers who have relied on the current rules to modify contracts for STLDI policies that are currently in place. Further, the proposed changes that are finalized in these rules will not result in an abrupt change in the maximum permitted duration of STLDI in many States. Of the States that currently permit STLDI, seven States and the District of Columbia already have a maximum permitted length of less than 3 months for STLDI while four additional States prohibit the sale of STLDI entirely, notwithstanding the longer duration permitted under the 2018 final rules.<sup>144</sup> Finally, as these final rules intend to protect against misleading marketing practices that harm consumers, the benefits of further differentiating STLDI from comprehensive coverage outweigh any potential unintended consequences of changing the maximum allowable duration of STLDI. As outlined in this section and elsewhere in these rules, the definition is well reasoned, is clearly within the Departments' authority, and is consistent with other applicable Federal law, and is therefore not arbitrary and capricious.

Some commenters expressed concern that the proposed definition of STLDI would interfere with the authority of States to regulate insurance pursuant to the McCarran-Ferguson Act and PHS Act. These commenters stated that the McCarran-Ferguson Act reserves the regulation of insurance to States so that States can tailor their health insurance policies to the needs of their residents. They stated that State regulators are better positioned to understand the unique characteristics and requirements of each State's respective insurance markets and are more respon-

sive to the needs of their insurance markets. Another commenter stated that under the PHS Act, Federal authority to regulate insurance is secondary to the primary authority of the States, and any Federal intrusion on State authority must be based on information that a State may not be substantially enforcing PHS Act requirements. A commenter noted that States have demonstrated their willingness and capacity to regulate STLDI coverage because half of States have regulations in place. For example, the commenter noted that the sale of STLDI is prohibited in some States<sup>145</sup> and other States have restricted the maximum allowed term of STLDI to 3, 6, or 12 months or coverage that terminates at the end of the calendar year.<sup>146</sup> Other commenters stated that some States only allow limited renewals of STLDI. Another State regulates STLDI by requiring that STLDI policies sold in the State provide certain consumer protections, implementing a separate risk pool, and creating a special enrollment period for consumers that exhaust the 36-month period of STLDI coverage, while setting minimum benefit and coverage requirements to meet the needs of seasonal employees that desire flexibility and low-cost health care coverage.<sup>147</sup> A commenter noted that 12 States currently prohibit health status underwriting for STLDI, which effectively bans STLDI in those States. The commenter stated that the proposed rules fail to balance States' interest in regulating health insurance issuers and their health insurance markets with Congress's intent to provide protections to consumers. On the other hand, a few commenters noted that variation in State oversight of STLDI has resulted in a patchwork of consumer protections across States, and one commenter stated that consumers would benefit from national-level STLDI regulation.

<sup>142</sup> Deam, Jenny (2021). "He Bought Health Insurance for Emergencies. Then He Fell Into a \$33,601 Trap," ProPublica, available at: <https://www.propublica.org/article/junk-insurance>.

<sup>143</sup> See the Regulatory Impact Analysis in section V of this preamble.

<sup>144</sup> See [Healthinsurance.org](https://www.healthinsurance.org) (2023). "Duration and Renewals of 2023 Short-Term Medical Plans by State," available at: <https://www.healthinsurance.org/wp-content/uploads/2023/09/state-by-state-short-term-health-insurance.pdf>; see also Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-term Limited-duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>145</sup> The commenter noted that STLDI is not for sale in a number of States including California, Colorado, Connecticut, Hawaii, Maine, Massachusetts, New Jersey, New Mexico, New York, Rhode Island, Vermont, and Washington. See also [Healthinsurance.org](https://www.healthinsurance.org) (2023). "Duration and Renewals of 2023 Short-Term Medical Plans by State," available at: <https://www.healthinsurance.org/wp-content/uploads/2023/09/state-by-state-short-term-health-insurance.pdf> (As of September 6, 2023, STLDI is not for sale in 14 States - California, Colorado, Connecticut, Hawaii, Maine, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Rhode Island, Vermont, and Washington - and the District of Columbia.)

<sup>146</sup> The commenter stated that Illinois allows the sale of STLDI that lasts for up to 180 days, and in New Hampshire, STLDI contracts can last for up to 6 months with a renewal or extension of up to a total of 18 months.

<sup>147</sup> The commenter stated that Iowa imposed minimum benefit and coverage requirements on short-term plans above Federal standards.

These final rules establish the Federal definition of STLDI with respect to the maximum length of the initial contract term, the maximum allowable duration (including renewals and extensions), and a consumer notice. The Departments acknowledge and respect States' authority to regulate the business of insurance. The Departments generally agree that States retain the authority to regulate STLDI and further note that these final rules do not change or otherwise modify the existing ERISA or PHS Act preemption standard.<sup>148</sup> As such, States may impose requirements tailored to the needs of their populations, and may adopt limitations on stacking, as well as limitations on sales and marketing practices. Relatedly, in section III. B of this preamble, in these final rules, the Departments added language to the notice to alert consumers as to how the coverage they are purchasing might vary from individual health insurance coverage. States may impose additional language requirements for a consumer notice and remain free to regulate STLDI.

The Departments agree that the States play an important role in regulating STLDI and recognize the federalism implications of the proposed rules and these final rules.<sup>149</sup> As noted by commenters, the McCarran-Ferguson Act generally affirms the preeminence of State regulation, and also explicitly allows for Federal regulation when an act of Congress specifically relates to the business of insurance.<sup>150</sup> However, the commenters' argument that Federal authority to regulate insurance is secondary to the primary authority of the States conflates Federal authority to regulate insurance under section 1012 of the McCarran-Ferguson Act with HHS's authority under section 2723 of the PHS Act to enforce requirements in

part A and D of title XXVII of the PHS Act against issuers.<sup>151</sup> Under section 2723 of the PHS Act, States have authority to enforce the requirements of part A and D of title XXVII of the PHS Act, and where the State fails to substantially enforce a provision (or provisions) of part A or D with respect to health insurance issuers in the State, HHS shall enforce such provision (or provisions) in the State. In contrast, the McCarran-Ferguson Act balances State and Federal interests in regulating the business of insurance. Section 1012(a) of the McCarran-Ferguson Act maintained State regulatory authority by enabling State preemption of some Federal law, and section 1012(b) of the McCarran-Ferguson Act limited Federal regulatory authority by generally exempting the "business of insurance" from Federal law.<sup>152</sup> Although Congress allowed an exception for State preemption of Federal law in this way, Congress also preserved Federal authority to regulate insurance provided that, to overcome the State preemption, congressional action must specifically relate to the business of insurance.<sup>153</sup> It is without question that HIPAA, the ACA, and the other Acts of Congress that added Federal consumer protections and requirements applicable to health insurance issuers offering group and individual health insurance coverage specifically relate to the business of insurance. In addition, as discussed earlier, the Departments have clear legal authority to define STLDI and set standards to distinguish it from individual health insurance coverage. This includes authority to adjust the interpretations for and implementation of the terms "short-term" and "limited-duration" that set the length of the initial contract term and the maximum duration (including renewals and extensions) for

STLDI, as well as to update the consumer notice. As outlined previously, Congress provided the Departments with explicit authority to promulgate regulations as may be necessary or appropriate to carry out the provisions of the Code, ERISA, and the PHS Act. The Departments are of the view that the Federal regulatory definition of STLDI in these final rules is necessary and appropriate to carry out the provisions of the Code, ERISA, and the PHS Act. Further, the Departments must give meaning to the undefined statutory term STLDI, and the meaning must distinguish it from individual health insurance coverage. This is because the PHS Act imposes certain requirements on individual health insurance coverage and does not impose those same requirements on STLDI. The Departments are also of the view that it is necessary and appropriate for consumers considering the purchase of STLDI, and those purchasing such insurance, to be aware that such coverage is not subject to the Federal consumer protections and requirements for comprehensive coverage. Defining STLDI in a way that requires a short, standard description of how the coverage might vary from individual health insurance coverage allows for a clear determination by regulators that the policy is STLDI, and promotes ease of understanding by consumers. As explained previously and detailed in the 2023 proposed rules, the changes to the Federal definition of STLDI, including the updates to the consumer disclosure notice, are reflective and responsive to changes observed by the Departments in market conditions and the legal landscape.

These final rules define STLDI for purposes of the Code, ERISA, and the PHS Act. Insurance coverage that meets the definition of STLDI in these final rules

<sup>148</sup> Section 731 of ERISA and sections 2724 and 2762 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a) and 148.210(b)).

<sup>149</sup> See 88 FR at 44648 - 44649. See also the federalism discussion in section V.H of this preamble.

<sup>150</sup> Compare "The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business ..." 15 USC 1012(a), with "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, that after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended [15 U.S.C. 41 et seq.], shall be applicable to the business of insurance to the extent that such business is not regulated by State Law. ..." 15 USC 1012(b).

<sup>151</sup> HHS also has authority under section 2761 of the PHS Act to enforce the requirements in part B of title XXVII of the PHS Act against issuers in situations where a State fails to substantially enforce one or more provisions of part B with respect to health insurance issuers in the State.

<sup>152</sup> See Steffen, Peter B. (2000) "After Fabe: Applying the *Pireno* Definition of Business of Insurance in First-Clause McCarran-Ferguson Act Cases," University of Chicago Legal Forum: Vol. 2000, available at: <https://chicagounbound.uchicago.edu/uclf/vol2000/iss1/15> ("The first clause enabled [S]tate law to supersede [F]ederal law; the second clause provided a [F]ederal antitrust exemption for the 'business of insurance'... The Act gave [S]tates some powers they did not have before, by stating in the first clause that only a [F]ederal law that 'specifically relates to the business of insurance' can preempt a [S]tate law dealing with insurance. Congressional legislation merely affecting insurance would not meet the first-clause test and thus would not, be exempt from the general prohibition on preemption. Rather, in order to apply, [F]ederal law must specifically relate to the 'business of insurance'...").

<sup>153</sup> *Id.*, citing Lee R. Russ, 3 Couch on Insurance sec. 2:4 at 2-12 (Clark 1994) ("McCarran-Ferguson turns the traditional rule of [F]ederal preemption of [S]tate law on its head.").

will qualify for the exception to the Federal definition of individual health insurance coverage and be exempt from the Federal consumer protections and requirements applicable to comprehensive coverage.

Nothing in these final rules prevents regulation of STLDI for purposes of State law. For example, States may determine whether to permit the sale of STLDI in their insurance markets. If a State law permits or requires an action that is inconsistent with the Federal definition of STLDI, any coverage offered pursuant to that State law that does not meet the standards set forth in these final rules would not qualify as STLDI under these final rules and would be subject to the Federal consumer protections and requirements applicable to comprehensive coverage. For example, if a State were to prohibit policies issued in that State from including the Federal consumer notice, then coverage in that State that did not include the Federal consumer notice language would not qualify for the exclusion from the PHS Act definition of individual health insurance coverage and thus would be subject to the Federal consumer protections and requirements applicable to individual health insurance coverage.

Amending the Federal regulation defining STLDI protects the distinctively Federal role and interest in ensuring that the Federal definition for STLDI clearly distinguishes STLDI from individual health insurance coverage for consumers in every State. As discussed in the preamble to the 2023 proposed rules, many STLDI policies that are sold through associations are sold across numerous States. Often consumers are purchasing STLDI policies in a different State from the State in which the policy is regulated. This can create challenges for both consumers and State regulators. The Departments are of the view that establishing a shorter Federal maximum duration for STLDI may reduce the incentives for issuers to offer STLDI through associations to the extent that they are using associations as a way to avoid State limits on duration. This, in turn, will help minimize consumer confusion related to coverage offered through associations. In addition, STLDI with

a shorter maximum allowable duration would decrease the impact of STLDI on Federal Government spending. As discussed in section III.A.6 of this preamble, STLDI that has a maximum allowable duration of up to 36 months, including renewals and extensions, has an annual impact on Federal PTC spending due to selection-induced effects.

The Departments are of the view that these final rules appropriately balance States' interests in regulating health insurance issuers and their health insurance markets with Congress' intent to establish a general Federal framework for health insurance coverage, including the provision of certain key protections to consumers enrolled in comprehensive coverage.

Some commenters expressed general support for the proposed definition of STLDI. Commenters in favor of the proposed definition noted that it would return STLDI to its traditional and intended purpose of providing temporary, stopgap coverage between periods of comprehensive coverage, and not serve as a long-term substitute for comprehensive coverage. Some of these commenters highlighted that low health literacy rates, a long maximum allowed term of STLDI that mimics the duration of comprehensive coverage, and deceptive marketing practices cause many consumers to confuse STLDI with comprehensive coverage. These commenters also stated that STLDI lacks Federal consumer protections and is inadequate to serve patients grappling with complex medical needs such as those that require maternity care or habilitative care; behavioral health problems; or chronic diseases such as cancer and cardiovascular disease. These commenters further stated that unwary consumers unexpectedly are underinsured when they enroll in STLDI and may end up forgoing needed, routine medical treatment and exacerbating chronic medical conditions because of limited benefits or high cost-sharing responsibilities. Consequently, consumers may then be sicker when they finally seek care in the emergency room for untreated medical conditions, which can increase costs absorbed by providers and facilities, costing the health care system more in the long run. Commenters who

supported the STLDI definition in the proposed rules warned that some consumers who enroll in STLDI as an alternative to comprehensive coverage can become subject to unexpected medical debt leading to unforeseen long-term financial consequences. Other commenters that supported the revised Federal definition for STLDI stated that while STLDI is highly profitable for health insurance issuers, agents, and brokers, the impact of STLDI on the risk pools for individual health insurance coverage indicates that it is necessary to clarify the distinctions between STLDI and comprehensive coverage. Other commenters expressed general opposition to the STLDI definition proposed in the 2023 proposed rules. These commenters stated that while STLDI is not adequate coverage for everyone, STLDI provides a useful, short-term, affordable option, particularly for consumers who do not have access to PTC subsidies, and provides access to specialists that are not in-network with many comprehensive coverage options.

The Departments acknowledge that the changes to the Federal definition of STLDI that are finalized in these rules may result in individuals who prefer STLDI losing access to such coverage as a long-term coverage option. However, as explained previously and in the 2023 proposed rules, the Departments have concluded that these concerns are now outweighed by the negative financial and health consequences that some individuals who enroll in STLDI in lieu of comprehensive coverage experience; consumer challenges in differentiating STLDI from individual health insurance coverage, particularly in light of low health literacy rates and aggressive marketing; and the negative impact on the risk pools for individual health insurance coverage when healthier individuals enroll in STLDI in lieu of individual health insurance coverage.<sup>154</sup>

As the availability of affordable comprehensive coverage options has increased since the 2018 final rules were finalized, the Departments are of the view that STLDI is no longer needed to provide a year-round coverage option for individuals and should be limited to a temporary coverage option for shorter periods when an individual experiences gaps between

<sup>154</sup> See section V of this preamble for the regulatory impact analysis; see also 88 FR 44596 at 44608 (2023).

comprehensive coverage. The Departments agree with commenters that the definition of STLDI under the 2018 final rules heightened the risk that uninformed consumers will mistakenly purchase STLDI as a substitute for comprehensive coverage, and under current market conditions, unnecessarily expose themselves to severe financial risks if they have complex medical needs or conditions.

The Departments agree with commenters that the lack of key Federal consumer protections and requirements that apply to benefits offered by STLDI<sup>155</sup> results in STLDI being an inadequate substitute for comprehensive coverage, especially for those with complex medical needs. Some consumers with complex health conditions may enroll in STLDI because a preferred provider may be in-network with an STLDI policy but out-of-network with comprehensive coverage plans.<sup>156</sup> However, STLDI plans are typically associated with higher overall financial risk due to high premium increases that may be imposed upon an individual whose health condition worsens. For example, a study that examined the potential impacts of STLDI and associated State policies on cancer diagnoses found that individuals in States that prohibited STLDI were associated with an increase in early-stage cancer diagnoses when compared to States that did not regulate STLDI.<sup>157</sup> In addition, because issuers of STLDI can engage in medical underwriting, individuals can be charged higher premiums based on health status, gender, age and other factors.<sup>158</sup> Enrolling in comprehensive coverage instead of STLDI prior to when a

consumer is diagnosed with a complex medical condition or incurs major medical expenses will promote access to care and improve overall health outcomes.

In addition, the Departments share commenters' concerns that low health literacy rates can have a detrimental impact on health insurance decision-making, putting some consumers at increased risk for purchasing STLDI when they are looking to purchase comprehensive coverage. Low health literacy rates combined with potentially erroneous assumptions about minimum standards for coverage makes the average consumer vulnerable to deceptive marketing practices and creates barriers to accessing health care and comprehensive coverage. As discussed in the preamble to the 2023 proposed rules, consumers may not understand that while some STLDI policies may have lower premiums than comprehensive coverage, consumers may incur steep and potentially debt-inducing health care bills once enrolled in STLDI due to limited benefits provided by such coverage, limited Federal consumer protections, and high-cost sharing requirements.<sup>159</sup> A qualitative study cited by commenters examined consumer comprehension of marketing materials for STLDI and found that not only did participants have low health insurance literacy rates, but they struggled to understand the plan's limitations because the ACA has shaped their expectations about what "typical" health plans cover.<sup>160</sup> As a result, consumers often expect that all health insurance provides the same benefits and protections even absent deceptive marketing practices, increasing the importance of

guardrails to distinguish comprehensive coverage from STLDI. These concerns are exacerbated in underserved communities, given their low rates of health literacy.<sup>161</sup> As discussed in the 2023 proposed rule, in addition to systemic and social structures that impact access to health care,<sup>162</sup> health literacy can make it more difficult for historically underserved and marginalized groups to navigate high deductibles, expanded cost sharing, coverage exclusions and narrow formularies found in STLDI.<sup>163</sup> These barriers can lead to consumers rationing their medicine or not taking it at all or delaying necessary health care services, causing devastating consequences to their health.<sup>164</sup> Shortening the maximum allowable term and duration of STLDI will serve as a clear indicator to consumers about the nature of each coverage option and instill more confidence in their coverage decisions. The Departments are also concerned about the prevalence of deceptive marketing practices, as noted by commenters who referenced secret shopper studies and anecdotes about negative consumer experiences, including when deceptive marketing practices were used to encourage consumers to enroll in STLDI instead of receiving education about their eligibility for low-cost comprehensive coverage or to inhibit consumers from choosing the coverage they need to access health care and protect themselves from financial burdens.

Finally, the Departments agree that it is necessary and appropriate to revisit the Federal STLDI definition to further distinguish between these types of coverage given concerns about the impact on risk

<sup>155</sup> See, for example, Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>156</sup> In some circumstances, even accounting for the expense of using an out-of-network provider, comprehensive coverage still may be the less expensive choice overall because of lower out-of-pocket spending a consumer would enjoy when enrolled in comprehensive coverage. In many cases, expenses for premiums and cost sharing for comprehensive coverage enrollees are still lower than the uncovered costs associated with STLDI, particularly when an individual undergoes costly medical treatment.

<sup>157</sup> Barnes, Justin, Anne Kirchhoff, Robin Yabroff, and Fumiko Chino (2023). "State Policies Regulating Short-Term Limited Duration Insurance Plans and Cancer Stage at Diagnosis," *JNCI Cancer Spectrum*, Volume 7, Issue 5, available at: <https://doi.org/10.1093/jncics/pkad060>.

<sup>158</sup> See Pollitz, Karen, Michelle Long, Ashley Semanskee, and Rabah Kamal (2018). "Understanding Short-Term Limited Duration Health Insurance," KFF, available at: <https://www.kff.org/affordable-care-act/issue-brief/understanding-short-term-limited-duration-health-insurance>. See also Lueck, Sarah (2018). "Key Flaws of Short-Term Health Plans Pose Risks to Consumers," Center on Budget and Policy Priorities, available at: <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers>.

<sup>159</sup> See, for example, 88 FR 44596 at 44608, 44612, 44613, 44615-44617, 44646 (July 12, 2023).

<sup>160</sup> Georgians for a Healthy Future (2019). "Report on Testing Consumer Understanding of a Short-Term Health Insurance Plan," available at: [https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report\\_NAIC-Consumer-Reps.pdf](https://healthyfuturega.org/wp-content/uploads/2019/04/Consumer-Testing-Report_NAIC-Consumer-Reps.pdf).

<sup>161</sup> Kutner M, Greenberg E, Jin Y, Paulsen C. The Health Literacy of America's Adults: Results from the 2003 National Assessment of Adult Literacy (NCES 2006-483). Washington, DC: U.S. Department of Education, National Center for Education Statistics; 2006.

<sup>162</sup> Muvuka, B., et al (2020). "Health Literacy in African-American Communities: Barriers and Strategies," *Health Literacy Research and Practice*, available at: <https://journals.healio.com/doi/full/10.3928/24748307-20200617-01>.

<sup>163</sup> 88 FR 44596 at 44608, 44613, 44615 (July 12, 2023).

<sup>164</sup> Schumacher, Jessica R. et al. (2013). "Potentially Preventable Use of Emergency Services: The Role of Low Health Literacy," *Medical Care* 51(8), August 2013, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3756810>.

pools. As discussed in section II.C of this preamble, STLDI siphons off healthier individuals from the risk pools for individual health insurance coverage, thereby raising premiums for such coverage.

Some commenters expressed particular concern about the impact of deceptive and aggressive marketing practices for STLDI given the increase in consumers currently looking for health coverage options as States resume Medicaid eligibility redeterminations due to the expiration of the FFCRA Medicaid continuous enrollment condition, as discussed in section II.B of this preamble. These commenters explained that many consumers who lose Medicaid coverage and are seeking new coverage at a low cost will be vulnerable to misleading or aggressive sales and marketing tactics that obscure the differences between comprehensive coverage and STLDI, and might therefore mistakenly enroll in STLDI in lieu of comprehensive coverage. These commenters noted that underserved populations with low health literacy and incomes below the FPL may be particularly vulnerable.

The Departments recognize that more individuals may be considering new coverage options as a result of an increased volume of Medicaid eligibility redeterminations, and therefore may be particularly susceptible to this type of misleading or aggressive sales and marketing tactics even though affordable options for comprehensive coverage may be available to them. CMS has made it a priority to ensure that as many people as possible maintain continuous comprehensive coverage during this “unwinding period.”<sup>165</sup> CMS has a robust plan in place to reach people with Medicaid or CHIP coverage, so that they are aware of the steps they need to take to maintain their Medicaid or CHIP coverage, or, if no longer eligible, to smoothly transition to other forms of coverage, such as individual health

insurance coverage purchased through an Exchange.<sup>166</sup> This plan includes new policy and operational flexibilities, such as a temporary exceptional circumstances special enrollment period available through HealthCare.gov for qualified individuals and their families who lose Medicaid or CHIP coverage following the end of the continuous enrollment condition; multi-pronged, large-scale national and local outreach and stakeholder engagement efforts; and investments and innovations in enrollment assistance.<sup>167</sup> State-based Exchanges have taken similar steps to update or implement new special enrollment period policies, as well as conduct outreach and stakeholder engagement, to support qualified individuals and their families who lose Medicaid or CHIP coverage following the end of the continuous enrollment condition. Despite these efforts, current data shows that a substantial number of people have lost coverage and may want to enroll in coverage.<sup>168</sup>

Commenters requested that the Departments clarify whether any of the existing special enrollment periods would allow a consumer to access comprehensive coverage if their STLDI coverage ends outside of an open enrollment period. Some commenters recommended that the Departments create a new special enrollment period for individuals to enroll in comprehensive coverage after their STLDI coverage ends, or that allows an individual to enroll in coverage through an Exchange upon the termination of STLDI coverage specifically for situations where a consumer elected STLDI following a loss of employment-based coverage due to a job transition or to provide temporary coverage during an employer’s waiting period. Some commenters expressed concern about the potential for consumers to experience gaps in coverage in the absence of access to a special enrollment period, explaining that those consumers purchas-

ing a 3-month STLDI plan mid-calendar year would become financially vulnerable with no continued coverage options until the next open enrollment period.

The Departments affirm that individuals who lose eligibility for STLDI coverage, such as when their STLDI policy ends, are already eligible for a special enrollment period and have 60 days to enroll in group health plan coverage, either insured or self-funded.<sup>169</sup> HHS did not propose to create a new individual market special enrollment period for individuals to enroll in individual health insurance coverage (on- or off-Exchange) at the expiration of their STLDI coverage and declines to do so in these final rules. Providing consumers with an individual market special enrollment period to purchase off-Exchange or on-Exchange coverage when they lose eligibility for STLDI or their STLDI policy ends could confuse or mislead consumers who are considering their health coverage options. Consumers may delay enrolling in comprehensive coverage when first available, on the expectation that such coverage would be available at any time, even if STLDI coverage does not renew or is otherwise terminated. Also, as explained previously, inflating the fraction of low-risk individuals who enroll in STLDI rather than individual health insurance coverage will have negative consequences for the risk pools for individual health insurance coverage.

Furthermore, there are other options for individuals who anticipate experiencing longer gaps between comprehensive coverage. For example, an individual who loses comprehensive coverage may be eligible for a special enrollment period that allows them to enroll in group coverage sponsored by their employer, the employer of their parent, spouse or partner, or individual health insurance coverage, either directly with the issuer, or through the Exchanges, where they

<sup>165</sup> See Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children’s Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition— Frequently Asked Questions (FAQ) (January 27, 2023), available at: <https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf>.

<sup>166</sup> See CMS (2023). “Unwinding and Returning to Regular Operations after COVID, Medicaid and CHIP Renewals Outreach and Educational Resources,” available at: <https://www.medicare.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/medicaid-and-chip-renewals-outreach-and-educational-resources/index.html>.

<sup>167</sup> See CMS (August 26, 2022). “Biden-Harris Administration Makes Largest Investment Ever in Navigators Ahead of HealthCare.gov Open Enrollment Period,” available at: <https://www.cms.gov/newsroom/press-releases/biden-harris-administration-makes-largest-investment-ever-navigators-ahead-healthcaregov-open>.

<sup>168</sup> See Corallo, Bradley, Jennifer Tolbert, Patrick Drake, Sophia Moreno, and Robin Rudowitz, (2024). “Halfway Through the Medicaid Unwinding: What Do the Data Show?” KFF, available at: <https://www.kff.org/policy-watch/halfway-through-the-medicaid-unwinding-what-do-the-data-show>.

<sup>169</sup> See 26 CFR 54.9801–6, 29 CFR 2590.701–6, 45 CFR 146.117.

may be eligible for APTC.<sup>170,171</sup> In some circumstances, they may be eligible for other coverage such as government-based assistance for qualified individuals under Medicaid, CHIP, or BHP.<sup>172</sup> In addition, if a consumer experiences a reduction in benefits or termination of employment and is uncertain as to when they will be eligible for other comprehensive coverage, the consumer in many cases has the option of electing coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)<sup>173</sup> (18, 29, or 36 months depending on the nature of the COBRA qualifying event) or State mini-COBRA continuation coverage laws. Also, as discussed in section III.A.2 of this preamble, an individual who enrolls in STLDI coverage from one issuer and wishes to purchase another STLDI policy maintains the option of enrolling in STLDI coverage with another issuer that is not a member of the same controlled group.

One commenter suggested that the Departments require that certain consumer protection provisions apply to STLDI. Other commenters urged the Departments to extend the prohibition on rescissions to STLDI. One of these commenters explained that STLDI issuers can rescind the patient's coverage following post-claims underwriting,<sup>174</sup> leaving patients without any financial or medical protection and at high risk of incurring medical debt.

The Departments appreciate commenters' suggestions regarding ways in which to ensure STLDI provides key Federal consumer protections. The Departments agree that STLDI can place a consumer's health and financial well-being at risk if they experience a significant medical event or have a complex medical condi-

tion. As discussed in this preamble at section II.B, consumers may be susceptible to deceptive marketing and sales practices that often mask post-claims underwriting practices by STLDI issuers and the exclusion of key essential health benefits and Federal consumer protections under STLDI plans. Consumers may be unaware of the limitations of their STLDI coverage until they need care or have incurred significant medical expenses, particularly those with low health literacy. However, the Departments did not propose to apply Federal consumer protections to STLDI and are not finalizing in these final rules the extension of any of the individual health insurance coverage Federal consumer protections and requirements to STLDI.<sup>175</sup> The Departments further note it would be inconsistent with the statute to extend the Federal prohibition on rescissions to STLDI, as Congress limited its applicability to group health plans and health insurance issuers offering group or individual health insurance coverage.<sup>176</sup> In addition, as discussed in section III.A.2 of this preamble, the Departments have determined that limiting extensions and renewals of STLDI instead of applying guaranteed renewability to STLDI appropriately distinguishes STLDI from individual health insurance coverage.

Other commenters suggested that the Departments collect data on key elements, including, for example, compensation paid by issuers to brokers or agents; plan-level enrollment/disenrollment and claims data that is disaggregated by age, income, race/ethnicity, and geographic locations; coverage limits; and other data to enable regulators and stakeholders to assess whether and how children and families are being served by STLDI.

The Departments agree with commenters that it would be useful to have access to more data on STLDI. HHS is committed to collecting information from issuers offering STLDI regarding any direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in STLDI, as authorized under section 2746 of the PHS Act.<sup>177</sup> However, beyond this requirement, the Departments do not currently have authority to collect data from issuers of STLDI. States, in contrast, can survey and collect data on STLDI under State authority and the NAIC Market Analysis and Procedures Working Group annually collects data from issuers of STLDI.<sup>178</sup> The Departments encourage States that do not already collect such data to consider the collection of data from STLDI issuers, as suggested by commenters, to assist with Federal and State oversight of STLDI.

## 2. Definitions of “Short-term” and “Limited-duration”

The 2023 proposed rules proposed to amend the Federal definition of “short-term, limited-duration insurance” in 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 to reflect a new interpretation of the phrase “short-term” to mean a policy, certificate, or contract of insurance with an issuer that has an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date of the policy, certificate, or contract of insurance.<sup>179</sup> The 2023 proposed rules also proposed to interpret “limited-duration” to mean a maximum coverage period that is no longer than 4 months in total, including renewals and extensions.<sup>180</sup> For this

<sup>170</sup> 45 CFR 155.420.

<sup>171</sup> 45 CFR 147.104(b)(2).

<sup>172</sup> Medicaid eligibility requirements vary by State.

<sup>173</sup> Pub. L. 99-272, April 7, 1986.

<sup>174</sup> Post-claims underwriting refers to the practice of engaging in an underwriting review after a claim is made rather than going through the time and expense of doing such a review to assess the consumer's actuarial risk and medical conditions at the time the policy is purchased.

<sup>175</sup> While STLDI is generally not subject to the Federal consumer protections and requirements for comprehensive coverage that apply to individual health insurance coverage, the agent and broker compensation disclosure and reporting requirements in section 2746 of the PHS Act apply to health insurance issuers offering individual health insurance coverage or STLDI. Those requirements will be addressed by HHS in a separate rulemaking. *See* Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement; Proposed Rules, 86 FR 51730 at 51740 – 51744 and 51770 – 51771 (Sept. 16, 2021).

<sup>176</sup> *See* PHS Act section 2712.

<sup>177</sup> *See* Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement; Proposed Rules, 86 FR 51730 at 51740 – 51744 and 51770 – 51771 (Sept. 16, 2021).

<sup>178</sup> The NAIC is currently collecting additional data on STLDI as part of its Market Conduct Annual Statement data call for STLDI offered in 2023. *See* <https://content.naic.org/mcas-2023.htm>.

<sup>179</sup> 88 FR 44596 at 44610-44611 (July 12, 2023).

<sup>180</sup> *Id.* at 44611-44614 (July 12, 2023).

purpose, the Departments proposed that a renewal or extension would include the term of a new STLDI policy, certificate, or contract of insurance issued by the same issuer to the same policyholder within the 12-month period, beginning on the original effective date of the initial policy, certificate, or contract of insurance. As proposed, in this context, the phrase “same issuer” would refer to the entity licensed to sell the policy, consistent with the definition of health insurance issuer in 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103. Under this proposal, the duration of coverage would be calculated based on the total number of days of coverage (either consecutive or non-consecutive) that a policyholder is enrolled in an STLDI policy with the same issuer within the prior 12-month period, regardless of whether the coverage issued to the policyholder is under the same or a new policy, certificate, or contract of insurance.

The calculation for the duration of coverage, however, would not include days of coverage under an STLDI policy, certificate, or contract of insurance sold to the same policyholder by a *different* issuer. As the Departments explained in the preamble to the 2023 proposed rules, this proposed distinction would effectively limit stacking of policies sold by the same issuer, would be easier for issuers to track and comply with than if applied across different issuers, and would allow consumers to purchase subsequent STLDI policies from other issuers within a 12-month period.<sup>181</sup>

As explained in the preamble to the 2023 proposed rules, the new proposed definition for STLDI is consistent with the group market rules regarding the 90-day waiting period provision under the ACA and with STLDI’s traditional role of serving as a temporary coverage for individuals transitioning between other types of comprehensive coverage. The proposed definition is also similar to the less-than-3-month maximum term for STLDI under the 2016 final rules and under a number of State laws,<sup>182</sup> and aligns with the goal of Executive Order 14009 to support protections for people with preexisting conditions.

The Departments requested comments on the proposed new interpretations of the phrases “short-term” and “limited-duration.” The Departments also requested comments on whether the interpretation of “short-term” in the proposed definition of STLDI should be some other length, such as no longer than 4 months, and why, and whether there are circumstances under which issuers should be allowed to renew or extend STLDI for periods of time beyond what would be permitted in the proposed rules. The Departments also requested comments on whether there are additional ways to differentiate STLDI from comprehensive coverage options, including information on State approaches or limits on the sale of STLDI by a different issuer, and how the subsequent issuer would determine whether or not an applicant had previous STLDI with another issuer. The Departments also solicited comments on whether to broaden the limits on stacking to include issuers that are members of the same controlled group.

Given that the majority of comments addressed the definitions of “short-term” and “limited-duration” together, the Departments are addressing comments related to the maximum allowed length and the definitions for these two terms together, along with the comments related to the practice of stringing together multiple or consecutive policies, a practice known as “stacking.”

Commenters suggested various options for the allowable maximum duration. Some commenters supported finalizing the maximum duration as proposed. These commenters agreed that STLDI serves as an adequate gap filler for consumers that need a bridge between comprehensive forms of coverage, and a 3-month initial term makes it easier for a consumer to distinguish between STLDI and comprehensive coverage. In addition, some of these commenters supported a short initial term to protect consumers from the inherent risks of enrolling in coverage that does not provide Federal consumer protections or comprehensive health benefits, and to curb negative impacts on the risk pools for individual health insurance

coverage. Some commenters were of the view that the proposed definitions of the terms “short-term” and “limited-duration” better align with the plain language of the statute than the current definitions. Others supported shortening the initial maximum allowable period to a period less than allowed under the current rules, but longer than the proposed 3-month period, for example a period of less than 6 months, to strike a balance between the drawbacks of STLDI with consumers’ need for gap-coverage when coverage is needed for a short period of time, they have no other insurance options, or comprehensive coverage is otherwise unaffordable. Other commenters stated that STLDI policies should be permitted to have longer durations as long as they end by December 31 of the calendar year in which the policy period commences, at which point individuals can enroll in comprehensive coverage during the annual individual market open enrollment period. One commenter, who supported the proposed maximum duration, suggested that the Departments require that all initial contract terms end by December 31 of the policy year in which the policy commences (even when the STLDI policy is purchased late in the year), to minimize situations where consumers miss the annual individual market open enrollment period. The commenter suggested that requiring STLDI policies to end by December 31 would cause consumers to look for new coverage during the individual market open enrollment period and increase the likelihood that they would enroll in comprehensive coverage. The commenter further suggested that, for alignment with the proposed maximum duration, the Departments could allow renewal for up to 4 months (past December 31), but only if the full 4-month period of coverage is not sold at the same time and that an additional notice is sent to consumers about the annual individual market open enrollment period.

Other commenters opposed modifying the initial maximum allowed length of “short-term” and instead recommended keeping the 2018 final rule’s maximum allowed length for an initial contract term

<sup>181</sup> *Id.* at 44612 (July 12, 2023).

<sup>182</sup> See, for example, D.C. Code §31-3303.13d; 18 Del. Admin. Code 1320-4.0; Haw. Rev. Stat. § 431:10A-605; Md. Code Ann., Insurance § 15-1301(s); N.M. Stat. § 13.10.3.8; Or. Rev. Stat. §743B.005; and Ver. Stat. Ann. tit. 8 § 4084a(c). See also Healthinsurance.org (2023). “Duration and Renewals of 2023 Short-Term Medical Plans by State,” available at: <https://www.healthinsurance.org/wp-content/uploads/2023/09/state-by-state-short-term-health-insurance.pdf>.

of less than 12 months. With respect to the definition of “limited-duration,” some commenters suggested the Departments redefine the standard to allow a longer maximum length than proposed. One commenter requested that the Departments define “limited-duration” as up to 12 to 18 months. Another commenter suggested that the Departments define “limited-duration” as up to 9 months in a 12-month period to allow consumers who do not have a qualifying event for a special enrollment period to purchase comprehensive coverage to use STLDI to bridge the gap between annual open enrollment periods in the individual market.

Commenters who supported a longer allowable maximum duration than the proposed period stated that limiting the maximum allowed length to no more than 3 months and a 1-month extension fails to account for all circumstances for which a consumer may need access to STLDI. Commenters gave examples of consumers who may benefit from being able to purchase longer-duration STLDI coverage, such as workers experiencing a change in employment, or unemployment; contract workers who do not have coverage through their employer; self-employed individuals or owners of a small business; college students who are not on their parent’s insurance; workers in industries that require frequent travel, such as nurses and truckers; consumers with varying and unpredictable incomes; or consumers eligible for little or no APTC who would encounter a substantial premium expense if they enrolled in comprehensive coverage. In advocating for a longer maximum allowed duration, one commenter also noted that the average length of unemployment is 20.6 weeks, while according to a group of issuers and marketers of STLDI the average length of enrollment in STLDI is only 7 months. Other commenters stated that the maximum allowable length of STLDI should be left to the States. Some commenters suggested the Departments require issuers offering STLDI with renewals and extensions of up to 4 months to guarantee that the renewal or extension be available to the consumer without additional underwriting if the consumer chooses to renew or extend their coverage.

Although the Departments acknowledge that there will be times when consumers may experience gaps in comprehensive coverage that exceed the maximum allowable duration for STLDI finalized in these rules, the Departments are not persuaded that a longer maximum initial contract term or longer maximum duration, taking into account renewals or extensions, is appropriate. Maintaining the definition that permits a longer initial length of up to 1 year would not alleviate the challenges consumers currently face in distinguishing STLDI from individual health insurance coverage, would continue to place consumers who enroll in STLDI at financial risk, and would not mitigate the impact on the risk pools for individual health insurance coverage or those consumers purchasing individual health insurance coverage. Because of low health literacy, consumers face the risk of inadvertently enrolling in STLDI coverage that does not sufficiently provide coverage for unexpected or significant medical events that arise during the coverage period.

The Departments are not persuaded by comments that urged the Departments to align the maximum duration with a time frame that reflects average periods of unemployment, such as 6 to 9 months, rather than the proposed limit. The limit of no-more-than 3 months with a 1-month extension aligns with the 90-day waiting period limitation and 1-month additional reasonable and bona fide employment-based orientation period that is permitted under the ACA. The Departments are of the view that aligning the maximum duration of an STLDI policy with the period Federal law expressly permits as an “orientation” period in employment-based coverage most appropriately reflects STLDI’s traditional role to fill temporary gaps in coverage.

Consumers who purchase STLDI during a 90-day waiting period have a predictable end to their gap in coverage. Their gap is defined, and generally temporary, and thus is exactly the type of gap that STLDI traditionally serves to fill. In contrast, a loss in coverage due to a loss of employment is not the type of gap that STLDI traditionally is intended to fill because consumers that

experience a loss of employment do not have certainty regarding how long their gap in comprehensive coverage will be, and for some that gap will not be temporary and may extend beyond the average length of unemployment. By enrolling in STLDI in lieu of COBRA continuation coverage or individual health insurance coverage during the 60-day period for which they are eligible for a special enrollment period for loss of qualifying coverage, these consumers may lose access to comprehensive coverage until the next individual market open enrollment period. While STLDI may be an appropriate choice for some individuals during a period of unemployment, the Departments concluded that aligning the maximum duration with the 90-day waiting period limitation and 1-month additional reasonable and bona fide employment-based orientation period better captures the traditional role of STLDI. In addition, consumers are more likely to face an unexpected health issue during a longer coverage period – such as 6, 9, or 12 months – and may find themselves insufficiently protected by the typically limited benefits of an STLDI policy and potential resulting financial burdens.

By allowing an initial term of no more than 3 months, the interpretation of “short-term” for purposes of the revised Federal definition of STLDI finalized in these rules provides a clear demarcation from the 1-year length of a policy year for individual health insurance coverage. In addition, as discussed earlier, STLDI’s traditional role is to provide coverage for temporary gaps for consumers transitioning between comprehensive coverage. A maximum period of no more than 3 months and 1-month extension (for a total maximum duration of 4 months, including renewals or extensions) is more appropriate for coverage intended to fill a temporary gap in comprehensive coverage. As explained in the preamble to the 2016 final rules, for longer gaps in coverage, guaranteed availability of coverage and special enrollment period requirements in the individual market under the ACA ensure that individuals can purchase individual health insurance coverage through or outside of the Exchange that is minimum essential coverage and includes the Federal consumer protections and requirements for



comprehensive coverage.<sup>183</sup> Many consumers will also have the opportunity to enroll in comprehensive coverage offered by an employer and some may be eligible for other coverage, such as Medicaid, CHIP or BHP.

The Departments are similarly not persuaded by the recommendation that STLDI be permitted to have a longer maximum duration, provided that coverage ends by December 31. Although the Departments appreciate that this approach would minimize gaps in coverage between when an individual's STLDI ends and when they can enroll in comprehensive individual health insurance coverage during the annual individual market open enrollment period, the Departments are concerned that such an approach would not sufficiently distinguish STLDI from individual health insurance coverage, which also ends on December 31. Finally, as mentioned in the 2023 proposed rules, the maximum allowable length of no more than 3 months and a 1-month extension represents a balance between providing a flexible standard that captures many of the circumstances for which an individual would want to enroll in STLDI, responds to the significant changes in the legal landscape and market conditions since the Departments last addressed STLDI, and addresses the low value that STLDI provides to consumers when used as a substitute for comprehensive coverage.

Some commenters requested that the Departments impose a guaranteed renewability requirement on STLDI to prevent additional underwriting if a consumer chooses to renew or extend their coverage. The Departments have determined that limiting extensions and renewals of STLDI instead of applying guaranteed renewability to STLDI appropriately distinguishes STLDI from individual health insurance coverage. As such, these final rules do not impose a guaranteed renewability requirement on STLDI. Underwriting practices, including post-claims underwriting are outside the scope of these final rules.

Many commenters supported the new proposed interpretation of "limited-dura-

tion" and accompanying proposed definition of renewal or extension to address stacking of STLDI policies by the same issuer to the same policyholder within a 12-month period. These commenters stated that issuers have exploited this loophole to sell consumers consecutive STLDI policies that collectively sidestep the maximum duration limits, deliberately misleading consumers about differences between STLDI and comprehensive coverage. According to some of these commenters, addressing the stacking loophole would reduce the risk of consumers unknowingly enrolling in coverage with inadequate benefits for an extended period of time. Commenters further stated stacking practices provide consumers with a false sense of security that they purchased a viable long-term substitute for comprehensive coverage and make it more challenging for consumers to distinguish STLDI from individual health insurance coverage.

Commenters expressed concern about the exposure to financial risk that consumers face when purchasing stacked STLDI policies, explaining that a consumer typically faces new deductibles, new annual out-of-pocket limitations, and new preexisting condition limitations with each new STLDI policy term. A commenter noted that consumers may not understand that a health event experienced when covered under one STLDI policy could serve as the basis to impose a preexisting exclusion under a subsequent STLDI policy to deny benefits for the same condition.

Other commenters questioned the basis for the Departments to adopt this part of the definition of "limited-duration" to address stacking of policies sold by the same issuer, members of the same controlled group, and/or by unrelated issuers, stating that the Departments do not have authority to constrain consumer choice. A commenter argued that preventing consumers from purchasing subsequent STLDI policies from an issuer of their choice is contrary to the statute, which looks at the issuer's conduct rather than the consumer's conduct, and would run afoul of the decision in *Central United*

*Life Ins. Co. v. Burwell*.<sup>184</sup> The commenter further stated that Congress unambiguously specified in the ACA and HIPAA the types of insurance and actors

Congress intended to regulate, and Congress consistently chose to exempt STLDI from the definition of individual health insurance coverage and to regulate issuer behavior instead of consumer behavior. Another commenter encouraged the Departments to defer to States on whether and to what extent an issuer could sell consecutive or multiple STLDI policies to consumers within a 12-month period. Other commenters stated that addressing the stacking loophole would leave consumers financially vulnerable, as some will not understand that their STLDI coverage cannot be renewed or extended with the same issuer and will have limited coverage options outside the annual individual market open enrollment period.<sup>185</sup>

Some commenters who supported addressing the stacking loophole encouraged the Departments to extend the new interpretation of "limited-duration" and the accompanying definition of renewal or extension to include all issuers that are a part of the same controlled group. These commenters stated that issuers with shared ownership should not be able to exploit their corporate structure to avoid consumer protections and effectively circumvent the otherwise applicable maximum duration limits for STLDI coverage. Some commenters suggested that extending the limitation to include all issuers in the same controlled group could help address concerns regarding STLDI sold through associations,<sup>186</sup> as associations might be positioned to facilitate the issuance of stacked STLDI policies from different subsidiaries of the same controlled group. One commenter stated that members of the same controlled group should have the data and member-tracking capabilities to know if a consumer has purchased an STLDI policy within the 12 months from another issuer within the same controlled group.

