March 28, 2024

CMS Issues Final Rules Updating Standards for STLDI, Defers Key Changes to Fixed Indemnity Insurance

On Thursday (March 28), the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments), released final rules regarding short-term, limited-duration insurance (STLDI) and independent, non-coordinated excepted benefits coverage. The final rules pull back the Trump-era expansion of STLDI coverage, limiting the length of the initial contract term to no more than three months and the maximum coverage period to no more than four months, considering any renewals or extensions. The rules also finalize new consumer notice requirements for both STLDI and fixed indemnity excepted benefits coverage.

The rules *do not* finalize proposals regarding the payment standards and non-coordination requirement for fixed indemnity excepted benefits coverage, including those to require hospital indemnity or fixed indemnity plans sold in the individual and group markets to prohibit benefits from being paid on a per-item or per-service basis, although the Departments noted their continued interest in the matter. The rules also *do not* finalize proposals to clarify that payments from employer-provided fixed indemnity health insurance plans (and other similar plans) are not excluded from a taxpayer's income if the amounts are paid without regard to the amount of incurred medical expenses. A fact sheet noted that Treasury and the IRS are not finalizing the proposals at this time "to provide more time to study the issues and concerns raised by commenters."

Changes go into effect for new STLDI policies sold or issued on or after September 1, 2024. The revised consumer notice standards apply to STLDI with respect to coverage periods beginning on or after September 1, 2024, and to group and individual market fixed indemnity excepted benefits coverage with respect to plan years beginning on or after January 1, 2025.

- For more information on the proposed rules: Fact Sheet, Press Release, Final Rules

Final Rules: High-level Summary

Short-Term Limited Duration Insurance

The final rules change the definition of STLDI to limit the initial duration of such plans to three months and limit plan renewals to one month, for a maximum coverage period of four months, including renewals and extensions. Previously, the rules defined STLDI as coverage that has an initial contract term of fewer than 12 months and a maximum total coverage period of up to 36 months, including renewals and extensions. The final rules also ban the practice of "stacking," in which the same issuer issues multiple STLDI policies to the same policyholder within a 12-month period, collectively evading duration limits.

The final rules also amend the federal notice standard aimed at helping consumers better distinguish between comprehensive coverage and STLDI. The notice must be prominently displayed on the first page of the policy, certificate, or contract of insurance, including for renewals and extensions, and included in any marketing, application, and enrollment (or reenrollment) materials.

For policies, certificates, or contracts of STLDI sold or issued on or after September 1, 2024, the maximum term and duration amendments to the definition of STLDI in the final rules apply for coverage periods beginning on or

after September 1, 2024. For those sold or issued before September 1, 2024, coverage may continue to have an initial contract term of fewer 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 revised consumer notice provisions apply to STLDI with respect to coverage periods (including renewals and extensions) beginning on or after September 1, 2024.

Fixed Indemnity Excepted Benefits Coverage

The final rules revise the consumer notice that is currently required for fixed indemnity excepted benefits coverage in the individual market and establish a new requirement to provide a consumer notice in the group market. The notice is designed to highlight the differences between fixed indemnity excepted benefits coverage and comprehensive coverage. The revised consumer notice provisions apply to group and individual market fixed indemnity excepted benefits coverage, for both new and existing coverage, with respect to plan years (in the individual market, coverage periods) beginning on or after January 1, 2025.

The rules *do not* finalize proposals regarding the payment standards and non-coordination requirement for fixed indemnity excepted benefits coverage, including those to require hospital indemnity or fixed indemnity plans sold in the individual and group markets to prohibit benefits from being paid on a per-item or per-service basis, although the Departments noted their continued interest to address those issues in the future. The Departments say they "remain concerned about the issues those proposals sought to address, and intend to address the issues in future rulemaking, after additional study and consideration of concerns raised in comments."

The rules also *do not* finalize proposals to clarify that payments from employer-provided fixed indemnity health insurance plans (and other similar plans) are not excluded from a taxpayer's income if the amounts are paid without regard to the actual amount of any incurred medical expenses. Additionally, they *do not* finalize proposals to clarify that the taxpayer must meet substantiation requirements for reimbursements for qualified medical expenses from any employer-provided accident and health plan to be excluded from the taxpayer's gross income. The Treasury Department and the IRS noted they are not finalizing the proposed amendments at this time "to provide more time to study the issues and concerns raised by commenters."

Impact Analysis

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 percent each year, and Federal spending on the PTCs will be lower by $120 million each year, relative to the current status quo. The cumulative reduction in Federal spending on the PTC is estimated to be (an undiscounted) $360 million from 2026 to 2028.

The Departments also estimate benefits including improvement in market stability and market risk pools for comprehensive coverage, along with consumer benefits such as reduction in high out-of-pocket costs and improved health outcomes for those who switch from STLDI, or fixed indemnity excepted benefits coverage to comprehensive coverage. Costs include potential premium increases for individuals who switch coverage, potential increase in the number of uninsured or those experiencing a coverage gap, potential decrease in compensation for agents and brokers, and potential increase in health care spending.

Requests for Comment

In the proposed rules, the Departments included several requests for comments to better understand how specified disease excepted benefits coverage is marketed, sold, and used by consumers, as well as to better understand how level-funded plans are designed and used in the self-insurance market. While these are not

addressed in the final rules, the Departments note they will take the comments received into consideration as they determine whether additional guidance or rulemaking is warranted in the future.

If you have questions, please contact Heather Meade or Laura Dillon.

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