

That airspace extending upward from 700 feet above the surface within a 6.4-mile radius of Lompoc Airport, and within 4 miles each side of the 090° bearing from the airport extending to 12.8 miles east of the airport, and within 4 miles each side of the 113° bearing from the airport extending to 20.4 miles southeast of the airport.

Issued in Seattle, Washington, on February 7, 2018.

B.G. Chew,

Acting Manager, Operations Support Group, Western Service Center.

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DEPARTMENT OF THE TREASURY

Internal Revenue Service

26 CFR Part 54

[REG-133491-17]

RIN 1545-BO41

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Part 2590

RIN 1210-AB86

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 144, 146, and 148

[CMS-9924-P]

RIN 0938-AT48

Short-Term, Limited-Duration Insurance

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: Proposed rule.

SUMMARY: This rule contains proposals amending the definition of short-term, limited-duration insurance for purposes of its exclusion from the definition of individual health insurance coverage. This action is being taken to lengthen the maximum period of short-term, limited-duration insurance, which will provide more affordable consumer choice for health coverage.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. EST on April 23, 2018.

ADDRESSES: In commenting, please refer to file code CMS-9924-P. Because of

staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <https://www.regulations.gov>. Follow the “Submit a comment” instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9924-P, P.O. Box 8010, Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-9924-P, Mail Stop C4-26-05, 7500 Security Boulevard, Baltimore, MD 21244-1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244-1850.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Amber Rivers or Matthew Litton of the Department of Labor, at 202-693-8335; Karen Levin, Internal Revenue Service, Department of the Treasury, at (202)

317-5500; David Mlawsky, Centers for Medicare & Medicaid Services, Department of Health and Human Services, at 410-786-1565.

Customer Service Information:

Individuals interested in obtaining information from the Department of Labor concerning employment-based health coverage laws may call the Employee Benefits Security Administration (EBSA) Toll-Free Hotline, at 1-866-444-EBSA (3272) or visit the Department of Labor’s website (<http://www.dol.gov/ebsa>). In addition, information from the Department of Health and Human Services (HHS) on private health insurance for consumers can be found on the Centers for Medicare & Medicaid Services (CMS) website (www.cms.gov/ccio) and information on health reform can be found at www.HealthCare.gov.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that website to view public comments.

I. Background

This proposed rule contains amendments to the definition of “short-term, limited-duration insurance” 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.

A. General Statutory Background and Enactment of PPACA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA),¹ added title XXVII to the Public Health Service Act (PHS Act), part 7 to the Employee Retirement Income Security Act of 1974 (ERISA), and Chapter 100 to the Internal Revenue Code (the Code), providing portability and nondiscrimination rules with respect to health coverage. These provisions of the PHS Act, ERISA, and the Code were later augmented by other laws, including the Mental Health Parity Act of 1996,² the Paul Wellstone and Pete Domenici Mental Health Parity and

¹ Public Law 104-191, 110 Stat. 1936 (August 21, 1996).

² Public Law 104-204, 110 Stat. 2944 (September 26, 1996).

Addiction Equity Act of 2008,³ the Newborns' and Mothers' Health Protection Act,⁴ the Women's Health and Cancer Rights Act,⁵ the Genetic Information Nondiscrimination Act of 2008,⁶ the Children's Health Insurance Program Reauthorization Act of 2009,⁷ Michelle's Law,⁸ and the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA).⁹

PPACA reorganizes, amends, and adds to the provisions of Part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. PPACA added section 715 of ERISA and section 9815 of the Code to 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.

B. President's Executive Order

On October 12, 2017, President Trump issued Executive Order 13813 entitled "Promoting Healthcare Choice and Competition Across the United States".¹⁰ This Executive Order states in relevant part: "Within 60 days of the date of this order, the Secretaries of the Treasury, Labor, and Health and Human Services shall consider proposing regulations or revising guidance, consistent with law, to expand the availability of [short-term, limited-duration insurance]. 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."

C. 2017 Tax Legislation

Section 5000A of the Code, added by PPACA, provides that all non-exempt applicable individuals must maintain minimum essential coverage or pay the individual shared responsibility payment.¹¹ On December 22, 2017, the

President signed tax reform legislation into law.¹² This legislation includes a provision under which the individual shared responsibility payment included in section 5000A of the Code is reduced to \$0, effective for months beginning after December 31, 2018.

D. Short-Term, Limited-Duration Insurance

Short-term, limited-duration insurance is a type of health insurance coverage that was designed to fill temporary gaps in coverage that may occur when an individual is transitioning from one plan or coverage to another plan or coverage. Although short-term, limited-duration insurance is not an excepted benefit,¹³ it is exempt from the PHS Act's individual-market requirements because it is not individual health insurance coverage.¹⁴ Section 2791(b)(5) of the PHS Act provides "[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."¹⁵

Code and Treasury regulations at 26 CFR 1.5000A-3 provide exemptions from the requirement to maintain minimum essential coverage 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 minimum essential coverage.

¹² Public Law 115-97, 131 Stat. 2054.

¹³ Sections 2722 and 2763 of the PHS Act, section 732 of ERISA, and section 9831 of the Code provide that the respective requirements of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code generally do not apply to certain types of benefits, known as "excepted benefits." Excepted benefits are described in section 2791(c) of the PHS Act, section 733(c) of ERISA, and section 9832(c) of the Code. See also 26 CFR 54.9831-1(c), 29 CFR 2590.732(c), 45 CFR 146.145(b), and 45 CFR 148.220.