The Departments agree with commenters that supported the Departments' authority to address the stacking loophole as part of the definition of renewal or

<sup>183</sup> 81 FR 75318 (Oct. 31, 2016).

<sup>184</sup> 827 F.3d 70, 74 (D.C. Cir. 2016).

<sup>185</sup> See section III.A.4 of this preamble.

<sup>186</sup> For further discussion on STLDI sold through associations, see section III.A.5 of this preamble.

extension for purposes of the new interpretation of “limited-duration.” As stated in the preamble to the 2023 proposed rules, the Departments are concerned that stacking practices lengthen the duration of STLDI coverage without offering the benefits of comprehensive coverage that is subject to Federal consumer protections and requirements for comprehensive coverage, including limitations on medical underwriting, the prohibition of preexisting condition exclusions, and the prohibition on coverage rescissions. Using the stacking loophole, issuers could enroll consumers in multiple consecutive STLDI policies that together provide coverage for 12 months (or longer), in effect circumventing the rules related to maximum duration and making it more challenging for consumers to distinguish STLDI from comprehensive coverage.<sup>187</sup>

As discussed in section III.A.1 of this preamble, the Departments have clear authority to interpret and implement the Code, ERISA, and the PHS Act as they do here. This includes the authority to issue regulations on STLDI to define it and set standards that distinguish it from individual health insurance coverage. Providing a definition for what a renewal or extension means in the context of the new interpretation of “limited-duration” is included within this authority and is not a constraint on consumer behavior. Instead, the definition and standards, as proposed and finalized, apply to health insurance issuers that elect to offer STLDI. Further, consumers will continue to have access to STLDI plans that are generally exempt from the Federal consumer protections and requirements for comprehensive coverage.<sup>188</sup> Neither the proposed rules nor these final rules sought to extend to STLDI or otherwise make changes with respect to the applicability of those consumer protections and requirements.

After considering comments, the Departments are finalizing as proposed that a renewal or extension, for purposes of applying the interpretation of “limited-duration” under the new STLDI definition

adopted in these final rules, includes the term of a new STLDI policy, certificate, or contract of insurance issued by the same issuer to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance. Subsequent sales to the same policyholder by the same issuer within the same 12-month period will be treated comparably to renewals for purposes of calculating and applying the limited-duration standard.

The Departments also agree that extending the definition of renewal or extension for purposes of applying the new interpretation of “limited-duration” to limit stacking of STLDI policies sold by issuers that are members of the same controlled group is appropriate and necessary. This prevents issuers from circumventing the maximum duration standards in the revised Federal STLDI definition adopted in these final rules by marketing policies of one member of a controlled group to policyholders enrolled in STLDI coverage of another member of the controlled group, keeping that policyholder enrolled in STLDI coverage for more than the maximum allowed coverage period. The final rules therefore provide that for purposes of applying the new interpretation of “limited-duration,” a renewal or extension includes the term of a new STLDI policy, certificate, or contract of insurance offered by either the same issuer or, if the issuer is a member of a controlled group, any other issuer that is a member of the same controlled group. For these purposes, a “controlled group” means any group treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Code. HHS uses a similar definition of “controlled group” for purposes of the guaranteed renewability rules and QHP issuer standards, and the Departments anticipate the usage is familiar to health insurance issuers.<sup>189</sup>

The relevant metric to calculate whether the duration of coverage sold by the same issuer or any other issuer that is a member of the same controlled group to

the same policyholder satisfies the revised Federal interpretation of “limited-duration” in these final rules is the total number of days of coverage (either consecutive or non-consecutive) that the policyholder is enrolled in an STLDI policy with the same issuer or any other issuer that is a member of the same controlled group. That calculation applies regardless of whether the coverage is a renewal or extension under the same policy, certificate, or contract of insurance, or if it involves the issuance of a new STLDI policy, certificate, or contract of insurance to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance.

Several commenters requested that the Departments expand the approach to address the stacking loophole to also include the sale of STLDI policies by unaffiliated issuers. These commenters were concerned that stacking will continue through policies sold by multiple issuers. Some commenters questioned whether focusing only on stacking policies sold by the same issuer achieves the goals described in the proposed rules because consumers could still stack STLDI purchased from different issuers. One commenter expressed concern that the proposed limitation on stacking by only the same issuer would harm consumers because seeking STLDI policies from multiple issuers would result in the coverage offering different networks and benefits. A commenter that supported extending the approach to address the stacking loophole to also apply to STLDI policies sold by unaffiliated issuers shared that some States prohibit consumers from enrolling in STLDI for more than 3 months in a 12-month period, regardless of issuer. Another commenter, who was supportive of the general concept of limiting stacking across issuers, cautioned that it would be exceedingly difficult for issuers to implement a limit on the sale of multiple STLDI policies by different issuers within the same year at this time. Some commenters who supported the

<sup>187</sup> 88 FR 44596 at 44612-44613 (July 12, 2023).

<sup>188</sup> While STLDI is generally not subject to the Federal consumer protections and requirements for comprehensive coverage that apply to individual health insurance coverage, the agent and broker compensation disclosure and reporting requirements in section 2746 of the PHS Act apply to health insurance issuers offering individual health insurance coverage or STLDI.

<sup>189</sup> See 45 CFR 147.106(d)(3) and (4) (providing an exception to market withdrawal under guaranteed renewability regulations) and 156.20 (defining an “issuer group” for purposes of QHP issuer standards).

extension of the approach to unaffiliated issuers explained that such an approach could be implemented by issuers certifying, by consumer attestation, or by another similar mechanism, that the policyholder has not purchased STLDI coverage from any issuer within the previous 12-month period, while others suggested that the Departments create a safe harbor for issuers that require consumers to sign attestations regarding previous STLDI coverage.

While the Departments appreciate these comments and recommendations, the Departments decline to extend the definition of renewal or extension for purposes of applying the revised interpretation of “limited-duration” to limit stacking of policies issued by unaffiliated issuers. As explained in the proposed rules, the Departments are cognizant of the administrative burden for issuers of tracking and ensuring compliance with such a prohibition.<sup>190</sup> However, States may choose to further address issuer stacking practices, such as by prohibiting stacking across issuers not within the same controlled group.

One commenter suggested the Departments limit an issuer’s ability to issue subsequent STLDI policies to members of the same household. The Departments did not propose to limit an issuer’s ability to sell subsequent STLDI policies to members of the same household and decline to adopt such a limitation in these final rules. Members of the same household may need temporary, stopgap coverage at different times over a 12-month period. Limiting the ability of members of the same household to purchase STLDI coverage would remove flexibility for consumers and unnecessarily complicate their health insurance enrollment process because issuers would have to determine whether members of the same household have enrolled in any STLDI coverage during the previous 12-month period each

time any member of the household enrolls in STLDI, which could create an administrative burden on issuers. Furthermore, whereas limiting stacking across affiliated issuers in the same controlled group will prevent issuers from using their corporate structure to circumvent the rules related to maximum duration, it is not apparent to the Departments that limiting stacking across unaffiliated issuers or different members of the same household accomplishes any similar goal. Finally, the administrative burden of tracking members of the same household may outweigh any potential benefit of restricting the sale of multiple STLDI policies to individuals who reside in the same household.

Some commenters requested that the Departments affirm that consumers are entitled to renewal guarantees that might be offered by an STLDI issuer. As explained in the preamble to the 2018 final rules, renewal guarantees generally permit a policyholder, when purchasing their initial insurance contract, to pay an additional amount in exchange for a guarantee that the policyholder can elect to purchase, for periods of time following the expiration of the initial contract, another policy or policies at some future date, at a specific premium that would not require any additional underwriting.<sup>191</sup> The Departments affirm that the final rules do not address renewal guarantees. However, the Departments acknowledge that the revisions to the Federal definition—including the provision that requires counting the term of a new STLDI contract issued by the same issuer or, if the issuer is a member of a controlled group, any other issuer that is a member of the same controlled group, to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, contract, or certificate of insurance toward the total maximum duration of STLDI—would limit the guarantees that such instruments may be able to provide.<sup>192</sup>

### 3. Sales and Marketing Practices

In the 2023 proposed rules, the Departments expressed concerns about reports of aggressive and deceptive sales and marketing practices related to STLDI where STLDI is marketed as a substitute for comprehensive coverage, despite being exempt from most of the Federal individual market consumer protections and requirements for comprehensive coverage.<sup>193,194</sup> The Departments solicited comments on additional ways to help consumers distinguish between comprehensive coverage and STLDI. In particular, the Departments requested comments on ways to prevent or otherwise mitigate the potential for direct competition between comprehensive coverage and STLDI during the open enrollment period for comprehensive individual health insurance coverage.<sup>195</sup>

Many commenters agreed that STLDI deceptive marketing practices have caused many consumers to confuse STLDI with comprehensive coverage. These commenters stated that these misleading marketing practices often attract younger, healthier consumers who may not realize how limited STLDI coverage is until faced with out-of-pocket costs. Commenters observed that studies indicate that STLDI has been aggressively and deceptively marketed to consumers especially during the open enrollment period for comprehensive individual health insurance coverage,<sup>196</sup> which has left consumers at increased risk of purchasing plans that do not meet their medical needs. Commenters also noted that the population of individuals affected by States resuming Medicaid eligibility redeterminations due to the end of the FFCRA’s Medicaid continuous enrollment condition has been vulnerable to these practices. Commenters highlighted evidence of salespeople neglecting to tell consumers that they may be eligible for subsidized ACA plans, asserting that an individual’s health needs would

<sup>190</sup> 88 FR 44596 at 44646 (July 12, 2023).

<sup>191</sup> See 83 FR 38219, 38220 (Aug. 3, 2018).

<sup>192</sup> While the Departments may be limited in their ability to take an enforcement action with respect to transactions involving products or instruments that are not health insurance coverage, the Departments may have the authority to regulate the coverage issued pursuant to such a product or instrument.

<sup>193</sup> See 88 FR 44596 at 44613 (July 12, 2023).

<sup>194</sup> The agent and broker compensation disclosure and reporting requirements in section 2746 of the PHS Act apply to health insurance issuers offering individual health insurance coverage or STLDI.

<sup>195</sup> See 88 FR 44596 at 44613-44614 (July 12, 2023).

<sup>196</sup> Government Accountability Office (2020). “Private Health Coverage: Results of Covert Testing for Selected Offerings,” available at: <https://www.gao.gov/products/gao-20-634r>.

be covered by an STLDI plan despite plan documents contradicting these assertions, or misstating an STLDI plan's coverage of certain preexisting conditions. Commenters also included examples of deceptive marketing practices (some of which were identified during secret shopper studies), such as marketing materials with images of activities for which coverage of associated injuries are excluded, marketing materials with logos of well-known issuers that are not affiliated with the STLDI being sold, or websites selling STLDI that include the words "Obamacare" or "ACA."

One commenter suggested that the Departments should monitor and limit marketing of STLDI that is conducted in a manner that may lead consumers to unwittingly enroll in STLDI. The commenter stated that multiple States have already implemented prohibitions against aggressive and deceptive marketing of STLDI products to protect individuals. The commenter stated that a Federal prohibition on such marketing tactics would ensure that people are aware of the most affordable and comprehensive health coverage options available to them, are not exposed to deceptive marketing practices, and are able to avoid potentially catastrophic gaps in coverage.

Other commenters expressed concern regarding the sale of STLDI over the telephone and Internet. The commenters cited studies showing an increase in sales over the telephone and Internet since the 2018 final rules. Commenters stated that although telephone and Internet sales are convenient for consumers, the incentives to provide reliable customer service are low.

Commenters noted that such sales methods are prone to abuse and make it hard for consumers to get concrete, verifiable answers about the product they are being sold before they buy it. Other commenters suggest that sellers of STLDI be reviewed for compliance with laws enforced by the Federal Trade Commission that prohibit deceptive marketing practices. Some commenters suggested that marketers of STLDI sold over the telephone or Internet should be required

to provide a clear warning to consumers about the true coverage terms prior to the conclusion of a sale.

Some commenters encouraged the Departments to collaborate with State departments of insurance to combat misleading marketing practices. Commenters noted that the expansion of STLDI following the 2018 final rules has presented challenges for State regulators attempting to monitor the applicable State market and protect potential consumers against deceptive marketing practices. Commenters suggested that the Departments, in collaboration with the Federal Trade Commission and the Federal Bureau of Investigation, should investigate and stop lead generators and sales agents who use deceptive marketing techniques through websites, social media, phone calls, and other means.

Several commenters urged the Departments to establish a Federal prohibition on the sale of STLDI during the annual open enrollment period for comprehensive individual health insurance coverage. Commenters cautioned that when STLDI is marketed and sold during the annual individual market open enrollment period, the potential for consumer confusion is particularly acute. Commenters explained that sellers take advantage of the annual open enrollment period when more consumers are shopping for comprehensive individual health insurance coverage to push them into products that are not comprehensive and argued that halting sales of STLDI during this period would decrease consumer confusion and facilitate access to comprehensive coverage. Another commenter stated that legitimate needs for STLDI coverage may arise at any time of year and recommended that if the Departments place restrictions on the sale of STLDI during the annual individual market open enrollment period, those restrictions should be limited to the sale of products with a January 1 effective date.

Another commenter suggested that the Departments explicitly prohibit Federal and State Exchanges from linking to or advertising STLDI. The commenter stated that HHS should also impose a similar requirement on agents and brokers to pro-

hibit side-by-side advertising of STLDI or other non-compliant plans on the same webpage as individual health insurance coverage that is subject to the Federal consumer protections and requirements for comprehensive coverage.

One commenter suggested that the Departments consider prohibiting the offering of higher broker commissions for the sale of STLDI than commissions for the sale of comprehensive coverage, arguing that this type of prohibition could significantly decrease the financial incentive for agents and brokers to encourage consumers to purchase STLDI over comprehensive coverage and help reduce direct competition between these two types of products.

Some commenters encouraged the Departments to invest in and take steps to increase consumer education and enrollment assistance activities that could improve consumer understanding of the differences between comprehensive coverage and STLDI.

Other commenters suggested placing requirements on agents and brokers or the consumer to better ensure consumers understand the differences between STLDI and comprehensive coverage. For example, one commenter suggested that the Departments require agents and brokers to sign an attestation that the information given to the consumer by the agent or broker spells out in plain language the terms of the STLDI coverage and acknowledges that the consumer understands the limitations. The commenter asserted this would help ensure that underserved communities and patients with chronic medical conditions who struggle to find affordable health insurance options are not targeted by unscrupulous sales and marketing tactics. Another commenter urged the Departments to adopt the same disclosure and consent requirements applicable to agents, brokers, and web-brokers assisting consumers in a Federally-facilitated Exchange or State Exchange using the Federal platform for agents, brokers, and web-brokers assisting consumers purchasing STLDI.<sup>197</sup> One commenter suggested that the Departments require a statement for consumers to sign acknowledging that

<sup>197</sup> See 45 CFR 155.220 for standards applicable to agents and brokers and web-brokers who assist qualified individuals, qualified employers, or qualified employees enrolling in qualified health plans.

the coverage does not meet the minimum standards required under the ACA and does not provide equivalent Federal consumer protections.

The Departments appreciate these comments and suggestions and will take them into consideration in any future regulations or guidance defining STLDI. In addition, the Departments appreciate the recommendations regarding steps that the Departments can take outside of rulemaking to educate consumers about their health coverage options and limit the possibility that consumers inadvertently purchase STLDI when shopping for comprehensive coverage. HHS has already taken steps separate from these final rules to limit the potential for individuals to inadvertently purchase an STLDI plan when shopping for a qualified health plan and will consider additional opportunities to do so. HealthCare.gov, the platform for the Federally-facilitated Exchanges and State Exchanges using the Federal platform, neither links to nor advertises STLDI.<sup>198</sup> In addition, for the Federally-facilitated Exchanges and State Exchanges using the Federal platform, direct enrollment entities<sup>199</sup> are generally required to use three different website pages to display and market coverage – one for qualified health plans offered through the Exchange, one for individual health insurance coverage offered outside the Exchange, and one for any other products, including STLDI.<sup>200</sup> Direct enrollment entities participating in the Federally-facilitated Exchanges and State Exchanges using the Federal platform must also limit marketing of

non-QHPs, such as STLDI, during the Exchange eligibility application and QHP selection process.<sup>201</sup> In its proposed rule entitled “Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO-OP) Program; and Basic Health Program,” HHS proposed to apply these requirements to direct enrollment entities operating in State Exchanges and to web-brokers that assist with or facilitate enrollment in coverage in a manner that constitutes enrollment through the State-based Exchanges.<sup>202</sup>

#### 4. Notice

In the preamble to the 2023 proposed rules, the Departments explained that the notice is important to help consumers distinguish between comprehensive coverage and STLDI and ensure that consumers are aware of the limitations of STLDI.<sup>203</sup> The Departments proposed to amend the existing STLDI notice to further clarify the differences between STLDI and comprehensive coverage and identify options for consumers to obtain comprehensive coverage in concise, understandable language that would be meaningful to them.<sup>204</sup> The Departments proposed to apply the amendments to the notice to all STLDI policies sold or issued on or after the effective date of the final rules and to existing STLDI policies for notices provided upon renewal or extension on or after the effective date of the final rules.<sup>205</sup>

In the 2023 proposed rules, the Departments proposed that the notice must be displayed (in either paper or electronic form) prominently in at least 14-point font, on the first page of the policy, certificate, or contract of insurance (including for renewals or extensions), in any marketing and application materials provided in connection with enrollment in such coverage, including on websites that advertise or enroll individuals in STLDI, and in any enrollment and reenrollment materials that are provided at or before the time an individual has the opportunity to enroll or reenroll in coverage (including on any website used to facilitate reenrollment in STLDI).<sup>206</sup>

In these final rules, the Departments are finalizing the revised notice with modifications to implement feedback from comments and consumer testing, improve consumer comprehension of the notice, and further distinguish between STLDI and comprehensive coverage. As discussed in section III.A.6 of this preamble, the revised notice must be provided with respect to both new and existing STLDI for coverage periods (including renewals or extensions) beginning on or after September 1, 2024.

Some commenters were generally opposed to revisions to the notice standard. These commenters expressed concern that the Federal revised notice may not comport with notices that State legislatures and regulators create, often in consultation with consumer advocates and State insurance experts. A commenter expressed concern that the information about ACA

<sup>198</sup> See section 1311(d)(2) of the ACA, which generally prohibits an Exchange from making available any health plan that is not a qualified health plan. See also CMS, Frequently Asked Questions on Reuse of Exchange for Ancillary Products (March 29, 2013), available at: <https://www.cms.gov/ccio/resources/files/downloads/ancillary-product-faq-03-29-2013.pdf>.

<sup>199</sup> “Direct enrollment entity” means an entity that an Exchange permits to assist consumers with direct enrollment in qualified health plans offered through the Exchange in a manner considered to be through the Exchange as authorized by 45 CFR 155.220(c)(3), 45 CFR 155.221, or 45 CFR 156.1230. 45 CFR 155.20.

<sup>200</sup> 45 CFR 155.221(b)(1).

<sup>201</sup> 45 CFR 155.221(b)(3).

<sup>202</sup> 88 FR 82510, 82568 and 82562 (Nov. 24, 2023) (“Consistent with §§ 156.1230(b)(1) and (2), to directly enroll consumers in a manner that is considered to be through the Exchange, QHP issuer DE entities are required to comply with the applicable requirements in § 155.221 . . . In this rulemaking, we propose to extend these FFE requirements to also apply them to QHP issuer DE entities in State Exchanges. As proposed to be applied in these State Exchanges, QHP issuer DE entities would similarly be required to provide consumers with correct information, without omission of material fact, regarding the Exchanges, QHPs offered through the Exchanges, and insurance affordability programs. In addition, QHP issuer DE entities in State Exchanges would also be required to refrain from marketing or conduct that is misleading (including by having a DE website that the State Exchange determines could mislead a consumer into believing they are visiting the Exchange’s website), coercive, or discriminates based on race, color, national origin, disability, age, or sex . . . Finally, we propose . . . to extend the current web-broker FFE standard of conduct established at § 155.220(j)(2)(i) to also apply to web-brokers assisting consumers in State Exchanges, and consequently to these State Exchanges. Section 155.220(j)(2)(i) requires agents, brokers, or web-brokers that assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees, in coverage in a manner that constitutes enrollment through an FFE, or assist individuals in applying for APTCs and CSRs for QHPs sold through an FFE, must provide consumers with correct information, without omission of material fact, regarding the FFEs, QHPs offered through the FFEs, and insurance affordability programs . . . and refrain from marketing or conduct that is misleading (including by having a DE website that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov*), coercive, or discriminates based on race, color, national origin, disability, age, or sex.”)

<sup>203</sup> 88 FR 44596 at 44614 (July 12, 2023).

<sup>204</sup> *Id.* at 44614-44618.

<sup>205</sup> *Id.* at 44618-44619.

<sup>206</sup> *Id.* at 44614-44616.

coverage in the proposed notice would confuse the average person shopping for health coverage. Another commenter suggested that the Departments defer to the NAIC and State regulatory experts who are currently drafting minimum standards for STLDI products. A commenter suggested that States should have the option to substitute their own required disclosure language in place of the Federal mandated language and that notice provisions should only be applicable if a State has no comparable notice provisions.

Another commenter shared a study asserting that the revised notice did not substantially improve consumer understanding of STLDI and that any notice should be of short length because most consumers have trouble understanding lengthy explanations that tend to present multiple concepts in the same notice. Other commenters supported the proposed revisions to the notice standard and agreed that the revisions would help educate consumers about the differences between comprehensive coverage and STLDI before a decision is finalized about health coverage in a way that would alleviate downstream concerns about applicable benefits and costs.

The Departments agree that it is important to provide consumers with concise, accurate information to evaluate insurance products so that consumers may make informed decisions about health insurance coverage. The Departments sought to address potential confusion caused by the notice by requesting comments on the proposed notice standard and conducting consumer testing. Based on current research highlighting deceptive marketing practices and consumer confusion,<sup>207,208,209</sup> the Departments are of the view that it is necessary and appropriate for issuers of STLDI to disclose key differences between comprehensive coverage and STLDI before completing the sale or renewal so consumers can

make informed decisions. The revised notice standard under these final rules will help clarify the differences between STLDI and comprehensive coverage. As the Departments agree that the revisions to the notice standard alone will not protect consumers from deceptive marketing practices, revisions to the notice standard are being finalized in tandem with revisions to the definitions of the terms “short-term” and “limited-duration.” The Departments disagree with and decline to adopt the suggestion that the notice should not be part of the Federal definition of STLDI.

With respect to concerns about the lack of State input in the revisions to the notice standard, the Departments consulted plain language experts, conducted consumer testing, and considered comments on the 2023 proposed rules from State regulators, consumer advocates, and other interested parties. The Departments therefore disagree that there was a lack of State input. The Departments concluded that a uniform Federal notice best furthers the Departments’ interest in ensuring that information is communicated to consumers to enable them to identify and distinguish STLDI from comprehensive coverage. Therefore, the Departments decided not to specify that the revised notice would be applicable only if a State has no comparable notice provision. In addition, these final rules do not prevent States from requiring additional language be included with the notice for purposes of State law or prohibit issuers from including additional language in their notices. Policies that do not include the language in the revised notice under these final rules will not be considered STLDI coverage, and therefore will not qualify for the exception for STLDI from the definition of individual health insurance coverage for purposes of Federal law.

One commenter alleged that the revised notice standard raised First Amendment concerns because the notice violates the

First Amendment’s prohibition on compelled speech. The commenter argued that the revised notice standard constitutes a content-based restriction and is not justified because it is not narrowly tailored to serve a compelling government interest.

The Departments disagree with this commenter. The rules do not require the provision of a notice, but instead simply provide that coverage offered without such a notice would not qualify as STLDI and would be subject to the Federal consumer protections and requirements applicable to comprehensive coverage. Moreover, as discussed in section III.B.1 of this preamble, required disclosures of factual, uncontroversial information in commercial speech are subject to more deferential First Amendment scrutiny and have been upheld where the disclosure requirement reasonably relates to a government interest, and is not unjustified or unduly burdensome.<sup>210</sup> Regardless, the Departments believe that the revised notice standard would pass muster under any form of First Amendment scrutiny.

The Departments have a substantial, and even compelling, government interest in combatting deceptive marketing practices by ensuring consumers are informed about the key differences between STLDI and comprehensive coverage, are aware of their option to purchase comprehensive coverage, and have access to resources for additional information about the range of available health coverage options so consumers can make informed choices. As discussed in section II.B of this preamble, this is currently of particular importance due to significant changes in market conditions and in the legal landscape and low health literacy amid widespread deceptive marketing practices that play on consumer confusion about the benefits and limitations of STLDI. The revised notice communicates factual information to consumers about the differences between STLDI and comprehensive coverage and explains how con-

<sup>207</sup> For one example of deceptive marketing practices, see Federal Trade Commission (2022). “FTC Action Against Benefytt Results in \$100 Million in Refunds for Consumers Tricked into Sham Health Plans and Charged Exorbitant Junk Fees,” available at: <https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-action-against-benytt-results-100-million-refunds-consumers-tricked-sham-health-plans-charged>.

<sup>208</sup> Palanker, Dania and Kevin Lucia (2021). “Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk,” Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk>. (Noting that fixed indemnity insurance may be “bundled” with other non-comprehensive insurance products in such a way that “the plans look like comprehensive coverage” while still offering limited benefits). See also Palanker, Dania, JoAnn Volk, and Maanasa Kona (2019). “Seeing Fraud and Misleading Marketing, States Warn Consumers About Alternative Health Insurance Products,” Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2019/seeing-fraud-and-misleading-marketing-states-warn-consumers-about-alternative-health>.

<sup>209</sup> Government Accountability Office (2020). “Private Health Coverage: Results of Covert Testing for Selected Offerings,” available at: <https://www.gao.gov/products/gao-20-634r>.

<sup>210</sup> The U.S. Supreme Court recognized this standard of scrutiny in *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985) (“*Zauderer*”) and later confirmed it in *National Institute of Family and Life Advocates v. Becerra*, 138 S. Ct. 2361, 2372, 2376 (2018) (“*NIFLA*”).

sumers can find resources when consumers have questions about the different coverage options. Finally, the revised notice is reasonably related to, and narrowly tailored to, the government's interest in informing consumers about STLDI coverage, and combating deceptive marketing practices and potential sources of misinformation, by directing consumers to appropriate resources to learn more about the range of available health coverage options. The notices do not include irrelevant or superfluous information unrelated to these interests. Accordingly, these final rules serve substantial government interests.

In addition, the revised notice standard is not unjustified, unduly burdensome, or insufficiently tailored to the interests described previously. As stated in the preamble to the 2023 proposed rules, the Departments are concerned about consumers who are at risk of significant financial liability if they enroll in STLDI that exposes consumers to high health care costs that are not covered by their STLDI policy. The language on the Federal revised notice includes factual, uncontroversial information. The Departments consulted plain language experts, conducted consumer testing, and considered comments on the proposed revised notice to ensure the language was factual, easy to read, and understandable. Furthermore, the revised notice standard does not unduly burden issuer speech because issuers remain free to communicate with consumers about their coverage using any methods of communication they choose. As discussed in section V.B.2.d of this preamble, the Departments estimate that the cost to issuers of displaying the revised notice will be relatively low, because the Departments have adopted static language that issuers do not have to tailor to the policy or State of sale. For the reasons discussed previously, the Departments are of the view that requiring STLDI issuers to provide a notice that provides factual information to consumers prior to when the consumers purchase coverage is reasonably related to the government's stated interests in ensuring consumers can distinguish STLDI and comprehensive coverage and are informed

of options to purchase comprehensive coverage, should the consumer wish to obtain such coverage. The information required to be disclosed is clearly identified and has a direct nexus to that legitimate government interest.

Finally, the revised notice standard is narrowly tailored to inform consumers about the limitations of STLDI and to combat deceptive marketing practices and potential sources of misinformation by directing consumers to appropriate resources to learn more about their health coverage options. The notice does not include irrelevant or superfluous information unrelated to informing and directing consumers to appropriate resources.

The Departments sought comments on whether the proposed placement for the notice substantially improves the likelihood that consumers have a meaningful opportunity to review the notice and their health coverage options before applying for, enrolling in, or reenrolling in STLDI, as well as any practical or logistical barriers to providing this notice as proposed. In particular, the Departments sought comments from members of underserved communities, and organizations that serve such communities, on whether the language accessibility, formatting, and content of the notice sufficiently mitigate barriers that exist to ensuring all individuals can read, understand, and consider the full range of their health coverage options.<sup>211</sup>

Most commenters supported the proposed placement of the notice on the first page of any policy, certificate, or contract of insurance (including for renewals and extensions), website used to facilitate enrollment (or reenrollment) in STLDI, and marketing and application materials provided in connection with enrollment in STLDI, because the benefits of simplifying access to the notice far outweighs any associated burden of including the information in these locations.

One commenter suggested that issuers should have the flexibility to put the notice for renewals on a separate document and not on the face page of the policy, certificate, or contract of insurance because some States require pre-approval of notice pro-

visions. Another commenter supported the notice being provided in the same format that sales of STLDI are conducted, since misleading marketing often occurs when STLDI is not sold in person and consumers are given limited time to contemplate their insurance choices before being pressured to choose a product. For example, if enrollment occurs over the telephone, the commenter suggested the seller should be required to read the notice to the consumer and record their acknowledgement, or if the enrollment occurs via the internet, a prominent notice should be featured during the accompanying online sign-up process. Other commenters recommended that the Departments require audio and video advertisements to include an audio version of the notice within the first 10 seconds of any advertisement of STLDI coverage. Another commenter suggested that telephone solicitors, brokers or agents making sales calls, or in-person sales should be required to inquire as to the consumer's preferred language through a qualified language translator or language telephone line. Commenters also suggested that the notice be provided in multiple common languages other than English that are spoken in the United States in a manner that is culturally appropriate, readable, and clear so that consumers can make appropriate coverage decisions. Commenters highlighted the importance of the notice being accessible to individuals with disabilities.

The Departments are finalizing the standard for the notices to be prominently displayed on the first page of applicable materials<sup>212</sup> in at least 14-point font, as proposed. Because ensuring that consumers understand any limitations of what they are purchasing is of utmost importance, provision of the notice should not be saved until the time of enrollment when consumers may feel pressured to sign up and effectuate coverage instead of restarting their search for a different insurance product. The Departments agree with commenters that the need for consumers to have easy access to the notice during enrollment and reenrollment outweighs the burden associated with placement of the notice on the first page of applicable materials. The

<sup>211</sup> 88 FR 44596 at 44617 (July 12, 2023).

<sup>212</sup> The applicable materials on which the STLDI notice must be prominently displayed (in either paper or electronic form) are the first page of the policy, certificate, or contract of insurance (including for renewals or extensions), any marketing and application materials provided in connection with enrollment in such coverage, including on websites that advertise or enroll individuals in STLDI, and in any enrollment and reenrollment materials provided at or before the time an individual has the opportunity to enroll or reenroll in coverage (including on any website used to facilitate reenrollment in STLDI).

Departments further agree with commenters that if the STLDI policy is sold online or electronically then the notice should be communicated in the same format as the sale. Further, consistent with the proposal in the 2023 proposed rules, the placement standard under these final rules extends the notice to websites that advertise or offer the opportunity to enroll (or reenroll) in STLDI. Although these final rules provide that the notice must be prominently displayed in any marketing materials provided in connection with enrollment (or reenrollment) in STLDI, the Departments decline to require audio and video advertisements include an audio version of the notice within the first 10 seconds of any advertisement of STLDI coverage. The Departments did not include a proposal on audio and video advertisements in the 2023 proposed rules and therefore decline to address such other types of communication formats in these final rules.

The Departments agree that it is important that the notice be accessible and

understandable to individuals with limited English proficiency. While the Departments did not propose and are not finalizing language access standards specific to these notices as part of this rulemaking, the Departments remind plans and issuers that they are required to comply with other State and Federal laws establishing accessibility and language access standards to the extent applicable. For example, recipients of Federal financial assistance must comply with Federal civil rights laws that prohibit discrimination. These laws may include section 1557 of the Affordable Care Act,<sup>213</sup> title VI of the Civil Rights Act of 1964,<sup>214</sup> section 504 of the Rehabilitation Act of 1973,<sup>215</sup> and the Americans with Disabilities Act of 1990.<sup>216</sup> Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include provision of language assistance services such as written translation of written content in paper or electronic

form into languages other than English. Sections 1557 and 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services at no cost to the individual. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Additionally, section 508 of the Rehabilitation Act of 1973 requires that information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply.

In the 2023 proposed rules, the Departments requested comment on two potential formats for the revised notice standard<sup>217</sup> (Notice A and Notice B).

The proposed STLDI notice (Notice A) was as follows:

### Notice to Consumers About Short-Term, Limited-Duration Insurance

**IMPORTANT:** This is short-term, limited-duration insurance. This is temporary insurance. **It isn't comprehensive health insurance.** Review your policy carefully to make sure you understand what is covered and any limitations on coverage.

- This insurance might not cover or might limit coverage for:
  - preexisting conditions; or
  - essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, and substance use services, prescription drugs, or preventive care).
- You won't qualify for Federal financial help to pay for premiums or out-of-pocket costs.
- You aren't protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

Visit [HealthCare.gov](https://www.healthcare.gov) online or call 1-800-318-2596 (TTY: 1-855-889-4325) to review your options for comprehensive health insurance. If you're eligible for coverage through your employer or a family member's employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy.

<sup>213</sup> 42 U.S.C. § 18116.

<sup>214</sup> 42 U.S.C. § 2000d *et seq.*

<sup>215</sup> 29 U.S.C. § 794.

<sup>216</sup> 42 U.S.C. § 12101 *et seq.*

<sup>217</sup> 88 FR 44596 at 44616-44617 (July 12, 2023).



An alternative proposed STLDI notice (Notice B) was as follows:

### WARNING

**This is not comprehensive insurance.** This is short-term, limited-duration insurance.

This plan has fewer protections than comprehensive insurance options you can find on HealthCare.gov.

<b>This Insurance</b>	<b>Insurance on HealthCare.gov</b>
<ul style="list-style-type: none"><li>• May deny you coverage if you have a preexisting condition</li></ul>	<ul style="list-style-type: none"><li>• You cannot be denied coverage because of a preexisting condition</li></ul>
<ul style="list-style-type: none"><li>• There may be no limit to the amount you have to pay out-of-pocket for care</li></ul>	<ul style="list-style-type: none"><li>• The most you have to pay out-of-pocket for essential health benefits in a year is limited</li></ul>
<ul style="list-style-type: none"><li>• You will not qualify for Federal financial help to pay your premiums and out-of-pocket costs</li></ul>	<ul style="list-style-type: none"><li>• You may qualify for Federal financial help to pay your premiums and out-of-pocket costs</li></ul>
<ul style="list-style-type: none"><li>• You may not have access to all essential health benefits, including: pediatric, hospital, emergency, maternity, mental health, and substance use disorder services, prescription drugs, and preventive care</li></ul>	<ul style="list-style-type: none"><li>• You will have access to all essential health benefits, including: pediatric, hospital, emergency, maternity, mental health, and substance use disorder services, prescription drugs, and preventive care</li></ul>

#### Questions?

- For more info about comprehensive coverage, visit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325).
- For more info about your employer's coverage, or a family member's employer coverage, contact the employer.

For questions or complaints about this policy, contact your State department of insurance.

The Departments received comments in support of both notice formats. Some commenters supported implementing the format of Notice A because they found the bulleted format easier to read and more understandable than a chart. Other commenters supported implementing the format of Notice B because they were of the view that the format is easier to follow and has more concise language. A commenter stated that consumers understand information better that is presented in charts. Another commenter suggested that the Departments design a notice format that would allow issuers to check boxes next to relevant provisions. Other commenters recommended that the Departments con-

duct consumer testing of the content and presentation of the notices through focus groups or surveys to ensure the notices are understandable. These commenters stated that notices should be tested with multiple audiences, particularly given current disparities in health insurance literacy rates and concerns for individuals with limited English proficiency and with disabilities.

HHS consulted plain language experts and engaged in consumer testing as part of the consideration of comments on the revised notice. Based on the testing of Notice A and Notice B, feedback from plain-language experts, along with consideration of comments on the revised notice, the Departments are finalizing the

table format used in Notice B, with content modifications that are discussed in detail this section. Consumer testing revealed that the table format, comparing key features of STLDI and insurance offered through HealthCare.gov, helped consumers best distinguish between STLDI coverage and comprehensive coverage, and understand the differences between such coverage types.

After taking into account feedback from the comments, consulting with plain-language experts, and conducting consumer testing, the Departments are finalizing the following language for the notice to improve readability and effectiveness of the notice:

**IMPORTANT: This is a short-term, limited-duration policy,  
NOT comprehensive health coverage**

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov.

<b>This policy</b>	<b>Insurance on HealthCare.gov</b>
<b>Might not cover you</b> due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
<b>Might not cover</b> things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have <b>no limit on what you pay</b> out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You <b>won't qualify</b> for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
<b>Doesn't have to meet</b> Federal standards for comprehensive health coverage	All plans must meet Federal standards

**Looking for comprehensive health insurance?**

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under "Insurance Departments."

The Departments took into consideration all comments received on the notice. As mentioned in this section, following an initial review of the comments, HHS performed consumer testing to evaluate the effectiveness and readability of different messages and notice formats, including messages or changes to the proposed revised notice recommended by commenters. These final rules revise the content of the proposed notice to better inform consumers considering purchasing STLDI about the differences between STLDI and comprehensive coverage, support informed coverage purchasing decisions, and promote readability. The revised notice balances including information about STLDI with readability and length so that consumers will be more likely to read and understand the notice.

The Departments sought comments on whether additional changes to the notice language would improve readability or further help individuals distinguish STLDI from comprehensive coverage, and whether there are practical or legis-

tical barriers that would present challenges to compliance with the new proposed notice standard. The Departments solicited comments on all aspects of the proposed revisions to the notice standard, including whether to add a website link and telephone number for HealthCare.gov, and the proposed placement of the notice in the marketing, application, and enrollment (or reenrollment) materials, including the extension of the notice provision to websites that advertise or offer the opportunity to enroll (or reenroll) in STLDI and on the associated administrative burden for issuers, agents, brokers, or others who will be involved in providing the notice to consumers.

Many commenters suggested specific changes to the content of the revised notice standard. A commenter requested that the notice be displayed in highly readable fonts such as a Sans Serif font in a 14-point font to improve the readability of the notice. Some commenters suggested that the notice include additional information to explain what it means that

STLDI is exempt from most Federal consumer protection laws. Some commenters recommended that the notice include a statement that STLDI coverage commonly conducts post-claims underwriting and may deny claims for chronic health conditions, surgeries, and other common services. A commenter recommended that the Departments add language warning consumers about the possibility of rescissions because STLDI issuers often engage in post-claims chart review to search for signs of an undisclosed preexisting condition and thereby rescind coverage. The commenter recommended that the notice state: "This insurance may rescind or retroactively cancel your coverage and not pay claims based on your medical history." The Departments are finalizing the requirement that the notice be in 14-point font size. While the final rules do not include a requirement that the notice be displayed in a specific font, the Departments would not consider the notice to be prominently displayed unless the font used is clear and readable. The revised

notice standard will give issuers the flexibility to use a font that aligns with the format of their policies. In addition, the Departments revised the content of the chart based on comments and consumer testing. As a result, the chart clarifies that STLDI is not required to meet the Federal standards for comprehensive coverage and might not cover chronic health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health and substance use. In contrast, the notice does not specifically caution consumers that STLDI might conduct post-claims underwriting, or post-claims rescissions. The Departments had to balance providing useful information that clarifies the differences between STLDI and comprehensive coverage and the readability, length, and effectiveness of the notice. The differences highlighted in the notice were selected primarily because consumer testing showed they were more effective at helping consumers distinguish between STLDI and comprehensive coverage than other options considered.

Some commenters suggested the notice address the 10 categories of essential health benefits<sup>218</sup> and state explicitly which essential benefits are not covered. Other commenters requested that the notice address coverage for certain types of items or services, such as maternity services, habilitative and rehabilitative services, and devices, so that consumers fully understand what coverage could be missing when purchasing STLDI. While the Departments agree that it is important to highlight for consumers that essential health benefits might not be covered by an STLDI policy, the notice only highlights a few categories of essential health benefits, including prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, and physical therapy. The Departments had to balance the importance of notifying consumers of the types of benefits that might not be covered, with the importance of not overcrowding the notice so that the notice is easy to read and understand.

Some commenters supported the notice including information about where consumers can access additional information about comprehensive coverage options,

including referencing HealthCare.gov or the State Exchange website where the consumer resides, including when the coverage is sold by associations. Some commenters requested that the notice explain what subsidies may be available for consumers that enroll in coverage on the Exchanges instead of STLDI to increase transparency of the costs to consumers. Some commenters suggested adding information on the timing of the annual individual market open enrollment period to underscore the differences between STLDI and comprehensive individual health insurance coverage and help consumers plan their transition to Exchange coverage. Commenters also suggested that providing information on special enrollment periods for those losing Medicaid or employer coverage would further clarify consumers' coverage options. Additionally, given the potential for varied open enrollment or special enrollment periods across different States, a commenter recommended adding language saying, "Because State Based Exchanges may have different enrollment timelines, if you lose coverage always check your eligibility on HealthCare.gov or your State Based Exchange for possible enrollment options."

The Departments agree with commenters that it is important for the notice to include information about where consumers can access additional information about comprehensive coverage options, and are finalizing a notice standard that includes information about HealthCare.gov. Through this website, consumers in States with a Federally-facilitated Exchange or State Exchange using the Federal platform can purchase comprehensive coverage, and consumers in States with a State Exchange can get directed to the State Exchange. In addition, HealthCare.gov provides additional information about comprehensive coverage that might help consumers further distinguish STLDI coverage from comprehensive coverage, and may help consumers better understand the notice. The Departments considered including in the revised notice standard additional details, as suggested by commenters, about open enrollment,

special enrollment periods, and subsidies. However, the Departments are concerned about the length these topics could add to the notice, and the burden associated with customizing the notices to include enrollment time frames which can vary slightly from State to State. After consideration of the comments, the Departments are finalizing the revised notice standard without information on these topics. However, the Departments note that information on each of these topics is available on HealthCare.gov, and the notice directs consumers to HealthCare.gov for additional information on health coverage options.

Some commenters suggested additional or alternative language to focus consumers' attention or to convey key points. A commenter suggested using the phrase "Important Notice – Please Read Carefully" as the title to better catch the attention of consumers and inform them that this is important information they should consider prior to purchase. Another commenter supported the use of the word "WARNING" in capital letters as a heading in the notice for clarity. A commenter suggested adding to the introductory notice language, "This plan has fewer protections, provides fewer benefits, and has higher out of pocket costs than comprehensive insurance options you can find on HealthCare.gov." A commenter suggested that the Departments replace the last sentence of the introductory paragraph with something very close to the following in bold text, "You may be able to get much better coverage for less money (with tax credits) through a health insurance exchange even outside of open enrollment." A commenter suggested that the Department should change the heading of the second column of the comparison table from "Insurance on HealthCare.gov" to "Comprehensive Insurance on HealthCare.gov." One commenter encouraged the Departments to remove the statement that STLDI is not comprehensive coverage because of a study that indicated that 95 percent of STLDI plans provide comprehensive coverage. A commenter suggested that the Departments revise "You won't qualify for [F]ederal help to pay for premiums or out-of-pocket costs,"

<sup>218</sup> See section 1302 of the ACA, and 45 CFR 156 subpart B (defining essential health benefits).

to “Most people qualify for tax credits that will lower out of pocket costs if they purchase coverage that meets certain [F]ederal requirements. For more information, visit [this website].” In addition, the Departments could create a website to link consumers to clear information, the commenter stated.

The Departments took into consideration comments that suggested alternative language to include in the introductory paragraph. Based on consumer testing, the Departments are finalizing the revised notice standard with the heading, “IMPORTANT,” instead of “WARNING.” The Departments are of the view that “IMPORTANT” is sufficient to draw attention to the notice. In addition, the Departments revised the introductory paragraph to clarify that STLDI and insurance options on HealthCare.gov are not the only insurance options that might provide comprehensive coverage. While employer coverage is not included in the table, the Departments finalized the revised notice standard with a bullet point reminding consumers that have access to employer coverage to contact that employer about coverage options. The Departments are of the view that suggested additions to the introductory paragraph add content that is already accounted for in the table section of the notice. The Departments are not revising the notice heading for the second column. The heading, “Insurance on HealthCare.gov,” effectively communicates that the column applies to insurance options available on HealthCare.gov.

Some commenters provided recommendations for ways to enhance consumers’ understanding of the notice. One commenter suggested that the Departments define key terms used in the notice and use alternate language to indicate that the coverage is “comprehensive” because some consumers believe that it means the best or most expensive coverage that most consumers do not need. A commenter discouraged the use of terms “may” and “might” because they fall short of conveying how STLDI does not meet Federal standards.

The Departments considered comments and worked with plain language experts to ensure that the revised notice standard is

written in plain language that maximizes readability for the average consumer. While consumer testing revealed that consumers did not always understand terms used in the notice (including the term “comprehensive”), the testing showed that consumers were still able to distinguish between STLDI and comprehensive coverage, based on the notice. Therefore, the Departments are of the view that defining key terms is not critical to the effectiveness of the notice and are finalizing the revised notice standard without defining key terms. In addition, the Departments will use the term “might” to preface certain rows in the table. It is important to include the term “might” to ensure that the content in the table accurately describes all STLDI coverage, as some STLDI might voluntarily, or under State law, provide the consumer protections listed in the notice.

Some commenters were in support of including the name and State of domicile of the issuer, name and State of domicile of the association (if applicable), website, and telephone number for the State department of insurance tailored to each STLDI policy in the notices included in marketing, application, and renewal materials to help consumers access regulators and consumer advocacy resources that can assist consumers regarding questions or concerns about their policies. Commenters stated that STLDI coverage filed in another State or sold through an out-of-State association should be required to include in the notice both the contact information of the insurance regulator in the State in which the consumer resides and the State in which the plan is filed, to aid in maintaining accountability for issuers and associations selling these insurance products. Commenters stated that access to such information will assist consumers in receiving accurate information about insurance products to make informed decisions about coverage and should be made available in the preferred language of individuals and families. Commenters argued that State regulators often have difficulty monitoring and regulating STLDI sold through out-of-State associations, the associations may attempt to operate outside the reach of the State in

which the STLDI is sold, and consumers may be unaware of what State has regulatory authority over the product they are purchasing.

Other commenters were opposed to including State-specific information in the notices because the information would be of limited benefit to consumers and unnecessarily increase the administrative burden and costs for issuers. Another commenter suggested that the Departments provide a link to the directory of State insurance departments that the NAIC maintains.

In developing the proposed revised notice language, the Departments sought to balance the goals of distinguishing STLDI from comprehensive coverage and combatting deceptive marketing practices, as well as reducing misinformation by directing consumers to appropriate resources, with the need to provide a concise, understandable notice that would be meaningful and useful to consumers.<sup>219</sup> The Departments understand commenters’ concerns regarding the burden associated with customizing notices to include State-specific information. However, the Departments also recognize the value of including State-specific information, such as appropriate contact information. After consideration of comments and the results of consumer testing, the Departments are finalizing changes to the notice to incorporate uniform language as part of the required content for the revised notice standard that directs individuals to an NAIC webpage where they can find the contact information for the applicable State regulatory agency. This approach avoids adding an administrative burden on issuers to tailor the notice for each plan depending on the domicile of each consumer. In the case of STLDI sold by out-of-State associations, the link to the NAIC webpage would provide consumers with access to contact information for State regulators in the State where the consumer purchased the STLDI coverage as well as the State where the STLDI is issued. Although this is a link to a non-United States Government website, the Departments are including this link in the notice because it allows consumers to access State-specific contact information, without requiring plans and issuers to cus-

<sup>219</sup> See 88 FR 44596 at 44614-44615 (July 12, 2023).

tomize the notice. The Departments cannot attest to the accuracy of information provided on the NAIC webpage or any other linked third-party site. The NAIC link is provided for reference only and the inclusion in the notice of a link to a non-United States Government website does not constitute an endorsement by the Departments. Also, the privacy protections generally provided by United States Government websites do not apply to third-party sites.

In addition, as described earlier in this section, the Departments incorporated static language as part of the content for the revised notice standard finalized in these final rules that direct individuals to HealthCare.gov where individuals can navigate to their State's Exchange or get information about different types of health coverage options. This approach is intended to balance the desire to ensure individuals can access State-specific information with not increasing the burden on issuers associated with the development of customized notices that provide State-specific contact information. Since the Departments are not including State-specific or association-specific contact information as part of the revised notice standard, the Departments decline to specify a certain agency's contact information that should be included for products that are filed in multiple States.

The preamble to the 2023 proposed rules explained that the Departments were considering whether to add a statement to the notice describing the maximum permitted length of STLDI under the Federal definition, explaining that coverage cannot be renewed or extended beyond the maximum allowable duration, and explaining that the length of STLDI may be shorter subject to State law. The Departments sought comments on this approach, including how best to clearly and concisely communicate such information to consumers, including how to address the bifurcated applicability dates with respect to the proposals around the maximum allowed length; whether such information is already included elsewhere in the plan documents; and on the asso-

ciated administrative burden for issuers, agents, brokers, or others who would be involved in providing the notice to consumers. The Departments also sought comments on whether information about the maximum allowed length of new or existing STLDI and options regarding renewal and extensions would be included in enrollment materials (or reenrollment materials) provided to enrollees as part of the normal course of business.

Commenters generally supported adding a statement to the notice describing the maximum allowed length of STLDI under Federal and State rules, where applicable. One commenter requested that the Departments add, "coverage is intended to last for 3 months, if you enroll in the plan you may have to wait until the next open enrollment period to enroll in comprehensive coverage." A commenter suggested adding a sentence to the notice after the second sentence of the introductory paragraph that says, "Coverage cannot last beyond 4 months or even less depending on the State in which you live." This minimally increases the length of the notice while informing the consumer that the policy cannot be renewed beyond 4 months or a shorter period depending on the State in which the consumer resides, the commenter stated.

While the Departments appreciate that information on maximum duration may be useful to consumers, the Departments remain concerned about how to clearly and concisely communicate such information to consumers using static language, without creating confusion for consumers if the duration of their policy differs from the maximum duration standards in the notice – for example, because of the bifurcated applicability dates,<sup>220</sup> shorter maximum durations allowed under State law, or the specifics of their policy. Given these concerns and based on consumer testing and consultation with plain language experts, the Departments are finalizing the notice without adding information on the maximum permitted length of STLDI. Since States have the flexibility to enact a different maximum permitted length of STLDI, including a standardized maxi-

imum permitted length in the revised notice standard may confuse consumers. The Departments are also mindful of limiting the amount of information provided on the notice for readability and comprehension and are of the view that the burden on issuers of requiring issuers to tailor their notices to each State outweighs the potential benefits of adding more language to the notice to capture State-specific information on the maximum permitted length for the STLDI policy. In addition, the Departments anticipate that information on the maximum allowed length of the STLDI coverage is included in the policy, certificate, or contract of insurance, and that options for renewal and extensions are typically included in enrollment materials (or reenrollment materials) provided to enrollees as part of the normal course of business.

The Departments solicited comments on whether it would be beneficial to consumers to require issuers to include language in the notice that clearly informs consumers that the notice is an officially required document, such as "This notice is required by Federal law." One commenter suggested that including such a statement would further validate the importance of the notice and accentuate the caution warranted when considering purchasing STLDI, while another commenter argued that the statement would add length to the notice and is not critical for consumers' understanding of their rights. Consumer testing revealed that some testers found the inclusion of that phrase at the bottom of the notice helpful and reported that it made the information on the notice seem more legitimate, other consumers stated this statement suggested that the STLDI policy was endorsed by the Federal Government. After consideration of the comments and results from consumer testing, the Departments are finalizing the notice without the inclusion of a statement that the notice is required by Federal law. The Departments are of the view that any potential benefit of including the language is outweighed by the risk that some consumers will interpret the statement as a Federal endorsement of the policy.

<sup>220</sup> See section III.A.6 of this preamble for discussion of the STLDI applicability dates finalized in these final rules.

## 5. Short-Term, Limited-Duration Insurance Sold Through Associations

In section III.A.5 of the preamble to the 2023 proposed rules, the Departments explained that they understand most sales of STLDI occur through group trusts or associations that are not related to employment (sometimes referred to as individual membership associations)<sup>221</sup> and solicited comments on what steps, if any, can be taken to support State oversight of STLDI sold to or through associations.<sup>222</sup> Under these arrangements, out-of-State issuers file STLDI products for approval in one State and then sell the same policies in other States through an association, many times with few requirements on consumers to participate in the association, other than payment of association dues. State regulators have reported that they often lack the authority to track sales of policies made through out-of-State associations and are unable to approve or regulate such policies when offered for sale by issuers that are not licensed by their State. Further, as explained in section III.A.V of the preamble to the 2023 proposed rules, the Departments have received feedback that many issuers take advantage of the ambiguity about which State's jurisdiction applies to the STLDI they sell to avoid State regulation.<sup>223</sup> For example, one study found that in a review of 34 policy brochures for STLDI, 28 of the brochures included references to associations.<sup>224</sup> Consumers may not understand that some STLDI marketed in their States are not regulated by their State and do not include State-specific consumer protections.

The Departments received comments agreeing that association-based STLDI coverage is often used as a vehicle to avoid local State regulation, with one commenter stating that such coverage is increasing in prevalence for employers with 10 or fewer employees. Commenters explained that because these association products are sold in States in which they are not registered,

States have limited ability to protect their consumers from hidden fees and limited benefits. Nevertheless, some commenters asserted that States are best positioned to oversee the marketing of association-based STLDI coverage. Some commenters encouraged the Departments to work with States and the NAIC to improve oversight of products sold through out-of-State associations including collecting and sharing data and clarifying State authority to regulate these arrangements on behalf of their residents. Another commenter urged the Departments to consider additional enforcement mechanisms to ensure that STLDI issuers are not selling STLDI products in States in which they are not approved and ensure that consumers have recourse to file complaints when necessary.

As with the current regulatory definition of STLDI, the provisions of these final rules apply to STLDI sold to or through associations. As explained in the preamble to the 2023 proposed rules, coverage that is provided to or through associations, but not related to employment, and is sold to individuals, either as certificate holders or policyholders, is not group coverage under section 9832 of the Code, section 733(b)(4) of ERISA, and section 2791(b)(4) of the PHS Act.<sup>225</sup> If the coverage is offered to an association member other than in connection with a group health plan, the coverage is considered coverage in the individual market under Federal law, regardless of whether it is considered group coverage under State law. Thus, any health insurance sold to individuals through a group trust or association, other than in connection with a group health plan, or sold to a group trust or association to the extent the insurance is intended to cover association members who are individuals, must meet the definition of STLDI at 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103, or else be considered individual health insurance coverage that is subject to all the Federal individual market consumer protections

and requirements for comprehensive coverage.

The Departments are aware that some group trusts and associations have also marketed STLDI policies to employers as a form of employer-sponsored coverage. As explained in section I.C of this preamble, there is no provision excluding STLDI from the Federal definition of group health insurance coverage.<sup>226</sup> Thus, any health insurance that is sold to or through a group trust or association in connection with a group health plan and which purports to be STLDI would in fact be group health insurance coverage and must comply with the Federal consumer protections and requirements for comprehensive coverage applicable to the group market. Failure to meet those requirements could result in penalties for employers offering such coverage.<sup>227</sup>

The Departments did not propose changes specific to association-based STLDI coverage and are not finalizing any such changes in these final rules. The Departments will continue to work closely with States, both individually and through the NAIC, to support State oversight and enforcement efforts of STLDI offered through associations.

## 6. Applicability Dates

In the 2023 proposed rules, the Departments proposed applicability dates for the proposed amendments to the Federal definition of STLDI that distinguish between new and existing STLDI under 26 CFR 54.9833-1, 29 CFR 2590.736, and 45 CFR 146.125 and 148.102.

The Departments also proposed a technical amendment to 26 CFR 54.9833-1, 29 CFR 2590.736, and 45 CFR 146.125 (regarding applicability dates) to remove outdated language. The Departments proposed the technical amendment would apply to all coverage (that is, both new and existing STLDI) as of the effective date of the final rules.

<sup>221</sup> See 88 FR 44596 at 44618 (July 12, 2023).

<sup>222</sup> *Id.*

<sup>223</sup> *Id.*

<sup>224</sup> *Id.* (citing Curran, Emily, Dania Palanker, and Sabrina Corlette (2019). "Short-term Plans Sold Through Out-of-State Associations Threaten Consumer Protections," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2019/short-term-health-plans-sold-through-out-state-associations-threaten-consumer-protections>.)

<sup>225</sup> 88 FR 44596 at 44618 (July 12, 2023) (citing 45 CFR 144.102(c)).

<sup>226</sup> See section 2791(b)(5) of the PHS Act, which excludes STLDI from the definition of "individual health insurance coverage".

<sup>227</sup> Section 4980D of the Code.

The Departments did not receive any comments on the proposed applicability dates for the technical amendments and are finalizing them as proposed.

For new STLDI sold or issued on or after the effective date of the final rules, the Departments proposed that the amendments to the definition of STLDI would apply for coverage periods beginning on or after such date. For STLDI sold or issued before the effective date of the final rules (including any subsequent renewal or extension consistent with applicable law), the Departments proposed that the current Federal definition of such coverage would continue to apply with respect to the maximum allowable duration. Therefore, under the proposed rules, existing STLDI could continue to have an initial contract term of less than 12 months and a maximum duration of up to 36 months (taking into account any renewals or extensions), subject to any limits under applicable State law.

The Departments proposed that the amendments to the notice provision at paragraph (2) of the proposed definition of “short-term, limited-duration insurance” in 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 would apply for coverage periods beginning on or after the effective date of the final rules, regardless of whether the coverage was sold or issued before, on, or after the effective date of the final rules.

The Departments sought comments on whether the proposed revised notice standard should apply only to new STLDI or should apply to both new STLDI and existing coverage upon renewal or extension, and whether the application of the proposed revised notice standard to existing STLDI should instead be delayed until January 1, 2025, or some other date. The Departments sought comments on whether all STLDI policies and any renewals or extensions of such coverage, including existing coverage sold or issued prior to the effective date of the final rules, should instead end upon the effective date of the final rules or some other date. The Departments also sought comments on

whether an applicability date that would provide a longer transition period for consumers with policies, certificates, or contracts of STLDI sold or issued before the effective date of the final rules could help alleviate any potential market disruption. In addition, the Departments sought comments on whether it would be more reasonable for all STLDI policies, and any renewals or extensions of such coverage in effect before the date the final rules are published, to end before January 1, 2025, or some other date.

Only a few commenters commented on the applicability date for new STLDI policies. One commenter stated that it is critically important for consumers that the proposed amendments to the Federal definition of STLDI take effect as soon as possible for new STLDI policies to better inform consumers about the differences between STLDI and comprehensive coverage and protect consumers from deceptive marketing practices. A few commenters suggested that the Departments delay the applicability date for new STLDI policies, with recommended dates ranging from between 90 days and 12 months after the effective date of the final rules. Commenters recommended providing this additional time because STLDI products have already been filed and approved for 2024 and issuers need more time to evaluate plan designs, update system processes, re-file policy forms with State regulators and complete other administrative tasks.

The Departments agree that an applicability date of 75 days following publication of these final rules might cause challenges for some States and issuers as they move to revise plan designs and file new policy forms that comply with the Federal definition of STLDI under these final rules. The Departments are mindful of the administrative obstacles identified by commenters and are of the view that providing more time to comply with the revised Federal definition of STLDI will be beneficial both to issuers and States. However, the Departments are also mindful of the caution from commenters that the potential for consumer confusion is particularly

acute when STLDI is marketed and sold during the annual individual market open enrollment period. Although these final rules do not prohibit the sale or marketing of STLDI during the individual market open enrollment period, the Departments are of the view that the potential for consumer confusion about whether they are considering purchasing an STLDI plan or comprehensive coverage will be substantially lessened if the final rules go into effect for new STLDI policies before the beginning of the next individual market open enrollment period.<sup>228</sup> Therefore, after consideration of comments, these final rules provide that the new definition of STLDI will apply to new STLDI policies, certificates, or contracts of insurance for coverage periods beginning on or after September 1, 2024.<sup>229</sup> This applicability date will provide issuers and States with more time to come into compliance with these final rules for new STLDI policies. It will also allow uninsured consumers who enroll in a new STLDI policy on or after September 1, 2024, to bridge the gap to when new comprehensive coverage purchased during the next individual market open enrollment period would begin. The Departments decline to extend the applicability for new STLDI policies further to ensure an end to the marketing of STLDI with a longer maximum allowed length prior to the beginning of open enrollment for the 2025 individual market plan year.<sup>230</sup>

The Departments received some comments on the applicability date with respect to the maximum allowable duration for existing STLDI (including renewals and extensions). A few commenters requested that the revised maximum allowable duration apply to existing policies as soon as possible. These commenters stated that agents and brokers may attempt to steer as many consumers as possible into policies that are subject to the 2018 final rules prior to the applicability date for new policies, locking consumers into less protective coverage with a longer duration, and potentially destabilizing the risk pools for individual health insurance coverage.

<sup>228</sup> The next individual market open enrollment period begins on November 1, 2024. See 45 CFR 155.410(e)(4)(i).

<sup>229</sup> For new STLDI policies, the new maximum duration standards and the revised notice established in these final rules will apply for coverage periods beginning on or after September 1, 2024.

<sup>230</sup> The individual market open enrollment period for plan year 2025 begins on November 1, 2024. See 45 CFR 155.410(e)(4)(i).

Commenters stated that this is particularly concerning as more consumers are shopping for health coverage as States resume Medicaid eligibility redeterminations due to the end of the FFCRA's Medicaid continuous enrollment condition. Another commenter stated that the Departments should apply the same applicability date for the maximum duration to new and existing policies because having a different applicability date for new and existing STLDI could create confusion for consumers and issuers. However, a different commenter suggested that the proposed applicability date for the revised maximum duration to apply to existing coverage would minimize confusion for currently enrolled consumers. One commenter supported the proposed applicability date for the revised maximum duration to apply to existing STLDI, as the dates allow issuers to honor their contractual obligations while avoiding unnecessary disruptions in coverage. Another commenter suggested aligning the applicability date for the revised maximum duration to apply to existing STLDI with the existing term or the start of the subsequent plan year for Exchange coverage, whichever comes first, and providing a 60-day special enrollment period to consumers whose coverage ends after the individual market open enrollment period. Other commenters recommended that the Departments postpone the applicability date for the revised maximum duration for STLDI to apply to existing policies to accommodate the end of the initial contract term, but prevent renewals or extensions to strike a balance between avoiding disruption of current plans and prolonging the harms of the maximum permitted duration under the current Federal definition of STLDI. These commenters also suggested this alternative approach would simplify the application of the revised maximum duration for STLDI coverage under the final rules. Other commenters suggested setting a different fixed applicability date for the revised maximum duration for STLDI to apply to existing policies that aligns with the start of the individual market open enrollment period for plan years 2025 or 2026.<sup>231</sup>

The Departments appreciate the need to implement the changes to the revised maximum duration for STLDI as soon as practical to mitigate the risk of consumers mistakenly enrolling in STLDI in lieu of comprehensive coverage. At the same time, the Departments recognize that some consumers who are already enrolled in STLDI purchased such coverage with the understanding it would continue for a given period of time, consistent with the current Federal definition of STLDI and applicable State law. Such individuals may also have purchased coverage with the expectation that they could renew coverage, consistent with the current Federal definition and applicable State law. While the Departments want to balance avoiding prolonging the harms of a longer maximum permitted duration, to minimize disruption and confusion for individuals who purchased or were enrolled in STLDI prior to the effective date of the final rules, the Departments are finalizing the proposal to permit such individuals to remain covered under STLDI for the maximum initial contract term, as well as for renewals and extensions, to the extent permitted under the 2018 final rules, subject to any limits under applicable State law. Although the Departments are not applying the revised maximum duration for STLDI to renewals or extensions of existing coverage, consumers can opt not to renew or extend their coverage prior to reaching the maximum duration permitted for such coverage. The Departments are not persuaded by the concern that having different applicability dates for the revised maximum duration for new and existing coverage will create confusion for consumers and issuers. As noted by one commenter, allowing individuals with existing coverage to continue their coverage for the maximum duration allowed when they purchased STLDI may instead minimize confusion and align with the consumer's expectations when they purchased the coverage. Confusion for consumers who newly enroll in STLDI coverage on or after September 1, 2024, is likely to be minimal since they would not be eligible to purchase, renew, or extend an STLDI policy for the longer maximum duration

permitted under the 2018 final rules. The Departments are of the view that the different applicability dates will also create minimal confusion and burden for issuers, which already need to track which STLDI policies are eligible for renewal or extension and for how long. The Departments are finalizing the applicability date for existing STLDI policies with respect to the maximum allowable duration for such coverage as proposed.

As discussed in section III.A.1 of this preamble, HHS declines to create a special enrollment period for individuals to enroll in individual health insurance coverage at the expiration of their STLDI coverage. However, nothing in Federal law would prevent an individual from discontinuing their STLDI coverage prior to its expiration date to align the end of their STLDI coverage with the start of individual health insurance coverage or other comprehensive coverage.

Some commenters supported applying the proposed revised notice to new STLDI sold or issued on or after the effective date of the final rules and to existing coverage upon renewal or extension. Another commenter recommended that the Departments apply the proposed amendments to the notice only to new STLDI sold or issued on or after the effective date of the final rules and to existing coverage starting 12 months after the publication of these final rules. Some commenters expressed concern that the proposed applicability dates for the revised STLDI notice did not provide enough time for implementation in States that require notices be submitted to the State department of insurance for review or approval.

The Departments agree with commenters that the revised notice should promptly apply to both new and existing (upon renewal or extension) STLDI coverage to alert all consumers who are considering purchasing or renewing STLDI to the differences between comprehensive coverage and STLDI. The notice is key to providing consumers with the information necessary to make an informed decision about the range of available coverage options. However, the Departments recognize that it would be burdensome on issu-

<sup>231</sup> The individual market open enrollment periods for plan years 2025 and 2026 begins on November 1, 2024, and November 1, 2025, respectively. See 45 CFR 155.410(e)(4)(i).



ers to finalize three separate applicability dates (that is, for the notice provisions, for the maximum duration standards applicable to new policies, and for the maximum duration standards applicable to existing policies). In addition, the Departments acknowledge that issuers in some States may need to engage with their State regulator prior to implementing the new notice. After consideration of comments, the Departments are finalizing a delayed applicability date for the revised notice to align with the delayed applicability date finalized in these final rules for new STLDI coverage. Specifically, the revised notice specified in these final rules must be provided for new STLDI policies sold or issued on or after September 1, 2024, and with respect to existing coverage, upon renewal or extension that occurs on or after September 1, 2024.

### *B. Independent, Noncoordinated Excepted Benefits Coverage*

In the group market, for hospital indemnity or other fixed indemnity insurance to qualify as an excepted benefit, among other criteria, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, \$100/day), regardless of the amount of expenses incurred. In contrast, under the current individual market regulations, fixed indemnity insurance can pay on a per-period and/or per-service basis and be considered an excepted benefit. In the 2023 proposed rules, HHS proposed to realign the individual market regulations with the group market regulations, which would require hospital indemnity or other fixed indemnity insurance to pay a fixed dollar amount per day (or per other period) of hospitalization or illness to be considered an excepted benefit in the individual market, consistent with the group market rules.

The Departments also proposed additional payment standards for hospital indemnity or other fixed indemnity insurance to be considered an excepted benefit in the group market. HHS proposed paral-

el payment standards for fixed indemnity excepted benefits coverage in the individual market. Under the 2023 proposed rules, fixed indemnity excepted benefits would be required to be paid regardless of the items or services received, actual or estimated amount of expenses incurred, severity of illness or injury experienced, or any other characteristics particular to a course of treatment received by a covered participant, beneficiary, or enrollee.

The preamble to the 2023 proposed rules also explained that the Departments are aware that some employers offer employees a “package” of coverage options that include a non-excepted benefit group health plan that provides minimal coverage (for example, coverage of preventive services only) with fixed indemnity insurance that provides benefits associated with receiving a broad category of other services for which coverage is excluded from the non-excepted benefit group health plan. The Departments explained they are concerned that some employers are attempting to circumvent the Federal consumer protections and requirements for comprehensive coverage that otherwise apply to group health plans by offering most benefits associated with receiving health care services under fixed indemnity insurance labeled as an excepted benefit, potentially leaving employees without crucial Federal consumer protections.

To address this concern and clarify the Departments’ interpretation of the requirement that hospital indemnity and other fixed indemnity insurance must offer “noncoordinated” benefits to be considered an excepted benefit, the Departments proposed to add a new example to the group market regulations to reflect that the prohibition on coordination of benefits is not limited to only those situations involving a formal coordination-of-benefits arrangement. The proposed example illustrated a scenario with a fixed indemnity insurance policy and a group health plan maintained by the same plan sponsor in which a formal coordination-of-benefits arrangement was not present but there was

nonetheless coordination between the provision of benefits under the fixed indemnity insurance policy and an exclusion of benefits under the group health plan. HHS proposed to apply the same interpretation of the noncoordination requirement to individual market fixed indemnity excepted benefits coverage.<sup>232</sup>

The Departments proposed a consumer notice for group market fixed indemnity benefits coverage. HHS also proposed amendments to the existing consumer notice for individual market fixed indemnity excepted benefits coverage. These proposals would ensure that fixed indemnity excepted benefits coverage is properly identified in marketing, application, and enrollment (or reenrollment) materials as fixed indemnity excepted benefits coverage, rather than comprehensive health insurance that is subject to Federal consumer protections, which would help a prospective enrollee distinguish between fixed indemnity excepted benefits coverage and comprehensive coverage options. With these proposals, the Departments aimed to support informed consumer choice by promoting consumer awareness of the limitations of fixed indemnity excepted benefits coverage and to help prevent consumers from mistakenly purchasing such coverage as an alternative to or replacement for comprehensive coverage.

The Departments received many comments in response to all of these proposals. These final rules adopt the new notice for fixed indemnity excepted benefits coverage offered in the group market and update the existing notice for such coverage offered in the individual market. In response to comments and consumer testing, the Departments have modified the content and applicability date of the notice, as discussed in more detail later in sections III.B.1 and III.B.3 of this preamble. However, to provide more time to study the issues and concerns raised in comments, these final rules do not address any other provision of the 2023 proposed rules relating to fixed indemnity excepted benefits coverage (with the exception of

<sup>232</sup> Consistent with the interpretation and application of the statutory requirement that fixed indemnity excepted benefits coverage in the individual market must be offered on a noncoordinated basis, HHS proposed to modify the requirement at current 45 CFR 148.220(b)(4)(ii) to specify that benefits under fixed indemnity excepted benefits coverage must be paid with respect to an event without regard to whether benefits are provided with respect to such an event under any other health coverage “maintained by the same issuer.” HHS is not finalizing this proposed modification to the individual market noncoordination standard at this time.

certain technical amendments to the HHS individual market regulation proposed in the 2023 proposed rules, as discussed in more detail later in section III.B.2 of this preamble). The Departments remain concerned with practices that appear to circumvent Federal consumer protections and requirements and intend to address the other proposals for hospital indemnity or other fixed indemnity insurance in future rulemaking, taking into account comments received on these issues.

No inference should be drawn from the decision not to finalize the proposed payment standards or noncoordination example as part of these final rules, and plans and issuers should not assume that current market practices that are inconsistent with the 2023 proposed payment standards or noncoordination example comply with the existing Federal regulations that apply to fixed indemnity excepted benefits coverage.

To the contrary, many comments received in response to the 2023 proposed rules underscored the Departments' concerns that hospital indemnity or other fixed indemnity insurance is being used by some issuers, plan sponsors, plans, agents, and brokers to circumvent the Federal consumer protections and requirements applicable to comprehensive coverage, while offering products that blur the lines between the two types of coverage. The Departments remain concerned about the deceptive marketing and sale of hospital indemnity and other fixed indemnity insurance, including the creation of hospital indemnity or other fixed indemnity insurance with detailed fee schedules. These types of fixed indemnity insurance products are not consistent with the traditional role of hospital or other fixed indemnity insurance serving as a form of income or wage replacement that the statutory exception was intended to cover. Instead, they mimic comprehensive coverage, without providing the Federal consumer protections or meeting the requirements applicable to comprehensive coverage. This leaves individuals who mistakenly purchase such coverage in lieu of comprehensive coverage without criti-

cal consumer protections, exposing them to significant health and financial risk.

Similarly, the Departments remain concerned about the practice of offering a “package” of coverage options that includes a non-excepted benefit plan that provides minimal coverage (such as coverage only for preventive services)<sup>233</sup> plus a fixed indemnity insurance policy that provides benefits associated with a broad range of items and services for which the other coverage maintained by the employer (or, in the individual market, maintained by the same issuer) excludes benefits. The Departments remain concerned that these plan designs are structured as coordinated arrangements to circumvent the Federal consumer protections and requirements for comprehensive coverage that otherwise would apply. This is particularly concerning if the employers, employees, or individuals are under the impression or are misled to believe that their two coverages, when combined, provide comprehensive coverage, and they therefore forgo pursuing other available options that would provide comprehensive coverage.

The Departments intend to address these issues in future rulemaking.

The Departments emphasize that, to be considered fixed indemnity excepted benefits coverage under the current Federal group market regulations, the benefits must be paid only on a per-period basis. Under this standard, the Departments expect that fixed indemnity excepted benefit coverage would not be designed with fee schedules that, in effect, provide benefits for specific items and services, such as wellness screening exams or prescription drugs, rather than wage or income replacement. The Departments are aware that some issuers merely affix a “per day” term to benefits for specific items and services, such as \$50 per blood test per day. As stated in the preamble to the 2023 proposed rules, when analyzing whether a policy, certificate, or contract of insurance is subject to the Federal consumer protections and requirements for comprehensive coverage, the Departments will look past the label used to examine whether the pol-

icy, certificate, or contract of insurance qualifies as an excepted benefit or whether it is comprehensive coverage that is subject to the Federal consumer protections and requirements applicable to such coverage. The Departments encourage State regulators to take a similar approach and intend to work with States to ensure that issuers comply with relevant requirements.

## 1. Notices

To ensure that consumers purchasing fixed indemnity excepted benefits coverage are aware of the type of coverage they are purchasing, including the limitations of the coverage, and that it is not mistakenly purchased as an alternative or replacement for comprehensive coverage, the Departments proposed to require a consumer notice be prominently displayed when offering fixed indemnity excepted benefits coverage in the group market, in alignment with the existing requirement to provide such a notice when offering fixed indemnity excepted benefits coverage in the individual market. The Departments proposed that if a plan or issuer provides the required group market notice in accordance with the provisions in the 2023 proposed rules, the obligation to provide the notice would be satisfied for both the plan and issuer.

In developing the proposed notice for the group market and revising the notice for the individual market, the Departments sought to balance two goals. One goal was to combat potential sources of misinformation by directing consumers to appropriate resources to learn more about comprehensive coverage and understand how that coverage differs from fixed indemnity excepted benefits coverage. The other goal was to provide a concise, understandable notice that would be meaningful to, and actionable by, consumers.

HHS also proposed technical amendments reorganizing the regulatory text to move the provision regarding the placement and materials on which the notice must appear for fixed indemnity excepted benefits coverage in the individual market, as well as amendments to the content and

<sup>233</sup> The Departments note that such an arrangement would not be treated as providing minimum value if it failed to provide substantial coverage of inpatient hospital services and physician services. 26 CFR 1.36B-6; 45 CFR 156.145.

formatting for the notice itself, to align with the proposal to adopt a notice for the group market.

Many commenters supported requiring prominent display of the proposed consumer notice in both markets to help consumers distinguish fixed indemnity excepted benefits coverage from comprehensive coverage, make individuals aware of opportunities to purchase comprehensive coverage, and inform them of possible eligibility for subsidies to purchase comprehensive coverage. Commenters strongly supported disclosures to explain the limited nature of fixed indemnity excepted benefits coverage. One commenter stated that there is a need for a model consumer notice that is succinct, clear, and prominent, especially because prior efforts have not stopped abusive marketing tactics. One commenter stated that clear, consistent, and consumer-friendly disclosures are the best mechanism to ensure fixed indemnity policies are marketed in a clear and appropriate manner, particularly if consumers are purchasing coverage online. Another commenter stated that the proposed notice language was consistent with current industry standards and expressed support for even stronger disclosure language.

The Departments agree with these commenters. By requiring a prominent disclosure notice to consumers who are considering enrolling or reenrolling in individual or group market fixed indemnity excepted benefits coverage, the Departments aim to ensure that consumers are informed about the type of coverage they are purchasing, and thereby reduce the potential for consumers to mistakenly enroll in such coverage as their primary source of coverage and to increase consumer understanding of the differences between fixed indemnity excepted benefits coverage and comprehensive coverage.

The Departments also agree with commenters that the notices should provide information to consumers in a clear and concise manner regarding opportunities to purchase comprehensive coverage, espe-

cially regarding their possible eligibility for subsidies. As noted in the preamble to the 2023 proposed rules and in section III.A.1 of this preamble, individuals belonging to underserved populations often experience greater health challenges, as well as greater challenges accessing and using health care services, compared to the general population, including worse health outcomes, higher rates of chronic conditions, lower access to health care, and more frequent experiences of discrimination in health care settings.<sup>234</sup> Members of these populations may be particularly vulnerable to misinformation or misleading or aggressive sales tactics. A notice can help combat misinformation and misleading or aggressive sales practices by helping consumers distinguish between comprehensive coverage and fixed indemnity excepted benefits coverage.

For these reasons, as well as research identifying disparities in health insurance literacy among underserved populations and people with incomes below the FPL,<sup>235</sup> the Departments proposed, and are finalizing in these rules, the adoption of a consumer notice that must be provided when offering fixed indemnity excepted benefits coverage in the group market. HHS is also finalizing revisions to the existing consumer notice that must be provided when offering fixed indemnity excepted benefits coverage in the individual market. In the Departments' view, these notices will help ensure that all consumers, including those in underserved communities, have the necessary information to make an informed choice after considering and comparing the full range of health coverage options available to them.

Some commenters stated that changes or additional notices were not necessary because existing notice provisions are sufficient. One commenter stated that although they agree that consumers need to understand what they are buying, the proposed notice provisions are not necessary since State-required consumer warnings already exist, and a Federal notice is not the proper mechanism to promote

consumer education or awareness. Some commenters suggested that existing fixed indemnity insurance policies should be exempt from any notice requirement since the consumer has already enrolled and presumably knows what they purchased.

The Departments disagree with commenters that stated that existing notice provisions are sufficient, that the proposed notice provisions are unnecessary because State-required notices exist, and that a Federal notice is not the proper mechanism to promote consumer education or awareness. The existing Federal notice provision only applies to the individual market, leaving consumers in the group market potentially uninformed about the limited nature of their fixed indemnity excepted benefit coverage and unaware of resources to learn more about other coverage options. In addition, while some State-required notices may exist, they are not mandated nationwide. In the Departments' view, a Federal notice provision is the proper mechanism to promote consumer education or awareness by conveying a consistent message at or before the time a consumer has an opportunity to enroll in the fixed indemnity excepted benefit coverage in the individual and group markets. Without such a notice consumers may be left unaware or uninformed, because notices may not be provided at all, or would be provided at the plan's or issuer's discretion. Other mechanisms, such as public service announcements, would not ensure that information has been provided to every prospective consumer.

Additionally, the Departments are of the view that requiring issuers to provide the consumer notice contemporaneously with marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll in the coverage (rather than separately from the application process or after a product has already been purchased) will ensure that consumers are made aware of the type of coverage they are considering, are made

<sup>234</sup> See CMS Office of Minority Health (2022). "The Path Forward: Improving Data to Advance Health Equity Solutions," available at: <https://www.cms.gov/files/document/path-forward-he-data-paper.pdf>.

<sup>235</sup> Edward, Jean, Amanda Wiggins, Malea Hoepf Young, and Mary Kay Rayens (2019). "Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform," *Health Literacy Research and Practice*, available at: <https://pubmed.ncbi.nlm.nih.gov/31768496/>. See also Villagra, Victor and Bhumika Bhuvra (2019). "Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference," *The American Journal of Managed Care*, available at: <https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference>.

aware of information resources at their State Department of Insurance, and are provided with options for purchasing comprehensive coverage at the time when they most need this information to support their decision-making process.

The Departments also do not agree that existing policies should be exempt from the applicable notice. Although a consumer may have already purchased fixed indemnity excepted benefit coverage in the past, the consumer may not have been aware of the limitations of such coverage or available comprehensive coverage options and may wish to evaluate all of their options before reenrolling. Therefore, the Departments are finalizing the proposal to provide the group market notice at or before the time participants are given the opportunity to enroll or reenroll in coverage prominently on the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment (or reenrollment) materials, and decline to provide an exemption for existing group market fixed indemnity excepted benefit coverage. HHS is similarly finalizing the individual market proposal to prominently display the notice on the first page of any marketing, application, and enrollment or reenrollment materials that are provided at or before the time an individual has the opportunity to apply, enroll or reenroll in coverage, and on the first page of the policy, certificate, or contract of insurance, and also declines to provide an exemption for existing individual market fixed indemnity excepted benefit coverage. These changes will ensure that fixed indemnity excepted benefit coverage is clearly identified as fixed indemnity coverage and not comprehensive coverage when marketed and sold in both the group and individual markets.

Some commenters opposed the adoption of a notice requirement in the group market and questioned its permissibility in the individual market. These commenters argued the Departments have no legal

authority to require group health plans and issuers offering fixed indemnity excepted benefits coverage in the group market to provide such a notice. One commenter, while recognizing that the existing individual market notice was not at issue in *Central United Life Ins. Co. v. Burwell*, argued that requiring a notice was akin to the type of additional criterion that the D.C. Circuit found impermissible in the case.<sup>236</sup>

The Departments disagree with commenters that question the Departments' legal authority to adopt a consumer notice for fixed indemnity excepted benefits coverage in the group and individual markets. Through the enactment of the Federal excepted benefits statutes,<sup>237</sup> Congress generally preserved Federal authority to interpret and implement the statutory provisions governing these insurance products. Congress also provided the Departments with explicit authority to promulgate regulations as the Secretaries determine may be necessary or appropriate to carry out the provisions of the Code, ERISA, and the PHS Act.<sup>238</sup> These statutes collectively provide the Departments authority to interpret and implement the requirements for hospital indemnity or other fixed indemnity insurance to qualify as excepted benefits coverage under the Federal framework, and to adopt a consumer disclosure notice in regulation to ensure that the statutes themselves function as Congress intended. As explained in the 2023 proposed rules<sup>239</sup> and in section I.D. and this section III.B of the preamble of these final rules, fixed indemnity excepted benefits coverage is not an adequate substitute for comprehensive coverage, in part because it is not subject to Federal consumer protections and requirements that apply to comprehensive coverage. Consumers who purchase fixed indemnity excepted benefits coverage under the mistaken impression that such coverage is subject to Federal consumer protections and requirements for comprehensive coverage are at significant risk of

financial and health hardships that may not become clear to the consumer until the occurrence of a costly health event.<sup>240</sup>

Consumers cannot adequately access Federal consumer protections to which they are entitled when it is unclear to which products they apply, and the effects of these protections are diluted when consumers are unclear what type of product they are purchasing and how and when they are protected by Federal law. Therefore, a consumer notice that clearly identifies a product as fixed indemnity excepted benefits coverage and distinguishes such a product from comprehensive coverage, clarifies and strengthens these protections for consumers. In addition, the notice prevents plans and issuers from marketing products that have been approved as an excepted benefit as comprehensive coverage to which Federal protections apply. Therefore, the Departments are of the view that it is necessary and appropriate for plans and issuers to provide consumers with a consumer notice that clearly labels fixed indemnity excepted benefits coverage and provides consumers with information sufficient to notify the consumer that such coverage is not subject to the Federal consumer protections and requirements for comprehensive coverage.

The Departments also disagree with the commenter who stated requiring a notice was akin to the type of additional criterion that the D.C. Circuit found impermissible in *Central United Life Ins. Co. v. Burwell*. Adoption of the Federal consumer notice is not an impermissible requirement being added to the statutory criteria for fixed indemnity excepted benefits coverage. To ensure that the Code, ERISA, and the PHS Act function as intended, the notice ensures that fixed indemnity excepted benefits coverage is marketed and labeled as such, rather than as comprehensive coverage. As discussed in this section III.B.1 of this preamble, the rules do not require the provision of a notice, but instead simply provide that insurance offered without such a notice would not qualify as fixed

<sup>236</sup> 827 F.3d 70 (D.C. Cir. 2016).

<sup>237</sup> See section 9831 of the Code, section 732 of ERISA, and sections 2722(b)-(c), 2763, and 2791(c) of the PHS Act.

<sup>238</sup> See section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act.

<sup>239</sup> See, for example, 88 FR 44596 at 44619, 44620, 44645-44646 (July 12, 2023).

<sup>240</sup> See *id.* at 44605, 44606 (citing Appleby, Julie (2017). "Brokers Tout Mix-And-Match Coverage To Avoid High-Cost ACA Plans," KFF, available at: <https://kffhealthnews.org/news/brokers-tout-mix-and-match-coverage-to-avoid-high-cost-aca-plans>), 44608 (citing Avila, Jaie (2019). "Show Me Your Bill Helps Wipe Out \$70K in Charges After Heart Attack," News 4 San Antonio, available at: <https://news4sanantonio.com/news/trouble-shooters/show-me-your-bill-helps-wipe-out-70k-in-charges-after-heart-attack>) (July 12, 2023).

indemnity excepted benefits coverage and would be subject to the Federal consumer protections and requirements applicable to comprehensive coverage. Plans and issuers will not be prohibited from selling hospital indemnity and other fixed indemnity insurance, and consumers may continue to choose to purchase it, but unless the coverage includes the requisite notice identifying it as coverage not subject to the Federal consumer protections and requirements subject to comprehensive coverage, it would be subject to such protections and requirements. Additionally, the notice is being adopted to further the Departments' interest in ensuring that consumers are fully aware that they are purchasing fixed indemnity excepted benefits coverage rather than comprehensive coverage, are aware of their options to purchase comprehensive coverage, and have access to information resources that support informed consumer decision-making with regard to health coverage.

Further, the changes to the individual market consumer notice and the adoption of a notice in the group market are reflective and responsive to changes observed by the Departments in market conditions and the legal landscape. As discussed in section II.A of this preamble, market conditions have changed and increased the availability of affordable options for comprehensive coverage. As discussed in section II.D of this preamble, the legal landscape has also changed. The decision in *Central United Life Ins. Co. v. Burwell* and the passage of the Tax Cuts and Jobs Act increase the likelihood that individuals would purchase fixed indemnity excepted benefits coverage as a substitute for comprehensive coverage. As a result of those changes, the Departments are of the view that notices will help combat deceptive marketing practices and potential sources of misinformation by clearly identifying fixed indemnity excepted benefits coverage and distinguishing such coverage from comprehensive coverage, directing consumers to appropriate resources to learn more about comprehensive coverage, and identifying key differences between that

coverage and fixed indemnity excepted benefits coverage.

Many commenters stated that the proposals regarding notices in the 2023 proposed rules usurp States' authority. Several commenters pointed to the McCarran-Ferguson Act, stating that only Congress may infringe on the States' exercise of their authority to regulate insurance.

Several commenters stated that Federal regulatory changes are not necessary because States and the NAIC have been working on the NAIC Models 40, 170, 171 and 880 that address these coverage options,<sup>241</sup> and when those are adopted by States, they will adequately address the Departments' concerns. Several commenters stated that amendments to the Federal regulations are not necessary because States have enforcement authority to discipline agents, discipline issuers, limit marketing practices, and limit product features if there are instances of fixed indemnity excepted benefits coverage being sold as a replacement for comprehensive coverage.

The Departments agree that the States play an important role in regulating fixed indemnity excepted benefits coverage and acknowledge the federalism implications of the proposed rules and these final rules.<sup>242</sup> As noted by commenters, the McCarran-Ferguson Act generally affirms the preeminence of State regulation, and also explicitly allows for Federal regulation when an act of Congress specifically relates to the business of insurance. As discussed in section III.A.1 of this preamble, the McCarran-Ferguson Act balances State and Federal interests in regulating the business of insurance. Section 1012(a) of the McCarran-Ferguson Act maintained State regulatory authority by enabling State preemption of some Federal law, and section 1012(b) of the McCarran-Ferguson Act limited Federal regulatory authority by generally exempting the "business of insurance" from Federal law. Although Congress allowed for State preemption of Federal law in this way, Congress also preserved Federal authority to regulate insurance provided that, to overcome the State preemption, congressional action

must specifically relate to the business of insurance. As previously noted, HIPAA, the ACA, and the other Acts of Congress specifically relate to the business of insurance. Given that Congress defined and set forth criteria for fixed indemnity excepted benefits coverage to be exempt from the Federal consumer protections and requirements for comprehensive coverage,<sup>243</sup> there is clear congressional action specifically addressing the business of insurance, thereby preserving Federal regulatory authority to interpret and implement the Federal statutory provisions governing these insurance products.