¹⁴ The definition of short-term, limited-duration insurance has some limited relevance with respect to group health plans and group health insurance issuers. For example, an individual who loses coverage due to moving out of an HMO service area in the individual market triggers a special enrollment right into 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). Also, a group health plan that wraps around individual health insurance coverage is an excepted benefit if certain conditions are satisfied. See 26 CFR 54.9831-1(c)(3)(vii), 29 CFR 2590.732(c)(3)(vii), and 45 CFR 146.145(b)(3)(vii).

¹⁵ 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

The PHS Act does not define short-term, limited-duration insurance. Under regulations implementing HIPAA, and that continued to apply through 2016, short-term, limited-duration insurance was defined 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."¹⁶

To address the issue of short-term, limited-duration insurance being sold as a type of primary coverage, as well as concerns regarding possible adverse selection impacts on the risk pool for PPACA-compliant plans, the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (together, the Departments)¹⁷ published a proposed rule on June 10, 2016 in the **Federal Register** entitled "Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance."¹⁸ The June 2016 proposed rule changed the definition of short-term, limited-duration insurance that had been in place for nearly 20 years by revising the definition to specify that short-term, limited-duration insurance could not provide coverage for 3 months or longer (including any renewal period(s)).¹⁹

The June 2016 proposed rule also included a requirement that the following notice be prominently displayed in the contract and in any application materials provided in connection with enrollment in short-term, limited-duration insurance, in 14 point type:

THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE

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 short-term, limited-duration insurance from the definition of group health insurance coverage. Thus, any insurance that is sold in the group market and purports to be short-term, limited-duration insurance must comply with Part A of title XXVII of the PHS Act, part 7 of ERISA, and Chapter 100 of the Code.

¹⁶ 62 FR 16894 at 16928, 16942, 16958 (April 8, 1997), 69 FR 78720 (December 30, 2004).

¹⁷ Note, however, that in section headings listing only 2 of the 3 Departments, the term "Departments" generally refers only to the 2 Departments listed in the heading.

¹⁸ 81 FR 38019.

¹⁹ 81 FR 38019, 38032-33.

³ Public Law 110-343, 122 Stat. 3881 (October 3, 2008).

⁴ Public Law 104-204, 110 Stat. 2935 (September 26, 1996).

⁵ Public Law 105-277, 112 Stat. 2681-436 (October 21, 1998).

⁶ Public Law 110-233, 122 Stat. 881 (May 21, 2008).

⁷ Public Law 111-3, 123 Stat. 64 (February 4, 2009).

⁸ Public Law 110-381, 122 Stat. 4081 (October 9, 2008).

⁹ The Patient Protection and Affordable Care Act, Public Law 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152, was enacted on March 30, 2010.

¹⁰ 82 FR 48385.

¹¹ The eligibility standards for exemptions can be found at 45 CFR 155.605. Section 5000A of 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.²⁰

Some stakeholders who submitted comments on the June 2016 proposed rule supported the rule and the Departments' stated goals. Several commenters agreed that the proposed rule would limit the number of consumers relying on short-term, limited-duration insurance as their primary form of coverage and improve the PPACA's individual market single risk pools. However, other commenters expressed concerns about restricting the use of short-term, limited-duration insurance (as originally defined under the HIPAA regulations) because it provides an additional, often much more affordable coverage option than an insurance policy that complies with all of the requirements of the PPACA. Some commenters explained that individuals who do not qualify for premium tax credits and need temporary coverage, or who cannot afford Consolidated Omnibus Budget Reconciliation Act²¹ (COBRA) continuation coverage, or who missed an opportunity to sign up for coverage during open enrollment or special enrollment periods, might need to rely on short-term, limited-duration insurance coverage for 3 months or longer. Commenters highlighted how a person with just a less-than-3-month policy who develops a health condition might have no coverage options for the condition after their coverage expires until the beginning of the plan year that corresponds to the next individual market open enrollment period. Other commenters also expressed opposition to the proposed rule citing their belief that States are in the best position to regulate short-term, limited-duration insurance and that the proposed rule would limit State flexibility. Finally, several commenters observed that PPACA-compliant policies are often network-based but short-term, limited-duration insurance policies typically are not, thus offering consumers a greater choice of health care providers. This is particularly true in rural areas, one commenter stated.

After reviewing public comments and feedback received from stakeholders, on October 31, 2016, the Departments finalized the June 2016 proposed rule without change in a final rule published in the **Federal Register** entitled "Excepted Benefits; Lifetime and

Annual Limits; and Short-Term, Limited-Duration Insurance".²²

On June 12, 2017, HHS published a request for information in the **Federal Register** entitled "Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients",²³ which solicited public 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. Several commenters stated that changes to the October 2016 final rule may provide an opportunity to achieve these goals. Consistent with many comments submitted on the June 2016 proposed rule, commenters stated that shortening the permitted length of short-term, limited-duration insurance policies had deprived individuals of affordable coverage options. One commenter explained that due to the increased costs of PPACA-compliant major medical coverage, many financially-stressed individuals may be faced with a choice between short-term, limited-duration insurance coverage and going without any coverage at all. One commenter highlighted the need for short-term, limited-duration insurance coverage among individuals who are in-between jobs. Another commenter explained that States have the primary responsibility to regulate short-term, limited-duration insurance and opined that the October 2016 final rule was overreaching on the part of the Federal government.

The Departments are also aware that, while individuals who qualify for premium tax credits are largely insulated from significant premium increases (that is, the government, and thus federal taxpayers, largely bear the cost of the higher premiums), individuals who are not eligible for subsidies are particularly harmed by increased premiums in the individual market due to a lack of other, more affordable alternative coverage options. Based on CMS data on Exchange plan selections and data compiled from issuer regulatory filings at the State level, for the first quarters of 2016 and 2017, the number of off-Exchange and unsubsidized enrollees with individual market coverage fell by nearly 2 million, representing an almost 25 percent

decrease.²⁴ Further, in 2018, about 26 percent of enrollees (living in 52 percent of counties) have access to just one insurer in the Exchange.²⁵ Short-term, limited-duration insurance has become increasingly attractive to some individuals as premiums have escalated for PPACA-compliant plans and affordable choices in the individual market have dwindled.

II. Overview of the Proposed Regulations

In light of Executive Order 13813 directing the Departments to consider proposing regulations or revising guidance to expand the availability of short-term, limited-duration insurance, as well as continued feedback from stakeholders expressing concerns about the October 2016 final rule, the Departments are proposing to amend the definition of short-term, limited-duration insurance so that it may offer a maximum coverage period of less than 12 months after the original effective date of the contract, consistent with the original definition in the 1997 HIPAA rule (that is, the proposed rule would expand the potential maximum coverage period by 9 months). This proposed definition states that the expiration date specified in the contract takes into account any extensions that may be elected by the policyholder without the issuer's consent.

In addition, this proposed rule would revise the required notice that must appear in the contract and any application materials for short-term, limited-duration insurance. The Departments are concerned that short-term, limited-duration insurance policies that provide coverage lasting almost 12 months may be more difficult for some individuals to distinguish from PPACA-compliant coverage which is typically offered on a 12-month basis. Accordingly, under this proposed rule, one of two versions (as explained below) of the following notice would be required to be prominently displayed (in at least 14 point type) in the contract and in any application materials

²⁴ See Mark Farrah and Associates, "A Brief Look at the Turbulent Individual Health Insurance Market," July 19, 2017. Available at: <http://www.markfarrah.com/healthcare-business-strategy-print/A-Brief-Look-at-the-Turbulent-Individual-Health-Insurance-Market.aspx>. Also, see the Centers for Medicare and Medicaid Services, "2017 Effectuated Enrollment Snapshot," June 12, 2017. Available at: <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>.

²⁵ See Kaiser Family Foundation, "Insurer Participation on ACA Marketplaces, 2014–2018," November 10, 2017. <http://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces/>.

²⁰ 82 FR 38032.

²¹ Public Law 99–272, 100 Stat. 82 (April 7, 1986).

²² 81 FR 75316.

²³ 82 FR 26885.

provided in connection with enrollment:

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOESN'T COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. 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.

As stated below, the Departments are proposing that the applicability date for this proposed rule, if finalized, would be 60 days after the publication of the final rule, and that policies sold on or after that date would have to meet the requirements of the final rule in order to constitute short-term, limited-duration insurance. As previously discussed, the individual shared responsibility payment is reduced to \$0 for months beginning after December 2018. Consequently, the Departments propose that the final two sentences of the notice must appear only with respect to policies sold on or after the applicability date of the rule, if finalized, that have a coverage start date before January 1, 2019. The Departments solicit comments on this revised notice, and whether its language or some other language would best ensure that it is understandable and sufficiently appraises individuals of the nature of the coverage.

The current definition of short-term, limited-duration insurance applies for policy years beginning on or after January 1, 2017. In the October 2016 final rule, the Departments recognized that State regulators may have approved short-term, limited-duration insurance products for sale in 2017 that met the definition in effect prior to January 1, 2017.²⁶ Accordingly, HHS noted it would not take enforcement action against an issuer with respect to its sale of a short-term, limited-duration insurance product before April 1, 2017, on the ground that the coverage period is 3 months or more, provided that the coverage ended on or before December 31, 2017, and otherwise complies with the definition of short-term, limited-

duration insurance in effect under the final rule.²⁷ As stated in the October 2016 final rule, States may also elect not to take enforcement actions against issuers with respect to such coverage sold before April 1, 2017. The current definition in the October 2016 final rule, and the non-enforcement policy as applied to policies sold before April 1, 2017, and that end on or before December 31, 2017, would continue to apply unless and until this rule is finalized.