In addition, as previously noted, Congress also provided the Secretaries of the Treasury, Labor, and HHS with explicit authority to promulgate regulations as may be necessary or appropriate to carry out the provisions of the Code, ERISA, and the PHS Act.<sup>244</sup> This includes the authority for the Departments to interpret and implement the requirements for hospital indemnity or other fixed indemnity insurance to qualify as excepted benefits coverage under Federal law, and also provides the authority to adopt a consumer notice. The Code, ERISA, and the PHS Act impose certain requirements on comprehensive coverage and do not impose those same requirements on fixed indemnity excepted benefits coverage. The Departments believe it is necessary and appropriate that plans and issuers provide consumers considering the purchase (or renewal) of fixed indemnity excepted benefits coverage, and those actually purchasing such insurance, a notice that clearly identifies the insurance as fixed indemnity excepted benefits coverage and is sufficient to put consumers on notice that such coverage is not subject to the Federal consumer protections and requirements for comprehensive coverage. The notices also direct consumers to resources where they can learn about the range of available coverage options, and the notices are designed to help combat the misinformation and deceptive tactics that can lead to consumers mistakenly enrolling in fixed indemnity excepted benefits coverage in lieu of comprehensive coverage. This will

<sup>241</sup> NAIC model laws are available at: <https://content.naic.org/model-laws>.

<sup>242</sup> For further discussion of the Federalism implications of these final rules, see section V.H of this preamble.

<sup>243</sup> See sections 9831 and 9832 of the Code, sections 732 and 733 of ERISA, and sections 2722, 2763, and 2791 of the PHS Act.

<sup>244</sup> See section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act.

help ensure that consumers who purchase fixed indemnity excepted benefits coverage are doing so based on an informed decision and not in error.

The notice provisions being finalized in these final rules do not infringe on States' authority to regulate insurance. States retain authority to regulate fixed indemnity excepted benefits coverage. States may impose standards or requirements on hospital indemnity or other fixed indemnity insurance for purposes of State law, such as a requirement to provide a State-specific notice in relation to fixed indemnity excepted benefits coverage offered by issuers in their State, including any notice developed as part of an NAIC Model Act or Regulation.

However, hospital indemnity or other fixed indemnity insurance that does not include the language in the revised notice under these final rules would not be considered fixed indemnity excepted benefits coverage for purposes of Federal law and thus would be subject to the Federal consumer protections and requirements applicable to comprehensive coverage.

The Departments are of the view that these final rules appropriately balance States' interests in regulating health insurance issuers and their health insurance markets with Congress' intent to establish a general Federal framework for health insurance coverage, including the provision of certain key protections to consumers enrolled in comprehensive coverage and the creation of an exemption for insurance products that meet the requirements to be considered excepted benefits coverage. The Departments recognize that States have been working with the NAIC to revise several model acts and regulations related to marketing and sales practices and those models might address some of the Departments' concerns. However, those models establish minimum standards and States' adoption of any NAIC model is optional. States may choose to codify some or none of the standards set forth in the NAIC models, which have yet to be finalized. The Departments will engage with States and the NAIC as they revise several NAIC Model Acts and reg-

ulations to update the minimum standards for non-comprehensive coverage products, including fixed indemnity excepted benefits coverage. The Departments look forward to reviewing the information and data collected on such products from the NAIC data call that is currently underway.

A few commenters stated that the notice provisions in the individual and group markets raised First Amendment concerns, alleging that the Departments did not articulate a compelling governmental interest because the 2023 proposed rules failed to provide any substantial evidence that consumer confusion is widespread. Those commenters further asserted that the notice provisions for the group and individual markets are not narrowly tailored, and that requiring display on the first page of marketing and enrollment materials (in addition to application materials) is not justified.

The Departments disagree that the proposed notice provisions for fixed indemnity excepted benefits coverage raise First Amendment concerns. The rules do not require the provision of a notice, but instead simply provide that hospital indemnity or other fixed indemnity insurance offered without such a notice would not qualify as fixed indemnity excepted benefits coverage and would be subject to the Federal consumer protections and requirements applicable to comprehensive coverage. Moreover, as the United States Supreme Court recognized in *Zauderer v. Office of Disciplinary Counsel*,<sup>245</sup> and later reiterated in *National Institute of Family and Life Advocates v. Becerra*,<sup>246</sup> required disclosures of factual, uncontroversial information in commercial speech are subject to more deferential First Amendment scrutiny. Under the approach articulated in *Zauderer*, courts have upheld required disclosures of factual information in the realm of commercial speech where the disclosure reasonably relates to a substantial government interest and is not unjustified or unduly burdensome such that it would chill protected speech. Regardless, the Departments believe that the revised notice standard would pass muster under any form of First Amendment scrutiny.<sup>247</sup>

The language on the Federal notices for fixed indemnity excepted benefits coverage includes factual, uncontroversial information, reasonably relates to a government interest, and is not unjustified or unduly burdensome. In addition, the Departments have reviewed and responded to public comments that raised concerns about proposed text. For example, certain language that appeared in the proposed rules that commenters deemed controversial, such as "Warning," are not being finalized. HHS conducted consumer testing to ensure the language in the required notice was not misinterpreted to deliver any untrue messages.

The Departments have a substantial, and even compelling, government interest in ensuring consumers are aware of the type of product they are considering purchasing, are informed about key differences between fixed indemnity excepted benefits coverage and comprehensive coverage, are aware of their option to purchase comprehensive coverage, and have access to resources for additional information about the range of available health coverage options so consumers can make informed choices. As discussed in section II.B of this preamble, this is of particular importance at present due to the changing legal landscape and low health literacy, as well as the increased reports of deceptive marketing practices that play on consumer confusion about the benefits and limitations of fixed indemnity excepted benefits coverage. The notices clearly label products as fixed indemnity excepted benefits coverage and communicate factual information to consumers about the differences between fixed indemnity excepted benefits coverage and comprehensive coverage and explain how consumers can find resources when they have questions about the different coverage options. As stated in the preamble to the 2023 proposed rules, the Departments are concerned about consumers who mistakenly enroll in fixed indemnity excepted benefits coverage in lieu of comprehensive coverage and are therefore at risk of significant financial liability because their health care costs may greatly exceed the fixed cash benefit

<sup>245</sup> 471 U.S. 626 (1985).

<sup>246</sup> 585 U.S. 755 (2018).

<sup>247</sup> See also *Pharmaceutical Care Management Association v. Rowe*, 429 F.3d 294, 316 (1st Cir. 2005)

to which they may be entitled—if benefits are even provided for their health-related event.<sup>248</sup> Accordingly, the notices adopted in these final rules serve a legitimate government interest, are justified, and are reasonably related to these government interests.

Furthermore, these notices do not unduly burden plan or issuer speech because nothing in the final rules would “drown out” a plan’s or issuer’s own message or “effectively rule out” any mode of communication.<sup>249</sup> Plans and issuers remain free to communicate with consumers using methods and media they have always used or may choose to use in the future. The burden associated with displaying the applicable notice should be low since the Departments have adopted static language, meaning that the plan or issuer does not have to tailor or modify the Federal notice. For the reasons discussed previously, the Departments are of the view that informing consumers prior to purchase or reenrollment of fixed indemnity excepted benefits coverage and directing them to resources to learn more about the range of available coverage options is highly related to the government’s aforementioned interest in ensuring that consumers make informed decisions.

The Departments are aware of some complex fixed indemnity policies in the individual market that pay benefits based on extensive variable schedules and other policies that promote a certain network of providers. Such plan designs mimic comprehensive coverage and can skew a consumer’s understanding of the nature and extent of the fixed indemnity excepted benefits coverage. The Departments provided examples of consumer confusion regarding the limitations and exclusions associated with fixed indemnity excepted benefits coverage in the preamble to the 2023 proposed rules<sup>250</sup> and received additional examples from commenters. Some commenters provided examples of benefit designs that are modeled after comprehensive coverage and may cause confusion, including products requiring that enrollees

meet a deductible before benefits are paid, making payments directly to providers, or using provider networks that purport to give the member a reduced or discounted medical bill for using an in-network provider. The preamble to the 2023 proposed rules also described certain arrangements in the group market that the Departments are concerned can mislead enrollees into believing they have comprehensive coverage when that is not the case.

Both the draft notice that was proposed for the group and individual markets in the 2023 proposed rules and the version being finalized in these rules are reasonably related and narrowly tailored to the government’s interest in informing consumers about the limitations of fixed indemnity excepted benefits coverage, and combating deceptive marketing practices and potential sources of misinformation, by directing consumers to appropriate resources to learn more about the range of available health coverage options.<sup>251</sup> The notices do not include irrelevant or superfluous information unrelated to these interests.

As the Departments explained in the preamble to the 2023 proposed rules, requiring plans and issuers to display a notice on the first page of marketing, application, and enrollment materials in both markets plus on the first page of the policy, certificate, or contract of insurance in the individual market is justified to ensure that the notice is provided on documents that consumers are most likely to have the opportunity to review before application, enrollment, or reenrollment. In the Departments’ view, requiring the notice only on the first page of the application is insufficient, as evidenced by ongoing consumer confusion.

The Departments proposed to require that plans and issuers prominently display the notice (in either paper or electronic form, including on a website) in at least 14-point font on the first page of any marketing, application, and enrollment materials that are provided to participants at or before the time participants

are given the opportunity to enroll in the group market fixed indemnity excepted benefit coverage. In addition, if participants are required to reenroll (in either paper or electronic form) for purposes of renewal or reissuance of group market fixed indemnity excepted benefits coverage, the Departments proposed that the notice must be displayed in all reenrollment materials that are provided to participants at or before the time participants are given the opportunity to reenroll in coverage. The Departments explained that they consider marketing materials to include any documents or website pages that advertise the benefits or offer an opportunity to enroll (or reenroll) in group market fixed indemnity excepted benefits coverage. The Departments are finalizing the proposed requirements related to the placement of the group market consumer notice as proposed.

HHS proposed slightly different placement standards for the individual market consumer notice. The requirements reflect the differences between the types of documents that consumers typically receive when considering enrolling or reenrolling in fixed indemnity excepted benefits coverage in the individual market compared to participants in the group market. With respect to individual market fixed indemnity excepted benefits coverage, HHS proposed that issuers must also prominently display the notice (in either paper or electronic form) in at least 14-point font on the first page of the policy, certificate, or contract of insurance, including renewals or extensions, because individual market consumers are likely to receive those documents upon enrollment. This is in addition to prominently displaying the notice on the first page (in either paper or electronic form) of any marketing, application, and enrollment (or reenrollment) materials for individual market fixed indemnity excepted benefit coverage, and prominently displaying the notice on websites that advertise or offer an opportunity to enroll (or reenroll) in such coverage. HHS proposed the additional locations for

<sup>248</sup> 88 FR 44596 at 44606 (July 12, 2023).

<sup>249</sup> See *NIFLA*, 138 S. Ct. at 2378.

<sup>250</sup> 88 FR 44596 at 44621-22 (July 12, 2023).

<sup>251</sup> 88 FR 44625 “[T]he Departments aim to reduce the potential for consumers to mistakenly enroll in hospital indemnity or other fixed indemnity insurance as their primary source of coverage and increase consumer understanding of the differences between fixed indemnity excepted benefits coverage and comprehensive coverage.”

display, rather than just application materials as required in the 2014 final rule, due to concern of ongoing consumer confusion.

These proposals related to notice placement were intended to ensure that the notice is provided on documents that consumers are most likely to have the opportunity to review before application, enrollment, or reenrollment, based on the Departments' understanding of how consumers receive information related to group market versus individual market fixed indemnity excepted benefits coverage. HHS is finalizing the proposed requirements related to placement of the individual market consumer notice as proposed.

Many commenters supported the proposed placement of the notices in marketing, application, and enrollment and reenrollment materials, including websites and materials shared electronically. Some commenters also generally stated that the notices should be provided early and often so that consumers are not confronted with notice or warning language only after selecting a plan for purchase.

Some commenters expressed opposition to including the applicable notice with all marketing, application, and enrollment materials, suggesting such requirements are excessive and may reduce the impact of the notice. These commenters recommended the notice be provided in only the enrollment materials or using the existing individual market standard, which requires placement in the application materials only.

The Departments are finalizing the proposed standards regarding the placement and applicable materials on which the group market notice must appear without modification. HHS is similarly finalizing the proposed standards regarding the placement and applicable materials on which the revised individual market notice must appear without modification. The Departments disagree with the comment-

ers who stated that including the notice on all of these materials is excessive and may reduce the impact of the notice itself. Including the notice on the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment (or reenrollment) materials (as well as, in the individual market, the policy, certificate, or contract of insurance) is intended to ensure that the notice is provided on documents that consumers are most likely to have the opportunity to review before application, enrollment or reenrollment. To achieve this, as some commenters pointed out, it is important that the notice be available both early in the enrollment (or reenrollment) process and often.

Therefore, it is the Departments' view that requiring the notice in several locations – rather than just the enrollment materials or only in the application – is not excessive due to the goal of maximizing consumers' opportunity to review the notice throughout their decision-making process, which is likely to increase the impact of the notice. The repetition will also help mitigate the potential for consumers to mistakenly enroll in fixed indemnity excepted benefits coverage as a substitute for comprehensive coverage and will help combat deceptive marketing practices and potential sources of misinformation by directing consumers to appropriate resources to learn more about the range of available health coverage options.

The Departments recognize that providing notices imposes costs on plans and issuers and identified other scenarios where the benefits to consumers would be minimal and do not justify the administrative burden on plans and issuers to provide the notice. Specifically, these final rules do not require plans and issuers to provide the notice to beneficiaries, as well as participants, in the group market. In the Departments' view, requiring plans and issuers offering fixed indemnity excepted

benefits coverage in the group market to provide notice to participants (rather than to both participants and any beneficiaries) appropriately balances the need to ensure that participants who are considering whether to enroll themselves and their beneficiaries in such coverage are sufficiently informed of their health coverage options with the administrative burden on plans and issuers to provide the notice.

In addition, because the group policy, certificate, or contract of insurance in the group market is often provided to the plan sponsor or the group health plan administrator, these final rules do not require that plans and issuers include the consumer notice in those documents for group market fixed indemnity excepted benefits coverage because doing so would not support the goal of ensuring that the consumers themselves receive the information so they can make an informed decision before enrolling (or reenrolling) in coverage. Similarly, in the individual market, HHS did not propose and is not finalizing a requirement for the notice to be provided to dependents of the individual enrolling in coverage. Instead, the individual market notice must be provided only to the policyholder.

The Departments proposed and are finalizing that the group market notice must be prominently displayed in at least 14-point font on the first page of any applicable marketing, application or enrollment materials.<sup>252</sup> Consistent with the approach outlined in the 2023 proposed rules, under these final rules, the Departments consider a notice to be prominently displayed if it is easily noticeable to a typical consumer within the context of the page (either paper or electronic) on which it is displayed (for example, using a font color that contrasts with the background of the document; ensuring the notice is not obscured by any other written or graphic content on the page; and, when displayed on a website, ensuring the notice is visible without requiring the viewer to click on a

<sup>252</sup> As previously discussed in this section III.B.1 of this preamble, the Departments are finalizing the proposed requirements regarding the placement and materials on which the group market notice must appear without modification. As such, the group market notice must be prominently displayed on all marketing, application, and enrollment (or reenrollment) materials. The notice must also be prominently displayed on websites that advertise or offer an opportunity to enroll (or reenroll) in group market fixed indemnity excepted benefits coverage.

<sup>253</sup> As previously discussed in this section III.B.1 of this preamble, HHS is finalizing the proposed requirements regarding the placement and materials on which the individual market notice must appear without modification. As such, the revised individual market notice must be prominently displayed on the first page of the policy, certificate, or contract of insurance, as well as on all marketing, application, and enrollment (or reenrollment) materials. The notice must also be prominently displayed on websites that advertise or offer an opportunity to enroll (or reenroll) in individual market fixed indemnity excepted benefits coverage.



link to view the notice). HHS proposed, and is finalizing, the same prominent display requirements for the individual market notices that must appear on the first page of any applicable materials.<sup>253</sup>

Some commenters supported the proposal that the notices be prominently displayed on the first page of applicable materials in at least 14-point font. Another commenter suggested that instead of the 14-point font standard, the Departments should require that the notices are “easily noticeable to a typical consumer within the context of the page.” One commenter recommended that when fixed indemnity excepted benefits coverage is sold as part of a bundled package, the applicable notice should be displayed on the front page of the bundled package, not just on the first page of fixed indemnity material, to help consumers see the notice instead of having it be embedded among many pages of material. One commenter stated that State regulators will often require pre-approval of any materials if the issuer adds any language to a previously approved insurance document, and that commenter requested that issuers have the flexibility to provide the required consumer notice on a separate document rather than the first page of the marketing, application, or enrollment (or reenrollment) materials.

The Departments agree with commenters who supported the prominent display of the notice on the first page of applicable materials in at least 14-point font. The Departments are of the view that this will help ensure that the notice is displayed in

a location and font size that consumers are likely to see and will do so more effectively than a less subjective standard like an “easily noticeable” standard. The individual market regulations have required the prominent display of the notice in at least 14-point font and the Departments maintain that standard for simplicity and consistency.

The Departments appreciate the suggestion that when fixed indemnity excepted benefits coverage is sold as part of a bundled package, the notice should be displayed on the front page of the bundled package, not just on the first page of fixed indemnity material, to help consumers see the notice instead of having it be embedded among many pages of material. However, in some cases, placing the notice on the front of such a bundle may lead to increased consumer confusion if, for example, the consumer is unclear as to which insurance sold as part of the bundle is described in the notice. Therefore, the Departments decline to adopt a standard that requires the notice be displayed on the front page of a bundled package.

Likewise, the Departments decline to specify the manner in which materials must be presented to States for review and approval including approval of new language in a previously approved document. Issuers should work with States to determine which pages that include the notice must be submitted to the State for review and approval, the manner of submission, and how to verify that the submission is the first page of the material.

The Departments are finalizing the proposal that the group market notice must be prominently displayed in at least 14-point font on the first page of the applicable materials, and HHS is finalizing the parallel proposal for prominent display of the individual market notice on the first page of the applicable materials.

The existing notice requirement, which currently applies only in the individual market, requires that the following language be provided in application materials in at least 14-point type:

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

To align the notice with the changes made by the Tax Cuts and Jobs Act to section 5000A of the Code (reducing the individual shared responsibility payment to \$0), and to clarify the message to consumers, the 2023 proposed rule proposed revisions to the individual market notice and solicited comments on two options for the notice. As previously discussed, the Departments also proposed to adopt a new notice provision for the group market and solicited comments on the same two options for the group market notice.

The first option (Format A) was as follows:

#### *Notice to Consumers About Fixed Indemnity Insurance*

**IMPORTANT:** This is fixed indemnity insurance. **This isn’t comprehensive health insurance** and **doesn’t** have to include most Federal consumer protections for health insurance.

Visit [HealthCare.gov](https://www.healthcare.gov) online or call 1-800-318-2596 (TTY: 1-855-889-4325) to review your options for comprehensive health insurance. If you’re eligible for coverage through your employer or a family member’s employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy.

The second option (Format B) was as follows:

#### **WARNING**

**This is not comprehensive health insurance.** This is fixed indemnity insurance.

This may provide a cash benefit when you are sick or hospitalized. It is not intended to cover the cost of your care.

Contact your State department of insurance if you have questions or complaints about this policy.

For info on comprehensive health insurance coverage options:

- Visit [HealthCare.gov](https://www.healthcare.gov) online or call 1-800-318-2596 (TTY: 1-855-889-4325)
- Contact your employer or family member’s employer

One commenter stated that the general promise of a cash benefit on Format B could be read too broadly by a consumer with low health insurance literacy. Another commenter suggested that the phrase “Important Notice – Please Read Carefully” should appear at the top of the notice because that phrase would better catch the attention of consumers and inform them that this is important information that they should consider prior to making a decision. Another commenter suggested the notice should include the words “by law” before the phrase “does not have to include” most Federal consumer protections on Format A to make it clear that this coverage, by law, is not subject to the ACA or other Federal health coverage mandates. Several commenters indicated that information on the notice should be provided in a bulleted format to ensure that all factors are clearly listed. Some commenters recommended adopting Format B for greater accessibility and stated that version is written more concisely and in plain language. One commenter suggested Format B provides clarity to the reader about the nature of the insurance product by using the term “WARNING” instead of “IMPORTANT.”

Other commenters opposed the use of Format B, stating that this option was misleading, confusing, and inaccurate. Several commenters suggested that the use of the term “WARNING” inappropriately implies that the coverage is inherently dangerous, noting that in other Federal labeling requirements, the use of the term “WARNING” is limited to extreme situations where the product itself is inherently unsafe. These commenters stated that hospital indemnity or other fixed indemnity insurance is not inherently hazardous or harmful, and the term “IMPORTANT” would be more appropriate and accurate. Some commenters stated that Format B included language regarding covering the cost of care, which is not entirely accurate, and that the language suggests the policy is subject to, but avoiding, Federal coverage mandates. Those commenters stated that Format B may therefore exacerbate consumer confusion.

In response to the comments on the proposed content for the notices and the different formats outlined in the 2023

proposed rules, HHS performed consumer testing to evaluate commenters’ suggestions and better understand how the different formats for the notice could be interpreted by consumers. This consumer testing found that some consumers were unclear on the meaning of the phrase “cash benefit” within the context of the notice in Format B. Consumers also reported they were confused by the phrase “it is not intended to cover the cost of your care” in Format B of the proposed notice; some consumers noted that phrase only referred to their out-of-pocket costs that may be associated with the policy, such as a deductible or copay. The consumer testing also revealed that consumers prefer “IMPORTANT” and viewed “WARNING” as too strong. They stated that “IMPORTANT” was sufficient to draw their attention to the notice, and that adding the words “by law” before the phrase regarding Federal consumer protections was superfluous and not necessary.

In response to comments stating that Format B was written more concisely and in plain language, as well as the results of the consumer testing and feedback from plain language experts, the Departments are finalizing a modified version of Format B. The modified version provides information using a bulleted format to ensure all information is clearly listed, as commenters recommended.

The Departments modified Format B to address comments that claimed that format was misleading, confusing, and inaccurate. The finalized notice does not include the phrase “cash benefit” or “by law” or the word “Warning.” HHS is similarly not including these same phrases in the individual market notice that is finalized in these final rules. The Departments also decline to add “Important Notice – Please Read Carefully” because consumer testing revealed that including the word “IMPORTANT” in all uppercase was sufficient to identify the applicable notice as a document that should be read. The Departments have revised the group market notice language to include “You’re still responsible for paying the cost of your care” because consumers who were tested understood that terminology better than the proposed phrase “It is not intended to cover the cost of your care” included in Format B of the proposed notice. In

addition to that phrase, the Departments are also adding the statement “The payment you get isn’t based on the size of your medical bill” to highlight that the fixed indemnity excepted benefit is a fixed payment amount and not related to the billed amount. For the same reason, the Departments have also revised the group market notice language to state “Since this policy isn’t health insurance, it doesn’t have to include most [F]ederal consumer protections that apply to health insurance,” rather than the proposed statement in Format B of the proposed notice that the policy “doesn’t have to include most Federal consumer protections for health insurance.” The revised phrasing avoids suggesting that the policy is subject to, but avoiding, the Federal consumer protections and requirements applicable to comprehensive coverage. HHS is adopting the same revisions to the language in the revised individual market consumer notice.

The Departments welcomed comments on any benefits or burdens that would be associated with including information to direct consumers to State-specific resources as part of the notice, including identifying the applicable State Exchange if the fixed indemnity excepted benefits coverage is filed in a State that does not use HealthCare.gov. The Departments also welcomed comments on any burdens that would be created by providing State-specific contact information for the State agency responsible for regulating fixed indemnity excepted benefits coverage in the State where the coverage is filed, rather than a generic reference to the consumer’s State department of insurance, as proposed in both Format A and Format B. For products that are filed in multiple States, the Departments solicited comments on whether the notice should include the name and phone number for the State department of insurance of the State in which the individual to whom the fixed indemnity excepted benefits coverage is sold or marketed resides, unless the product is not filed in that State. Under this approach, if the product is not filed in the State in which the individual to whom the fixed indemnity excepted benefits coverage is sold or marketed resides, the notice would need to include the name and phone number for the department of insurance

of the State in which the fixed indemnity excepted benefits coverage policy is filed.

Several commenters supported including State-specific details in the notice, including contact information for the State's Exchange and department of insurance. One commenter strongly supported including State-specific contact information in the notice, to ensure that consumers have access to the resources they need to understand their hospital indemnity and other fixed indemnity insurance policy.

Other commenters opposed customization of the notice to include State-specific resources, stating customization would increase administrative burden and cost and potentially create consumer confusion. One commenter noted that some companies that make fixed indemnity excepted benefits products available in multiple States often use universally applicable brochures for those products, and those issuers would be required to stop longstanding, efficient marketing and enrollment processes with little benefit to consumers, who can easily obtain State-specific contact information elsewhere.

One commenter did not support the inclusion of contact information for each State department of insurance but recommended that the Departments consider directing consumers to the NAIC's online directory, available at [naic.org](http://naic.org). The Departments did not receive comments regarding which State agency's contact information should be included for products that are filed in multiple States.

In developing the notice language, the Departments sought to balance the goals of distinguishing fixed indemnity excepted benefits coverage from comprehensive

coverage, combatting deceptive marketing practices, and reducing misinformation by directing consumers to appropriate resources to learn about the range of available coverage options, with the need to provide a concise, understandable notice that would be meaningful and useful to consumers. The Departments understand commenters' concerns regarding the burden associated with customizing notices to include State-specific information. However, the Departments also recognize the value of including State-specific information, such as appropriate contact information if the consumer has questions or wants more information about available coverage options.

After consideration of comments and the results of consumer testing, the Departments are finalizing changes to the notice to incorporate uniform language as part of the required content for the Federal notices that directs individuals to an NAIC webpage where they can find the contact information for the applicable State regulatory agency. As discussed in section III.A.4 of this preamble, the inclusion of the NAIC link in the notice does not constitute an endorsement by the Departments. Since the Departments are not requiring State-specific contact information on the Federal notice, the Departments decline to specify a certain agency's contact information that should be included for products that are filed in multiple States.

The Departments are also incorporating static language as part of the content for the group market notice in these final rules that direct individuals to [HealthCare.gov](http://HealthCare.gov), where individuals can navigate to their State's Exchange, whether a Federally-facilitated Exchange, State Exchange on the

Federal platform or a State Exchange. HHS is adopting similar static language for the individual market notice. This approach is intended to balance the desire to ensure individuals can access State-specific information with not increasing the burden on plans and issuers associated with the development of customized notices that provide State-specific information.

The Departments also solicited comments on whether it would be beneficial to consumers to require plans and issuers to include language on the notice that clearly informs consumers that the notice is an officially required document, such as "This notice is required by Federal law." The Departments did not receive comments regarding inclusion of that phrase on the required notice for fixed indemnity excepted benefits coverage but performed consumer testing on notices that included the phrase. Consumer testing revealed that some consumers stated that including that phrase at the bottom of the notice was helpful and that it made the information on the notice seem more legitimate, while other consumers stated the phrase meant the fixed indemnity excepted benefits policy itself was endorsed by the Federal Government. Given the potential for consumer confusion, the Departments are not including a statement that the notice is required by Federal law.

In response to comments and after consideration of the results from the consumer testing, to enhance readability, the Departments made several changes to incorporate a combination of the language from both Format A and Format B in the 2023 proposed rules and are finalizing the following content for the group market notice:

### **IMPORTANT: This is a fixed indemnity policy, NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

### **Looking for comprehensive health insurance?**

- **Visit [HealthCare.gov](http://HealthCare.gov)** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

### **Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](http://naic.org)) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

HHS is finalizing the same content for the revised individual market notice for fixed indemnity excepted benefits coverage.

Some commenters recommended requiring that the formatting of the notice be accessible to people with a range of disabilities and that it be made available in the most commonly spoken languages in each State. The Departments agree that it is important that the notices are accessible and understandable to individuals with disabilities, as well as to individuals with limited English proficiency. The Departments are mindful of the challenges faced by individuals with physical, sensory, or cognitive disabilities, including but not limited to individuals who use screen readers and other assistive technology.

While the Departments did not propose and are not finalizing accessibility or language access standards specific to these notices as part of this rulemaking, the Departments remind plans and issuers that they are required to comply with other State and Federal laws establishing accessibility and language access standards to the extent applicable. For example, recipients of Federal financial assistance must comply with Federal civil rights laws that prohibit discrimination. These laws may include section 1557 of the Affordable Care Act,<sup>254</sup> title VI of the Civil Rights Act of 1964,<sup>255</sup> section 504 of the Rehabilitation Act of 1973,<sup>256</sup> and the Americans with Disabilities Act of 1990.<sup>257</sup> Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include provision of language assistance services such as written translation of written content, in paper or electronic form into languages other than English. Sections 1557 and 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate

auxiliary aids and services at no cost to the individual. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Additionally, section 508 of the Rehabilitation Act of 1973 requires that information provided through information and communication technology also must be accessible to individuals with disabilities unless certain exceptions apply.

## 2. Technical Amendment

HHS proposed a technical amendment to the individual market excepted benefits rules to remove the existing requirement at 45 CFR 148.220(b)(4)(i) that fixed indemnity excepted benefits coverage must be provided only to individuals who attest, in their fixed indemnity insurance application, that they have other health coverage that is MEC, or that they are treated as having MEC due to their status as a bona fide resident of any possession of the United States pursuant to section 5000A(f)(4)(B) of the Code. This proposal would strike from the regulatory text the provision that was vacated in *Central United Life Ins. Co. v. Burwell*.<sup>258</sup> HHS did not receive any comments regarding this proposed technical amendment and is finalizing as proposed. HHS is also finalizing the proposed conforming amendments to 45 CFR 148.220 to redesignate paragraphs (b)(4)(ii) through (iv) as paragraphs (b)(4)(i) through (iii).<sup>259</sup>

## 3. Applicability Dates

The Departments proposed that the new group market notice provisions would apply to both new and existing group market fixed indemnity excepted benefits coverage for plan years beginning on or after

the effective date of the final rules. HHS proposed a similar applicability date for the revised individual market fixed indemnity excepted benefits coverage notice. After consideration of comments, the Departments are finalizing delayed applicability dates for the notices, such that plans and issuers will be required to comply with the notice provisions finalized in these rules for plan years (in the individual market, coverage periods) (including renewals) beginning on or after January 1, 2025. To streamline the regulatory text, the Departments are finalizing the applicability date for the notice provision for fixed indemnity excepted benefits coverage in the group market at 26 CFR 54.9831-1(c)(4)(ii)(D), 29 CFR 2590.732(c)(4)(ii)(D), and 45 CFR 146.145(b)(4)(ii)(D) rather than at 26 CFR 54.9831-1(c)(4)(iv), 29 CFR 2590.732(c)(4)(iv), and 146.145(b)(4)(iv), as proposed. HHS is finalizing the applicability date for the notice provisions for fixed indemnity excepted benefit coverage in the individual market at 45 CFR 148.220(b)(4)(iii),<sup>260</sup> rather than at 148.220(b)(4)(iv).

Several commenters supported issuing updated notices to existing policyholders by applying the notice provisions finalized in these rules to coverage periods (including renewals) beginning on or after January 1, 2025. Other commenters stated the notice provisions should not apply before January 1, 2027, for all individual and group coverage, regardless of when the coverage is issued or sold. Some commenters urged the Departments to apply the notice provisions only to new coverage sold after the effective date of the final rules, alleging that the application to existing coverage would be impermissibly retroactive. Those commenters stated that applying the notice to existing policies would inappropriately interfere with a covered individual's current contract and their choice to continue the policy. Some commenters asserted that imposing

<sup>254</sup> 42 U.S.C. 18116.

<sup>255</sup> 42 U.S.C. 2000d *et seq.*

<sup>256</sup> 29 U.S.C. 794.

<sup>257</sup> 42 U.S.C. 12101 *et seq.*

<sup>258</sup> 827 F.3d 70 (D.C. Cir. 2016).

<sup>259</sup> These provisions are being redesignated without any changes to the regulatory text.

<sup>260</sup> Under 45 CFR 148.220(b)(4)(iii)(B) of these final rules, the notice in § 148.220(b)(4)(iv) contained in 45 CFR part 148, revised as of October 1, 2023, continues to apply to individual market fixed indemnity excepted benefits coverage for coverage periods beginning before January 1, 2025. However, HHS will not consider insurance to fail to be fixed indemnity excepted benefits coverage in the individual market under the Federal framework if an issuer adopts the revised notice in these final rules for coverage periods beginning before January 1, 2025. HHS encourages States to adopt a similar approach if their issuers elect to adopt the revised notice for coverage periods that begin before January 1, 2025.

the notice provision on existing policies would be confusing and impractical.

Another commenter recommended the applicability date for the notice provision for new coverage should be at least 24 months after publication of the final rules, to allow issuers time to update and refile products and marketing materials to reflect the necessary changes and provide State regulators with the time necessary to review and approve products and updated marketing materials. The commenters stated that it would be extremely difficult or impossible for issuers of group market coverage to make the required changes for notices to all marketing and enrollment materials for hospital indemnity and other fixed indemnity products before the effective date of these final rules. One commenter stated that it would be impossible for issuers of individual market coverage to comply with the proposed applicability dates because of the length of time necessary to obtain State-level approval for revised individual insurance contracts.

The Departments decline to extend the applicability date to January 1, 2027, as suggested by some commenters. In the Departments' view the benefits of providing the notice to consumers at an earlier time outweighs the burden on plans and issuers to incorporate the notice by the delayed applicability date for plan years (in the individual market, coverage periods) (including renewals) beginning on or after January 1, 2025. To minimize the burden, the Departments are finalizing notices that cannot be modified or customized; therefore, plans and issuers will not have to spend time or resources to develop their own notices to comply with the Federal notice standard. Plans and issuers may need to modify their website or other marketing materials to comply with the Federal notice standard and may need to submit materials for State review, but the Departments do not agree with commenters that those modifications require 24 months or more.

The Departments also disagree with commenters who stated that applying the notice to existing policies would inappro-

priately interfere with a covered individual's current contract. The notice does not change the terms of the contract to which the issuer and policyholder agreed. The notice will be provided to a currently covered individual at the time of renewal; therefore, there is no interference with a current contract, and the notice does not prevent an individual from renewing or reenrolling in fixed indemnity excepted benefits coverage. The Departments therefore disagree that the application of the notice provisions to existing enrollees at the time of renewal or reenrollment is impermissibly retroactive because it applies to future coverage periods and does not take away or impair vested rights or create new obligations or duties with respect to past transactions. The Departments also disagree that applying the notice provisions to existing policies would be confusing and impractical. The Departments are of the view that consumers should have information about the range of available coverage options and have an opportunity to reconsider their coverage options. The notice standard under these final rules allows consumer to make an informed decision whether to maintain their existing fixed indemnity excepted benefits coverage and whether to also pursue or maintain comprehensive coverage.

The Departments are not persuaded by comments suggesting it would be extremely difficult or impossible for plans and issuers to make changes to incorporate the applicable notice in all applicable materials for hospital indemnity and other fixed indemnity products before the proposed applicability date, which was the effective date of these final rules. Nevertheless, after consideration of the comments requesting additional time to modify marketing materials and plan documents, the Departments are finalizing an applicability date for the notices adopted under these final rules to apply in the group and individual markets of plan years (in the individual market, coverage periods) (including renewals) beginning on or after January 1, 2025.<sup>261</sup>

The Departments proposed that the severability provisions described in section IV of this preamble would apply to both new and existing group market fixed indemnity excepted benefits coverage beginning on the effective date of these final rules. HHS proposed that the technical amendment described in section III.B.2 of this preamble and the severability provisions described in section IV of this preamble would apply to both new and existing individual market fixed indemnity excepted benefits coverage on the effective date of these final rules. HHS is only finalizing the technical amendment to remove the language in existing 45 CFR 148.220(b)(4)(i) and make conforming amendments to redesignate paragraphs (b)(4)(ii) through (iv) as paragraphs (b)(4)(i) through (iii).

HHS did not receive comments related to the applicability date for the technical amendments it is finalizing in these final rules or severability provision in the individual market regulations and is finalizing them as proposed. The Departments are also finalizing as proposed the applicability date for the group market severability provisions.

#### **IV. Severability**

The Departments are finalizing amendments to the Federal definition of "short-term, limited-duration insurance" and certain regulatory provisions regarding the requirements for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit in the group or individual market, for the purpose of distinguishing STLDI and fixed indemnity excepted benefits coverage from comprehensive coverage. The Departments' authority to finalize and adopt these amendments is well-established in law and practice and should be upheld in any legal challenge. However, in the event that any portion of these final rules is declared invalid, the Departments intend that the other provisions, which could still function sensibly, would be severable.

<sup>261</sup> HHS reminds issuers that the existing individual market notice for fixed indemnity excepted benefits coverage, codified in 45 CFR 148.220(b)(4)(iv), revised as of October 1, 2023, continues to apply for coverage periods beginning before January 1, 2025. However, HHS will not consider insurance to fail to be fixed indemnity excepted benefits coverage in the individual market under the Federal framework if an issuer adopts the revised notice in these final rules for coverage periods beginning before January 1, 2025. HHS encourages States to adopt a similar approach if their issuers elect to adopt the revised notice for coverage periods that begin before January 1, 2025.

Specifically, if any provision finalized in these final rules related to STLDI is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, it shall be considered severable from its section and other sections of these rules; and it shall not affect the remainder thereof or the application of the provision to other entities not similarly situated or to dissimilar conditions. Thus, if a court were to find the portion of the STLDI definition that limits stacking, the portion of the STLDI definition that establishes a Federal consumer notice, or any other aspect of the revised Federal STLDI definition to be unlawful, the Departments intend the remaining aspects of these final rules related to STLDI to stand.

Similarly, if any finalized provision in this rulemaking related to group or individual market fixed indemnity excepted benefits coverage is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, it shall be considered severable from its section and other sections of these rules; and such invalidation shall not affect the remainder thereof or the application of the provision to other entities not similarly situated or to dissimilar conditions.

The Departments also intend for the STLDI amendments in this rulemaking to be severable from the fixed indemnity excepted benefits coverage amendments, and vice versa.

The Departments did not receive any comments on the proposed group market severability provisions and are finalizing the proposed severability provisions as proposed. HHS also did not receive any comments on the proposed individual market severability provision and is finalizing that provision as proposed.

## V. Regulatory Impact Analysis

### *A. Summary – Departments of Health and Human Services and Labor*

These final rules revise the Federal definition of STLDI for new policies, cer-

tificates, or contracts of insurance sold or issued on or after September 1, 2024, to provide that the coverage must have an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date. These final rules also revise the Federal definition of STLDI so that the maximum total coverage duration, taking into account any renewals or extensions, is no longer than 4 months. For purposes of this definition, a renewal or extension includes the term of a new STLDI policy, certificate, or contract of insurance issued by the same issuer or, if the issuer is a member of a controlled group, any other issuer that is a member of such controlled group, to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance.

For new STLDI – meaning policies, certificates, or contracts of STLDI sold or issued on or after September 1, 2024 – the amendments to the definition of STLDI addressing maximum term and duration in these final rules apply for coverage periods beginning on or after September 1, 2024. Under these final rules, existing STLDI – meaning policies, certificates, or contracts of STLDI sold or issued before September 1, 2024 (including any subsequent renewals or extensions consistent with applicable law) – may continue to have an initial contract term of less than 12 months and a maximum duration of up to 36 months (taking into account any renewals or extensions), subject to any limits under applicable State law.

These final rules further revise the Federal definition of STLDI to provide that a revised notice must be prominently displayed (in either paper or electronic form) in at least 14-point font on the first page of the policy, certificate, or contract of insurance and in any marketing, application, and enrollment materials, including for renewals or extensions (including on websites that advertise or enroll individuals in STLDI). These notice provisions apply for both new and existing STLDI for coverage periods beginning on or after September 1, 2024.

Additionally, these final rules amend the regulations regarding fixed indemnity excepted benefits coverage in the individual market to provide that a revised notice must be prominently displayed (in either paper or electronic form) on the first page of the policy, certificate, or contract of insurance, and any marketing, application, and enrollment (or reenrollment) materials that are provided at or before the time an individual has the opportunity to apply, enroll, or reenroll in coverage. These final rules also amend the regulations regarding fixed indemnity excepted benefits coverage in the group market to provide that a notice must be prominently displayed (in either paper or electronic form) on the first page of any marketing, application, and enrollment (or reenrollment) materials that are provided to participants at or before the time participants are given the opportunity to enroll (or reenroll) in the coverage. These notice provisions for group and individual market fixed indemnity excepted benefits coverage are applicable to both new and existing coverage with respect to plan years (in the individual market, coverage periods) beginning on or after January 1, 2025.

The Departments are finalizing the proposed severability provisions and HHS is also finalizing technical and conforming amendments to the individual market regulation regarding fixed indemnity excepted benefits coverage, which are not expected to have a material impact.

The Departments have examined the effects of these final rules as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993),<sup>262</sup> Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011),<sup>263</sup> Executive Order 14094 (April 6, 2023),<sup>264</sup> the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999),<sup>265</sup> and the Congressional Review Act (5 U.S.C. 804(2)).

<sup>262</sup> Executive Order 12866 of September 30, 1993, 58 FR 51735 (October 4, 1993).

<sup>263</sup> Executive Order 13563 of January 18, 2011, 76 FR 3821 (January 21, 2011).

<sup>264</sup> Executive Order 14094 of April 6, 2023, 88 FR 21879 (April 11, 2023).

<sup>265</sup> Executive Order 13132 of August 4, 1999, 64 FR 43255 (August 10, 1999).

*B. Executive Orders 12866, 13563, and 14094 – Departments of Health and Human Services and Labor*

Executive Orders 12866 and 13563 direct 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). The Executive Order 14094 entitled “Modernizing Regulatory Review” amends section 3(f)(1) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) having an annual effect on the economy of \$200 million or more in any 1 year (adjusted every 3 years by the Administrator of the Office of Information and Regulatory Affairs (OIRA) of the Office of Management and Budget (OMB) for changes in gross domestic product), or adversely affecting in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, Territorial, or Tribal governments or communities; (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 legal or policy issues for which centralized review would meaningfully further the President’s priorities or the principles set forth in Executive

Order 12866, as specifically authorized in a timely manner by the Administrator of OIRA in each case.<sup>266</sup>

A regulatory impact analysis (RIA) must be prepared for significant rules. Based on the Departments’ estimates, OMB’s OIRA has determined this rulemaking is significant under section 3(f)(1) as measured by the \$200 million threshold in any 1 year. Therefore, OMB has reviewed these rules, and the Departments have provided the following assessment of their impact. With respect to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996, also known as the Congressional Review Act, OMB’s OIRA has also determined that these rules fall within the definition provided by 5 U.S.C. 804(2).

### 1. Need for Regulatory Action

The 2018 final rules permit enrollment in an STLDI policy with a total duration that could extend up to 36 months (including renewals or extensions). This insurance might therefore be viewed as (and, in some cases, has been deceptively marketed as) a substitute for comprehensive coverage, rather than as a way to bridge a temporary gap in comprehensive coverage.<sup>267</sup> Evidence shows that the number of consumers buying STLDI increased following the effective date of the 2018 final rules. Data from the NAIC indicate that the number of individuals covered by STLDI in the individual market more than doubled between 2018 and 2019, from approximately 87,000 to 188,000, and further increased to approximately 238,000 in 2020, before declining to approximately 173,000 in 2021 following

the expansion of PTC subsidies provided through the ARP.<sup>268</sup> The number of individuals covered by STLDI sold to individuals (not enrolled as members of an association) rose once again in 2022, however, to approximately 236,000.<sup>269</sup> While these figures do not capture the total number of individuals covered by STLDI throughout each year (rather, only at the end of the calendar year), and do not include individuals covered by STLDI sold to or through associations, they do show the trend of increased enrollment in STLDI following the implementation of the 2018 final rules. Projections by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) suggest that 1.5 million people could currently be enrolled in STLDI,<sup>270</sup> and CMS previously estimated that 1.9 million individuals would enroll in STLDI by 2023.<sup>271</sup> However, as noted in section V.B.2.b of this preamble, these projections were developed prior to the expansion of PTC subsidies provided through the ARP and the IRA.

Given that STLDI generally is not subject to the Federal consumer protections and requirements for comprehensive coverage applicable to individual health insurance coverage, STLDI policies tend to offer limited benefit coverage and have relatively low actuarial values.<sup>272</sup> These plans therefore expose enrollees to the risk of high out-of-pocket health expenses and medical debt.<sup>273</sup>

In recent years, fixed indemnity insurance is increasingly being designed to resemble comprehensive coverage, and consumers might therefore mistakenly view it as a substitute for comprehensive coverage rather than as an insurance policy that provides independent, noncoordi-

<sup>266</sup> Executive Order 14094 of April 6, 2023, 88 FR 21879 at 21879 (April 11, 2023).