Effective Date and Applicability Date

The Departments propose that this rule, if finalized, would be effective 60 days after publication of the final rule. With respect to the applicability date, the Departments propose that insurance policies sold on or after the 60th day following publication of the final rule, if finalized, would have to meet the definition of short-term, limited-duration insurance in the final rule in order to be considered such insurance. The Departments propose that group health plans and group health insurance issuers, to the extent they must distinguish between short-term, limited-duration insurance and individual market health insurance (such as for purposes of determining whether an individual has moved out of a health maintenance organization (HMO) service area in the individual market, which would trigger a special enrollment right into a group health plan or for purposes of offering limited wraparound coverage (which wraps around individual health insurance or the Basic Health Plan as an excepted benefit²⁸), must apply the definition of short-term, limited-duration insurance in the final rule as of the 60th day following publication of the final rule. The current regulations specify the applicability date for the definition of short-term, limited-duration insurance at 26 CFR 54.9833-1; 29 CFR 2590.736, 45 CFR 146.125; and 45 CFR 148.102. Therefore, the Departments propose conforming amendments to those rules as part of this rulemaking. The Departments also propose a technical update in 26 CFR 54.9833-1; 29 CFR 2590.736; and 45 CFR 146.125 to delete the reference to the applicability date for amendments to 26 CFR 54.9831-1(c)(5)(i)(C); 29 CFR 2590.732(c)(5)(i)(C); and 45 CFR 146.145(c)(5)(i)(C)

²⁷ This non-enforcement policy is limited to the requirement that short-term, limited-duration insurance must be less than 3 months. It does not relieve issuers of short-term, limited-duration insurance of the notice requirement, which applies for policy years beginning on or after January 1, 2017.

²⁸ See footnote 14.

(regarding supplemental coverage excepted benefits).²⁹ Given that the applicability date for the amendments to those sections has passed, it is no longer necessary to mention the "future" applicability date.³⁰ HHS similarly proposes to amend § 148.102 to remove the reference to the applicability date for amendments to § 148.220(b)(7) (regarding supplemental coverage excepted benefits).³¹

Request for Comments

The Departments seek comments on all aspects of this proposed rule, including whether the length of short-term, limited-duration insurance should be some other duration. The Departments seek comments on any regulations or other guidance or policy that limits issuers' flexibility in designing short-term, limited-duration insurance or poses barriers to entry into the short-term, limited-duration insurance market.

In addition, the Departments seek comments on the conditions under which issuers should be able to allow short-term, limited-duration insurance to continue for 12 months or longer with the issuer's consent. Among other things, the Departments solicit comments on whether any processes for expedited or streamlined reapplication for short-term, limited-duration insurance that would simplify the reapplication process and minimize the burden on consumers may be appropriate; whether federal standards are appropriate for such processes; and whether any clarifications are needed regarding the application of the definition of short-term, limited-duration insurance in the proposed rule to such practices. For example, an expedited process could involve setting minimum federal standards for what must be considered as part of the streamlined reapplication process while allowing insurers to consider additional factors in accordance with contract terms. The Departments are also interested in information on any State approaches (including any approaches that States are considering adopting) to minimize the burden of the reapplication process for issuers and consumers.

²⁹ The reference in current regulations at 45 CFR 146.125 to the applicability date of 45 CFR 146.145(c)(5)(i)(C) was a drafting error. It was intended to be a reference to 45 CFR 146.145(b)(5)(i)(C).

³⁰ The applicability date for these amendments (policy years and plan years beginning on or after January 1, 2017) remains unchanged.

³¹ The applicability date for these amendments (policy years beginning on or after January 1, 2017) remains unchanged.

²⁶ 81 FR 75318 through 75319.

Because short-term, limited-duration insurance can be priced in an actuarially fair manner (by which the Departments mean that it is priced so that the premium paid by an individual reflects the risks associated with insuring the particular individual or individuals covered by that policy), subject to State law, individuals who are likely to purchase short-term, limited-duration insurance are likely to be relatively young or healthy. Allowing such individuals to purchase policies that are not in compliance with PPACA may impact the individual market single risk pools. As explained in section III., “Economic Impact and Paperwork Burden” of this proposed rule, the Departments estimate that in 2019, after the elimination of the individual shared responsibility payment, between 100,000 and 200,000 individuals previously enrolled in Exchange coverage would purchase short-term, limited-duration insurance policies instead. This would cause the average monthly individual market premiums and average monthly premium tax credits to increase, leading to an increase in total annual advance payments of the premium tax credit (APTC)³² in the range of \$96 million to \$168 million. The Departments seek comments on these estimates, and welcome other estimates of the increase in enrollment in short-term, limited-duration insurance under this proposal, and the health status and age of individuals who would purchase these policies.

The Departments also seek comments on the proposed effective and applicability dates of this rule, if finalized. The Departments seek comments on whether the proposed fixed applicability date, which would first impose the new definition of short-term, limited-duration insurance on group health plans and group health insurance issuers on a date that may occur in the middle of a plan year, would cause any special challenges for group health plans and group health insurance issuers.

III. Economic Impact and Paperwork Burden

A. Summary—Department of Labor and Department of Health and Human Services

This rule proposes to amend the definition of short-term, limited-duration insurance coverage so that the coverage (taking into account extensions elected by the policyholder without the

issuer’s consent) has a maximum period of less than 12 months after the original effective date of the contract. This rule also seeks comments on all aspects of this proposed rule, including whether the maximum length of short-term, limited-duration insurance should be some other duration; under what conditions issuers should be able to allow short-term, limited-duration insurance to continue for 12 months or longer with the issuer’s consent; and on the proposed revisions to the notice that must appear in the contract and any application materials.