<sup>267</sup> For one example of deceptive marketing practices, see Federal Trade Commission (2022). “FTC Action Against Benefytt Results in \$100 Million in Refunds for Consumers Tricked into Sham Health Plans and Charged Exorbitant Junk Fees,” available at: <https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-action-against-benefytt-results-100-million-refunds-consumers-tricked-sham-health-plans-charged>.

<sup>268</sup> National Association of Insurance Commissioners (2022). Accident and Health Policy Experience Reports for 2018-2021, available at: <https://naic.soutrnglobal.net/portal/Public/en-US/Search/SimpleSearch>.

<sup>269</sup> National Association of Insurance Commissioners (2023). “2022 Accident and Health Policy Experience Report,” available at: <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>. <sup>270</sup> Congressional Budget Office (2020). “CBO’s Estimates of Enrollment in Short-Term, Limited-Duration Insurance,” available at: <https://www.cbo.gov/publication/56622>. CBO and JCT projected that enrollment in STLDI would reach 1.6 million by 2028. See Congressional Budget Office (2019). “How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans,” available at: <https://www.cbo.gov/publication/54915>.

<sup>271</sup> CMS Office of the Actuary (2018). “Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule,” available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf>.

<sup>272</sup> See, for example, Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>273</sup> See, for example, Deam, Jenny (2021). “He Bought Health Insurance for Emergencies. Then He Fell Into a \$33,601 Trap,” ProPublica, available at: <https://www.propublica.org/article/junk-insurance>.

nated income replacement benefits that is distinct from comprehensive coverage.<sup>274</sup>

In addition, because STLDI and fixed indemnity insurance are sold outside of the Exchanges and are generally not subject to the Federal consumer protections and requirements for comprehensive coverage, consumers may have limited information about the limitations, value, and quality of the coverage being sold.<sup>275</sup> Recent evidence of consumer confusion and improper marketing regarding STLDI<sup>276</sup> and fixed indemnity insurance<sup>277</sup>

support the need to improve consumer understanding of these types of insurance (and their coverage limitations) compared to comprehensive coverage. The provisions finalized in these final rules will help ensure that consumers can better understand and properly distinguish STLDI and fixed indemnity excepted benefits coverage from comprehensive coverage, and access resources to learn more about their health coverage options.

These final rules will encourage enrollment in comprehensive coverage

and lower the risk that STLDI and fixed indemnity excepted benefits coverage are viewed or marketed as a substitute for comprehensive coverage.<sup>278</sup>

## 2. Summary of Impacts

The expected benefits, costs, and transfers associated with these final rules are summarized in Table 1 and discussed in detail later in this section V.B.2 of this preamble.

<sup>274</sup> See, for example, Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Health Coverage Is a Problematic Form of ‘Junk Insurance,’” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>.

<sup>275</sup> See Williams, Jackson (2022). “Addressing Low-Value Insurance Products With Improved Consumer Information: The Case of Ancillary Health Products,” National Association of Insurance Commissioners, *Journal of Insurance Regulation*, available at: <https://content.naic.org/sites/default/files/cipr-jir-2022-9.pdf>.

<sup>276</sup> See, for example, Deam, Jenny (2021). “He Bought Health Insurance for Emergencies. Then He Fell Into a \$33,601 Trap,” ProPublica, available at: <https://www.propublica.org/article/junk-insurance>. See also Palanker, Dania and Kevin Lucia (2021). “Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk,” Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk>. See also Schwab, Rachel and Maanasa Kona (2018). “State Insurance Department Consumer Alerts on Short-Term Plans Come Up Short,” Center on Health Insurance Reforms, available at: <https://chirblog.org/state-insurance-department-consumer-alerts-short-term-plans-come-short/>. See also Corlette, Sabrina, Kevin Lucia, Dania Palanker, and Olivia Hoppe (2019). “The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,” Urban Institute, available at: <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>.

<sup>277</sup> See, for example, Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Health Coverage Is a Problematic Form of ‘Junk Insurance,’” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>. See also Government Accountability Office (2020). “Private Health Coverage: Results of Covert Testing for Selected Offerings,” available at: <https://www.gao.gov/products/gao-20-634r>.

<sup>278</sup> As discussed in section I.B of this preamble, these final rules build on Executive Order 14009, “Strengthening Medicaid and the Affordable Care Act,” and Executive Order 14070, “Continuing to Strengthen Americans’ Access to Affordable, Quality Health Coverage,” by encouraging enrollment in high-quality, comprehensive coverage. The Departments also note that the affordability of comprehensive coverage offered in the individual market has increased for many consumers in recent years, due in part to the expanded PTC subsidies provided through the ARP and the IRA, as discussed in section II of this preamble. Further, as discussed in section II of this preamble, the COVID-19 PHE has highlighted the importance of encouraging enrollment in comprehensive coverage.



**TABLE 1: Accounting Table**

Benefits:				
Non-Quantified:				
<ul style="list-style-type: none"> <li>• Reductions in information asymmetries in health insurance markets through increased consumer understanding of STLDI and fixed indemnity excepted benefits coverage in relation to comprehensive coverage.</li> <li>• Increased enrollment in comprehensive coverage, with an estimated increase in enrollment in individual health insurance coverage purchased on an Exchange by approximately 60,000 people in 2026, 2027 and 2028 associated with the provisions regarding STLDI.</li> <li>• Improvement in market stability and market risk pools for comprehensive coverage.</li> <li>• Reduction in the risk of high out-of-pocket health expenses, lower incidence of medical debt, improved health outcomes, and increased health equity, for individuals who switch from STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage) to comprehensive coverage.</li> <li>• Potential reduction in the overall number of STLDI coverage rescissions or claims denials, if enrollment in STLDI declines.</li> <li>• Potential reduction in deceptive or aggressive marketing practices and harm from such practices involving the sale of STLDI and fixed indemnity excepted benefits coverage.</li> </ul>				
Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$111,140	2024	7 percent	2024-2028
	\$103,367	2024	3 percent	2024-2028
Quantified:				
<ul style="list-style-type: none"> <li>• One-time regulatory review costs of approximately \$358,578 for issuers of STLDI, issuers of fixed indemnity excepted benefits coverage, and other interested parties.</li> <li>• One-time costs of approximately \$129,015 for issuers of STLDI and fixed indemnity excepted benefit coverage associated with complying with the notice provisions.</li> </ul>				
Non-Quantified:				
<ul style="list-style-type: none"> <li>• Potential increase in premium costs for individuals who switch from STLDI or fixed indemnity excepted benefit coverage (when used as a substitute for comprehensive coverage) to comprehensive coverage and who are not eligible for the PTC.</li> <li>• Potential increase in the number of uninsured individuals or the number of individuals experiencing a coverage gap, if some individuals with STLDI coverage purchased after the applicability date are no longer able to renew or extend their current policy, choose not to purchase a new policy from another issuer of STLDI, and can only obtain comprehensive coverage during open enrollment, or choose not to purchase comprehensive coverage.</li> <li>• Potential decrease in compensation for agents and brokers if there is a reduction in sales of STLDI and fixed indemnity excepted benefits coverage.</li> <li>• Potential increase in health care spending, if individuals switch from STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage) to comprehensive coverage and increase their use of health care as a result.</li> <li>• Potential costs to States, if States enact or implement new legislation in response to these final rules.</li> <li>• Potential costs to State departments of insurance associated with reviewing amended marketing materials and plan documents filed by issuers of STLDI and fixed indemnity excepted benefits coverage in response to these final rules.</li> </ul>				
Transfers:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	-\$67.1 million	2024	7 percent	2024-2028
	-\$69.9 million	2024	3 percent	2024-2028
Quantified:				
<ul style="list-style-type: none"> <li>• Reduction in gross premiums for individuals enrolled in individual health insurance coverage purchased on an Exchange by approximately 0.5 percent in 2026, 2027, and 2028.</li> <li>• Decrease in Federal PTC spending of approximately \$120 million in 2026, 2027, and 2028.</li> </ul>				
Non-Quantified:				
<ul style="list-style-type: none"> <li>• Potential transfer from issuers to consumers if consumers switch from STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage) to comprehensive coverage and experience a reduction in out-of-pocket costs.</li> </ul>				

Table 2 presents the estimated effects of the provisions regarding STLDI on enrollment in and gross premiums for individual health insurance coverage purchased on an Exchange, and on Federal spending on the PTC (by calendar year), as discussed further in sections

V.B.2.c and V.B.2.e of this preamble. The Departments estimate that, starting in 2026, total enrollment in individual health insurance coverage purchased on an Exchange will be higher by 60,000 individuals each year, premiums for this coverage will be lower by 0.5 per-

cent each year, and Federal spending on the PTC will be lower by \$120 million each year, relative to the current status quo. The cumulative reduction in Federal spending on the PTC will be (an undiscounted) \$360 million from 2026 to 2028.

**TABLE 2: Estimated Effects of the Provisions Regarding STLDI on Enrollment in and Gross Premiums for Individual Health Insurance Coverage Purchased on an Exchange and on Federal Spending on the PTC**

Calendar Year	2024	2025	2026	2027	2028
Change in Enrollment in Individual Health Insurance Coverage Purchased on an Exchange	0	0	60,000	60,000	60,000
Percentage Change in Gross Premiums for Individual Health Insurance Coverage Purchased on an Exchange	0	0	-0.5	-0.5	-0.5
Change in Federal Spending on the PTC (in millions)	\$0	\$0	-\$120	-\$120	-\$120

a. Background

STLDI and fixed indemnity excepted benefits coverage generally are not subject to the Federal consumer protections and requirements for comprehensive coverage, as discussed in more detail in section I.A of this preamble. When used as a long-term substitute for comprehensive coverage, STLDI and fixed indemnity insurance expose enrollees to financial and health risks, as discussed in this section and section II.B of this preamble.

STLDI and fixed indemnity insurance typically do not cover all essential health benefits (including, for example, prescription drugs, maternity services, and mental health and substance use disorder services), and typically do not cover pre-existing conditions.<sup>279</sup> STLDI may offer

fewer benefits overall.<sup>280</sup> Fixed indemnity insurance is designed to provide a source of income replacement or financial support following a qualifying health-related event, and benefits are often far below a covered individual’s incurred costs related to a medical event.<sup>281</sup> STLDI and fixed indemnity insurance typically have lower loss ratios or actuarial values than coverage subject to the Federal consumer protections and requirements for comprehensive coverage. In one study of the medical claims of approximately 47 million enrollees in commercial plans in 2016, for example, the implied actuarial value of the STLDI coverage in the study was 49 percent, compared to an implied actuarial value of approximately 74 percent for off-Exchange comprehensive coverage plans and an implied actuarial value of 87

percent for on-Exchange plans.<sup>282</sup> Additionally, according to an NAIC report, across 28 issuers of STLDI in the individual market in 2021, the nationwide loss ratio was approximately 70 percent.<sup>283</sup> The same report stated that across 95 issuers of “other medical (non-comprehensive)” coverage in the individual market, which includes fixed indemnity insurance, the nationwide loss ratio was approximately 40 percent in 2021.<sup>284</sup> By contrast, according to data from medical loss ratio (MLR) annual reports for the 2021 MLR reporting year, the average MLR in the individual market for comprehensive coverage was approximately 87 percent in 2021.<sup>285</sup>

A few commenters also noted that STLDI and fixed indemnity insurance have low average loss ratios as com-

<sup>279</sup> See, for example, Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>. See also Pollitz, Karen, Michelle Long, Ashley Semanskee, and Rabah Kamal (2018). “Understanding Short-Term Limited Duration Health Insurance,” KFF, available at: <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>. See also Sanger-Katz, Margot (2018). “What to Know Before You Buy Short-Term Health Insurance,” *The New York Times*, available at: <https://www.nytimes.com/2018/08/01/upshot/buying-short-term-health-insurance-what-to-know.html>. See also Partnership to Protect Coverage (2021). “Under-Covered: How ‘Insurance-Like’ Products are Leaving Patients Exposed,” available at: [https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Undercovered\\_Report\\_03252021.pdf](https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Undercovered_Report_03252021.pdf). See also Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Health Coverage Is a Problematic Form of ‘Junk Insurance’ USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>.

<sup>280</sup> See, for example, Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>281</sup> See Williams, Jackson (2022). “Addressing Low-Value Insurance Products With Improved Consumer Information: The Case of Ancillary Health Products,” National Association of Insurance Commissioners, *Journal of Insurance Regulation*, available at: <https://content.naic.org/sites/default/files/cipr-jir-2022-9.pdf>.

<sup>282</sup> Pelech, Daria and Karen Stockley (2022). “How Price and Quantity Factors Drive Spending in Nongroup and Employer Health Plans,” Health Services Research, available at: <https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13962>.

<sup>283</sup> The loss ratio is calculated as ((Incurred Claims Amount + Change in Contract Reserves) / Premiums Earned). Data regarding issuers of STLDI and “other non-comprehensive coverage” are only available for the individual market. See National Association of Insurance Commissioners (2022). “2021 Accident and Health Policy Experience Report,” available at: <https://naic.soutrnglobal.net/portal/Public/en-US/Search/AdvancedSearch>.

<sup>284</sup> National Association of Insurance Commissioners (2022). “2021 Accident and Health Policy Experience Report,” available at: <https://naic.soutrnglobal.net/portal/Public/en-US/Search/AdvancedSearch>. Data regarding issuers of non-comprehensive coverage are only available for the individual market.

<sup>285</sup> Based on internal calculations. Source: CMS, Medical Loss Ratio Data and System Resources, available at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr>.

pared to comprehensive coverage. These comments and the previously-mentioned statistics suggest that relative to issuers of comprehensive coverage, issuers of STLDI tend to spend a lower percentage of premium dollars on health care items and services, and issuers of fixed indemnity insurance tend to spend a lower percentage of premium dollars on payment of benefits. STLDI and fixed indemnity insurance can therefore be highly profitable for issuers,<sup>286</sup> depending on the extent to which issuers incur costs related to marketing (including agent/broker compensation<sup>287</sup>), policy underwriting, and overhead.

Low average loss ratios for STLDI and fixed indemnity insurance, along with relatively high commission rates for agents and brokers of those policies, reduce the value of STLDI and fixed indemnity insurance for consumers. Agents and brokers act as intermediaries between consumers and issuers. Their income is primarily derived from commissions, which tend to be a percentage of premiums paid by the consumer to the issuer. The commissions are incorporated into the cost of an insurance plan, and therefore indirectly affect the total price paid by the consumer for the coverage purchased. There is limited data available on commission rates paid by issuers to agents and brokers. Agent and broker commission rates tend to vary significantly between health insurance coverage options, though issuers of STLDI and fixed indemnity insurance tend to pay higher commissions.<sup>288</sup> The Depart-

ments received several comments indicating that agents and brokers receive a higher percentage of the plan's premium as a commission for selling STLDI or fixed indemnity insurance as compared to individual health insurance coverage. This was also confirmed in the Departments' review of some broker compensation disclosures.<sup>289</sup> The Departments acknowledge that lower cost alternatives to comprehensive coverage may not result in higher total compensation for agents and brokers, since the premiums for comprehensive coverage might be higher than the premiums for STLDI and fixed indemnity insurance. However, higher commission rates for agents and brokers from sales of STLDI and fixed indemnity insurance can incentivize aggressive and/or deceptive marketing tactics that may mislead customers into enrolling in STLDI or fixed indemnity insurance instead of comprehensive coverage.<sup>290,291,292</sup> One study suggests that commissions for STLDI are up to 10 times higher than those obtained for enrollment in individual health insurance coverage (averaging approximately 23 percent of premiums for STLDI, compared to 2 percent of premiums for individual health insurance coverage).<sup>293</sup> Another source corroborates this finding by noting that issuers of STLDI pay commissions close to 20 percent of premiums.<sup>294</sup>

In the 2023 proposed rules, the Departments stated that the limited coverage provided through most STLDI and fixed indemnity excepted benefits coverage exposes individuals enrolled

in these policies to health and financial risks, including the risk of high medical bills and high out-of-pocket expenses. The Departments further noted that these high out-of-pocket expenses, in turn, could contribute to an increased risk of medical debt and bankruptcy, which is particularly problematic given the extent of medical debt already present in the United States.<sup>295</sup> As discussed in section II.B of this preamble, commenters provided the Departments with examples of how enrollment in fixed indemnity insurance, when used as a substitute for comprehensive coverage, could expose individuals to financial risk. However, many commenters also noted that fixed indemnity insurance can reduce financial risk for individuals, given that it provides payments for unexpected expenses associated with a health-related event. The Departments acknowledge that fixed indemnity insurance can reduce financial risk when used as a supplement to comprehensive coverage but remain concerned about the financial risk for individuals when it is used as a substitute for comprehensive coverage.

Misleading marketing of STLDI and fixed indemnity insurance is reported to have taken place during annual individual market open enrollment and special enrollment periods (including during the 2021 COVID-19 special enrollment period, when Exchanges using the Federal platform made available a 6-month special enrollment period on HealthCare.gov to allow qualified individuals to enroll in individual health insurance cov-

<sup>286</sup> See Appleby, Julie (2018). "Short-Term Health Plans Boost Profits For Brokers And Insurers," NPR, available at: <https://www.npr.org/sections/health-shots/2018/12/21/678605152/short-term-health-plans-boost-profits-for-brokers-and-insurers>. See also Pear, Robert (2018). "'Short Term' Health Insurance? Up to 3 Years Under New Trump Policy," *The New York Times*, available at: <https://www.nytimes.com/2018/08/01/us/politics/trump-short-term-health-insurance.html>.

<sup>287</sup> Compensation includes commissions, fees, or other incentives (for example, rewards or bonuses) as established in the relevant contract between an issuer and the agent or broker.

<sup>288</sup> See Lucia, Kevin, Sabrina Corlette, Dania Palanker, and Olivia Hoppe (2018). "Views From the Market: Insurance Brokers' Perspectives on Changes to Individual Health Insurance," Urban Institute, available at: <https://www.urban.org/research/publication/views-market-insurance-brokers-perspectives-changes-individual-health-insurance>.

<sup>289</sup> The Departments reviewed information detailing broker compensation from an agent/broker, two large issuers, and a health insurance agency.

<sup>290</sup> See, for example, Appleby, Julie (2018). "Short-Term Health Plans Boost Profits For Brokers And Insurers," NPR, available at: <https://www.npr.org/sections/health-shots/2018/12/21/678605152/short-term-health-plans-boost-profits-for-brokers-and-insurers>.

<sup>291</sup> Government Accountability Office (2020). "Private Health Coverage: Results of Covert Testing for Selected Offerings," available at: <https://www.gao.gov/products/gao-20-634r>.

<sup>292</sup> However, even as some issuers offer higher compensation for STLDI, many brokers continue to refuse to sell products they view as overly risky for consumers, like STLDI. See, for example, Corlette, Sabrina, Erik Wengle, Ian Hill, and Olivia Hoppe (2020). "Perspective from Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks," Urban Institute, available at: <https://www.urban.org/research/publication/perspective-brokers-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks>.

<sup>293</sup> U.S. House of Representatives Committee on Energy and Commerce (2020). "Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk," available at: <https://democrats-energycommerce.house.gov/newsroom/press-releases/ec-investigation-finds-millions-of-americans-enrolled-in-junk-health>.

<sup>294</sup> Sanger-Katz, Margot (2018). "What to Know Before You Buy Short-Term Health Insurance," *The New York Times*, available at: <https://www.nytimes.com/2018/08/01/upshot/buying-short-term-health-insurance-what-to-know.html>.

<sup>295</sup> See, for example, Consumer Financial Protection Bureau (2022). "Medical Debt Burden in the United States," available at: [https://files.consumerfinance.gov/f/documents/cfpb\\_medical-debt-burden-in-the-united-states\\_report\\_2022-03.pdf](https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf).

erage during the COVID-19 PHE).<sup>296</sup> For example, one study showed that enrollment in STLDI policies through brokers increased by approximately 60 percent in December 2018 and by more than 120 percent in January 2019, suggesting that overall enrollment in STLDI spiked during the annual individual market open enrollment period.<sup>297</sup> One survey suggests that lead-generating websites direct consumers to insurance brokers selling both STLDI and other types of non-comprehensive coverage, including fixed indemnity insurance, and that these types of coverage are often marketed to resemble comprehensive coverage.<sup>298</sup>

A number of States and the District of Columbia enacted legislation or issued regulations regarding STLDI after the 2018 final rules were published. State regulatory actions regarding STLDI have been wide-ranging. For example, according to one report, as of September 2023, four States prohibited STLDI, seven States and the District of Columbia limited the total duration of enrollment in STLDI (including renewals or extensions) to less than 3 months, and eight States have limited the initial contract terms for enrollment in STLDI to less than 6 months.<sup>299</sup> Other State regulatory actions on STLDI have included banning coverage rescissions (except in cases of fraud on the part of the enrollee), adding

preexisting condition protections, and requiring a certain MLR, among other restrictions.<sup>300</sup> Lastly, some States have largely aligned their regulations regarding STLDI with the 2018 final rules.<sup>301</sup> In some States that allow sales of STLDI, but have additional consumer protections in place (for example, prohibitions on renewals of STLDI coverage), issuers do not offer STLDI.<sup>302</sup>

Recent analysis has found that States that allow the initial contract term of STLDI to last up to 364 days have seen a 27 percent reduction in enrollment, on average, in non-Exchange plans that are subject to the Federal consumer protections and requirements for comprehensive coverage from 2018 to 2020, compared with a 4 percent reduction in enrollment, on average, in those plans in States that banned STLDI or limited its duration to 6 months or less.<sup>303</sup> This analysis also found that market-wide risk scores (a measure of relative expected health care costs for a population) declined more in States that banned or limited STLDI (-11.8 percent) than in States with less restrictions on STLDI (-8.3 percent), suggesting that the less restrictive States saw more healthier individuals enroll in STLDI policies in lieu of comprehensive coverage, which put upward pressure on the average expected health care costs among those with comprehensive coverage.

## b. Number of Affected Entities

The provisions in these final rules will affect consumers enrolled in STLDI or fixed indemnity excepted benefits coverage, issuers of STLDI, issuers offering fixed indemnity excepted benefits coverage, and agents and brokers selling STLDI or fixed indemnity excepted benefits coverage. The provisions in these rules will also affect States if they enact or implement new legislation in response to these final rules. State departments of insurance will also be impacted to the extent they need to review amended marketing materials and plan documents filed by issuers.

With respect to consumers, individuals who are currently enrolled in STLDI or who may consider purchasing or choose to purchase STLDI in the future will be impacted by these final rules. Data from the NAIC indicate that 235,775 individuals were covered by STLDI sold to individuals at the end of 2022.<sup>304</sup> As noted in section V.B.1 of this preamble, this figure does not capture the total number of individuals covered by STLDI throughout the year and does not include individuals covered by STLDI sold to or through associations, through which most policies appear to be sold.<sup>305</sup> As noted in section V.B.1 of this preamble, projections by CBO and JCT suggest that 1.5 million people could currently be enrolled in STLDI,<sup>306</sup> and

<sup>296</sup> See Palanker, Dania and JoAnn Volk. (2021). "Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period." Center on Health Insurance Reforms, available at: <https://georgetown.app.box.com/s/mn7kgnhibn4kpb46tqm6i7putry9gt>. See also Corlette, Sabrina, Kevin Lucia, Dania Palanker, and Olivia Hoppe (2019). "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses." Urban Institute, available at: <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>. Regarding the establishment of the COVID-19 special enrollment period, see E.O. 14009; see also CMS (2021). "2021 Special Enrollment Period in Response to the COVID-19 Emergency," available at: <https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency>. Regarding the extension of the COVID-19 special enrollment period (to the 6-month period between February 15, 2021, and August 15, 2021), see CMS (2021). "Extended Access Opportunity to Enroll in More Affordable Coverage Through HealthCare.gov," available at: <https://www.cms.gov/newsroom/fact-sheets/extended-access-opportunity-enroll-more-affordable-coverage-through-healthcaregov>.

<sup>297</sup> U.S. House of Representatives Committee on Energy and Commerce (2020). "Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans Is Putting Americans at Risk," available at: <https://democrats-energycommerce.house.gov/newsroom/press-releases/ec-investigation-finds-millions-of-americans-enrolled-in-junk-health>.

<sup>298</sup> Corlette, Sabrina, Kevin Lucia, Dania Palanker, and Olivia Hoppe (2019). "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses." Urban Institute, available at: <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>.

<sup>299</sup> See Healthinsurance.org (2023). "Duration and Renewals of 2023 Short-Term Medical Plans by State," available at: <https://www.healthinsurance.org/wp-content/uploads/2023/09/state-by-state-short-term-health-insurance.pdf>.

<sup>300</sup> Palanker, Dania, Maanasa Kona, and Emily Curran (2019). "States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans." Commonwealth Fund, available at: <https://www.commonwealthfund.org/publications/issue-briefs/2019/may/states-step-up-protect-markets-consumers-short-term-plans>.

<sup>301</sup> See Healthinsurance.org (2023). "Duration and Renewals of 2023 Short-Term Medical Plans by State," available at: <https://www.healthinsurance.org/wp-content/uploads/2023/09/state-by-state-short-term-health-insurance.pdf>.

<sup>302</sup> See Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>303</sup> See Hall, Mark and Michael McCue (2022). "Short-Term Health Insurance and the ACA Market," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2022/short-term-health-insurance-and-aca-market>.

<sup>304</sup> National Association of Insurance Commissioners (2023). "2022 Accident and Health Policy Experience Report," available at: <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>.

<sup>305</sup> Pollitz, Karen, Michelle Long, Ashley Semansky, and Rabah Kamal (2018). "Understanding Short-Term Limited Duration Health Insurance," KFF, available at: <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

<sup>306</sup> Congressional Budget Office (2020). "CBO's Estimates of Enrollment in Short-Term, Limited-Duration Insurance," available at: <https://www.cbo.gov/publication/56622>. CBO and JCT projected that enrollment in STLDI would reach 1.6 million by 2028. See Congressional Budget Office (2019). "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans," available at: <https://www.cbo.gov/publication/54915>.

CMS previously estimated that 1.9 million individuals would enroll in STLDI by 2023.<sup>307</sup> However, the CBO and JCT and CMS estimates were developed prior to the expansion of PTC subsidies provided through the ARP and the IRA, which likely supported increased enrollment in individual health insurance coverage purchased on an Exchange in lieu of STLDI and other forms of health insurance not subject to the Federal consumer protections and requirements for comprehensive coverage, if only temporarily.<sup>308</sup> The number of enrollees in STLDI also might have been affected by changes in State law or regulation that have occurred since the 2018 final rules were issued. The Departments received a comment that also noted that the NAIC figure was likely an underestimate given that not all issuers report complete data to the NAIC. Another commenter—a State department of insurance—provided information about the number of individuals who had enrolled in STLDI in their State as of mid-2023. The Departments acknowledge that the NAIC figure likely underestimates the number of enrollees in STLDI, yet commenters did not offer additional data or information on the total number of consumers enrolled in STLDI across the country, and the Departments are not aware of another available source for these data.

Additionally, individuals who are currently enrolled in fixed indemnity excepted benefits coverage or who may choose to purchase or consider purchasing such coverage in the future will be affected by these final rules. Although the Departments are unaware of a definitive source for the number of fixed indemnity policies sold nationwide, the NAIC reports the total number of “other non-comprehensive coverage” policies<sup>310</sup> sold in the indi-

vidual market. These nearly 2.6 million policies or certificates, covering approximately 4 million individuals, include fixed indemnity products along with other insurance products, and provide a potential estimate of the number of potential fixed indemnity policies or certificates and number of covered lives in the individual market. The Departments sought comments on the number of consumers who would be affected by the fixed indemnity excepted benefits coverage provisions in the proposed rules. Some commenters referenced a survey of 39 issuers of fixed indemnity or specified disease products. The survey indicated that approximately 3.4 million individuals are currently covered by fixed indemnity products in the individual market and approximately 4.7 million individuals are currently covered by fixed indemnity products in the group market.<sup>311</sup> Several issuers that commented on the proposed rules also provided information on the number of consumers currently enrolled in their fixed indemnity or other supplemental insurance products, with one issuer indicating that 47,900 of its customers were enrolled in fixed indemnity insurance without being enrolled in comprehensive coverage. One association commenting on the rules estimated that the number of supplemental policies in force for school employees “is in the multi-millions.”

Based on the NAIC and industry estimates, the number of individuals with individual market fixed indemnity excepted benefits coverage who could be affected by these final rules could be up to 4 million, and the number of individuals with group market fixed indemnity excepted benefits coverage who could be affected by these final rules could be up to 4.7 million. However, because it is not clear what

percentages of the NAIC and industry estimates are specific to fixed indemnity excepted benefits coverage rather than fixed indemnity insurance in general, the number of individuals affected by the provisions for fixed indemnity excepted benefits coverage in these final rules is likely to be lower than these estimates.

These final rules may also indirectly impact consumers enrolled in comprehensive coverage because of the potential impact of increased enrollment in comprehensive coverage on individual and group market risk pools, premiums, plan offerings, or issuer participation. While the Departments are unable to estimate whether or how these final rules will impact plan offerings or issuer participation in the individual and group markets for comprehensive coverage, in sections V.B.2.c and V.B.2.e of this preamble, the Departments discuss the estimated effects of the provisions regarding STLDI included in these final rules on enrollment in and premiums for individual health insurance coverage purchased on an Exchange.

Issuers of STLDI and fixed indemnity excepted benefits coverage will be directly impacted by these final rules. The NAIC reported that there were at least 28 issuers of STLDI in the individual market across the U.S. in 2022 and at least 93 issuers of “other non-comprehensive coverage” (including fixed indemnity insurance) in the individual market across the U.S. in 2022.<sup>312</sup> Data regarding issuers of STLDI and “other medical (non-comprehensive)” coverage are only available for the individual market. The Departments anticipate that many of these issuers also offer coverage in the group market. The Departments sought comments on the number of entities that would be affected by the proposed rules, including the num-

<sup>307</sup> CMS Office of the Actuary (2018). “Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule,” available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf>.

<sup>308</sup> See, for example, Ortaliza, Jared, Krutika Amin, and Cynthia Cox (2022). “As ACA Marketplace Enrollment Reaches Record High, Fewer Are Buying Individual Market Coverage Elsewhere,” KFF, available at: <https://www.kff.org/policy-watch/as-aca-marketplace-enrollment-reaches-record-high-fewer-are-buying-individual-market-coverage-elsewhere/>.

<sup>309</sup> Based on data from the NAIC, the number of individuals covered by STLDI rose from around 173,000 in 2021 to 236,000 in 2022, reversing the downward trend from 2020 to 2021. See National Association of Insurance Commissioners (2023). “2022 Accident and Health Policy Experience Report,” available at: <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>.

<sup>310</sup> See National Association of Insurance Commissioners (2023). “2022 Accident and Health Policy Experience Report,” available at: <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf> (“Other medical (non-comprehensive) coverage” includes “policies such as hospital only, hospital confinement, surgical, outpatient indemnity, intensive care, mental health/substance abuse, and organ and tissue transplant (including scheduled type policies), etc.” It is further noted that “expense reimbursement and indemnity plans should be included” in this definition, but that “this category does not include TRICARE/CHAMPUS Supplement, Medicare Supplement, or FEHB Program coverage.” Data from the NAIC regarding issuers of “other non-comprehensive coverage” are only available for the individual market.

<sup>311</sup> See AHIP-ACLI-BCBSA 2023 Survey: Fixed Indemnity and Specified Disease Plans, September 7, 2023, available at: <https://www.ahip.org/resources/ahip-acli-bcbsa-2023-survey>.

<sup>312</sup> National Association of Insurance Commissioners (2023). “2022 Accident and Health Policy Experience Report,” available at: <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>.

ber of issuers and associations offering STLDI and fixed indemnity excepted benefits coverage, but did not receive any data from commenters on the number of issuers in the STLDI or fixed indemnity excepted benefits coverage market that would be affected. Based on the NAIC data, and assuming some overlap between issuers in the individual and group market, the Departments anticipate that at least 28 issuers of STLDI and at least 93 issuers of fixed indemnity excepted benefits coverage could be affected by the provisions being finalized in these final rules.

However, the Departments note that this might overestimate the number of issuers of fixed indemnity excepted benefits coverage, given that the NAIC figure captures issuers of other forms of non-comprehensive medical coverage in addition to fixed indemnity insurance, and that even for those issuers of fixed indemnity insurance that are included in this figure, it is not clear what percentage of those issuers offer fixed indemnity excepted benefits coverage in particular.

Agents and brokers selling STLDI or fixed indemnity excepted benefits coverage will be impacted by these final rules. The Bureau of Labor Statistics estimates that there are 445,540 insurance agents nationwide, which includes agents and brokers that sell health insurance products in addition to other types of insurance (for example, life and property).<sup>313</sup> One professional association, which is estimated to represent one-third of active health insurance agents and brokers,<sup>314</sup> has approximately 100,000 members.<sup>315</sup> However, the Departments lack data about the number of agents and brokers that currently enroll individuals in STLDI or fixed indemnity excepted benefits coverage and did not receive any additional data from commenters.

### c. Benefits

*Increase in consumer awareness.* These final rules are expected to reduce the harm caused to consumers who are misled into

enrolling in STLDI or fixed indemnity excepted benefits coverage as an alternative to or replacement for comprehensive coverage. The notice provisions being finalized in these final rules will improve consumer understanding of STLDI and fixed indemnity excepted benefits coverage in relation to comprehensive coverage. The Departments received some comments noting that STLDI policies are often marketed as a more affordable alternative to comprehensive coverage, and received many comments stating that STLDI policies exclude critically important health care services, as discussed in section III.A.1 of this preamble. Many commenters stated that the 2023 proposed rules would help consumers differentiate STLDI and fixed indemnity excepted benefits coverage from comprehensive coverage when shopping for health insurance. Some commenters also stated that the notice provisions for STLDI and fixed indemnity excepted benefits coverage would help combat deceptive marketing practices and would improve consumer understanding of the different options available when shopping for insurance. One commenter stated that enrollees in STLDI policies are functionally uninsured due to the narrow benefits and design limitations that are often poorly understood by consumers. Although several commenters expressed concern about the improper marketing of fixed indemnity insurance, some commenters suggested that such improper marketing practices are limited to a few “bad actors” in the market. One commenter stated that concerns over widespread consumer confusion are unsupported, and that consumer confusion could be addressed by policy alternatives like increased enforcement of deceptive marketing laws or enhanced consumer awareness campaigns, rather than the provisions proposed in the 2023 proposed rules. The Departments agree that the notice provisions will help ensure individuals are made aware that STLDI and fixed indemnity excepted benefits policies are not comprehensive coverage. The Depart-

ments are of the view that the provisions finalized in these final rules will reduce the level of deceptive marketing of STLDI and fixed indemnity excepted benefits policies, reduce the harm from such deceptive marketing practices, and increase the overall awareness of coverage options that include the full range of Federal consumer protections. These provisions will also help consumers more easily distinguish between STLDI or fixed indemnity excepted benefits coverage and individual health insurance coverage, thereby mitigating the risk that they mistakenly enroll in STLDI or fixed indemnity excepted benefits coverage in lieu of comprehensive coverage. The Departments appreciate the suggestions related to increased enforcement of deceptive marketing laws, and enhanced consumer awareness campaigns, but are of the view that these actions alone would not sufficiently address consumer confusion related to the current structure of STLDI and fixed indemnity excepted benefit coverage.

*Better health outcomes.* Consumers who switch from STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage) to comprehensive coverage are expected to have better access to health care, better consumer protections, and more robust benefits, and are therefore expected to experience better health outcomes. Several commenters stated that STLDI policies can limit access to health care and lead to negative health outcomes given the insufficient coverage of STLDI policies. Commenters stated that the inadequate coverage, particularly for individuals with chronic conditions, could lead to the use of high-cost services, such as emergency department visits or hospitalizations that could have been prevented if adequate care were accessible through their STLDI coverage. On the other hand, some commenters stated that enrollees in STLDI and fixed indemnity excepted benefits policies can benefit from receiving services provided by any provider and are not limited by provider networks estab-

<sup>313</sup> Bureau of Labor Statistics (2022). “National Occupational Employment and Wage Estimates,” available at: <https://www.bls.gov/oes/current/oes413021.htm>.

<sup>314</sup> Karaca-Mandic, Pinar, Feldman, Roger, and Peter Graven (2016). “The Role of Agents and Brokers in the Market for Health Insurance,” *Journal of Risk and Insurance*, available at: <https://onlinelibrary.wiley.com/doi/full/10.1111/jori.12139>.

<sup>315</sup> National Association of Benefits and Insurance Professionals (2023). “Who We Are,” available at: <https://nabip.org/who-we-are>.

lished by issuers offering comprehensive coverage.<sup>316</sup> Some commenters suggested that the STLDI provisions could restrict patients' access to certain providers or reduce access to care in general. Other commenters suggested that the STLDI provisions could influence the composition of health care utilization and spending—because of the limited benefits or high cost-sharing requirements of most STLDI policies, enrollees in STLDI policies may underutilize preventive care and overutilize higher-cost care.

The Departments acknowledge that there may be individuals whose provider may not be in-network with an issuer offering comprehensive coverage, and that individuals may experience changes in access to certain providers if they switch from STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage) to comprehensive coverage. However, given the limited benefits, limited consumer protections, and financial exposure associated with most STLDI and fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage), the Departments are of the view that individuals' overall financial risk would decrease and their overall access to health care would increase if they enrolled in comprehensive coverage. Furthermore, the Departments are of the view that overall health outcomes will improve for individuals who enroll in comprehensive coverage in lieu of STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage). For example, studies<sup>317</sup> that examined the potential impacts

of State policies regulating STLDI found that individuals in States that prohibited or restricted the sale of STLDI policies had more favorable cancer diagnoses when compared to individuals in States that did not prohibit or restrict STLDI policies. In summary, if individuals enroll in comprehensive coverage instead of STLDI or fixed indemnity excepted benefits coverage, the Departments expect that they will have increased access to care, decreased exposure to major medical expenses, and improved health outcomes.

*Potential increase in enrollment in comprehensive coverage.* The Departments anticipate that these final rules will lead to an increase in enrollment in comprehensive coverage. The Departments expect that individuals will be less likely to wait until they have incurred major medical expenses or developed a medical condition to look for opportunities to switch from STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage) to comprehensive coverage. Increased enrollment in comprehensive coverage in lieu of enrollment in STLDI is also expected to reduce the number of coverage rescissions, claims denials, and coverage exclusions associated with STLDI. However, as noted earlier in this section V.B.b of this preamble, the expanded PTC subsidies provided through the ARP and the IRA have likely already resulted in increased enrollment in individual health insurance coverage purchased on an Exchange in lieu of STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage), so the immediate overall

effects of these final rules on enrollment in, market stability of, and risk pools for comprehensive coverage are expected to be limited in 2024 and 2025.<sup>318</sup> The CMS Office of the Actuary (OACT) estimates that, relative to current law, the provisions regarding STLDI being

Barnes, Anne C. Kirchhoff, Fumiko Chino, Robin Yabroff, and Xuesong Han (2023). "Association of Federal and State Policies Regulating Short-term Limited Duration Insurance (STLD) Plans and Later Cancer Stage at Diagnosis." *JCO Oncology Practice*, Volume 19, Issue 11, available at: [https://ascopubs.org/doi/abs/10.1200/OP.2023.19.11\\_suppl.197](https://ascopubs.org/doi/abs/10.1200/OP.2023.19.11_suppl.197). finalized in these final rules will not affect enrollment in individual health insurance coverage purchased on an Exchange in 2024 and 2025, but will increase enrollment by approximately 60,000 people in 2026, 2027, and 2028.<sup>319</sup> Many commenters indicated that the STLDI provisions are likely to reduce premiums for individual health insurance coverage. Many commenters also pointed to the potential shift in enrollment from STLDI to individual health insurance coverage as having a potential impact on the risk pools for individual health insurance coverage.<sup>320</sup> The Departments agree with these comments and are of the view that the provisions for STLDI and fixed indemnity excepted benefits coverage being finalized in these final rules will lead to more stable markets and improved market risk pools for comprehensive coverage.

*Reduction in financial risk for consumers.* To the extent that these final rules lead to an increase in enrollment in individual health insurance coverage subject

<sup>316</sup> Issuers of STLDI and fixed indemnity excepted benefits coverage may also have provider networks, and one commenter (an issuer of STLDI) noted that their provider network has 1.5 million physicians and other health care professionals and approximately 7,000 hospitals and other facilities.

<sup>317</sup> See Barnes, Justin, Anne Kirchhoff, Robin Yabroff, and Fumiko Chino (2023). "State Policies Regulating Short-Term Limited Duration Insurance Plans and Cancer Stage at Diagnosis," *JNCI Cancer Spectrum*, Volume 7, Issue 5, available at: <https://doi.org/10.1093/jncics/pkad060>. See also Yang, Nuo Nova Nova, Jingxuan Zhao, Justin Michael

<sup>318</sup> See, for example, Ortaliza, Jared, Krutika Amin, and Cynthia Cox (2022). "As ACA Marketplace Enrollment Reaches Record High, Fewer Are Buying Individual Market Coverage Elsewhere," KFF, available at: <https://www.kff.org/policy-watch/as-aca-marketplace-enrollment-reaches-record-high-fewer-are-buying-individual-market-coverage-elsewhere/>. See also Ortaliza, Jared, Krutika Amin, and Cynthia Cox (2024). "Another Year of Record ACA Marketplace Signups, Driven in Part by Medicaid Unwinding and Enhanced Subsidies," KFF, available at: <https://www.kff.org/policy-watch/another-year-of-record-aca-marketplace-signups-driven-in-part-by-medicaid-unwinding-and-enhanced-subsidies/>.

<sup>319</sup> In developing these estimates, OACT assumed that STLDI would be significantly less expensive than individual health insurance coverage purchased on an Exchange (where available) and would be an attractive option for individuals and families with relatively low health care costs and little to no subsidies. Using their health reform model, OACT estimated that, under current law, about 60,000 people would move from individual health insurance coverage purchased on an Exchange to STLDI in 2026, when the additional PTC subsidies available through 2025 through the IRA expire. In addition, since those switching to STLDI are assumed to be healthier than average, the average premium for individual health insurance coverage purchased on an Exchange would increase by roughly 0.5 percent. Changing the maximum duration of an STLDI policy, certificate, or contract of insurance to no more than 4 months is expected to negate these effects.

<sup>320</sup> The Departments received an analysis from a commenter that estimated the potential impact of the STLDI provisions on enrollment and premiums in the individual market for comprehensive coverage. The analysis found that the STLDI provisions are likely to increase enrollment and lower premiums in the individual market for comprehensive coverage. The analysis utilized upper bound estimates of existing STLDI enrollment and analyzed varying scenarios of transition from STLDI coverage to individual health insurance coverage to estimate that such transitions could result in a 0.5 to 2 percent reduction in premiums. The commenter acknowledged that these impacts would vary by State given the different levels of STLDI regulations in States. Overall, the analysis notes that the net result is positive for consumers should there be a significant transition from STLDI coverage to individual health insurance coverage.

to the Federal consumer protections and requirements for comprehensive coverage in lieu of STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage), the Departments are of the view that these final rules will result in a reduction in out-of-pocket expenses, medical debt, and risk of medical bankruptcy for consumers switching to comprehensive coverage. These final rules could also lead to a reduction in potentially devastating surprise bills from out-of-network providers in emergency and certain other circumstances to the extent the rules lead to an increase in enrollment in individual health insurance coverage, which is subject to the surprise billing protections for consumers under the No Surprises Act. Many commenters agreed that the proposals being finalized in these final rules will support consumer protections. Many commenters also indicated that these final rules are critical to ensuring consumers' financial well-being and reducing their financial risk. Several commenters agreed that the proposed STLDI notice would ensure that consumers understand the type of coverage that they would be enrolling in and its limitations. Many commenters stated that STLDI policies expose enrollees to the risk of high out-of-pocket costs when an illness or injury occurs, and some commenters stated that this could lead to increased medical debt. One commenter indicated that families without comprehensive care are at risk of delaying care or going into debt. One commenter indicated that consumers may not realize how limited their STLDI coverage is until they are faced with high out-of-pocket costs for services commonly covered under comprehensive coverage. Commenters pointed to rehabilitation services, prescription drug costs, and cancer treatments as resulting in significantly higher out-of-pocket costs for consumers enrolled in STLDI when compared to comprehensive coverage. For example, the Departments reviewed a scenario study<sup>321</sup> that assessed the cost

implications of a hypothetical consumer who enrolls in a typical STLDI policy and is later diagnosed with breast cancer. The study found that this hypothetical consumer would incur between \$40,000 to \$63,000 in out-of-pocket expenses, compared to less than \$8,000 in a comprehensive coverage plan. While many commenters argued that fixed indemnity excepted benefits coverage reduces financial risk, other commenters argued that fixed indemnity excepted benefits coverage exposes individuals to financial risk when it is used as a substitute for comprehensive coverage. Lastly, some commenters specifically noted that the provisions regarding stacking of STLDI policies would benefit consumers by limiting circumvention of the provisions related to maximum duration, as discussed in section III.A.2 of this preamble. The Departments agree with these comments and are of the view that to the extent that consumers obtain comprehensive coverage in lieu of STLDI or fixed indemnity excepted benefits coverage, they are likely to experience lower out-of-pocket costs for their care. As noted in section V.B.2.a of this preamble, the Departments acknowledge that fixed indemnity excepted benefits coverage can reduce financial risk when used as a supplement to comprehensive coverage but remain concerned about the financial risk for individuals when it is used as a substitute for comprehensive coverage.

#### d. Costs

*Increase in premiums.* The Departments recognize that some individuals with STLDI or fixed indemnity excepted benefits coverage who switch to individual health insurance coverage might incur higher premium costs depending on their choice of available Exchange and off-Exchange plans, their PTC eligibility (if applicable), and the amount of APTC they receive (if any).<sup>322</sup> Several commenters noted that the STLDI provisions could

lead to higher premium costs for individuals if they switch to comprehensive coverage, and several commenters noted the low monthly premiums for STLDI relative to comprehensive coverage. One commenter acknowledged that STLDI has lower premiums because the Federal consumer protections and requirements for comprehensive coverage do not apply to this form of coverage. Some commenters stated that STLDI policies cover the select benefits certain consumers want. The Departments acknowledge that premiums for comprehensive coverage are generally higher than premiums for STLDI, but note that this is largely because comprehensive coverage offers more benefits with lower out-of-pocket costs. Further, as noted in section II.A of this preamble, comprehensive coverage for individuals has generally become more accessible and affordable in recent years, due in part to the expansion of PTC subsidies under the ARP and the IRA, and the provisions for STLDI finalized in these final rules are expected to put further downward pressure on gross premiums for individuals enrolled in individual health insurance coverage purchased on an Exchange. The Departments are of the view that any increase in costs is outweighed by the meaningful increase in benefits and consumer protections afforded to individuals enrolled in comprehensive coverage.

*Loss of coverage.* These final rules might also lead to an increase in the number of individuals without some form of health insurance coverage, if some individuals with STLDI purchased after the applicability date are no longer able to renew or extend their current policy, choose not to purchase a new policy from another issuer of STLDI, and can only obtain comprehensive coverage during an annual individual market open enrollment period, or choose not to purchase comprehensive coverage. Many commenters agreed with the Departments' analysis and noted that the provisions regarding STLDI coverage may reduce consumers' cover-

<sup>321</sup> American Cancer Society Cancer Action Network (2019). "Inadequate Coverage: An ACS CAN Examination of Short-Term Health Plans," available at: <https://www.fightcancer.org/sites/default/files/ACS%20CAN%20Short%20Term%20Paper%20FINAL.pdf>.

<sup>322</sup> This might occur if premiums for STLDI are lower than premiums for individual health insurance coverage. One study, for example, showed that by screening out individuals with pre-existing conditions and providing fewer comprehensive benefits, issuers may be able to offer STLDI at rates 54 percent below those for (unsubsidized) comprehensive coverage. See Levitt, Larry, Rachel Fehr, Gary Claxton, Cynthia Cox, and Karen Pollitz (2018). "Why do Short-Term Health Insurance Plans Have Lower Premiums than Plans that Comply with the ACA?" KFF, available at: <https://files.kff.org/attachment/Issue-Brief-Why-Do-Short-Term-Health-Insurance-Plans-Have-Lower-Premiums-Than-Plans-That-Comply-with-the-ACA>.



age options or lead to a loss of coverage or a coverage gap. Many commenters argued that restricting access to STLDI would not be appropriate for certain populations given their coverage needs (for seasonal employees working in another State, for example). These commenters noted that specific groups who benefit from STLDI policies are most likely to go without insurance as a result of the STLDI provisions, such as gig-economy workers, contract workers, college students, commercial truck drivers, and travel nurses. Some commenters suggested that the STLDI provisions could lead consumers to seek alternative forms of non-comprehensive coverage, including coverage offered in unregulated markets (for example, through health care sharing ministries). The Departments acknowledge that some individuals who purchase STLDI policies after the applicability date may lose coverage and must wait until the next annual individual market open enrollment period to purchase comprehensive coverage (for example, if an individual with STLDI purchased after the applicability date exhausts their renewal or extension options or is unable to enroll in STLDI offered by a different issuer outside of an open enrollment period) or may choose to become uninsured. Some individuals might also seek coverage in unregulated markets. Those individuals who become uninsured or obtain coverage in unregulated markets could face an increased risk of higher out-of-pocket expenses and medical debt, reduced access to health care, and potentially worse health outcomes. The Departments are of the view, however, that the overall risk that some individuals may become uninsured or lose coverage because of the above circumstances is outweighed by the fact that a substantial number of individuals will likely benefit as a result of the final rules' STLDI provisions. Overall, the Departments are of the view that STLDI serves better as a bridge between different sources of comprehensive coverage than as an alternative to comprehensive coverage.

*Increase in health care spending.* To the extent that these final rules lead to an increase in enrollment in comprehensive coverage, they might result in an increase in overall health care utilization and spending, given that comprehensive coverage tends to have higher loss ratios and actuarial values and generally offers lower cost-sharing requirements and more generous benefits.<sup>323</sup>

*Impact on States.* The Departments solicited comments on the magnitude of the costs that States might incur associated with enacting new legislation, implementing new laws, and updating existing regulations regarding STLDI and fixed indemnity excepted benefits coverage. However, the Departments received little information about the potential costs to States associated with the provisions being finalized in these final rules. One commenter generally stated that the STLDI provisions would cause economic harm to States, but the commenter did not quantify or otherwise specify the type or extent of the economic impact on States. While no State is required to enact new legislation or change its regulations under the provisions being finalized in these final rules, the Departments anticipate that some States could incur a one-time cost if they do enact new legislation or update their regulations.

Many commenters also stated that the 2023 proposed rules would generate costs for States associated with evaluating and approving redesigned products and policy forms. The Departments acknowledge that some State departments of insurance may incur costs to the extent they need to review amended marketing materials and plan documents filed by issuers.

*Costs to agents and brokers.* The Departments sought information on the number of agents and brokers who sell STLDI, fixed indemnity excepted benefits coverage, and individual health insurance coverage, respectively, and how their compensation might be affected by the provisions proposed in the 2023 proposed rules. Many commenters anticipated that

the financial impacts of the proposals on agents and brokers would be significant, particularly given the relatively low commission rates that agents and brokers receive from the sale of Exchange plans as compared to STLDI and fixed indemnity insurance. Another commenter stated that the Departments' analysis lacked sufficient data to account for the potential impacts on agents and brokers. However, commenters did not provide information on the number of agents and brokers that sell STLDI or fixed indemnity excepted benefits coverage or data that would assist in quantifying the impact of the provisions proposed in the 2023 proposed rules on agents and brokers. Nevertheless, the Departments acknowledge that the provisions being finalized in these final rules may affect agents and brokers if there is an impact on enrollment in STLDI or fixed indemnity excepted benefits products. There is the potential for agent and broker compensation associated with the sale of STLDI or fixed indemnity excepted benefits coverage to be negatively affected if there is a reduction in the sale of these types of coverage. There is also the potential for agent and broker compensation associated with the sale of individual health insurance coverage to be positively affected if there is an increase in sales of that coverage.

*Costs to issuers.* In the 2023 proposed rules, the Departments explained they expected that issuers would incur minimal costs associated with the notice provisions. The Departments also expected that since issuers change their policy documents routinely, the costs to issuers to make changes in response to these final rules would be part of issuers' usual business costs. However, many commenters stated that issuers would incur operational costs associated with the provisions for fixed indemnity excepted benefits coverage proposed in the 2023 proposed rules (to make necessary updates to systems and processes, and other administrative tasks, for example). Many commenters noted the costs to refile documents with

<sup>323</sup> As noted earlier in this RIA, many STLDI and fixed indemnity excepted benefits policies offer limited benefits coverage and have relatively low actuarial values. Many STLDI and fixed indemnity excepted benefit coverage issuers spend a relatively high percentage of premium dollars on administration and overhead. See National Association of Insurance Commissioners (2022). "Accident and Health Policy Experience Report for 2021," available at: <https://naic.soutrnglobal.net/portal/Public/en-US/Search/AdvancedSearch>. Regarding the differences in cost-sharing requirements and out-of-pocket expenses between STLDI and individual health insurance coverage, see, for example, Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

State departments of insurance, obtain State approvals, and ensure compliance, and the costs associated with new policy issuance, marketing, enrollment, and administration. While one commenter provided an estimate of the overall costs of implementing all of the provisions for fixed indemnity excepted benefits coverage proposed in the 2023 proposed rules, no commenter provided estimates of the costs associated with the provisions for STLDI or estimates specific to the notice provisions for STLDI and fixed indemnity excepted benefits coverage proposed in the 2023 proposed rules.

The Departments acknowledge these comments and anticipate that issuers will incur one-time costs to modify their products and plan documents to comply with the provisions for STLDI and fixed indemnity excepted benefits coverage that are being finalized in these final rules, with issuers also incurring costs related to filing amended marketing materials and plan documents with State departments of insurance. These costs are expected to vary by issuer depending on the number of States in which they offer products, State law requirements for STLDI or fixed indemnity excepted benefits coverage, the number of products they offer, and the overall scale of their operations.<sup>324</sup> These costs will include the costs associated with the notice provisions. Using wage information from the Bureau of Labor Statistics to account for median labor costs (including a 100 percent increase for the cost of fringe benefits and other indirect costs),<sup>325</sup> the Departments estimate that, on average for each issuer, a business operations specialist will need 4 hours (at an hourly labor cost of \$73.06), an administrative assistant will need 4 hours (at an hourly labor cost of \$42.38), and a web developer will need 8 hours (at an hourly

labor cost of \$75.56) to revise or place the notice that must be displayed in their marketing, application, and enrollment materials (including on websites) and in the individual market also to place the notice in the policy, certificate, or contract of insurance, to come into compliance with these final rules. The average cost per issuer to comply with the notice provisions is estimated to be approximately \$1,066.<sup>326</sup> As noted earlier in this RIA, the NAIC estimates that there are currently 28 issuers of STLDI in the individual market and 93 issuers of “other medical (non-comprehensive)” coverage in the individual market, which include fixed indemnity insurance.

Therefore, using the NAIC estimates, the total one-time cost to issuers of STLDI and fixed indemnity coverage to comply with the notice provisions will be at least approximately \$129,015.<sup>327</sup>

#### e. Transfers

*Transfers associated with transitions to comprehensive coverage.* Individuals currently enrolled in STLDI may be healthier—on average—than individuals enrolled in comprehensive coverage, because comprehensive coverage is subject to Federal consumer protections and requirements for comprehensive coverage that prohibit those plans from excluding individuals or charging higher premiums on the basis of health status, gender, and other factors, whereas STLDI policies do not have to comply with these requirements and are typically subject to medical underwriting. These final rules are expected to cause some individuals with relatively low health care costs to enroll in individual health insurance coverage in lieu of STLDI, which is expected to improve the risk pools for individual

health insurance coverage and lead to lower overall average premiums for individual health insurance coverage.

CMS previously estimated that gross premiums for individual health insurance coverage purchased on an Exchange in 2022 would be 6 percent higher under the 2018 proposed rules than they would have been in the absence of those rules.<sup>328</sup> CBO and JCT previously estimated that the 2018 final rules for STLDI, in conjunction with changes made through the 2018 Department of Labor rule entitled “Definition of ‘Employer’ Under Section 3(5) of ERISA—Association Health Plans,”<sup>329</sup> would increase premiums in the individual and small group health insurance coverage markets by around 3 percent.<sup>330</sup> An analysis of individual health insurance coverage rate filing materials for 2020 also found that the few issuers that explicitly included a premium adjustment because of the 2018 final rules increased premiums by between 0.5 percent and 2 percent in 2020.<sup>331</sup> These analyses suggest that these final rules should have an effect in the opposite direction, reducing gross premiums for individual health insurance coverage. OACT estimates that the provisions regarding STLDI will not affect gross premiums for individuals with individual health insurance coverage purchased on an Exchange in 2024 and 2025, given the expanded PTC subsidies provided through the IRA, but will reduce gross premiums by approximately 0.5 percent in 2026, 2027, and 2028, after the expanded PTC subsidies have ended.<sup>332</sup>

Many commenters agreed with the Departments that enrollment in STLDI adversely affects the risk pools for individual health insurance coverage, leading to higher premiums for individual health insurance coverage. Specifically, one commenter stated that this adverse

<sup>324</sup> The Departments do not have enough data or information to quantify these costs.

<sup>325</sup> See Bureau of Labor Statistics (2022). “National Occupational Employment and Wage Estimates,” available at: [https://www.bls.gov/oes/current/oes\\_nat.htm](https://www.bls.gov/oes/current/oes_nat.htm).

<sup>326</sup> (4 business operation specialist hours \* \$73.06) + (4 administrative assistant hours \* \$42.38) + (8 web developer hours \* \$75.56) = \$1,066.24.

<sup>327</sup> (28 STLDI issuers + 93 issuers of other medical (non-comprehensive) coverage) \* [(4 business operation specialist hours \* \$73.06) + (4 administrative assistant hours \* \$42.38) + (8 web developer hours \* \$75.56)] = \$129,015.04.

<sup>328</sup> CMS Office of the Actuary (2018). “Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule,” available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf>.

<sup>329</sup> 83 FR 28912 (June 21, 2018). This rule was vacated by the District Court of D.C. in *State of New York, et al. v. United States Department of Labor, et al.*, 363 F.Supp.3d 109 (D.D.C. 2019).

<sup>330</sup> Congressional Budget Office (2019). “How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans,” available at: <https://www.cbo.gov/publication/54915>.

<sup>331</sup> Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>332</sup> See section V.B.2.c of this preamble for a discussion of the enrollment effects that drive these premium changes.

selection and its effects would particularly disadvantage individuals with preexisting conditions. Furthermore, one study suggests that the 2018 final rules had a negative effect on the risk pools for individual health insurance coverage.<sup>333</sup> As such, the Departments continue to be of the view that access to STLDI has negative effects on the risk pools for individual health insurance coverage.

Some commenters also noted that enrollment in STLDI in lieu of comprehensive coverage could lead to fewer issuers in the Exchanges or otherwise distort or destabilize the markets for comprehensive coverage, while one commenter stated that the impact of enrollment in STLDI on the markets for comprehensive coverage would be rather limited (as indicated by OACT's impact estimates). A few commenters suggested that the STLDI provisions could potentially harm the market for individual health insurance coverage due to a reduction in competition, for example, with one commenter suggesting that the 2018 final rules promoted issuer competition in the overall market.<sup>334</sup> The Departments disagree with these commenters and note that STLDI and individual health insurance coverage are two very different products that are generally subject to different laws and regulations, and issuers of individual health insurance coverage are unlikely to have changed their product offerings to compete with STLDI.

Some commenters stated that enrollment in fixed indemnity excepted benefits coverage can adversely affect the risk pools for comprehensive coverage. A few commenters stated that the impact of fixed indemnity excepted benefits coverage on the risk pools for individual health insurance coverage purchased on an Exchange is limited or nonexistent. While

the Departments expect that the notice provisions being finalized in these final rules will encourage some individuals to enroll in comprehensive coverage instead of fixed indemnity excepted benefits coverage, the Departments do not expect such increased enrollment to have a significant impact on market risk pools and therefore expect a limited impact on premiums for comprehensive coverage, if any.

*Transfers from the Federal Government to individuals.* The provisions regarding STLDI are expected to reduce Federal PTC spending after the end of the expanded PTC subsidies provided through the IRA. Specifically, these provisions are expected to reduce gross premiums for individual health insurance coverage purchased on an Exchange and therefore lower per capita PTC spending. This effect is expected to be partly offset by an increase in the number of individuals enrolling in Exchange coverage that would be eligible to receive the PTC (by approximately 20,000 in 2026, 2027, and 2028). On net, OACT estimates that these provisions will have no impact on Federal spending on PTC in 2024 and 2025 given the expanded PTC subsidies provided through the IRA, but will reduce Federal spending on the PTC by approximately \$120 million in 2026, 2027, and 2028.<sup>335</sup> This reduction in Federal spending on the PTC is viewed as a reduction in the amount of the transfer from the Federal Government to individuals.

*Transfers among issuers, consumers, and providers.* These final rules could lead to a transfer in the form of reduced out-of-pocket expenses from issuers to consumers who switch from STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage) to comprehensive coverage, since more health care services

would be covered under comprehensive coverage and the out-of-pocket expenses (such as cost-sharing requirements) for comprehensive coverage might be lower than out-of-pocket expenses for STLDI or fixed indemnity excepted benefits coverage.<sup>336</sup>

Some commenters suggested that the STLDI provisions could lead to an increase in uncompensated care provided by providers and facilities, to the extent they lead to an increase in the number of individuals without any form of health insurance coverage who are unable to pay providers and facilities on an out-of-pocket basis, which would be a transfer from providers and facilities to uninsured individuals. However, a few commenters suggested that the STLDI provisions could lead to a decrease in uncompensated care provided by providers and facilities, to the extent that individuals with STLDI enroll in comprehensive coverage (which would generally offer more benefits and lower cost-sharing requirements, and increased access to health care) in lieu of STLDI; this would be a transfer from issuers of comprehensive coverage to providers and facilities. One commenter also suggested that the fixed indemnity excepted benefits coverage proposals in the 2023 proposed rules could generate costs for providers regarding receipt of payments from patients, which would be a transfer from providers to these individuals. The Departments lack data that would allow for a quantification of these effects but acknowledge that there may be a potential increase in uncompensated care provided by providers and facilities given the previously-mentioned impact of these final rules on out-of-pocket expenditures discussed in section V.B.2.d of this preamble.

<sup>333</sup> See Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>334</sup> The commenter cited a study that compared the trends in Exchange enrollment, premiums, and issuer participation in States that had additional restrictions on or prohibited STLDI and in States that fully permitted STLDI (in accordance with the 2018 final rules). The study concluded that States that fully permitted STLDI "...have lost fewer enrollees in the individual market, have had far more insurers offer coverage in the market, and have had larger premium reductions since the [2018 final rules] took effect," further noting that "the only States where individual market premiums have increased since 2018 are the five [S]tates that effectively prohibit short-term plans." See Blase, Brian (2021). "Individual Health Insurance Markets Improving in States that Fully Permit Short-Term Plans," Galen Institute, available at: <https://galen.org/assets/Individual-Health-Insurance-Markets-Improving-in-States-that-Fully-Permit-Short-Term-Plans.pdf>.

<sup>335</sup> In fiscal year terms, this would be a reduction in Federal spending of \$90 million in 2026, \$120 million in 2027, and \$120 million in 2028.

<sup>336</sup> As noted in the Costs subsection of this RIA, regarding the differences in cost-sharing requirements and out-of-pocket expenses between STLDI and individual health insurance coverage, see, for example, Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

## f. Uncertainty

As noted throughout this preamble, due to a lack of data and information, there are several areas of uncertainty regarding the potential impacts of these final rules. The Departments are unable to forecast how all of the provisions of these final rules will affect enrollment in STLDI and fixed indemnity excepted benefits coverage, as the Departments are uncertain how many individuals are currently enrolled in STLDI or fixed indemnity excepted benefits coverage, how many of those individuals will switch to comprehensive coverage, how many individuals will try to find another issuer of STLDI once their current policy ends, how many individuals will choose to remain enrolled in fixed indemnity excepted benefits coverage, or how many individuals will choose not to purchase any form of coverage.<sup>337</sup> As a result, there is also some uncertainty about the impacts on market risk pools, premiums, Federal expenditures on PTC, and on compensation for agents and brokers selling STLDI, fixed indemnity excepted benefits coverage, and individual health insurance coverage. One commenter noted that the uncertainty in the estimates pertaining to the number of affected entities undermines the Departments' analysis of impacts.

The Departments sought comments on all of these areas of uncertainty regarding the impacts of the 2023 proposed rules and where possible incorporated data and

information received during the comment period in estimating the impacts of these final rules. Despite the uncertainty discussed in this section and throughout this preamble, the Departments have enough data to be confident that the benefits of these final rules outweigh the costs, and that these final rules will help ensure that consumers can clearly distinguish STLDI and fixed indemnity excepted benefits from comprehensive coverage, protect market risk pools and stabilize premiums for comprehensive coverage, and promote access to affordable comprehensive coverage.

## g. Health Equity Impact

The Departments stated in section II.B of the preamble to the 2023 proposed rules that due to the typical underwriting practices and plan eligibility requirements in the market for STLDI, individuals might face higher premiums or might not be able to purchase STLDI because of pre-existing health conditions, gender, or other factors.<sup>338</sup> STLDI and fixed indemnity excepted benefits coverage policies typically do not cover certain essential health benefits including prescription drugs, mental health and substance use disorder services, or maternity services,<sup>339</sup> which could contribute to disparities in access to health care and health outcomes (regarding mental health, maternal health, or infant health, for instance).<sup>340</sup> Many commenters stated that issuers of STLDI

policies are able to discriminate against individuals on the basis of health status or preexisting conditions, age, or gender.

Consumers with low health literacy, which disproportionately includes consumers with low incomes,<sup>341</sup> might also be misled into purchasing STLDI or fixed indemnity excepted benefits coverage under the mistaken impression that it would lower their out-of-pocket costs while providing comprehensive coverage with lower premiums. Consumers with low income or who are members of underserved racial and ethnic groups are more likely to be uninsured and face barriers in accessing care.<sup>342</sup> Individuals in these populations arguably face the greatest health and financial consequences if STLDI or fixed indemnity excepted benefits coverage (when used as a substitute for comprehensive coverage) proves inadequate. These individuals are also potentially most vulnerable to practices like post-claims underwriting and rescission that are common in the STLDI market, which could leave them without any coverage in a health crisis. Some commenters shared the Departments' concern over the disproportionate impact that non-comprehensive products may have on consumers with low incomes and consumers of underserved racial and ethnic groups. Some commenters indicated that individuals with low health literacy are disproportionately impacted by misleading and deceptive marketing practices, as discussed in section III.A of this preamble.

<sup>337</sup> Previous studies have estimated the impact of the STLDI definition adopted in the 2018 final rules on enrollment in individual health insurance coverage, but in conjunction with the impact of elimination of the individual shared responsibility payment. See Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>338</sup> See, for example, Barnes, Justin and Fumiko Chino (2022). "Short-term Health Insurance Plans Come Up Short for Patients with Cancer," *JAMA Oncology*, Volume 8, Issue 8, available at: <https://jamanetwork.com/journals/jamaoncology/article-abstract/2793127>.

<sup>339</sup> Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

<sup>340</sup> See, for example, Hill, Latoya, Samantha Artiga, and Usha Ranji (2022). "Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them," KFF, available at: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/>.

<sup>341</sup> See, for example, Hill, Latoya, Samantha Artiga, and Usha Ranji (2022). "Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them," KFF, available at: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/>.

<sup>342</sup> See, for example, Rikard, RV, Maxine Thompson, Julie McKinney, and Alison Beauchamp (2016). "Examining Health Literacy Disparities in the United States: A Third Look at the National Assessment of Adult Literacy," *BMC Public Health*, Volume 16, Issue 1, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5022195/>. See also Davis, Stacy, Jonathan Wischhusen, Steven Sutton, Shannon Christy, Emmanuel Chavarria, Megan Sutter, Siddhartha Roy, Cathy Meade, and Clement Gwede (2020). "Demographic and Psychosocial Factors Associated with Limited Health Literacy in a Community-based Sample of Older Black Americans," *Patient Education and Counseling*, Volume 103, Issue 2, available at: <https://doi.org/10.1016/j.pec.2019.08.026>.

<sup>342</sup> See Tolbert, Jennifer, Kendal Orgera, and Anthony Damico (2020). "Key Facts about the Uninsured Population," KFF, available at: <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>. See also Artiga, Samantha, Latoya Hill, Kendal Orgera, and Anthony Damico (2021). "Health Coverage by Race and Ethnicity, 2010-2019," KFF, available at: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>. See also KFF (2021). "Adults Who Report Not Having a Personal Doctor/Health Care Provider by Race/Ethnicity," available at: <https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-raceethnicity/>. See also KFF (2021). "Adults Who Report Not Seeing a Doctor in the Past 12 Months Because of Cost by Race/Ethnicity," available at: <https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-seeing-a-doctor-in-the-past-12-months-because-of-cost-by-raceethnicity/>.

These final rules are expected to help address these health inequities by ensuring that consumers can more easily distinguish STLDI and fixed indemnity excepted benefits coverage from comprehensive coverage and thereby encouraging enrollment in comprehensive coverage.

#### h. Regulatory Review Cost Estimation

If regulations impose administrative costs on entities (for example, the time needed to read and interpret rules), regulatory agencies should estimate the total cost associated with regulatory review.<sup>343</sup> In the 2023 proposed rules, the Departments assumed that approximately 250 entities would review the 2023 proposed rules. The Departments acknowledged that the number of entities reviewing the 2023 proposed rules could be higher or lower than anticipated. The Departments ultimately received 571 unique comments on the 2023 proposed rules that pertained to the proposals for STLDI and fixed indemnity excepted benefits coverage, of which 247 commenters were identified as entities (for example, issuers, State insurance departments, industry associations, and advocacy organizations). Based on the comments received, the Departments now estimate that the 571 unique commenters that commented on the 2023 proposed rules, along with at least one additional individual from each of the 247 entities commenting on the 2023 proposed rules, will review these final rules. That is, the Departments estimate that at least 818 individuals will read and interpret these final rules.

Using wage information from the Bureau of Labor Statistics, for Business Operations Specialists (All Other), to account for median labor costs (including a 100 percent increase for the cost of fringe benefits and other indirect costs), the Departments estimate that the cost of reviewing these final rules will be \$73.06 per hour.<sup>344</sup> The Departments estimate that it will take each reviewing individual approximately 6 hours on average to review these final rules, with an associ-

ated cost of \$438.36 (6 hours x \$73.06). Therefore, the Departments estimate that the (one-time) total cost of reviewing these final rules will be approximately \$358,578 (818 x \$438.36). The Departments sought comments on this approach to estimating the total burden and cost for interested parties to read and interpret the rules, and received one comment arguing that reading and understanding the rules would take far longer than the 4 hours estimated in the 2023 proposed rules. The Departments agree that it might take some reviewers longer than the previously estimated 4 hours, or the currently estimated 6 hours, to read and interpret the rules, but that an average estimate is reasonable.

#### C. Regulatory Alternatives – *Departments of Health and Human Services and Labor*

In developing the proposed rules, the Departments considered various alternative approaches. The Departments considered leaving in place the duration standards for STLDI established in the 2018 final rules but concluded that the 2018 final rules' duration standards were too lengthy for the reasons described in section III.A.2 of this preamble. The Departments also considered proposing to limit the maximum duration of STLDI policies to a less-than-6-month period to minimize disruption for consumers in some (but not all) States that have implemented a less than-6-month period, to a less than-3-month period as implemented in the 2016 final rules, or otherwise shortening the maximum duration to a time period shorter than allowed under current regulations. However, as further discussed in in section III.A.2 of this preamble, the Departments ultimately decided to propose and finalize a maximum duration of no more than 4 months to align with the rules regarding the 90-day waiting period limitation and the 1-month reasonable and bona fide employment-based orientation period that is permitted under the ACA.

The Departments considered proposing to limit stacking of STLDI policies,

whether sold by the same or different issuer. However, after considering the potential challenges issuers and State regulators would face in attempting to determine whether an individual had previously enrolled in an STLDI policy with a different issuer, the Departments decided to propose to limit stacking only where STLDI is sold to an individual by the same issuer and sought comments on whether to extend the limit on stacking to STLDI sold to an individual by issuers that are members of the same controlled group. Some commenters suggested limiting stacking of multiple or consecutive STLDI policies sold by issuers that are members of the same controlled group or sold to members of the same household. Other commenters supported the Departments preventing stacking of STLDI policies sold by unaffiliated issuers. The Departments decided that limiting the sale of STLDI policies offered by issuers that are members of the same controlled group would prevent issuers from using their corporate structure to circumvent the rules related to maximum duration, but it is not apparent to the Departments that limiting stacking across unaffiliated issuers or different members of the same household accomplishes any similar goal.

For new STLDI sold or issued on or after the effective date of the final rules, the Departments proposed an applicability date for the amendments to the Federal definition of STLDI that would apply for coverage periods beginning on or after the effective date of the final rules. Some commenters expressed concern that issuers of STLDI would need more time to complete a number of administrative tasks – such as evaluating plan designs, updating system processes, and re-filing policy forms with State regulators – and suggested the Departments finalize an applicability date between 90 days and 12 months after the effective date of the final rules. Other commenters were concerned about the potential for consumer confusion when STLDI is marketed and sold during the annual individual market open enrollment period. To provide more

<sup>343</sup> See Office of the Assistant Secretary for Planning and Evaluation (2017). “Guidelines for Regulatory Impact Analysis,” available at: <https://aspe.hhs.gov/reports/guidelines-regulatory-impact-analysis>.

<sup>344</sup> See Bureau of Labor Statistics (2022). “National Occupational Employment and Wage Estimates,” available at: [https://www.bls.gov/oes/current/oes\\_nat.htm](https://www.bls.gov/oes/current/oes_nat.htm).

time for issuers to come into compliance with these final rules for new STLDI policies and ensure that STLDI with a longer maximum duration is not marketed during the next annual individual market open enrollment period, the Departments decided that for new STLDI sold or issued on or after September 1, 2024, the revised Federal definition of STLDI under these final rules will apply for coverage periods beginning on or after September 1, 2024. This will allow consumers who enroll in a new STLDI policy on or after September 1, 2024, to avoid a gap between the STLDI policy and when comprehensive coverage purchased during the next individual market open enrollment period will begin.

The Departments considered proposing a limit on the marketing or sale of STLDI during the annual individual market open enrollment period. The Departments are concerned that aggressive and deceptive marketing practices by some issuers have lured consumers, looking for comprehensive coverage, into enrolling in STLDI, exposing them to financial risk. The Departments appreciated the comments received regarding how the Departments can support State efforts to limit the marketing and/or sale of STLDI during the open enrollment period and will take these comments into consideration as the Departments consider potential actions they can take to address the marketing and sale of STLDI during the individual market open enrollment period.

With respect to the proposed amendments to the notices provided to consumers considering enrolling in or purchasing STLDI, the Departments considered including a complete list of Federal protections that apply to consumers enrolled in comprehensive coverage versus STLDI. This approach would more fully distinguish STLDI from comprehensive coverage and highlight in greater detail the risks to consumers of enrolling in STLDI instead of comprehensive coverage. However, after a review of the comments, consulting with plain language experts and conducting consumer testing, the Departments are of the view that providing a complete comparison of protections that a consumer would forgo by enrolling in STLDI rather than comprehensive coverage would result in a lengthy, complex

notice that could be difficult for the typical consumer to understand. Increasing the length and complexity of the notice would also increase burden for issuers to provide the notice on policy documents and marketing and application materials as required by these final rules. The Departments solicited comments on all aspects of the revised notice, including whether a different format or presentation would result in a more useful, consumer-friendly notice. For a more detailed discussion of the notices considered, please reference section III.A.4 of this preamble.

The Departments considered several options when finalizing the notice requirements for fixed indemnity excepted benefits coverage in the group market. HHS considered the same options when revising the content and standards for the consumer notice in the individual market. As discussed in section III.B.1 of this preamble, consideration was given to changes to the wording, appearance and timing related to the notice provisions. The Departments considered different applicability dates for these notices, including applying the notice to plan years (or in the individual market, coverage periods) (including renewals) beginning on or after the effective date of these final rules (as proposed), September 1, 2024 (which would align with the applicability date finalized in these rules for the STLDI notice provision), January 1, 2025, and later dates such as January 1, 2027. The Departments concluded that applying the notice to plan years (or in the individual market, coverage periods) (including renewals) beginning on or after January 1, 2025, strikes an appropriate balance between providing plans and issuers offering fixed indemnity excepted benefits coverage with additional time to add or update the notice and ensuring that the notices are present for new enrollments and renewals offered on a calendar year basis. The Departments are of view that a large proportion of group market fixed indemnity excepted benefits coverage, for which the notice will be new, are likely to be offered on a calendar year basis, as part of an employer's open enrollment period for their employees. In addition, one commenter suggested that the Departments should require an attestation from whom ever sells fixed indemnity excepted ben-

efits coverage, confirming that the risks and limitations were explained during the sale. The Departments are of the view that it would be more effective and efficient to provide all prospective enrollees with consistent messaging on all marketing, application, and enrollment materials (and, in the individual market, also on the first page of the policy, certificate, or contract of insurance). The Departments also declined to impose an attestation requirement based on the associated cost and administrative burden to plans, issuers, plan sponsors, agents, and brokers.

One commenter suggested that the Departments should explore additional consumer protection measures, such as requiring plans and issuers to provide prospective consumers with a complete and easily searchable schedule of benefits prior to purchase, as well as a longer free-look period in which an enrollee can cancel the plan for any reason at no cost. The Departments agree that these features would be beneficial and encourage plans and issuers to offer them to the extent feasible.

#### *D. Paperwork Reduction Act*

These final rules revise the Federal definition of STLDI to provide that a revised notice must be prominently displayed (in either paper or electronic form) in at least 14-point font on the first page of the policy, certificate, or contract of insurance and in any marketing, application, and enrollment materials, including for renewals or extensions (including on websites that advertise or enroll in STLDI). These notice provisions apply for both new and existing STLDI for coverage periods beginning on or after September 1, 2024.

These final rules also amend the regulations regarding fixed indemnity excepted benefits coverage in the individual market to provide that a revised notice must be prominently displayed (in either paper or electronic form) on the first page of the policy, certificate, or contract of insurance, and in any marketing, application, and enrollment (or reenrollment) materials. These final rules also amend the regulations regarding fixed indemnity excepted benefits coverage in the group market to provide that a notice must be

prominently displayed (in either paper or electronic form) on the first page of any marketing, application, and enrollment (or reenrollment) materials. These notice provisions for group and individual market fixed indemnity excepted benefits coverage are applicable to both new and existing coverage with respect to plan years (in the individual market, coverage periods) beginning on or after January 1, 2025.

The Departments are providing the exact text for the STLDI and fixed indemnity excepted benefits coverage notices in these final rules, and the language will not need to be customized. The burden associated with these notices is therefore not subject to the Paperwork Reduction Act of 1995 in accordance with 5 CFR 1320.3(c) (2) because these notices do not contain a “collection of information” as defined in 44 U.S.C. 3502(3). Consequently, this document need not be reviewed by OMB under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Departments solicited comments on the potential burden on issuers if the final rules were to include required notices with language that would need to be customized with State-specific information, as discussed in this preamble at section III.A.4 for STLDI and section III.B.1.

### *E. Regulatory Flexibility Act*

The Regulatory Flexibility Act (RFA) (5 U.S.C. 601, *et seq.*) requires agencies to analyze options for regulatory relief of small entities and to prepare a regulatory flexibility analysis to describe the impact of a rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The RFA generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit 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 data and conclusions presented in this section amount

to the Departments’ final regulatory flexibility analysis under the RFA.

#### 1. Need for Regulatory Action, Objectives, and Legal Basis

This rulemaking is authorized by section 9833 of the Code, section 734 of ERISA, and section 2792 of the PHS Act, which authorize the Secretaries of the Treasury, Labor, and HHS to issue such regulations as may be necessary or appropriate to carry out the provisions of chapter 100 of the Code, part 7 of subtitle B of title I of ERISA, and title XXVII of the PHS Act.

These final rules address specific issues that are critical to ensuring that consumers can clearly distinguish STLDI and fixed indemnity excepted benefits coverage from comprehensive coverage and make better informed decisions about the coverage they chose to purchase. As discussed earlier in this RIA, STLDI and fixed indemnity insurance tend to offer limited benefits and have relatively low actuarial values when compared to comprehensive coverage. Because STLDI and fixed indemnity insurance are sold outside of the Exchanges and are generally not subject to the Federal consumer protections and requirements for comprehensive coverage, consumers may have limited information about the limitations, value, and quality of the coverage being sold, and it might be mistakenly viewed as a substitute for comprehensive coverage.

Generally, these final rules revise the Federal definition of STLDI for new policies, certificates, or contracts of insurance to limit their term to 3 months and maximum duration, within a 12-month period, to 4 months. Additionally, these final rules further revise the Federal definition of STLDI and amend the regulations regarding fixed indemnity excepted benefits coverage to provide that a notice for both new and existing STLDI and fixed indemnity excepted benefits coverage must be prominently displayed (in either paper or electronic form) on the first page of any marketing, application, and enrollment (or reenrollment) materials, as described in this preamble at sections III.A.5 and III.B.1.

These final rules will support the goals of the ACA by increasing access to affordable and comprehensive health coverage, strengthening health insurance markets, and promote better consumer understanding of coverage options.

#### 2. Number of Affected Small Entities as Defined by the Regulatory Flexibility Act

The provisions in these final rules will affect issuers of STLDI, issuers of fixed indemnity excepted benefits coverage, and agents and brokers selling STLDI and fixed indemnity excepted benefits coverage. For purposes of analysis under the RFA, the Departments consider issuers of STLDI and issuers of fixed indemnity excepted benefits coverage that have average annual receipts of \$47 million or less as small entities. Health insurance issuers are generally classified under the North American Industry Classification System (NAICS) code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards,<sup>345</sup> entities with average annual receipts of \$47 million or less are considered small entities for this NAICS code. The Departments expect that few, if any, insurance companies underwriting health insurance policies fall below these size thresholds. Based on data from MLR annual report submissions for the 2021 MLR reporting year, approximately 87 out of 483 issuers of health insurance coverage nationwide had total premium revenue of \$47 million or less.<sup>346</sup> However, it should be noted that over 77 percent of these small companies belong to larger holding groups, and many, if not all, of these small companies are likely to have non-health lines of business that will result in their revenues exceeding \$47 million. The Departments expect this to be the case for issuers of STLDI and fixed indemnity excepted benefits coverage. As noted earlier in this RIA, the Departments are unable to precisely determine how many small issuers of STLDI and fixed indemnity excepted benefits coverage will be affected by these final rules. Nevertheless, the Departments note that the NAIC reported that there were at least 28 issuers of STLDI in the individual market across

<sup>345</sup> Small Business Administration (2023). “Table of Size Standards (last updated March 2023),” available at: <https://www.sba.gov/document/support-table-size-standards>.

<sup>346</sup> Based on internal calculations. Source: CMS, Medical Loss Ratio Data and System Resources, available at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

the U.S. in 2022 and at least 93 issuers of “other non-comprehensive coverage” (including fixed indemnity insurance) in the individual market across the U.S. in 2022.<sup>347</sup> Data regarding issuers of STLDI and “other medical (non-comprehensive)” coverage are only available for the individual market. The Departments have identified 2 issuers of STLDI and 3 issuers of fixed indemnity insurance that fall below the \$47 million threshold and could potentially be impacted by these final rules.<sup>348</sup> These issuers will incur costs associated with the notice provisions and could also incur one-time costs to modify their products to comply with the provisions for STLDI and fixed indemnity excepted benefits coverage that are being finalized in these final rules and to file amended marketing materials and plan documents with State departments of insurance, as discussed further in section V.E.3 of this preamble. The Departments solicited comments on the number of small issuers of STLDI and the number of small issuers of fixed indemnity excepted benefits coverage but did not receive any additional information to inform the analysis.

For purposes of analysis under the RFA, the Departments consider agents and brokers that have average annual receipts of \$15 million or less as small entities. Agents and brokers are classified under NAICS code 524210 (Insurance Agencies and Brokerages), with a size standard of \$15 million or less. These rules may affect agents and brokers if there is an impact on enrollment in STLDI or fixed indemnity excepted benefits products. There is the potential for the agent and broker compensation<sup>349</sup> associated with the sale of STLDI and fixed indemnity excepted benefits coverage to be negatively affected if there is a reduction in sales of that coverage. There is also the potential for agent and broker compensation associated with the sale of individual health insurance coverage to be positively affected if there is an increase in sales

of that coverage. However, due to a lack of data, the Departments were unable to precisely estimate how many agents and brokers might be affected by the 2023 proposed rules and the magnitudes of the potential changes in compensation.<sup>350</sup> The Departments solicited comments on the number of agents and brokers who sell STLDI, fixed indemnity excepted benefits coverage, and individual health insurance coverage, respectively, and how their compensation might be affected by the 2023 proposed rules. Many commenters stated that the financial impacts of the proposed Federal definitions for STLDI and fixed indemnity excepted benefits coverage on agents and brokers would be significant, particularly given the relatively low commission rates that agents and brokers receive from the sale of Exchange plans as compared to STLDI and fixed indemnity insurance. Another commenter stated that the regulatory flexibility analysis lacked sufficient data to account for the potential impacts on agents and brokers. Commenters did not provide additional information on the number of agents and brokers that sell STLDI and fixed indemnity insurance or data that would assist in quantifying the impact of these final rules on agents and brokers. As noted throughout this preamble, and discussed in section V.B.2.f of this preamble, due to a lack of data and information, there are several areas of uncertainty regarding the potential market impacts of these final rules. As a result, there is also some uncertainty about the potential impact on the compensation of agents and brokers.

To summarize, there is some uncertainty about the impacts of these rules on the revenue of issuers of STLDI and fixed indemnity excepted benefits coverage and the compensation of agents and brokers selling STLDI and fixed indemnity insurance. Nevertheless, the Departments acknowledge that to comply with these final rules, issuers of STLDI fixed indemnity excepted benefits coverage will

incur a cost and that agents and brokers may be impacted by these final rules due to the potential impacts on enrollment in STLDI or fixed indemnity excepted benefits products. A brief discussion of the regulatory alternatives is found in section V.E.4 of this preamble and a more detailed discussion of the regulatory alternatives considered is found in section V.C of this preamble.

### 3. Compliance Requirements and Costs

As discussed in section V.B.2.h of this preamble, the Departments estimate the one-time cost to review these final rules will be approximately \$438 per entity (6 hours x \$73.06). As noted in section V.B.2.d of this preamble, the Departments acknowledge that issuers will also incur one-time costs to modify their products to comply with the provisions for STLDI and fixed indemnity excepted benefits coverage that are being finalized in these rules and filing amended marketing materials and plan documents with State departments of insurance. These costs are expected to vary by issuer depending on the number of States in which they offer products, the number of products they offer, and the overall scale of their operations.<sup>351</sup> Issuers of STLDI and fixed indemnity excepted benefits coverage will incur costs associated with the notice provisions in these final rules, which the Departments estimate to be approximately \$1,066 per issuer,<sup>352</sup> as described in section V.B.2.d of this preamble.

### 4. Duplication, Overlap, and Conflict with Other Rules and Regulations

The Departments do not anticipate any duplication, overlap, or conflict with other rules and regulations associated with these rules. These rules revise current regulations to ensure that consumers can clearly distinguish STLDI and fixed indemnity

<sup>347</sup> *Id.*

<sup>348</sup> This was informed by a review of issuers’ financial records ranging from 2018-2022.

<sup>349</sup> Compensation includes commissions, fees, or other incentives (for example, rewards or bonuses) as established in the relevant contract between an issuer and the agent or broker.

<sup>350</sup> Previously, in 86 FR 51730, 51756, the Departments noted that a total of 55,541 agents and brokers work with issuers. Many of these agents and brokers are likely to be employed by small entities.

<sup>351</sup> The Departments do not have enough data or information to quantify these costs.

<sup>352</sup> (4 business operation specialist hours \* \$73.06) + (4 administrative assistant hours \* \$42.38) + (8 web developer hours \* \$75.96) = \$1,066.24.



excepted benefits coverage from comprehensive coverage.

## 5. Significant Alternatives

The regulatory alternatives considered in developing these rules are discussed in section V.C of this preamble. The Departments are of the view that none of these alternatives would both achieve the policy objectives and goals of these final rules as previously stated and be less burdensome to small entities. The Departments did receive comments on alternative timelines for issuers to comply with the requirements (including small entities). The Departments decided to delay the applicability dates for certain provisions to provide more time for issuers (including small entities) to modify their products and implement the required changes while still achieving the objectives of these final rules. For a more detailed discussion of the regulatory alternatives considered, please refer to section V.C of this preamble.

## 6. Impact on Small Rural Hospitals

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. The Departments welcomed comments on this and did not receive any comments specifically regarding the impact of the provisions proposed in the 2023 proposed rules on small rural hospitals. Many commenters did note that the provisions proposed in the 2023 proposed rules could increase the potential number of uninsured individuals and a few commenters indicated that hospitals may find themselves treating more uninsured patients that are unable to pay for the services rendered. While these final rules are not subject to section 1102 of the Social Security Act, the Departments are of the view that these final rules will not have a significant impact on the operations of a substantial number of small rural hospitals.

## F. Special Analyses – Department of the Treasury

Pursuant to the Memorandum of Agreement, Review of Treasury Regulations under Executive Order 12866 (June 9, 2023), tax regulatory actions issued by the IRS are not subject to the requirements of section 6 of Executive Order 12866, as amended. Therefore, a regulatory impact assessment is not required. 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.

## G. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a rule that includes any Federal mandate that may result in expenditures in any 1 year by State, local, or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. That threshold is approximately \$183 million in 2024. As detailed in section V.B.2.d of this preamble, the combined impact on State, local, or Tribal governments and the private sector is not expected to be above the \$183 million threshold.