The Departments have examined the effects of this rule as required by Executive Order 13563 (76 FR 3821, January 18, 2011, Improving Regulation and Regulatory Review), Executive Order 12866 (58 FR 51735, September 30, 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (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), the Congressional Review Act (5 U.S.C. 804(2)) and Executive Order 13771 (January 30, 2017, Reducing Regulation and Controlling Regulatory Costs).

B. Executive Orders 12866 and 13563—Department of Labor and Department of Health and Human Services

Executive Order 12866 (58 FR 51735) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 (76 FR 3821, January 21, 2011) is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a final rule—(1) having an annual effect on the economy of \$100 million or more in any 1 year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as “economically

significant”); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in the Executive Order.

A full regulatory impact analysis must be prepared for major rules with economically significant effects (for example, \$100 million or more in any 1 year), and a “significant” regulatory action is subject to review by the Office of Management and Budget (OMB). The Departments anticipate that this regulatory action is likely to have economic impacts of \$100 million or more in at least 1 year, and therefore meets the definition of “significant rule” under Executive Order 12866. Therefore, the Departments have provided an assessment of the potential costs, benefits, and transfers associated with this proposed rule. In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by OMB.

1. Need for Regulatory Action

This rule contains proposed amendments to the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of individual health insurance coverage. This regulatory action is taken in light of Executive Order 13813 directing the Departments to consider proposing regulations or revising guidance to expand the availability of short-term, limited-duration insurance, as well as continued feedback from stakeholders expressing concerns about the October 2016 final rule. While individuals who qualify for premium tax credits are largely insulated from significant premium increases, individuals who are not eligible for subsidies are harmed by increased premiums in the individual market due to a lack of other, more affordable alternative coverage options. The proposed rule would increase insurance options for individuals unable or unwilling to purchase PPACA-compliant plans.

2. Summary of Impacts

In accordance with OMB Circular A–4, Table 1 depicts an accounting statement summarizing the

³²The Departments are using data on APTC as an approximation of premium tax credits since this is the data that is available for 2017.

Departments' assessment of the benefits, costs, and transfers associated with this regulatory action.

TABLE 1—ACCOUNTING TABLE

Benefits:

Qualitative:

- Increased access to affordable health insurance for consumers unable or unwilling to purchase PPACA-compliant plans, potentially resulting in improved health outcomes for them.
- Increased choice at lower cost and increased protection (for consumers who are currently uninsured) from catastrophic health care expenses for consumers purchasing short-term, limited-duration insurance.
- Potentially broader access to health care providers compared to PPACA-compliant plans for some consumers.

Costs:

Qualitative:

- Reduced access to some services and providers for some consumers who switch from PPACA-compliant plans.
- Increased out-of-pocket costs for some consumers, possibly leading to financial hardship.
- Worsening of States' individual market single risk pools and potential reduced choice for some other individuals remaining in those risk pools.

Transfers	Low estimate (million)	High estimate (million)	Year dollar	Discount rate (percent)	Period covered
Annualized Monetized (\$/year)	\$96	\$168	2017	7	2019
	96	168	2017	3	2019

Quantitative:

- Transfer from the Federal government to enrollees in individual market plans in the form of increased APTC payments.

Qualitative:

- Transfer from enrollees in individual market plans who experience increase in premiums to individuals who switch to lower premium short-term, limited-duration insurance.
- Tax liability for consumers who replace PPACA-compliant plans and will thus no longer maintain minimum essential coverage in 2018.

Short-term, limited-duration insurance represents a small fraction of the health insurance market. Based on data from the National Association of Insurance Commissioners (NAIC), in 2016, before the October 2016 final rule became effective, total premiums earned for policies designated short-term, limited-duration by carriers were approximately \$146 million for approximately 1,279,500 member months and with approximately 160,600 covered lives at the end of the year. During the same period, total premiums for individual market (comprehensive major medical) coverage were approximately \$63.25 billion for approximately 175,689,900 member months with approximately 13.6 million covered lives at the end of the year.³³

Some public comments received in response to the June 2016 proposed rule stated that the majority of the short-term, limited-duration insurance policies were sold as transitional coverage, particularly for individuals seeking to cover periods of unemployment or other gaps between employer-sponsored coverage, and that the policies typically provided coverage

for less than 3 months. Accordingly, this proposed rule would have no effect on the consumers who purchase such coverage for less than 3 months and perhaps some issuers of those policies. While it is not clear how the October 2016 final rule affected the sales of short-term, limited-duration insurance, the sales of such coverage were increasing prior to the issuance of that rule. Given the prior trend and the recent increases in premiums in the individual market, the Departments anticipate that the rule, if finalized, would encourage more consumers to purchase short-term, limited-duration insurance for longer durations, including individuals who were previously uninsured and some who are currently enrolled in individual market plans, especially in 2019 and beyond, when the individual shared responsibility payment included in section 5000A of the Code is reduced to \$0, as provided under Public Law 115–97.

Benefits

Consumers who would be likely to purchase short-term, limited-duration insurance for longer periods would benefit from increased insurance options at lower premiums, as the average monthly premium in the fourth quarter of 2016 for a short-term, limited-

duration policy was approximately \$124 compared to \$393 for an unsubsidized PPACA-compliant plan.³⁴ This proposed rule would also benefit individuals who need coverage for longer periods for reasons previously discussed in the preamble, such as needing more than 3 months to find new employment, or finding PPACA-compliant plans to be unaffordable. Individuals who purchase short-term, limited-duration insurance as opposed to being uninsured would potentially experience improved health outcomes and have greater protection from catastrophic health care expenses. Individuals purchasing short-term, limited-duration policies could obtain broader access to health care providers compared to those PPACA-compliant plans that have narrow provider networks.³⁵ The Departments seek comments on how many consumers may purchase short-term, limited-duration insurance, rather than being uninsured or purchasing PPACA-compliant plans, and the benefits to

³³ National Association of Insurance Commissioners, 2016 Accident and Health Policy Experience Report, July 2017, available at http://www.naic.org/prod_serv/AHP-LR-17.pdf.

³⁴ <http://www.npr.org/sections/health-shots/2017/01/31/512518502/sales-of-short-term-insurance-plans-could-surge-if-health-law-is-relaxed>.

³⁵ The ability of short-term limited-duration plans to provide broad provider networks has been touted by some in the insurance community. <https://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539>.

them from having short-term, limited-duration insurance, as well as any impacts on the PPACA individual market single risk pools.

Issuers of short-term, limited-duration insurance would benefit from higher enrollment. They are likely to experience an increase in premium revenues and profits because such policies can be priced in an actuarially fair manner (by which the Departments mean that it is priced so that the premium paid by an individual reflects the risks associated with insuring the particular individual or individuals covered by that policy) and are not required to comply with PPACA medical loss ratio requirements for group and individual health insurance coverage.

Costs and Transfers

Short-term, limited-duration insurance policies would be unlikely to include all the elements of PPACA-compliant plans, such as the preexisting condition exclusion prohibition, coverage of essential health benefits without annual or lifetime dollar limits, preventive care, maternity and prescription drug coverage, rating restrictions, and guaranteed renewability. Therefore, consumers who switch to such policies from PPACA-compliant plans would experience loss of access to some services and providers and an increase in out-of-pocket expenditures related to such excluded services, benefits that in many cases consumers do not believe are worth their cost (which could be one reason why many consumers, even those receiving subsidies for PPACA-compliant plans, may switch to short-term, limited-duration policies rather than remain in PPACA-compliant plans). The Departments seek comments on the value of such excluded services to individuals who switch coverage. Depending on plan design, consumers who purchase short-term, limited-duration insurance policies and then develop chronic conditions could face financial hardship as a result, until they are able to enroll in PPACA-compliant

plans that would provide coverage for such conditions. Additionally, since short-term, limited-duration insurance does not qualify as minimum essential coverage, any individual enrolled in a short-term, limited-duration plan that lasts 3 months or longer in 2018 would potentially incur a tax liability for not having minimum essential coverage during that year. Starting in 2019, the individual shared responsibility payment included in section 5000A of the Code is reduced to \$0, as provided under Public Law 115-97.

Because short-term, limited-duration insurance policies can be priced in an actuarially fair manner, subject to State law, individuals who are likely to purchase such coverage are likely to be relatively young or healthy. Allowing such individuals to purchase policies that do not comply with PPACA, but with term lengths that may be similar to those of PPACA-compliant plans with 12-month terms, could potentially weaken States' individual market single risk pools. As a result, individual market issuers could experience higher than expected costs of care and suffer financial losses, which might prompt them to leave the individual market. Although choices of plans available in the individual market have already been reduced to plans from a single insurer in roughly half of all counties, this proposed rule may further reduce choices for individuals remaining in those individual market single risk pools. The Departments seek comments on these and any other potential costs.

The Departments anticipate that most of the individuals who switch from individual market plans to short-term, limited-duration insurance would be relatively young or healthy and would also not be eligible to receive APTC. If individual market single risk pools change as a result, it would result in an increase in premiums for the individuals remaining in those risk pools. An increase in premiums for individual market single risk pool coverage would result in an increase in Federal outlays for APTC.

Beginning in 2019, the individual shared responsibility payment included in section 5000A of the Code is reduced to \$0, as provided under Public Law 115-97. This would compound the effects of the provisions of this proposed rule (one potential exception being the impact on APTC payments). In order to estimate the impact on the individual market and APTC payments, the Departments used enrollment, premium and APTC data for 2017, observed rate increases for 2018, and assumed that 2019 rates will increase in line with medical expenditures and assumed the relative morbidities of the individuals leaving the individual market single risk pool to those remaining in the risk pool to be 75 percent. The Congressional Budget Office estimates that 3 million people will drop coverage in 2019 from the individual market and premiums will increase 10 percent on average, as a result of the change to the individual shared responsibility payment.³⁶ The Departments seek comments on how many of these individuals may purchase short-term, limited-duration insurance instead. Based on enrollment trends prior to the October 2016 final rule, the Departments project that approximately 100,000 to 200,000 additional individuals would shift from the individual market to short-term, limited-duration insurance in 2019. Most of these individuals would be young or healthy and only about 10 percent of them would have been subsidized by eligibility for APTC if they maintained their Exchange coverage. While the reduction in the number of subsidized enrollees would tend to reduce total APTC payments, increases in premiums would tend to increase them. The proposed rule's net effect on total APTC payments is uncertain, but federal outlays for APTC are estimated to increase by between \$96 million (\$54,948 million – \$54,852 million) and \$168 million (\$55,020 million – \$54,852 million) annually. Table 2 depicts the effects on average premiums³⁷ and APTC payments.