## H. Federalism

Executive Order 13132 establishes certain requirements that Federal agencies must meet when they issue rules that impose substantial direct costs on State and local governments, preempt State law, or otherwise have federalism implications.

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 participating in conference calls with and attending conferences of the NAIC.

In the Departments' view, these final rules have Federalism implications because they may 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. Health insurance issuers offering STLDI and plans and issuers offering fixed indemnity excepted benefits coverage must meet the minimum Federal standards for such coverage not to be subject to the Federal consumer protections and requirements for comprehensive coverage. States with State requirements for STLDI or fixed indemnity excepted benefits coverage that do not follow the minimum Federal standards for such coverage, as amended by these final rules, may therefore choose to update their laws and regulations regarding STLDI or fixed indemnity excepted benefits coverage to align with the minimum Federal standards so that such coverage issued in the State is treated as exempt from the Federal consumer protections and requirements for comprehensive coverage.

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 sections 2724 and 2762 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 Federal consumer protections and requirements for comprehensive coverage 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.<sup>353</sup> The conference report accompanying HIPAA, when this Federal preemption standard was first established

<sup>353</sup> A similar preemption provision was established for the Exchange and other Federal health insurance requirements that are codified outside of title XXVII of the PHS Act. See sections 1311(k) and 1321(d) of the ACA.

for the requirements in title XXVII of the PHS Act, indicates that this is intended to be the “narrowest” preemption of State laws.<sup>354</sup>

These final rules define STLDI for purposes of the Code, ERISA, and the PHS Act. Insurance coverage that meets the definition of STLDI in these final rules will qualify for the exception to the Federal definition of individual health insurance coverage and be exempt from the Federal consumer protections and requirements applicable to comprehensive coverage.

Nothing in these final rules prevents regulation of STLDI for purposes of State law. For example, States may determine whether to permit the sale of STLDI in their insurance markets. If a State law permits or requires an action that is inconsistent with the Federal definition of STLDI, any coverage offered pursuant to that State law that does not meet the standards set forth in these final rules would not qualify as STLDI under Federal law and would be subject to the Federal consumer protections and requirements applicable to comprehensive coverage. For example, if a State were to prohibit policies issued in that State from including the Federal consumer notice, then coverage in that State that did not include the Federal consumer notice language would not qualify for the exclusion from the PHS Act definition of individual health insurance coverage and thus would be subject to the Federal consumer protections and requirements applicable to individual health insurance coverage.

Similarly, if a State law were to require the removal of language from the Federal consumer notice for fixed indemnity excepted benefits coverage finalized in these final rules, any policy issued in the State that did not include the Federal notice would not be considered fixed indemnity excepted benefits coverage for purposes of Federal law and thus would be subject to the Federal consumer protections and requirements applicable to comprehensive coverage.

Many commenters on the 2023 proposed rules discussed the federalism implications of the proposed provisions for STLDI and fixed indemnity excepted benefits coverage, as discussed in sections III.A.1 and III.B.1, respectively of this preamble.

The Departments continue to be of the view that there is a need for action regarding STLDI and fixed indemnity excepted benefits coverage at the Federal level given, among other factors, the need to promote consumer understanding of coverage options and ensure consumers do not mistakenly enroll in STLDI and fixed indemnity excepted benefits coverage as a substitute for comprehensive coverage, the prevalence of aggressive and deceptive sales and marketing practices, reports of increased enrollment in STLDI through out-of-State associations, and the potential inability of States to regulate and collect information about these associations.<sup>355</sup>

While developing these final rules, the Departments have attempted to balance States’ interests in regulating health insurance issuers and their health insur-

ance markets with Congress’ intent to establish a general Federal framework for health insurance coverage, including the provision of certain key, uniform minimum protections to consumers enrolled in comprehensive coverage in every State. It is the Departments’ view that by doing so they have complied with the requirements of Executive Order 13132.

### *I. Congressional Review Act*

Pursuant to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996 (also known as the Congressional Review Act, 5 U.S.C. 801 et seq.), OIRA has determined that this rule meets the criteria set forth in 5 U.S.C. 804(2). Accordingly, this rule has been transmitted to the Congress and the Comptroller General for review.

**Heather C. Maloy,**

*Acting Deputy Commissioner for Services and Enforcement, Internal Revenue Service.*

**Aviva Aron-Dine,**

*Acting Assistant Secretary (Tax Policy), Department of the Treasury.*

**Lisa M. Gomez,**

*Assistant Secretary, Employee Benefits Security Administration, Department of Labor.*

**Xavier Becerra,**

*Secretary, Department of Health and Human Services.*

<sup>354</sup> See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018 and available at: <https://www.congress.gov/congressional-report/104th-congress/house-report/736/1>.

<sup>355</sup> Keith, Katie (2020). “New Congressional Investigation of Short-Term Plans,” *Health Affairs*, available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20200626.227261/full/>. See also Curran, Emily, Dania Palanker, and Sabrina Corlette (2019). “Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections,” Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2019/short-term-health-plans-sold-through-out-state-associations-threaten-consumer-protections>.

**List of Subjects**

*26 CFR Part 54*

Excise taxes, Health care, Pensions, Reporting and recordkeeping requirements.

*29 CFR Part 2590*

Child support, Employee benefit plans, Health care, Health insurance, Infants and children, Maternal and child health, Penalties, Pensions, Privacy, Reporting and recordkeeping requirements.

*45 CFR Parts 144 and 146*

Health care, Health insurance, Reporting and recordkeeping requirements.

*45 CFR Part 148*

Administrative practice and procedure, Health care, Health insurance, Insurance companies, Penalties, Reporting and recordkeeping requirements.

**DEPARTMENT OF THE TREASURY**

**Internal Revenue Service 26 CFR Part 54**

For the reasons stated in the preamble, the Department of the Treasury and the IRS amend 26 CFR part 54 as set forth below:

**PART 54—PENSION AND EXCISE TAX**

1. The general authority citation for part 54 continues to read as follows: Authority: 26 U.S.C. 7805, unless otherwise noted.  
\*\*\*\*\*

2. Section 54.9801-2 is amended by revising the definition of “Short-term, limited-duration insurance” to read as follows:

**§ 54.9801-2 Definitions.**

\*\*\*\*\*

*Short-term, limited-duration insurance* means health insurance coverage provided pursuant to a policy, certificate, or contract of insurance with an issuer that meets the conditions of paragraph (1) of this definition.

(1) *Short-term, limited-duration insurance* means health insurance coverage provided pursuant to a policy, certificate, or contract of insurance with an issuer that:

(i) Has an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date of the policy, certificate, or contract of insurance, and taking into account any renewals or extensions, has a duration no longer than 4 months in total. For purposes of this paragraph (1)(i), a renewal or extension includes the term of a new short-term, limited-duration insurance policy, certifi-

cate, or contract of insurance issued by the same issuer, or if the issuer is a member of a controlled group, any other issuer that is a member of such controlled group, to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance; and

(ii) Displays prominently on the first page (in either paper or electronic form, including on a website) of the policy, certificate, or contract of insurance, and in any marketing, application, and enrollment materials (including reenrollment materials) provided to individuals at or before the time an individual has the opportunity to enroll (or reenroll) in the coverage, in at least 14-point font, the language in the following notice:

**IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage**

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov.

<b>This policy</b>	<b>Insurance on HealthCare.gov</b>
<b>Might not cover you</b> due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
<b>Might not cover</b> things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have <b>no limit on what you pay</b> out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You <b>won't qualify</b> for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
<b>Doesn't have to meet</b> Federal standards for comprehensive health coverage	All plans must meet Federal standards

**Looking for comprehensive health insurance?**

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member’s job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners’ website ([naic.org](https://www.naic.org)) under “Insurance Departments.”

(2) For purposes of paragraph (1)(i) of this definition, the term “controlled group” means any group treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Code.

(3) If any provision of this definition is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such

holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of the definition and shall not affect the remainder thereof.

\*\*\*\*\*

3. Section 54.9831-1 is amended by adding paragraphs (c)(4)(ii)(D) and (c)(4)(iv) to read as follows:

**§ 54.9831-1 Special rules relating to group health plans.**

\*\*\*\*\*

(c) \*\*\*

(4) \*\*\*

(ii) \*\*\*

(D) For plan years beginning on or after January 1, 2025, with respect to hospital indemnity or other fixed indemnity insurance:

(1) The plan or issuer displays prominently on the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll in the coverage, in at least 14-point font, the language in the following notice:

**IMPORTANT: This is a fixed indemnity policy, NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you’re sick or hospitalized. You’re still responsible for paying the cost of your care.

- The payment you get isn’t based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn’t a substitute for comprehensive health insurance.
- Since this policy isn’t health insurance, it doesn’t have to include most Federal consumer protections that apply to health insurance.

**Looking for comprehensive health insurance?**

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member’s job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners’ website ([naic.org](https://www.naic.org)) under “Insurance Departments.”
- If you have this policy through your job, or a family member’s job, contact the employer.

(2) If participants are required to reenroll (in either paper or electronic form) for purposes of renewal or reissuance of the insurance, the notice described in paragraph (c)(4)(ii)(D)(I) of this section is prominently displayed in any marketing and reenrollment materials provided at or before the time participants are given the opportunity to reenroll in coverage.

(3) If a plan or issuer provides a notice satisfying the requirements in paragraphs

(c)(4)(ii)(D)(I) and (2) of this section to a participant, the obligation to provide the notice is considered to be satisfied for both the plan and issuer.

\*\*\*\*\*

(iv) *Severability.* If any provision of this paragraph (c)(4) is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue

to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of this paragraph (c)(4) and shall not affect the remainder thereof.

\*\*\*\*\*

4. Section 54.9833-1 is revised to read as follows:

**§ 54.9833-1 Applicability dates.**

Sections 54.9801-1 through 54.9801-6, and 54.9831-1 and this section are applicable for plan years beginning on or after July 1, 2005. Notwithstanding the previous sentence, for short-term, limited-duration insurance sold or issued on or after September 1, 2024, the definition of *short-term, limited-duration insurance* in § 54.9801-2 applies for coverage periods beginning on or after September 1, 2024. For short-term, limited-duration insurance sold or issued before September 1, 2024 (including any subsequent renewal or extension consistent with applicable law), the definition of *short-term, limited-duration insurance* in 26 CFR 54.9801-2, revised as of April 1, 2023, continues to apply, except that paragraph (2) of the definition of *short-term, limited-duration insurance* in § 54.9801-2 applies for coverage periods beginning on or after September 1, 2024.

**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**

5. The authority citation for part 2590 continues 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).

6. Section 2590.701-2 is amended by revising the definition of “Short-term, limited-duration insurance” to read as follows:

**§ 2590.701-2 Definitions.**

\*\*\*\*\*

*Short-term, limited-duration insurance* means health insurance coverage provided pursuant to a policy, certificate, or contract of insurance with an issuer that meets the conditions of paragraph (1) of this definition.

(1) *Short-term, limited-duration insurance* means health insurance coverage provided pursuant to a policy, certificate,

or contract of insurance with an issuer that:

(i) Has an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date of the policy, certificate, or contract of insurance, and taking into account any renewals or extensions, has a duration no longer than 4 months in total. For purposes of this paragraph (1)(i), a renewal or extension includes the term of a new short-term, limited-duration insurance policy, certificate, or contract of insurance issued by the same issuer, or if the issuer is a member of a controlled group, any other issuer that is a member of such controlled group, to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance; and

(ii) Displays prominently on the first page (in either paper or electronic form, including on a website) of the policy, certificate, or contract of insurance, and in any marketing, application, and enrollment materials (including reenrollment materials) provided to individuals at or before the time an individual has the opportunity to enroll (or reenroll) in the coverage, in at least 14-point font, the language in the following notice:

**IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage**

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov.

<b>This policy</b>	<b>Insurance on HealthCare.gov</b>
<b>Might not cover you</b> due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can’t deny you coverage due to preexisting health conditions
<b>Might not cover</b> things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have <b>no limit on what you pay</b> out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You <b>won’t qualify</b> for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
<b>Doesn’t have to meet</b> Federal standards for comprehensive health coverage	All plans must meet Federal standards

**Looking for comprehensive health insurance?**

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member’s job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners’ website ([naic.org](https://www.naic.org)) under “Insurance Departments.”

(2) For purposes of paragraph (1)(i) of this definition, the term “controlled group” means any group treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended.

(3) If any provision of this definition is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or

to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of the definition and shall not affect the remainder thereof.

\*\*\*\*  
7. Section 2590.732 is amended by adding paragraphs (c)(4)(ii)(D) and (c)(4)(iv) to read as follows:

**§ 2590.732 Special rules relating to group health plans.**

\*\*\*\*  
(c)\*\*\*

(4)\*\*\*  
(ii)\*\*\*

(D) For plan years beginning on or after January 1, 2025, with respect to hospital indemnity or other fixed indemnity insurance:

(1) The plan or issuer displays prominently on the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll in the coverage, in at least 14-point font, the language in the following notice:

**IMPORTANT: This is a fixed indemnity policy, NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you’re sick or hospitalized. You’re still responsible for paying the cost of your care.

- The payment you get isn’t based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn’t a substitute for comprehensive health insurance.
- Since this policy isn’t health insurance, it doesn’t have to include most Federal consumer protections that apply to health insurance.

**Looking for comprehensive health insurance?**

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member’s job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners’ website ([naic.org](https://www.naic.org)) under “Insurance Departments.”
- If you have this policy through your job, or a family member’s job, contact the employer.

(2) If participants are required to reenroll (in either paper or electronic form) for purposes of renewal or reissuance of the insurance, the notice described in paragraph (c)(4)(ii)(D)(I) of this section is prominently displayed in any marketing and reenrollment materials provided at or before the time participants are given the opportunity to reenroll in coverage.

(3) If a plan or issuer provides a notice satisfying the requirements in paragraphs (c)(4)(ii)(D)(I) and (2) of this section to a participant, the obligation to provide the

notice is considered to be satisfied for both the plan and issuer.

\*\*\*\*  
(iv) *Severability*. If any provision of this paragraph (c)(4) is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circum-

stances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of this paragraph (c)(4) and shall not affect the remainder thereof.

\*\*\*\*  
8. Section 2590.736 is revised to read as follows:

**§ 2590.736 Applicability dates.**

Sections 2590.701–1 through 2590.701–8 and 2590.731 through

2590.736 are applicable for plan years beginning on or after July 1, 2005. Notwithstanding the previous sentence, for short-term, limited-duration insurance sold or issued on or after September 1, 2024, the definition of *short-term, limited-duration insurance* in § 2590.701–2 applies for coverage periods beginning on or after September 1, 2024. For short-term, limited-duration insurance sold or issued before September 1, 2024 (including any subsequent renewal or extension consistent with applicable law), the definition of *short-term, limited-duration insurance* in 29 CFR 2590.701–2, revised as of July 1, 2023, continues to apply, except that paragraph (1)(ii) of the definition of *short-term, limited-duration insurance* in § 2590.701–2 applies for coverage periods beginning on or after September 1, 2024.

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**45 CFR Subtitle A**

For the reasons stated in the preamble, the Department of Health and Human Services amends 45 CFR parts 144, 146, and 148 as set forth below:

**PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE**

9. The authority citation for part 144 continues to read as follows:

**Authority:** 42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92, and 300gg–111 through 300gg–139, as amended.

10. Section 144.103 is amended by revising the definition of “Short-term, limited-duration insurance” to read as follows:

**§ 144.103 Definitions.**

\*\*\*\*\*

*Short-term, limited-duration insurance* means health insurance coverage provided pursuant to a policy, certificate, or contract of insurance with an issuer that meets the conditions of paragraph (1) of this definition.

(1) *Short-term, limited-duration insurance* means health insurance coverage provided pursuant to a policy, certificate, or contract of insurance with an issuer that:

(i) Has an expiration date specified in the policy, certificate, or contract of

insurance that is no more than 3 months after the original effective date of the policy, certificate, or contract of insurance, and taking into account any renewals or extensions, has a duration no longer than 4 months in total. For purposes of this paragraph (1)(i), a renewal or extension includes the term of a new short-term, limited-duration insurance policy, certificate, or contract of insurance issued by the same issuer, or if the issuer is a member of a controlled group, any other issuer that is a member of such controlled group, to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance; and

(ii) Displays prominently on the first page (in either paper or electronic form, including on a website) of the policy, certificate, or contract of insurance, and in any marketing, application, and enrollment materials (including reenrollment materials) provided to individuals at or before the time an individual has the opportunity to enroll (or reenroll) in the coverage, in at least 14-point font, the language in the following notice:

**IMPORTANT: This is a short-term, limited-duration policy, NOT comprehensive health coverage**

This is a temporary limited policy that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov.

<b>This policy</b>	<b>Insurance on HealthCare.gov</b>
<b>Might not cover you</b> due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
<b>Might not cover</b> things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have <b>no limit on what you pay</b> out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You <b>won't qualify</b> for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
<b>Doesn't have to meet</b> Federal standards for comprehensive health coverage	All plans must meet Federal standards

**Looking for comprehensive health insurance?**

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website ([naic.org](https://www.naic.org)) under “Insurance Departments.”

(2) For purposes of paragraph (1)(i) of this definition, the term “controlled group” means any group treated as a single employer under section 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended.

(3) If any provision of this definition is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of the definition and shall not affect the remainder thereof.

\*\*\*\*\*

### PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

11. The authority citation for part 146 continues to read as follows:

**Authority:** 42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92.

12. Section 146.125 is revised to read as follows:

#### § 146.125 Applicability dates.

Section 144.103 of this subchapter and §§ 146.111 through 146.119, 146.143, and 146.145 are applicable for plan years beginning on or after July 1, 2005. Notwithstanding the previous sentence, for short-term, limited-duration insurance sold or issued on or after September 1, 2024, the definition of *short-term, limited-duration insurance* in § 144.103 of this subchapter applies for coverage periods beginning on or after September 1, 2024. For short-term, limited-duration insurance sold or issued before September 1, 2024 (including any subsequent renewal or extension consistent with applicable law), the definition of *short-term, limited-duration insurance* in 45 CFR 144.103, revised as of October 1, 2023, continues to apply, except that paragraph (1)(ii) of the definition of *short-term, limited-duration insurance* in § 144.103 applies for coverage

periods beginning on or after September 1, 2024.

13. Section 146.145 is amended by adding paragraphs (b)(4)(ii)(D) and (b)(4)(iv) to read as follows:

#### § 146.145 Special rules relating to group health plans.

\*\*\*\*\*

(b) \*\*\*

(4) \*\*\*

(ii) \*\*\*

(D) For plan years beginning on or after January 1, 2025, with respect to hospital indemnity or other fixed indemnity insurance:

(1) The plan or issuer displays prominently on the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll in the coverage, in at least 14-point font, the language in the following notice:

### IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you’re sick or hospitalized. You’re still responsible for paying the cost of your care.

- The payment you get isn’t based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn’t a substitute for comprehensive health insurance.
- Since this policy isn’t health insurance, it doesn’t have to include most Federal consumer protections that apply to health insurance.

#### Looking for comprehensive health insurance?

- Visit [HealthCare.gov](https://www.healthcare.gov) or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member’s job, contact the employer.

#### Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners’ website ([naic.org](https://www.naic.org)) under “Insurance Departments.”
- If you have this policy through your job, or a family member’s job, contact the employer.

(2) If participants are required to reenroll (in either paper or electronic form) for purposes of renewal or reissuance of the insurance, the notice described in paragraph (b)(4)(ii)(D)(I) of this section is prominently displayed in any marketing and reenrollment materials provided at or before the time participants are

given the opportunity to reenroll in coverage.

(3) If a plan or issuer provides a notice satisfying the requirements in paragraphs (b)(4)(ii)(D)(I) and (2) of this section to a participant, the obligation to provide the notice is considered to be satisfied for both the plan and issuer.

\*\*\*\*\*

(iv) *Severability*. If any provision of this paragraph (b)(4) is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforce-



able, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of this paragraph (b)(4) and shall not affect the remainder thereof.

\* \* \* \* \*

**PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET**

14. The authority citation for part 148 continues to read as follows:

**Authority:** 42 U.S.C. 300gg through 300gg–63, 300gg–11 300gg–91, and 300–gg92, as amended.

15. Section 148.102 is amended by revising paragraph (b) to read as follows:

**§ 148.102 Scope and applicability dates.**

\* \* \* \* \*

(b) *Applicability dates.* Except as provided in §§ 148.124, 148.170, and 148.180, the requirements of this part apply to health

insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997. Notwithstanding the previous sentence, for short-term, limited-duration insurance sold or issued on or after September 1, 2024, the definition of *short-term, limited-duration insurance* in § 144.103 of this subchapter applies for coverage periods beginning on or after September 1, 2024. For short-term, limited-duration insurance sold or issued before September 1, 2024 (including any subsequent renewal or extension consistent with applicable law), the definition of *short-term, limited-duration insurance* in 45 CFR 144.103, revised as of October 1, 2023, continues to apply, except that paragraph (1)(ii) of the definition of *short-term, limited-duration insurance* in § 144.103 applies for coverage periods beginning on or after September 1, 2024.

16. Section 148.220 is amended by revising paragraph (b)(4) to read as follows:

**§ 148.220 Excepted benefits.**

\* \* \* \* \*

(b) \* \* \*

(4) Hospital indemnity or other fixed indemnity insurance only if—

(i) There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;

(ii) The benefits are paid in a fixed dollar amount per period of hospitalization or illness and/or per service (for example, \$100/day or \$50/visit) regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage; and

(iii)(A) For coverage periods beginning on or after January 1, 2025, the issuer displays prominently on the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment or reenrollment materials that are provided at or before the time an individual has the opportunity to apply, enroll or reenroll in coverage, and on the first page of the policy, certificate, or contract of insurance, in at least 14-point font, the language in the following notice:

**IMPORTANT: This is a fixed indemnity policy, NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you’re sick or hospitalized. You’re still responsible for paying the cost of your care.

- The payment you get isn’t based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn’t a substitute for comprehensive health insurance.
- Since this policy isn’t health insurance, it doesn’t have to include most Federal consumer protections that apply to health insurance.

**Looking for comprehensive health insurance?**

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member’s job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners’ website (naic.org) under “Insurance Departments.”
- If you have this policy through your job, or a family member’s job, contact the employer.

(B) For coverage periods beginning on or after January 1, 2015, and prior to January 1, 2025, the issuer continues to follow the notice provision in 45 CFR 148.220(b)(4)(iv), revised as of October 1, 2023.

(iv) If any provision of this paragraph (b)(4) is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending

further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in

which event the provision shall be severable from the remainder of this paragraph (b)(4) and shall not affect the remainder thereof.

\* \* \* \* \*

(Filed by the Office of the Federal Register March 28, 2024, 8:45 a.m., and published in the issue of the Federal Register for April 03, 2024, 89 FR 23338)

# Part III

## Certain Required Minimum Distributions for 2024

### Notice 2024-35

#### I. PURPOSE

This notice provides guidance relating to certain specified required minimum distributions (RMDs) for 2024. In addition, this notice announces that the final regulations that the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) intend to issue related to RMDs will apply for purposes of determining RMDs for calendar years beginning on or after January 1, 2025.

#### II. BACKGROUND

##### A. Section 401(a)(9)

Section 401(a)(9) of the Code requires a stock bonus, pension, or profit-sharing plan described in § 401(a) (or an annuity contract described in § 403(a)) to make minimum distributions starting by the required beginning date (as well as minimum distributions to beneficiaries if the employee dies before the required beginning date). Individual retirement accounts and individual retirement annuities (IRAs) described in § 408(a) and (b), annuity contracts, custodial accounts, and retirement income accounts described in § 403(b) (§ 403(b) plans), and eligible deferred compensation plans under § 457(b) are also subject to the rules of § 401(a)(9) pursuant to §§ 408(a)(6) and (b)(3), 403(b)(10), and 457(d)(2), respectively, and the regulations under those sections.

##### B. RMD Distribution Period

Section 401(a)(9) provides rules for RMDs from a qualified plan during the life of the employee in § 401(a)(9)(A) and after the death of the employee in § 401(a)(9)(B). In addition to setting forth a required beginning date for distributions, these rules identify the period over which the employee's entire interest must be distributed.

Specifically, § 401(a)(9)(A)(ii) provides that the entire interest of an employee in a qualified plan must be distributed, beginning not later than the employee's required beginning date, in accordance with regulations, over the life of the employee or over the lives of the employee and a designated beneficiary (or over a period not extending beyond the life expectancy of the employee and a designated beneficiary).

Section 401(a)(9)(B)(i) provides that, if the employee dies after distributions have begun, the employee's remaining interest must be distributed at least as rapidly as under the method of distributions being used by the employee under section 401(a)(9)(A)(ii) as of the date of the employee's death. Section 401(a)(9)(B)(ii) and (iii) provides that, if the employee dies before RMDs have begun, the employee's interest must either be: (1) distributed within 5 years after the death of the employee (5-year rule), or (2) distributed (in accordance with regulations) over the life or life expectancy of the designated beneficiary with the distributions beginning no later than 1 year after the date of the employee's death (subject to an exception in § 401(a)(9)(B)(iv) if the designated beneficiary is the employee's surviving spouse).

The rules of § 401(a)(9) are incorporated by reference in § 408(a)(6) and (b)(3) for IRAs, § 403(b)(10) for § 403(b) plans, and § 457(d) for eligible deferred compensation plans.

##### C. Section 401(a)(9)(H) as added by the SECURE Act

###### 1. Ten-year rule

Section 401(a)(9) of the Code was amended by § 401(a)(1) of the Setting Every Community Up for Retirement Enhancement Act of 2019 (SECURE Act), enacted on December 20, 2019, as Division O of the Further Consolidated Appropriations Act, 2020, Pub. L. 116-94, 133 Stat. 2534 (2019), to add § 401(a)(9)(H) to the Code. Generally, pursuant to § 401(a)(9)(H)(i), if an employee in a defined contribution plan has a design-

nated beneficiary, the 5-year period under the 5-year rule is lengthened to 10 years (10-year rule) and the 10-year rule applies regardless of whether the employee dies before the required beginning date. In addition, pursuant to § 401(a)(9)(H)(ii), the § 401(a)(9)(B)(iii) exception to the 10-year rule (under which the 10-year rule is treated as satisfied if distributions are paid over the designated beneficiary's lifetime or life expectancy) applies only if the designated beneficiary is an eligible designated beneficiary, as that term is defined in § 401(a)(9)(E)(ii).

Section 401(a)(9)(H)(iii) provides that when an eligible designated beneficiary dies before that individual's portion of the employee's interest in the plan has been entirely distributed, the beneficiary of the eligible designated beneficiary will be subject to a requirement that the remainder of that individual's portion be distributed within 10 years of the eligible designated beneficiary's death. In addition, § 401(a)(9)(E)(iii) provides that when an eligible designated beneficiary who is a minor child of the employee reaches the age of majority, that child will no longer be considered an eligible designated beneficiary and the remainder of that child's portion of the employee's interest in the plan must be distributed within 10 years of that date.

###### 2. Section 401(a)(9)(H) effective date

Section 401(b)(1) of the SECURE Act provides that, generally, the amendments made to § 401(a)(9)(H) of the Code apply to distributions with respect to employees who die after December 31, 2019. Pursuant to § 401(b)(2) and (3) of the SECURE Act, later effective dates apply for certain collectively bargained plans and governmental plans (as defined in § 414(d) of the Code).

Section 401(b)(4) of the SECURE Act provides that § 401(a)(9)(H) of the Code does not apply to payments under certain annuity contracts under which payment commenced (or the manner of payments was fixed) before December 20, 2019. Section 401(b)(5) of the SECURE Act provides that if an employee who participated in a plan died before § 401(a)(9)(H)

of the Code became effective with respect to the plan, and the employee's designated beneficiary died after that effective date, then that designated beneficiary is treated as an eligible designated beneficiary and § 401(a)(9)(H) applies to any beneficiary of that designated beneficiary.

#### *D. Excise tax under § 4974(a)*

Section 4974(a) provides that if the amount distributed during a year to a payee under any qualified retirement plan (as defined in § 4974(c)) or any eligible deferred compensation plan (as defined in § 457(b)) is less than that year's minimum required distribution (as defined in § 4974(b)), then an excise tax is imposed on the payee. Pursuant to § 302 of the SECURE 2.0 Act of 2022, enacted on December 29, 2022, as Division T of the Consolidated Appropriations Act, 2023, Pub. L. 117-328, 136 Stat. 4459 (2022), for taxable years beginning after December 29, 2022, this excise tax is equal to 25 percent of the amount by which the minimum required distribution for a year exceeds the amount actually distributed in that year. If a failure to take a minimum required distribution is corrected by the end of the correction window (generally, the end of the second year that begins after the year of the missed minimum required distribution), the excise tax is reduced from 25 percent to 10 percent.

#### *E. Section 401(a)(9) proposed regulations*

The Treasury Department and the IRS published proposed regulations regarding RMDs under § 401(a)(9) of the Code and related provisions in the Federal Register on February 24, 2022 (87 FR 10504), which provided that the regulations, when finalized, would apply beginning with the 2022 calendar year. Along with other matters, the proposed regulations address issues relating to the 10-year rule in § 401(a)(9)(H). Specifically, Prop. Reg. § 1.401(a)(9)-5(d)(1)(i) requires that, in the case of an employee who dies on or after the employee's required beginning date, distributions to the employee's beneficiaries for calendar years after the calendar year of the employee's death must satisfy § 401(a)(9)(B)(i). In addition, distributions to the employee's beneficiaries

must also satisfy § 401(a)(9)(B)(ii) (or if applicable, § 401(a)(9)(B)(iii)), taking into account § 401(a)(9)(E)(iii), (H)(ii), and (H)(iii).

In order to satisfy § 401(a)(9)(B)(i), the beneficiary of an employee who died after the employee's required beginning date must take an annual RMD beginning in the first calendar year after the calendar year of the employee's death. In order to satisfy § 401(a)(9)(B)(ii) (applied by substituting "10 years" for "5 years"), the remaining account balance must be distributed by the 10<sup>th</sup> calendar year after the calendar year of the employee's death (subject to an exception under § 401(a)(9)(B)(iii), if applicable). In order to satisfy both of those requirements, the proposed regulations generally provide that, in the case of an employee who dies after the employee's required beginning date with a designated beneficiary who is not an eligible designated beneficiary (and for whom the § 401(a)(9)(B)(iii) alternative to the 10-year rule is not applicable), annual RMDs must continue to be taken after the death of the employee, with a full distribution required by the end of the 10<sup>th</sup> calendar year following the calendar year of the employee's death.

In the case of a designated beneficiary who is an eligible designated beneficiary, the proposed regulations include an alternative to the 10-year rule under which annual lifetime or life expectancy payments would be made to the beneficiary beginning in the year following the year of the employee's death, in accordance with § 401(a)(9)(B)(iii). Under the proposed regulations, if an eligible designated beneficiary of an employee is using the lifetime or life expectancy payment alternative to the 10-year rule, then the eligible designated beneficiary (and, after the death of the eligible designated beneficiary, the beneficiary of the eligible designated beneficiary) would need to continue to take annual RMDs after the death of the employee (with the employee's entire interest distributed by no later than the 10<sup>th</sup> year after the year of the eligible designated beneficiary's death). The proposed regulations provide for similar treatment (that is, continued annual RMDs with a requirement that the employee's entire interest be distributed no later than the 10<sup>th</sup> year after a specified event) in the case of

a designated beneficiary who is a minor child of the employee (with the specified event being the child reaching the age of majority).

#### *F. Comments received by the Treasury Department and the IRS*

The Treasury Department and the IRS provided a 90-day comment period for the proposed regulations. Some individuals who are owners of inherited IRAs or are beneficiaries under defined contribution plans submitted comments indicating that they thought the new 10-year rule would apply differently than it would under the proposed regulations. Specifically, these commenters expected that, regardless of when an employee died, the 10-year rule would operate like the 5-year rule, such that there would not be any RMD due for a calendar year until the last year of the 5- or 10-year period following the specified event (the death of the employee, the death of the eligible designated beneficiary, or the attainment of the age of majority for the employee's child who is an eligible designated beneficiary). Commenters who are heirs or beneficiaries of individuals who died in 2020 explained that they did not take an RMD in 2021 and were unsure of whether they would be required to take an RMD in 2022. Commenters asserted that, if final regulations adopt the interpretation of the 10-year rule set forth in the proposed regulations, the Treasury Department and the IRS should provide transition relief for failure to take distributions that are RMDs due in 2021 or 2022 pursuant to § 401(a)(9)(H) in the case of the death of an employee (or designated beneficiary) in 2020 or 2021.

In response to the comments received on the proposed regulations, the Treasury Department and the IRS issued Notice 2022-53, 2022-45 IRB 437. Notice 2022-53 announced that the final regulations will apply no earlier than the 2023 distribution calendar year and provided guidance regarding certain amounts that were not paid in 2021 or 2022. Specifically, Notice 2022-53 provided that a defined contribution plan will not fail to be qualified for failing to make a specified RMD (as defined in section IV.C of that notice) in 2021 or 2022 and the taxpayer who

did not take a specified RMD will not be subject to the excise tax under § 4974 for failing to take the specified RMD. Subsequently, the Treasury Department and the IRS issued Notice 2023-54, 2023-31 IRB 382, which extended the relief in Notice 2022-53 to specified RMDs for 2023, and announced that the final regulations will apply no earlier than the 2024 distribution calendar year.

### III. APPLICABILITY DATE OF FINAL REGULATIONS

Final regulations regarding RMDs under § 401(a)(9) and related provisions are anticipated to apply for determining RMDs for calendar years beginning on or after January 1, 2025.

### IV. GUIDANCE FOR SPECIFIED RMDs FOR 2024

*A. Guidance for defined contribution plans that did not make a specified RMD.* A defined contribution plan that failed to make a specified RMD (as defined in section IV.C of this notice) will not be treated as having failed to satisfy § 401(a)(9) merely because it did not make that distribution.

*B. Guidance for certain taxpayers who did not take a specified RMD.* To the extent a taxpayer did not take a specified RMD (as defined in section IV.C of this notice), the IRS will not assert that an excise tax is due under § 4974.

*C. Definition of specified RMD.* For purposes of this notice, a specified RMD is any distribution that, under the interpretation included in the proposed regulations, would be required to be made pursuant to § 401(a)(9) in 2024 under a defined contribution plan or IRA that is subject to the rules of § 401(a)(9)(H) for the year in which the employee (or designated beneficiary) died if that payment would be required to be made to:

- a designated beneficiary of an employee under the plan (or IRA owner) if: (1) the employee (or IRA owner) died in 2020, 2021, 2022, or 2023, and on or after the employee's (or IRA owner's) required beginning date, and (2) the designated beneficiary is not using the lifetime or life expectancy payments exception under § 401(a)(9)(B)(iii); or

a beneficiary of an eligible designated beneficiary (including a designated beneficiary who is treated as an eligible designated beneficiary pursuant to § 401(b)(5) of the SECURE Act) if: (1) the eligible designated beneficiary died in 2020, 2021, 2022, or 2023, and (2) that eligible designated beneficiary was using the lifetime or life expectancy payments exception under § 401(a)(9)(B)(iii) of the Code.

### V. DRAFTING INFORMATION

The principal author of this notice is Jessica Weinberger of the Office of Associate Chief Counsel (Employee Benefits, Exempt Organizations, and Employment Taxes). For further information regarding this notice, contact Jessica Weinberger at (202) 317-6349 (not a toll-free number).

*26 CFR 601.105: Examination of returns and claims for refund; credit or abatement; determination of tax liability (Also: 842(b))*

## Rev. Proc. 2024-20

### SECTION 1. PURPOSE

This revenue procedure provides the domestic asset/liability percentages and domestic investment yields needed by foreign life insurance companies and foreign property and liability insurance companies to compute their minimum effectively connected net investment income under section 842(b) of the Internal Revenue Code for taxable years beginning after December 31, 2022. Instructions are provided for computing foreign insurance companies' liabilities for the estimated tax and installment payments of estimated tax for taxable years beginning after December 31, 2022. For more specific guidance regarding the computation of the amount of net investment income to be included by a foreign insurance company on its U.S. income tax return, see Notice 89-96, 1989-2 C.B. 417. For the domestic asset/liability percentage and domestic investment yield, as well as instructions for computing foreign insurance companies' liabilities for estimated tax and installment payments of estimated tax for taxable years beginning after December 31,

2021, see Rev. Proc. 2023-21, 2023-19 I.R.B. 837.

### SECTION 2. PERCENTAGES AND YIELDS

.01 DOMESTIC ASSET/LIABILITY PERCENTAGES FOR 2023. The Secretary determines the domestic asset/liability percentage separately for life insurance companies and property and liability insurance companies. For the first taxable year beginning after December 31, 2022, the relevant domestic asset/liability percentages are:

123.2 percent for foreign life insurance companies, and

207.3 percent for foreign property and liability insurance companies.

.02 DOMESTIC INVESTMENT YIELDS FOR 2023. The Secretary is required to prescribe separate domestic investment yields for foreign life insurance companies and for foreign property and liability insurance companies. For the first taxable year beginning after December 31, 2022, the relevant domestic investment yields are:

2.3 percent for foreign life insurance companies, and

2.7 percent for foreign property and liability insurance companies.

.03 SOURCE OF DATA FOR 2023. The section 842(b) percentages to be used for the 2023 taxable year are based on tax return data from the 2021 taxable year.

### SECTION 3. ESTIMATED TAXES

To compute estimated tax and the installment payments of estimated tax due for taxable years beginning after December 31, 2022, a foreign insurance company must compute its estimated tax payments by adding to its income other than net investment income the greater of (i) its net investment income as determined under section 842(b)(5) that is actually effectively connected with the conduct of a trade or business within the United States for the relevant period, or (ii) the minimum effectively connected net investment income under section 842(b) that would result from using the most recently available domestic asset/liability percentage and domestic investment yield. Thus, for installment payments due

after the publication of this revenue procedure, the domestic asset/liability percentages and the domestic investment yields provided in this revenue procedure must be used to compute the minimum effectively connected net investment income. However, if the due date of an installment is less than 20 days after the date this revenue procedure is published in the Internal Revenue Bulletin, the asset/liability percentages and domestic investment yields provided in Rev. Proc. 2023-21 may be used to compute the minimum effectively connected net investment income for such installment. For further guidance in computing estimated tax, see Notice 89-96.

#### SECTION 4. EFFECTIVE DATE

This revenue procedure is effective for taxable years beginning after December 31, 2022.

#### SECTION 5. DRAFTING INFORMATION

The principal author of this revenue procedure is Sheila Ramaswamy of the Office of Associate Chief Counsel (International). For further information regarding this revenue procedure contact Sheila Ramaswamy at (202) 317-6938 (not a toll-free number).

*26 CFR 601.601: Rules and Regulations  
(Also Part 1, §§ 25, 143, 6a.103A-1(b)(4), 6a.103A-2(f)(5).)*

## Rev. Proc. 2024-21

#### SECTION 1. PURPOSE

This revenue procedure provides issuers of qualified mortgage bonds, as defined in § 143(a) of the Internal Revenue Code (Code), and issuers of mortgage credit certificates, as defined in § 25(c), with (1) the nationwide average purchase price for residences located in the United States, and (2) average area purchase price safe harbors for residences located in statistical areas in each state, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, the Virgin Islands, and Guam. Section 7 of this revenue procedure requests comments on the

available data and method used for calculating the average area purchase price safe harbors.

#### SECTION 2. BACKGROUND

.01 Section 103(a) provides that, except as provided in § 103(b), gross income does not include interest on any State or local bond. Section 103(b)(1) provides that § 103(a) shall not apply to any private activity bond that is not a “qualified bond” within the meaning of § 141. Section 141(e) provides, in part, that the term “qualified bond” means any private activity bond if such bond (1) is a qualified mortgage bond under § 143, (2) meets the volume cap requirements under § 146, and (3) meets the applicable requirements under § 147.

.02 Section 143(a)(1) provides that the term “qualified mortgage bond” means a bond that is issued as part of a qualified mortgage issue. Section 143(a)(2)(A) provides that the term “qualified mortgage issue” means an issue of one or more bonds by a State or political subdivision thereof, but only if: (i) all proceeds of the issue (exclusive of issuance costs and a reasonably required reserve) are to be used to finance owner-occupied residences; (ii) the issue meets the requirements of subsections (c), (d), (e), (f), (g), (h), (i), and (m)(7) of § 143; (iii) the issue does not meet the private business tests of paragraphs (1) and (2) of § 141(b); and (iv) with respect to amounts received more than 10 years after the date of issuance, repayments of \$250,000 or more of principal on mortgage financing provided by the issue are used by the close of the first semiannual period beginning after the date the prepayment (or complete repayment) is received to redeem bonds that are part of the issue.

##### *Average Area Purchase Price*

.03 Section 143(e)(1) provides that an issue of bonds meets the purchase price requirements of § 143(e) if the acquisition cost of each residence financed by the issue does not exceed 90 percent of the average area purchase price applicable to such residence. Section 143(e)(5) provides that, in the case of a targeted area residence (as defined in § 143(j)), § 143(e)(1) shall be applied by substituting 110 percent for 90 percent.

.04 Section 143(e)(2) provides that the term “average area purchase price” means, with respect to any residence, the average purchase price of single-family residences (in the statistical area in which the residence is located) that were purchased during the most recent 12-month period for which sufficient statistical information is available. Under §§ 143(e)(3) and (4), respectively, separate determinations of average area purchase price are to be made for new and existing residences, and for two-, three-, and four-family residences.

.05 Section 143(e)(2) also provides that the determination of the average area purchase price shall be made as of the date on which the commitment to provide the financing is made or, if earlier, the date of the purchase of the residence.

.06 Section 143(k)(2)(A) provides that the term “statistical area” means (i) a metropolitan statistical area (MSA), and (ii) any county (or the portion thereof) that is not within an MSA. Section 143(k)(2)(C) further provides that if sufficient recent statistical information with respect to a county (or portion thereof) is unavailable, the Secretary may substitute another area for which there is sufficient recent statistical information for such county (or portion thereof). In the case of any portion of a State which is not within a county, § 143(k)(2)(D) provides that the Secretary may designate an area that is the equivalent of a county. Section 6a.103A-1(b)(4)(i) of the Income Tax Regulations (issued under § 103A of the Internal Revenue Code of 1954, the predecessor of § 143 of the Code) provides that the term “State” includes a possession of the United States and the District of Columbia.

.07 Section 6a.103A-2(f)(5)(i) provides that an issuer may rely upon the average area purchase price safe harbors published by the Department of the Treasury (Treasury Department) for the statistical area in which a residence is located. Section 6a.103A-2(f)(5)(i) further provides that an issuer may use an average area purchase price limitation different from the published safe harbor if the issuer has more accurate and comprehensive data for the statistical area.

*Qualified Mortgage Credit Certificate Program*

.08 Section 25(c) permits a State or political subdivision thereof to establish a qualified mortgage credit certificate program. In general, a qualified mortgage credit certificate program is a program under which the issuing authority elects not to issue an amount of private activity bonds that it may otherwise issue during the calendar year under § 146, and in its place, issues mortgage credit certificates to taxpayers in connection with the acquisition of their principal residences. Section 25(a)(1) provides, in general, that the holder of a mortgage credit certificate may claim a federal income tax credit equal to the product of the credit rate specified in the certificate and the interest paid or accrued during the tax year on the remaining principal of the indebtedness incurred to acquire the residence. Section 25(c)(2)(A)(iii)(III) generally provides that residences acquired in connection with the issuance of mortgage credit certificates must meet the purchase price requirements of § 143(e).

#### *Income Limitations for Qualified Mortgage Bonds and Mortgage Credit Certificates*

.09 Section 143(f) imposes limitations on the income of mortgagors for whom financing may be provided by qualified mortgage bonds. In addition, § 25(c)(2)(A)(iii)(IV) provides that holders of mortgage credit certificates must meet the income requirement of § 143(f). Generally, under §§ 143(f)(1) and 25(c)(2)(A)(iii)(IV), the income requirement is met only if all owner-financing under a qualified mortgage bond and all mortgage credit certificates issued under a qualified mortgage credit certificate program are provided to mortgagors whose family income is 115 percent or less of the applicable median family income. Section 143(f)(5), however, generally provides for an upward adjustment to the percentage limitation in high housing cost areas. High housing cost areas are defined in § 143(f)(5)(C) as any statistical area for which the housing cost/income ratio is greater than 1.2.

.10 Under § 143(f)(5)(D), the housing cost/income ratio with respect to any statistical area is determined by dividing (a) the applicable housing price ratio for such area by (b) the ratio that the area median gross income for such area bears

to the median gross income for the United States. The applicable housing price ratio is the new housing price ratio (new housing average area purchase price divided by the new housing average purchase price for the United States) or the existing housing price ratio (existing housing average area purchase price divided by the existing housing average purchase price for the United States), whichever results in the housing cost/income ratio being closer to 1.