TABLE 2—ESTIMATED EFFECT ON INDIVIDUAL MARKET EXCHANGES IN 2019

	Estimated number of subsidized enrollees in exchanges	Estimated number of unsubsidized enrollees in exchanges	Estimated average monthly premium	Estimated average monthly APTC	Estimated total monthly APTC	Estimated total annual APTC
No change in policy	8,459,000	4,671,000	\$649	\$512	\$4,331,000,000	\$51,972,000,000

³⁶ See Congressional Budget Office, Repealing the Individual Health Insurance Mandate: An Updated Estimate, November 2017, available at <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf>.

³⁷ Percent Premium Increase = (Total Enrollment – (Morbidity(75%) * Number

Switching)) / (Total Enrollment – Number Switching).

TABLE 2—ESTIMATED EFFECT ON INDIVIDUAL MARKET EXCHANGES IN 2019—Continued

	Estimated number of subsidized enrollees in exchanges	Estimated number of unsubsidized enrollees in exchanges	Estimated average monthly premium	Estimated average monthly APTC	Estimated total monthly APTC	Estimated total annual APTC
\$0 individual shared responsibility payment	8,122,000	1,608,000	714	563	4,573,000,000	54,852,000,000
100,000 People switching to short-term, limited-duration insurance ...	8,112,000	1,518,000	716	564	4,579,000,000	54,948,000,000
200,000 People switching to short-term, limited-duration insurance ...	8,102,000	1,428,000	718	566	4,585,000,000	55,020,000,000

There is significant uncertainty regarding these estimates, because changes in enrollment and premiums would depend on a variety of economic factors and it is difficult to predict how consumers and issuers would react to the proposed policy changes.

C. Regulatory Alternatives

One regulatory alternative would be to set the maximum duration for short-term, limited-duration insurance to a 6 month or 9 month period. However, this alternative would not adequately increase choices for individuals unable or unwilling to purchase PPACA-compliant plans.

D. Paperwork Reduction Act—Department of Health and Human Services

This proposed rule would revise the required notice that must be prominently displayed in the contract and in any application materials for short-term, limited-duration insurance. The Departments have proposed the exact text for this notice requirement and the language would not need to be customized. The burden associated with these notices is not subject to the Paperwork Reduction Act of 1995 in accordance with 5 CFR 1320.3(c)(2) because they do not contain a “collection of information” as defined in 44 U.S.C. 3502(3). Consequently, this document need not be reviewed by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

E. Regulatory Flexibility Act

The Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) (RFA) imposes certain requirements with respect to Federal rules that are subject to the notice and comment requirements of section 553(b) of the Administrative Procedure Act (5 U.S.C. 551 *et seq.*) and that are likely to have a significant economic impact on a substantial number of small entities. Unless an agency certifies that a proposed rule is

not likely to have a significant economic impact on a substantial number of small entities, section 603 of RFA requires that the agency present an initial regulatory flexibility analysis at the time of the publication of the notice of proposed rulemaking describing the impact of the rule on small entities and seeking public comment on such impact. Small entities include small businesses, organizations and governmental jurisdictions.

The RFA generally defines a “small entity” as—(1) a proprietary firm meeting the size standards of the Small Business Administration (13 CFR 121.201); (2) a nonprofit organization that is not dominant in its field; or (3) a small government jurisdiction with a population of less than 50,000. (States and individuals are not included in the definition of “small entity”). The Departments use as their measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

This proposed rule would impact health insurance issuers, especially those in the individual market. The Departments believe that health insurance issuers would be classified under the North American Industry Classification System code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards, entities with average annual receipts of \$38.5 million or less are considered small entities for these North American Industry Classification System codes. Issuers could possibly be classified in 621491 (Health Maintenance Organization Medical Centers) and, if this is the case, the SBA size standard is \$32.5 million or less.³⁸ The Departments believe that few, if any, insurance companies selling comprehensive health insurance

³⁸ “Table of Small Business Size Standards Matched to North American Industry Classification System Codes”, effective October 1, 2017, U.S. Small Business Administration, available at https://www.sba.gov/sites/default/files/files/Size_Standards_Table_2017.pdf.

policies (in contrast, for example, to travel insurance policies or dental discount policies) fall below these size thresholds. Based on data from Medical Loss Ratio (MLR) annual report submissions for the 2015 MLR reporting year,³⁹ approximately 92 out of over 530 issuers of health insurance coverage nationwide had total premium revenue of \$38.5 million or less, of which 64 issuers offer plans in the individual market. This estimate may overstate the actual number of small health insurance companies that may be affected, since almost 50 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 would result in their revenues exceeding \$38.5 million. Therefore, the Departments certify that this proposed rule would not have a significant impact on a substantial number of small entities.

In addition, section 1102(b) of the Social Security Act requires agencies to prepare a regulatory impact analysis if a rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. This proposed rule will not affect small rural hospitals. Therefore, the Departments have determined that this proposed rule would not have a significant impact on the operations of a substantial number of small rural hospitals.