#### *Average Area and Nationwide Purchase Price Limitations*

.11 Average area purchase price safe harbors for each state, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, the Virgin Islands, and Guam were last published in Rev. Proc. 2023-22, 2023-19 I.R.B. 838.

.12 The nationwide average purchase price was last published in section 4.02 of Rev. Proc. 2023-22. Guidance with respect to the United States and area median gross income figures that are used in computing the housing cost/income ratio described in § 143(f)(5) was published in Rev. Proc. 2021-19, 2021-15 I.R.B. 1008.

.13 This revenue procedure uses Federal Housing Administration (FHA) loan limits for a given statistical area to calculate the average area purchase price safe harbor for that area. FHA sets limits on the dollar value of loans it will insure based on median home prices and conforming loan limits established by the Federal Home Loan Mortgage Corporation. In particular, FHA sets an area's loan limit at 95 percent of the median home sales price for the area, subject to certain floors and caps measured against conforming loan limits.

.14 To calculate the average area purchase price safe harbors in this revenue procedure, the FHA loan limits are adjusted to take into account the differences between average and median purchase prices. Because FHA loan limits do not differentiate between new and existing residences, this revenue procedure contains a single average area purchase price safe harbor for both new and existing residences in a statistical area.

.15 The average area purchase price safe harbors listed in section 4.01 of this revenue procedure are based on FHA loan limits released November 28, 2023. FHA loan limits are available for statis-

tical areas in each state, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, the Virgin Islands, and Guam. See section 3.03 of this revenue procedure with respect to FHA loan limits revised after November 28, 2023.

.16 OMB Bulletin No. 03-04, dated and effective June 6, 2003, revised the definitions of the nation's metropolitan areas and recognized 49 new metropolitan statistical areas. The OMB bulletin no longer includes primary metropolitan statistical areas.

### **SECTION 3. APPLICATION**

#### *Average Area Purchase Price Safe Harbors*

.01 Average area purchase price safe harbors for statistical areas in each state, the District of Columbia, Puerto Rico, the Northern Mariana Islands, American Samoa, the Virgin Islands, and Guam are set forth in section 4.01 of this revenue procedure. Average area purchase price safe harbors are provided for single-family and two to four-family residences. For each type of residence, section 4.01 of this revenue procedure contains a single safe harbor that may be used for both new and existing residences. Issuers of qualified mortgage bonds and issuers of mortgage credit certificates may rely on these safe harbors to satisfy the requirements of §§ 143(e) and (f). Section 4.01 of this revenue procedure provides safe harbors for MSAs and for certain counties and county equivalents. If no purchase price safe harbor is available for a statistical area, the safe harbor for "ALL OTHER AREAS" may be used for that statistical area.

.02 If a residence is in an MSA, the safe harbor applicable to it is the limitation of that MSA. If an MSA falls in more than one state, the MSA is listed in section 4.01 of this revenue procedure under each state.

.03 If the FHA revises the FHA loan limit for any statistical area after November 28, 2023, an issuer of qualified mortgage bonds or mortgage credit certificates may use the revised FHA loan limit for that statistical area to compute (as provided in the next sentence) a revised average area purchase price safe harbor for the statistical area provided that the issuer maintains records evidencing the revised FHA loan

limit. The revised average area purchase price safe harbor for that statistical area is computed by dividing the revised FHA loan limit by 0.878.

.04 If, pursuant to § 6a.103A-2(f)(5)(i), an issuer uses more accurate and comprehensive data to determine the average area purchase price for a statistical area, the issuer must make separate average area purchase price determinations for new and existing residences. Moreover, when computing the average area purchase price for a statistical area that is an MSA, as defined in OMB Bulletin No. 23-01, the issuer must make the computation for the entire applicable MSA. When computing the average area purchase price for a statistical area that is not an MSA, the issuer must make the computation for the entire statistical area and may not combine statistical areas. Thus, for example, the issuer may not combine two or more counties.

.05 If an issuer receives a ruling permitting it to rely on an average area purchase price limitation that is higher than the applicable safe harbor in this revenue procedure, the issuer may rely on that

higher limitation for the purpose of satisfying the requirements of §§ 143(e) and (f) for bonds sold, and mortgage credit certificates issued, not more than 30 months following the termination date of the 12-month period used by the issuer to compute the limitation.

*Nationwide Average Purchase Price*

.06 Section 4.02 of this revenue procedure sets forth a single nationwide average purchase price for purposes of computing the housing cost/income ratio under § 143(f)(5).

.07 Issuers must use the nationwide average purchase price set forth in section 4.02 of this revenue procedure when computing the housing cost/income ratio under § 143(f)(5) regardless of whether they are relying on the average area purchase price safe harbors contained in this revenue procedure or using more accurate and comprehensive data to determine average area purchase prices for new and existing residences for a statistical area that are different from the published safe harbors in this revenue procedure.

.08 If, pursuant to section 6.02 of this revenue procedure, an issuer relies on the

average area purchase price safe harbors contained in Rev. Proc. 2023-22, the issuer must use the nationwide average purchase price set forth in section 4.02 of Rev. Proc. 2023-22 in computing the housing cost/income ratio under § 143(f)(5). Likewise, if, pursuant to section 6.04 of this revenue procedure, an issuer relies on the nationwide average purchase price published in Rev. Proc. 2023-22, the issuer must use the average area purchase price safe harbors set forth in section 4.01 of Rev. Proc. 2023-22 in computing the housing cost/income ratio under § 143(f)(5).

**SECTION 4. AVERAGE AREA AND NATIONWIDE AVERAGE PURCHASE PRICES**

.01 Average area purchase prices for single-family and two to four-family residences in MSAs, and for certain counties and county equivalents are set forth below. The safe harbor for “ALL OTHER AREAS” (found at the end of the table below) may be used for a statistical area that is not listed below.

**2024 Average Area Purchase Prices for Mortgage Revenue Bonds**

County Name	State	One-Unit Limit	Two-Unit Limit	Three-Unit Limit	Four-Unit Limit
ALEUTIANS WEST	AK	\$621,082	\$795,068	\$961,077	\$1,194,424
HOONAH-ANGOON C	AK	\$597,497	\$764,874	\$924,559	\$1,149,020
JUNEAU CITY AND	AK	\$630,255	\$806,860	\$975,262	\$1,212,028
KODIAK ISLAND B	AK	\$589,635	\$754,847	\$912,425	\$1,133,923
SITKA CITY AND	AK	\$668,253	\$855,455	\$1,034,055	\$1,285,120
SKAGWAY MUNICIPAL	AK	\$597,497	\$764,874	\$924,559	\$1,149,020
COCONINO	AZ	\$598,807	\$766,583	\$926,610	\$1,151,583
MARICOPA	AZ	\$604,049	\$773,305	\$934,700	\$1,161,667
PINAL	AZ	\$604,049	\$773,305	\$934,700	\$1,161,667
ALAMEDA	CA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
ALPINE	CA	\$573,912	\$734,680	\$888,099	\$1,103,672
CONTRA COSTA	CA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
EL DORADO	CA	\$870,040	\$1,113,812	\$1,346,362	\$1,673,197
INYO	CA	\$579,153	\$741,402	\$896,189	\$1,113,756
LOS ANGELES	CA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
MARIN	CA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879

County Name	State	One-Unit Limit	Two-Unit Limit	Three-Unit Limit	Four-Unit Limit
MENDOCINO	CA	\$622,393	\$796,777	\$963,128	\$1,196,931
MONO	CA	\$790,111	\$1,011,495	\$1,222,681	\$1,519,493
MONTEREY	CA	\$1,048,240	\$1,341,919	\$1,622,095	\$2,015,869
NAPA	CA	\$1,159,616	\$1,484,514	\$1,794,428	\$2,230,075
NEVADA	CA	\$733,768	\$939,372	\$1,135,461	\$1,411,137
ORANGE	CA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
PLACER	CA	\$870,040	\$1,113,812	\$1,346,362	\$1,673,197
RIVERSIDE	CA	\$733,768	\$939,372	\$1,135,461	\$1,411,137
SACRAMENTO	CA	\$870,040	\$1,113,812	\$1,346,362	\$1,673,197
SAN BENITO	CA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
SAN BERNARDINO	CA	\$733,768	\$939,372	\$1,135,461	\$1,411,137
SAN DIEGO	CA	\$1,146,513	\$1,467,765	\$1,774,204	\$2,204,894
SAN FRANCISCO	CA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
SAN JOAQUIN	CA	\$748,182	\$957,830	\$1,157,793	\$1,438,824
SAN LUIS OBISPO	CA	\$1,058,723	\$1,355,364	\$1,638,331	\$2,036,036
SAN MATEO	CA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
SANTA BARBARA	CA	\$955,209	\$1,222,852	\$1,478,133	\$1,836,984
SANTA CLARA	CA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
SANTA CRUZ	CA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
SOLANO	CA	\$780,939	\$999,759	\$1,208,439	\$1,501,832
SONOMA	CA	\$999,759	\$1,279,879	\$1,547,066	\$1,922,667
STANISLAUS	CA	\$589,635	\$754,847	\$912,425	\$1,133,923
VENTURA	CA	\$1,087,550	\$1,392,280	\$1,682,939	\$2,091,468
YOLO	CA	\$870,040	\$1,113,812	\$1,346,362	\$1,673,197
ADAMS	CO	\$930,313	\$1,190,949	\$1,439,622	\$1,789,073
ARAPAHOE	CO	\$930,313	\$1,190,949	\$1,439,622	\$1,789,073
BOULDER	CO	\$976,174	\$1,249,685	\$1,510,606	\$1,877,319
BROOMFIELD	CO	\$930,313	\$1,190,949	\$1,439,622	\$1,789,073
CHAFFEE	CO	\$720,665	\$922,566	\$1,115,180	\$1,385,899
CLEAR CREEK	CO	\$930,313	\$1,190,949	\$1,439,622	\$1,789,073
DENVER	CO	\$930,313	\$1,190,949	\$1,439,622	\$1,789,073
DOUGLAS	CO	\$930,313	\$1,190,949	\$1,439,622	\$1,789,073
EAGLE	CO	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
EL PASO	CO	\$589,635	\$754,847	\$912,425	\$1,133,923
ELBERT	CO	\$930,313	\$1,190,949	\$1,439,622	\$1,789,073
GARFIELD	CO	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
GILPIN	CO	\$930,313	\$1,190,949	\$1,439,622	\$1,789,073
GRAND	CO	\$851,695	\$1,090,341	\$1,317,935	\$1,637,876
GUNNISON	CO	\$721,976	\$924,275	\$1,117,231	\$1,388,406
JEFFERSON	CO	\$930,313	\$1,190,949	\$1,439,622	\$1,789,073
LA PLATA	CO	\$746,871	\$956,121	\$1,155,742	\$1,436,317
LARIMER	CO	\$720,665	\$922,566	\$1,115,180	\$1,385,899
MONTROSE	CO	\$639,427	\$818,596	\$989,448	\$1,229,689



County Name	State	One-Unit Limit	Two-Unit Limit	Three-Unit Limit	Four-Unit Limit
OURAY	CO	\$639,427	\$818,596	\$989,448	\$1,229,689
PARK	CO	\$930,313	\$1,190,949	\$1,439,622	\$1,789,073
PITKIN	CO	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
ROUTT	CO	\$1,153,065	\$1,476,139	\$1,784,345	\$2,217,484
SAN JUAN	CO	\$589,635	\$754,847	\$912,425	\$1,133,923
SAN MIGUEL	CO	\$1,191,063	\$1,524,791	\$1,843,137	\$2,290,576
SUMMIT	CO	\$1,146,513	\$1,467,765	\$1,774,204	\$2,204,894
TELLER	CO	\$589,635	\$754,847	\$912,425	\$1,133,923
WELD	CO	\$638,116	\$816,887	\$987,454	\$1,227,182
FAIRFIELD	CT	\$818,938	\$1,048,411	\$1,267,289	\$1,574,924
DISTRICT OF COL	DC	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
NEW CASTLE	DE	\$635,496	\$813,526	\$983,409	\$1,222,112
BAKER	FL	\$643,358	\$823,609	\$995,544	\$1,237,266
BROWARD	FL	\$707,562	\$905,816	\$1,094,899	\$1,360,719
CLAY	FL	\$643,358	\$823,609	\$995,544	\$1,237,266
COLLIER	FL	\$832,041	\$1,065,160	\$1,287,513	\$1,600,105
DUVAL	FL	\$643,358	\$823,609	\$995,544	\$1,237,266
MANATEE	FL	\$623,703	\$798,429	\$965,122	\$1,199,438
MARTIN	FL	\$622,393	\$796,777	\$963,128	\$1,196,931
MIAMI-DADE	FL	\$707,562	\$905,816	\$1,094,899	\$1,360,719
MONROE	FL	\$1,058,723	\$1,355,364	\$1,638,331	\$2,036,036
NASSAU	FL	\$643,358	\$823,609	\$995,544	\$1,237,266
OKALOOSA	FL	\$687,908	\$880,636	\$1,064,477	\$1,322,891
PALM BEACH	FL	\$707,562	\$905,816	\$1,094,899	\$1,360,719
SARASOTA	FL	\$623,703	\$798,429	\$965,122	\$1,199,438
ST. JOHNS	FL	\$643,358	\$823,609	\$995,544	\$1,237,266
ST. LUCIE	FL	\$622,393	\$796,777	\$963,128	\$1,196,931
WALTON	FL	\$687,908	\$880,636	\$1,064,477	\$1,322,891
BARROW	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
BARTOW	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
BUTTS	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
CARROLL	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
CHEROKEE	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
CLARKE	GA	\$622,393	\$796,777	\$963,128	\$1,196,931
CLAYTON	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
COBB	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
COWETA	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
DAWSON	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
DEKALB	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727

County Name	State	One-Unit Limit	Two-Unit Limit	Three-Unit Limit	Four-Unit Limit
DOUGLAS	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
FAYETTE	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
FORSYTH	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
FULTON	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
GREENE	GA	\$602,738	\$771,596	\$932,706	\$1,159,103
GWINNETT	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
HARALSON	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
HEARD	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
HENRY	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
JASPER	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
LAMAR	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
MADISON	GA	\$622,393	\$796,777	\$963,128	\$1,196,931
MERIWETHER	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
MORGAN	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
NEWTON	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
OCONEE	GA	\$622,393	\$796,777	\$963,128	\$1,196,931
OGLETHORPE	GA	\$622,393	\$796,777	\$963,128	\$1,196,931
PAULDING	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
PICKENS	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
PIKE	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
ROCKDALE	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
SPALDING	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
WALTON	GA	\$740,320	\$947,746	\$1,145,602	\$1,423,727
HAWAII	HI	\$589,635	\$754,847	\$912,425	\$1,133,923
HONOLULU	HI	\$888,384	\$1,137,284	\$1,374,733	\$1,708,461
KALAWAO	HI	\$1,139,962	\$1,459,390	\$1,764,063	\$2,192,304
KAUAI	HI	\$1,172,719	\$1,501,320	\$1,814,709	\$2,255,255
MAUI	HI	\$1,139,962	\$1,459,390	\$1,764,063	\$2,192,304
ADA	ID	\$668,253	\$855,455	\$1,034,055	\$1,285,120
BLAINE	ID	\$864,798	\$1,107,090	\$1,338,216	\$1,663,113
BOISE	ID	\$668,253	\$855,455	\$1,034,055	\$1,285,120
BONNER	ID	\$596,187	\$763,222	\$922,566	\$1,146,513
CAMAS	ID	\$864,798	\$1,107,090	\$1,338,216	\$1,663,113
CANYON	ID	\$668,253	\$855,455	\$1,034,055	\$1,285,120
GEM	ID	\$668,253	\$855,455	\$1,034,055	\$1,285,120
KOOTENAI	ID	\$652,530	\$835,345	\$1,009,729	\$1,254,869
OWYHEE	ID	\$668,253	\$855,455	\$1,034,055	\$1,285,120
TETON	ID	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
VALLEY	ID	\$653,840	\$837,054	\$1,011,780	\$1,257,376
BARNSTABLE	MA	\$851,695	\$1,090,341	\$1,317,935	\$1,637,876
BRISTOL	MA	\$838,592	\$1,073,535	\$1,297,653	\$1,612,695

County Name	State	One-Unit Limit	Two-Unit Limit	Three-Unit Limit	Four-Unit Limit
DUKES	MA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
ESSEX	MA	\$982,725	\$1,258,059	\$1,520,746	\$1,889,909
MIDDLESEX	MA	\$982,725	\$1,258,059	\$1,520,746	\$1,889,909
NANTUCKET	MA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
NORFOLK	MA	\$982,725	\$1,258,059	\$1,520,746	\$1,889,909
PLYMOUTH	MA	\$982,725	\$1,258,059	\$1,520,746	\$1,889,909
SUFFOLK	MA	\$982,725	\$1,258,059	\$1,520,746	\$1,889,909
ANNE ARUNDEL	MD	\$759,974	\$972,927	\$1,176,023	\$1,461,498
BALTIMORE	MD	\$759,974	\$972,927	\$1,176,023	\$1,461,498
BALTIMORE CITY	MD	\$759,974	\$972,927	\$1,176,023	\$1,461,498
CALVERT	MD	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
CARROLL	MD	\$759,974	\$972,927	\$1,176,023	\$1,461,498
CECIL	MD	\$635,496	\$813,526	\$983,409	\$1,222,112
CHARLES	MD	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
FREDERICK	MD	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
HARFORD	MD	\$759,974	\$972,927	\$1,176,023	\$1,461,498
HOWARD	MD	\$759,974	\$972,927	\$1,176,023	\$1,461,498
MONTGOMERY	MD	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
PRINCE GEORGE'S	MD	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
QUEEN ANNE'S	MD	\$759,974	\$972,927	\$1,176,023	\$1,461,498
CUMBERLAND	ME	\$622,393	\$796,777	\$963,128	\$1,196,931
SAGadahoc	ME	\$622,393	\$796,777	\$963,128	\$1,196,931
YORK	ME	\$622,393	\$796,777	\$963,128	\$1,196,931
ANOKA	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
CARVER	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
CHISAGO	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
DAKOTA	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
HENNEPIN	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
ISANTI	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
LE SUEUR	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
MILLE LACS	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
RAMSEY	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
SCOTT	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
SHERBURNE	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
WASHINGTON	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
WRIGHT	MN	\$587,015	\$751,486	\$908,380	\$1,128,909
BROADWATER	MT	\$568,670	\$728,014	\$879,952	\$1,093,588
CARBON	MT	\$859,557	\$1,100,368	\$1,330,126	\$1,653,030
FLATHEAD	MT	\$636,806	\$815,235	\$985,403	\$1,224,618
GALLATIN	MT	\$818,938	\$1,048,411	\$1,267,289	\$1,574,924

County Name	State	One-Unit Limit	Two-Unit Limit	Three-Unit Limit	Four-Unit Limit
MISSOULA	MT	\$622,393	\$796,777	\$963,128	\$1,196,931
PARK	MT	\$642,047	\$821,957	\$993,550	\$1,234,702
RAVALLI	MT	\$575,222	\$736,389	\$890,093	\$1,106,179
STILLWATER	MT	\$859,557	\$1,100,368	\$1,330,126	\$1,653,030
YELLOWSTONE	MT	\$859,557	\$1,100,368	\$1,330,126	\$1,653,030
CAMDEN	NC	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
CHATHAM	NC	\$686,598	\$878,984	\$1,062,483	\$1,320,384
CURRITUCK	NC	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
DARE	NC	\$703,631	\$900,746	\$1,088,803	\$1,353,142
DURHAM	NC	\$686,598	\$878,984	\$1,062,483	\$1,320,384
FRANKLIN	NC	\$602,738	\$771,596	\$932,706	\$1,159,103
GATES	NC	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
GRANVILLE	NC	\$686,598	\$878,984	\$1,062,483	\$1,320,384
JOHNSTON	NC	\$602,738	\$771,596	\$932,706	\$1,159,103
ORANGE	NC	\$686,598	\$878,984	\$1,062,483	\$1,320,384
PASQUOTANK	NC	\$917,210	\$1,174,200	\$1,419,340	\$1,763,892
PERQUIMANS	NC	\$917,210	\$1,174,200	\$1,419,340	\$1,763,892
PERSON	NC	\$686,598	\$878,984	\$1,062,483	\$1,320,384
WAKE	NC	\$602,738	\$771,596	\$932,706	\$1,159,103
BILLINGS	ND	\$579,153	\$741,402	\$896,189	\$1,113,756
STARK	ND	\$579,153	\$741,402	\$896,189	\$1,113,756
DAWSON	NE	\$687,908	\$880,636	\$1,064,477	\$1,322,891
GOSPER	NE	\$687,908	\$880,636	\$1,064,477	\$1,322,891
ROCKINGHAM	NH	\$982,725	\$1,258,059	\$1,520,746	\$1,889,909
STRAFFORD	NH	\$982,725	\$1,258,059	\$1,520,746	\$1,889,909
BERGEN	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
BURLINGTON	NJ	\$635,496	\$813,526	\$983,409	\$1,222,112
CAMDEN	NJ	\$635,496	\$813,526	\$983,409	\$1,222,112
CAPE MAY	NJ	\$635,496	\$813,526	\$983,409	\$1,222,112
ESSEX	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
GLOUCESTER	NJ	\$635,496	\$813,526	\$983,409	\$1,222,112
HUDSON	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
HUNTERDON	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
MIDDLESEX	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
MONMOUTH	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
MORRIS	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
OCEAN	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
PASSAIC	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
SALEM	NJ	\$635,496	\$813,526	\$983,409	\$1,222,112

County Name	State	One-Unit Limit	Two-Unit Limit	Three-Unit Limit	Four-Unit Limit
SOMERSET	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
SUSSEX	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
UNION	NJ	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
LOS ALAMOS	NM	\$712,804	\$912,539	\$1,103,045	\$1,370,802
SANTA FE	NM	\$617,152	\$790,054	\$954,981	\$1,186,848
CARSON CITY	NV	\$581,773	\$744,763	\$900,233	\$1,118,826
DOUGLAS	NV	\$749,492	\$959,482	\$1,159,787	\$1,441,331
STOREY	NV	\$707,562	\$905,816	\$1,094,899	\$1,360,719
WASHOE	NV	\$707,562	\$905,816	\$1,094,899	\$1,360,719
BRONX	NY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
KINGS	NY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
NASSAU	NY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
NEW YORK	NY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
PUTNAM	NY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
QUEENS	NY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
RICHMOND	NY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
ROCKLAND	NY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
SUFFOLK	NY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
WESTCHESTER	NY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
DELAWARE	OH	\$622,393	\$796,777	\$963,128	\$1,196,931
FAIRFIELD	OH	\$622,393	\$796,777	\$963,128	\$1,196,931
FRANKLIN	OH	\$622,393	\$796,777	\$963,128	\$1,196,931
HOCKING	OH	\$622,393	\$796,777	\$963,128	\$1,196,931
LICKING	OH	\$622,393	\$796,777	\$963,128	\$1,196,931
MADISON	OH	\$622,393	\$796,777	\$963,128	\$1,196,931
MORROW	OH	\$622,393	\$796,777	\$963,128	\$1,196,931
PERRY	OH	\$622,393	\$796,777	\$963,128	\$1,196,931
PICKAWAY	OH	\$622,393	\$796,777	\$963,128	\$1,196,931
UNION	OH	\$622,393	\$796,777	\$963,128	\$1,196,931
BENTON	OR	\$681,356	\$872,261	\$1,054,336	\$1,310,301
CLACKAMAS	OR	\$774,388	\$991,328	\$1,198,298	\$1,489,242
CLATSOP	OR	\$602,738	\$771,596	\$932,706	\$1,159,103
COLUMBIA	OR	\$774,388	\$991,328	\$1,198,298	\$1,489,242
DESCHUTES	OR	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
HOOD RIVER	OR	\$825,489	\$1,056,786	\$1,277,429	\$1,587,515
MULTNOMAH	OR	\$774,388	\$991,328	\$1,198,298	\$1,489,242
WASHINGTON	OR	\$774,388	\$991,328	\$1,198,298	\$1,489,242
YAMHILL	OR	\$774,388	\$991,328	\$1,198,298	\$1,489,242

County Name	State	One-Unit Limit	Two-Unit Limit	Three-Unit Limit	Four-Unit Limit
BUCKS	PA	\$635,496	\$813,526	\$983,409	\$1,222,112
CHESTER	PA	\$635,496	\$813,526	\$983,409	\$1,222,112
DELAWARE	PA	\$635,496	\$813,526	\$983,409	\$1,222,112
MONTGOMERY	PA	\$635,496	\$813,526	\$983,409	\$1,222,112
PHILADELPHIA	PA	\$635,496	\$813,526	\$983,409	\$1,222,112
PIKE	PA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
BRISTOL	RI	\$838,592	\$1,073,535	\$1,297,653	\$1,612,695
KENT	RI	\$838,592	\$1,073,535	\$1,297,653	\$1,612,695
NEWPORT	RI	\$838,592	\$1,073,535	\$1,297,653	\$1,612,695
PROVIDENCE	RI	\$838,592	\$1,073,535	\$1,297,653	\$1,612,695
WASHINGTON	RI	\$838,592	\$1,073,535	\$1,297,653	\$1,612,695
BEAUFORT	SC	\$622,393	\$796,777	\$963,128	\$1,196,931
BERKELEY	SC	\$668,253	\$855,455	\$1,034,055	\$1,285,120
CHARLESTON	SC	\$668,253	\$855,455	\$1,034,055	\$1,285,120
DORCHESTER	SC	\$668,253	\$855,455	\$1,034,055	\$1,285,120
JASPER	SC	\$622,393	\$796,777	\$963,128	\$1,196,931
LAWRENCE	SD	\$617,152	\$790,054	\$954,981	\$1,186,848
CANNON	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
CHEATHAM	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
DAVIDSON	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
DICKSON	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
MACON	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
MAURY	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
ROBERTSON	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
RUTHERFORD	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
SMITH	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
SUMNER	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
TROUSDALE	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
WILLIAMSON	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
WILSON	TN	\$1,074,447	\$1,375,474	\$1,662,658	\$2,066,287
ATASCOSA	TX	\$635,496	\$813,526	\$983,409	\$1,222,112
BANDERA	TX	\$635,496	\$813,526	\$983,409	\$1,222,112
BASTROP	TX	\$651,219	\$833,693	\$1,007,735	\$1,252,363
BEXAR	TX	\$635,496	\$813,526	\$983,409	\$1,222,112
CALDWELL	TX	\$651,219	\$833,693	\$1,007,735	\$1,252,363
COLLIN	TX	\$642,047	\$821,957	\$993,550	\$1,234,702
COMAL	TX	\$635,496	\$813,526	\$983,409	\$1,222,112
DALLAS	TX	\$642,047	\$821,957	\$993,550	\$1,234,702
DENTON	TX	\$642,047	\$821,957	\$993,550	\$1,234,702

County Name	State	One-Unit Limit	Two-Unit Limit	Three-Unit Limit	Four-Unit Limit
ELLIS	TX	\$642,047	\$821,957	\$993,550	\$1,234,702
GUADALUPE	TX	\$635,496	\$813,526	\$983,409	\$1,222,112
HAYS	TX	\$651,219	\$833,693	\$1,007,735	\$1,252,363
HUNT	TX	\$642,047	\$821,957	\$993,550	\$1,234,702
JOHNSON	TX	\$642,047	\$821,957	\$993,550	\$1,234,702
KAUFMAN	TX	\$642,047	\$821,957	\$993,550	\$1,234,702
KENDALL	TX	\$635,496	\$813,526	\$983,409	\$1,222,112
MEDINA	TX	\$635,496	\$813,526	\$983,409	\$1,222,112
PARKER	TX	\$642,047	\$821,957	\$993,550	\$1,234,702
ROCKWALL	TX	\$642,047	\$821,957	\$993,550	\$1,234,702
TARRANT	TX	\$642,047	\$821,957	\$993,550	\$1,234,702
TRAVIS	TX	\$651,219	\$833,693	\$1,007,735	\$1,252,363
WILLIAMSON	TX	\$651,219	\$833,693	\$1,007,735	\$1,252,363
WILSON	TX	\$635,496	\$813,526	\$983,409	\$1,222,112
WISE	TX	\$642,047	\$821,957	\$993,550	\$1,234,702
BOX ELDER	UT	\$847,764	\$1,085,271	\$1,311,896	\$1,630,356
DAVIS	UT	\$847,764	\$1,085,271	\$1,311,896	\$1,630,356
GRAND	UT	\$691,839	\$885,649	\$1,070,573	\$1,330,468
JUAB	UT	\$685,287	\$877,275	\$1,060,432	\$1,317,878
MORGAN	UT	\$847,764	\$1,085,271	\$1,311,896	\$1,630,356
RICH	UT	\$660,392	\$845,429	\$1,021,921	\$1,270,023
SALT LAKE	UT	\$706,252	\$904,107	\$1,092,905	\$1,358,212
SUMMIT	UT	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
TOOELE	UT	\$706,252	\$904,107	\$1,092,905	\$1,358,212
UTAH	UT	\$685,287	\$877,275	\$1,060,432	\$1,317,878
WASATCH	UT	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
WASHINGTON	UT	\$676,115	\$865,539	\$1,046,247	\$1,300,217
WAYNE	UT	\$1,136,031	\$1,454,320	\$1,757,968	\$2,184,727
WEBER	UT	\$847,764	\$1,085,271	\$1,311,896	\$1,630,356
ALBEMARLE	VA	\$621,082	\$795,068	\$961,077	\$1,194,424
ALEXANDRIA CITY	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
AMELIA	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
ARLINGTON	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
CHARLES CITY	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
CHARLOTTESVILLE	VA	\$621,082	\$795,068	\$961,077	\$1,194,424
CHESAPEAKE CITY	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
CHESTERFIELD	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
CLARKE	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
COLONIAL HEIGHT	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
CULPEPER	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
DINWIDDIE	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
FAIRFAX	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879

County Name	State	One-Unit Limit	Two-Unit Limit	Three-Unit Limit	Four-Unit Limit
FAIRFAX CITY	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
FALLS CHURCH CI	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
FAUQUIER	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
FLUVANNA	VA	\$621,082	\$795,068	\$961,077	\$1,194,424
FRANKLIN CITY	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
FREDERICKSBURG	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
GLOUCESTER	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
GOOCHLAND	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
GREENE	VA	\$621,082	\$795,068	\$961,077	\$1,194,424
HAMPTON CITY	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
HANOVER	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
HENRICO	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
HOPEWELL CITY	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
ISLE OF WIGHT	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
JAMES CITY	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
KING AND QUEEN	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
KING WILLIAM	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
LOUDOUN	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
MADISON	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
MANASSAS CITY	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
MANASSAS PARK C	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
MATHEWS	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
NELSON	VA	\$621,082	\$795,068	\$961,077	\$1,194,424
NEW KENT	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
NEWPORT NEWS CI	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
NORFOLK CITY	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
PETERSBURG CITY	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
POQUOSON CITY	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
PORTSMOUTH CITY	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
POWHATAN	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
PRINCE GEORGE	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
PRINCE WILLIAM	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
RAPPAHANNOCK	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
RICHMOND CITY	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
SOUTHAMPTON	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
SPOTSYLVANIA	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
STAFFORD	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
SUFFOLK CITY	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
SUSSEX	VA	\$719,355	\$920,913	\$1,113,186	\$1,383,393
VIRGINIA BEACH	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
WARREN	VA	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
WILLIAMSBURG CI	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916
YORK	VA	\$786,180	\$1,006,425	\$1,216,586	\$1,511,916



<b>County Name</b>	<b>State</b>	<b>One-Unit Limit</b>	<b>Two-Unit Limit</b>	<b>Three-Unit Limit</b>	<b>Four-Unit Limit</b>
CHITTENDEN	VT	\$589,635	\$754,847	\$912,425	\$1,133,923
FRANKLIN	VT	\$589,635	\$754,847	\$912,425	\$1,133,923
GRAND ISLE	VT	\$589,635	\$754,847	\$912,425	\$1,133,923
CHELAN	WA	\$576,532	\$738,041	\$892,144	\$1,108,742
CLARK	WA	\$774,388	\$991,328	\$1,198,298	\$1,489,242
DOUGLAS	WA	\$576,532	\$738,041	\$892,144	\$1,108,742
ISLAND	WA	\$655,150	\$838,706	\$1,013,831	\$1,259,939
JEFFERSON	WA	\$589,635	\$754,847	\$912,425	\$1,133,923
KING	WA	\$1,113,756	\$1,425,835	\$1,723,501	\$2,141,886
KITSAP	WA	\$642,047	\$821,957	\$993,550	\$1,234,702
PIERCE	WA	\$1,113,756	\$1,425,835	\$1,723,501	\$2,141,886
SKAGIT	WA	\$621,082	\$795,068	\$961,077	\$1,194,424
SKAMANIA	WA	\$774,388	\$991,328	\$1,198,298	\$1,489,242
SNOHOMISH	WA	\$1,113,756	\$1,425,835	\$1,723,501	\$2,141,886
THURSTON	WA	\$622,393	\$796,777	\$963,128	\$1,196,931
WHATCOM	WA	\$687,908	\$880,636	\$1,064,477	\$1,322,891
WHITMAN	WA	\$602,738	\$771,596	\$932,706	\$1,159,103
PIERCE	WI	\$587,015	\$751,486	\$908,380	\$1,128,909
ST. CROIX	WI	\$587,015	\$751,486	\$908,380	\$1,128,909
JEFFERSON	WV	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
TETON	WY	\$1,310,101	\$1,677,470	\$2,027,576	\$2,519,879
GUAM	GU	\$642,047	\$821,957	\$993,550	\$1,234,702
NORTHERN ISLAND	MP	\$597,497	\$764,874	\$924,559	\$1,149,020
SAIPAN	MP	\$602,738	\$771,596	\$932,706	\$1,159,103
TINIAN	MP	\$606,669	\$776,666	\$938,802	\$1,166,680
CULEBRA	PR	\$606,669	\$776,666	\$938,802	\$1,166,680
ST. JOHN ISLAND	VI	\$1,206,787	\$1,544,901	\$1,867,463	\$2,320,770
ST. THOMAS ISLA	VI	\$728,527	\$932,649	\$1,127,371	\$1,401,053
All other areas - 2826 counties (floor):		\$567,710	\$726,875	\$878,614	\$1,091,936

.02 The nationwide average purchase price (for use in the housing cost/income ratio for new and existing residences) is \$510,100.

## SECTION 5. EFFECT ON OTHER DOCUMENTS

Rev. Proc. 2023-22 is obsolete except as provided in section 6 of this revenue procedure.

## SECTION 6. EFFECTIVE DATES

.01 Issuers may rely on this revenue procedure to determine average area purchase price safe harbors for commitments to provide financing or issue mortgage credit certificates that are made, or (if the purchase precedes the commitment) for residences that are purchased, in the period that begins on April 16, 2024, and ends on the date as of which the safe harbors contained in section 4.01 of this revenue procedure are rendered obsolete by a new revenue procedure.

.02 Notwithstanding section 5 of this revenue procedure, issuers may continue to rely on the average area purchase price safe harbors contained in Rev. Proc. 2023-22, with respect to bonds sold, or for mortgage credit certificates issued with respect to bond authority exchanged, before May 16, 2024, if the commitments to provide financing or issue mortgage credit certificates are made on or before June 15, 2024.

.03 Except as provided in section 6.04, issuers must use the nationwide average purchase price limitation contained in this revenue procedure for commitments to provide financing or issue mortgage credit certificates that are made, or (if the purchase precedes the commitment) for residences that are purchased, in the period that begins on April 16, 2024, and ends on the date when the nationwide average purchase price limitation is rendered obsolete by a new revenue procedure.

.04 Notwithstanding sections 5 and 6.03 of this revenue procedure, issuers may continue to rely on the nationwide average purchase price set forth in Rev. Proc. 2023-22 with respect to bonds sold, or for mortgage credit certificates issued with respect to bond authority exchanged, before May 16, 2024, if the commitments to provide financing or issue mortgage

credit certificates are made on or before June 15, 2024.

## SECTION 7. REQUEST FOR COMMENTS

.01 *Comments Regarding Guidance in this Revenue Procedure.* The Treasury Department and the IRS are reviewing the available data sources and method used to determine the average area purchase price safe harbors listed in section 4.01 of this revenue procedure and are considering possible changes in the data used to determine these safe harbors beginning in 2025.

The relationship between safe harbor values calculated under the current methodology and actual area purchase prices has been growing weaker over the past decade. The current methodology relies on the FHA single family forward mortgage limits, which are subject to both a floor and ceiling. Because 87 percent of counties are subject to the FHA mortgage limit floor and 2 percent of counties are subject to the FHA ceiling in 2024, most counties have a safe harbor value that does not closely relate to their average area purchase price under the current methodology.

The Treasury Department and the IRS are considering a shift away from using FHA mortgage limits as the basis for calculating average purchase prices and using median purchase prices as reported by the Department of Housing and Urban Development (HUD) as the basis to make such calculations. The Treasury and IRS solicit public comments on the use of this data and any alternative data sources that would generate average area purchase price safe harbors that more closely track area purchase prices.

Implementing such a change using HUD data would lead to large changes in safe harbors if done in a single year. One approach to implementing this change would be to phase in the new safe harbor amounts over five years, using the current 2024 values as a baseline and shifting towards the HUD values over time. The first year would maintain 80 percent of the 2024 values and 20 percent of values calculated using 2025 HUD data. The second year would be 60 percent of the 2024 values and 40 percent of the values calculated

using 2026 HUD data. The third, fourth, and fifth years would follow, such that the fifth year would feature 100 percent of actual 2029 price data.

A second approach would instead freeze values at the 2024 levels until such time when an area's average purchase price based on HUD data surpasses the frozen value, after which the safe harbor would follow the HUD data.

The Treasury and IRS also seek comments on these implementation approaches, as well as any other potential implementation approaches.

### .02 *Procedures for Submitting Comments.*

(1) *Deadline.* Written comments should be submitted by June 15, 2024.

(2) *Form and manner.* The subject line for the comments should include a reference to Revenue Procedure 2024-21. All commenters are strongly encouraged to submit comments electronically. However, comments may be submitted in one of two ways:

(a) Electronically via the Federal eRulemaking Portal at [www.regulations.gov](http://www.regulations.gov) (type IRS-2024-0019 in the search field on the [regulations.gov](http://www.regulations.gov) homepage to find this notice and submit comments); or

(b) By mail to: Internal Revenue Service, CC:PA:01:PR (Revenue Procedure 2024-21), Room 5203, P.O. Box 7604, Ben Franklin Station, Washington, DC 20044.

(3) *Publication of comments.* The Treasury Department and the IRS will publish for public availability any comment submitted electronically or on paper to its public docket on [regulations.gov](http://www.regulations.gov).

## SECTION 8. PAPERWORK REDUCTION ACT

The collection of information contained in this revenue procedure has been reviewed and approved by the Office of Management and Budget in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545-1877.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the

collection of information displays a valid OMB control number.

This revenue procedure contains a collection of information requirement in section 3.03. The purpose of the collection of information is to verify the applicable FHA loan limit that issuers of qualified mortgage bonds and qualified mortgage certificates have used to calculate the average area purchase price for a given metropolitan statistical area for purposes of §§ 143(e) and 25(c). The collection of information is required to obtain the benefit of using revisions to FHA loan limits

to determine average area purchase prices. The likely respondents are state and local governments.

The estimated total annual reporting and/or recordkeeping burden is: 15 hours.

The estimated annual burden per respondent and/or recordkeeper: 15 minutes.

The estimated number of respondents and/or recordkeepers: 60.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal

revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

## **SECTION 9. DRAFTING INFORMATION**

The principal authors of this revenue procedure are Zoran Stojanovic and David White of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this revenue procedure contact Mr. White at (202) 317-4562 (not a toll-free number).

## Part IV

### Deletions From Cumulative List of Organizations, Contributions to Which are Deductible Under Section 170 of the Code

#### Announcement 2024-20

##### Table of Contents

The Internal Revenue Service has revoked its determination that the organizations listed below qualify as organizations described in sections 501(c)(3) and 170(c)(2) of the Internal Revenue Code of 1986.

Generally, the IRS will not disallow deductions for contributions made to a listed organization on or before the date of announcement in the Internal Revenue Bulletin that an organization no longer qualifies. However, the IRS is not precluded from disallowing a deduction for any contributions made after an organization ceases to qualify under section 170(c)(2) if the organization has not timely filed a suit for declaratory judgment under section 7428 and if the contributor (1) had knowledge of the revocation of the ruling or determination letter, (2) was aware that such revocation was imminent, or (3) was in part responsible for or was aware of the activities or omissions of the organization that brought about this revocation.

If on the other hand a suit for declaratory judgment has been timely filed, contributions from individuals and organizations described in section 170(c)(2) that are otherwise allowable will continue to be deductible. Protection under section 7428(c) would begin on May 6, 2024 and would end on the date the court first determines the organization is not described in section 170(c)(2) as more particularly set for in section 7428(c)(1). For individual contributors, the maximum deduction protected is \$1,000, with a husband and wife treated as one contributor. This benefit is not extended to any individual, in whole or in part, for the acts or omissions of the organization that were the basis for revocation.

Name Of Organization	Effective Date of Revocation	Location
The Beard Foundation	1/1/2020	West Memphis, AR
Base Foundation	1/1/2020	Troy, MO
New Irvine Yan Charity Organization	1/1/2020	Irvine, CA

# Definition of Terms

*Revenue rulings and revenue procedures (hereinafter referred to as “rulings”) that have an effect on previous rulings use the following defined terms to describe the effect:*

*Amplified* describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

*Clarified* is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

*Distinguished* describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

*Modified* is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the

new ruling holds that it applies to both A and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

*Obsoleted* describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

*Revoked* describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

*Superseded* describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the

new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

*Supplemented* is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

*Suspended* is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

## Abbreviations

*The following abbreviations in current use and formerly used will appear in material published in the Bulletin.*

A—Individual.  
Acq.—Acquiescence.  
B—Individual.  
BE—Beneficiary.  
BK—Bank.  
B.T.A.—Board of Tax Appeals.  
C—Individual.  
C.B.—Cumulative Bulletin.  
CFR—Code of Federal Regulations.  
CI—City.  
COOP—Cooperative.  
Ct.D.—Court Decision.  
CY—County.  
D—Decedent.  
DC—Dummy Corporation.  
DE—Donee.  
Del. Order—Delegation Order.  
DISC—Domestic International Sales Corporation.  
DR—Donor.  
E—Estate.  
EE—Employee.  
E.O.—Executive Order.  
ER—Employer.

ERISA—Employee Retirement Income Security Act.  
EX—Executor.  
F—Fiduciary.  
FC—Foreign Country.  
FICA—Federal Insurance Contributions Act.  
FISC—Foreign International Sales Company.  
FPH—Foreign Personal Holding Company.  
FR.—Federal Register.  
FUTA—Federal Unemployment Tax Act.  
FX—Foreign corporation.  
G.C.M.—Chief Counsel’s Memorandum.  
GE—Grantee.  
GP—General Partner.  
GR—Grantor.  
IC—Insurance Company.  
I.R.B.—Internal Revenue Bulletin.  
LE—Lessee.  
LP—Limited Partner.  
LR—Lessor.  
M—Minor.  
Nonacq.—Nonacquiescence.  
O—Organization.  
P—Parent Corporation.  
PHC—Personal Holding Company.  
PO—Possession of the U.S.  
PR—Partner.  
PRS—Partnership.

PTE—Prohibited Transaction Exemption.  
Pub. L.—Public Law.  
REIT—Real Estate Investment Trust.  
Rev. Proc.—Revenue Procedure.  
Rev. Rul.—Revenue Ruling.  
S—Subsidiary.  
S.P.R.—Statement of Procedural Rules.  
Stat.—Statutes at Large.  
T—Target Corporation.  
T.C.—Tax Court.  
T.D.—Treasury Decision.  
TFE—Transferee.  
TFR—Transferor.  
T.I.R.—Technical Information Release.  
TP—Taxpayer.  
TR—Trust.  
TT—Trustee.  
U.S.C.—United States Code.  
X—Corporation.  
Y—Corporation.  
Z—Corporation.

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<sup>1</sup> A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2023–27 through 2023–52 is in Internal Revenue Bulletin 2023–52, dated December 26, 2023.

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<sup>1</sup> A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2023–27 through 2023–52 is in Internal Revenue Bulletin 2023–52, dated December 26, 2023.

# **Internal Revenue Service**

## **Washington, DC 20224**

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## **INTERNAL REVENUE BULLETIN**

The Introduction at the beginning of this issue describes the purpose and content of this publication. The weekly Internal Revenue Bulletins are available at [www.irs.gov/irb/](http://www.irs.gov/irb/).

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## **We Welcome Comments About the Internal Revenue Bulletin**

If you have comments concerning the format or production of the Internal Revenue Bulletin or suggestions for improving it, we would be pleased to hear from you. You can email us your suggestions or comments through the IRS Internet Home Page ([www.irs.gov](http://www.irs.gov)) or write to the Internal Revenue Service, Publishing Division, IRB Publishing Program Desk, 1111 Constitution Ave. NW, IR-6230 Washington, DC 20224.