F. Special Analysis—Department of the Treasury

Certain IRS regulations, including this one, are exempt from the requirements of Executive Order 12866, as supplemented and reaffirmed by Executive Order 13563. Therefore, a regulatory impact assessment is not required. Pursuant to Executive Order 13789, the Treasury Department and OMB are currently reviewing the scope and implementation of the existing

³⁹ Available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

exemption. Pursuant to section 7805(f) of the Code, this proposed rule has been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its 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 proposed rule that includes any Federal mandate that may result in expenditures in any 1 year by a State, local, or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. Currently, that threshold is approximately \$148 million. This proposed rule does not include any Federal mandate that may result in expenditures by State, local, or tribal governments, or the private sector, that may impose an annual burden that exceeds that threshold.

H. Federalism—Department of Labor and Department of Health and Human Services

Executive Order 13132 outlines fundamental principles of federalism. It requires adherence to specific criteria by Federal agencies in formulating and implementing policies that have “substantial direct effects” on the States, the relationship between the national government and States, or on the distribution of power and responsibilities among the various levels of government. Federal agencies promulgating regulations that have these federalism implications must consult with State and local officials, and describe the extent of their consultation and the nature of the concerns of State and local officials in the preamble to the final regulation.

Federal officials have discussed the issue of the term length of short-term, limited-duration insurance with State regulatory officials. This proposed rule has no federalism implications to the extent that current State law requirements for short-term, limited-duration insurance are the same as or more restrictive than the Federal standard proposed in this proposed rule. States may continue to apply such State law requirements.

I. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 *et seq.*) and will be transmitted to the Congress and to the

Comptroller General for review in accordance with such provisions.

J. Reducing Regulation and Controlling Regulatory Costs

Executive Order 13771, titled Reducing Regulation and Controlling Regulatory Costs, was issued on January 30, 2017. This proposed rule, if finalized as proposed, is expected to be an Executive Order 13771 deregulatory action.

IV. Statutory Authority

The Department of the Treasury regulations are proposed to be adopted pursuant to the authority contained in sections 7805 and 9833 of the Code.

The Department of Labor regulations are proposed to be adopted pursuant to the authority contained in 29 U.S.C. 1135 and 1191c; and Secretary of Labor’s Order 1–2011, 77 FR 1088 (Jan. 9, 2012).

The Department of Health and Human Services regulations are proposed to be adopted pursuant to the authority contained in sections 2701 through 2763, 2791, 2792 and 2794 of the PHS Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, 300gg–92 and 300gg–94), as amended.

List of Subjects

26 CFR Part 54

Pension excise taxes.

29 CFR Part 2590

Continuation coverage, Disclosure, Employee benefit plans, Group health plans, Health care, Health insurance, Medical child support, Reporting and recordkeeping requirements.

45 CFR Parts 144 and 146

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 148

Administrative practice and procedure, Health care, Health

insurance, Penalties, Reporting and recordkeeping requirements.

Kirsten B. Wielobob,

Deputy Commissioner for Services and Enforcement, Internal Revenue Service.

Signed this 8th day of February 2018.

Preston Rutledge,

Assistant Secretary, Employee Benefits Security Administration, Department of Labor.

Dated: February 1, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: February 9, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

For the reasons stated in the preamble, 26 CFR part 54 is proposed to be amended as follows:

PART 54—PENSION AND EXCISE TAX

■ **Par. 1.** The authority citation for part 54 continues to read in part as follows:

Authority: 26 U.S.C. 7805 * * *

■ **Par. 2.** Section 54.9801–2 is amended by revising the definition of “Short-term, limited-duration insurance” to read as follows:

§ 54.9801–2 Definitions.

* * * * *

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a contract with an issuer that:

(1) Has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer’s consent) that is less than 12 months after the original effective date of the contract;

(2) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following:

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOESN’T COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH

INSURANCE COVERAGE. 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.;

and

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following:

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOESN'T COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE.

* * * * *

■ Par. 3. Section 54.9833-1 is amended by revising the section heading and the last sentence to read as follows:

§ 54.9833-1 Applicability dates.

* * * Notwithstanding the previous sentence, the definition of "short-term, limited-duration insurance" in § 54.9801-2 applies [DATE 60 DAYS AFTER DATE OF PUBLICATION OF THE FINAL RULE IN THE FEDERAL REGISTER].

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons stated in the preamble, the Department of Labor proposes to amend 29 CFR part 2590 as set forth below:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

■ 4. 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).

■ 5. 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 contract with an issuer that:

(1) Has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract;

(2) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following:

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOESN'T COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. 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.;

and

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following:

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOESN'T COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE.

* * * * *

■ 6. Section 2590.736 is amended by revising the last sentence to read as follows:

§ 2590.736 Applicability dates.

* * * Notwithstanding the previous sentence, the definition of "short-term, limited-duration insurance" in § 2590.701-2 applies [DATE 60 DAYS AFTER DATE OF PUBLICATION OF THE FINAL RULE IN THE FEDERAL REGISTER].

DEPARTMENT OF HEALTH AND HUMAN SERVICES

For the reasons stated in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 144, 146, and 148 as set forth below:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

■ 7. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92.

■ 8. 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 contract with an issuer that:

(1) Has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract;

(2) With respect to policies having a coverage start date before January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following:

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOESN'T COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE. 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;

and

(3) With respect to policies having a coverage start date on or after January 1, 2019, displays prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14 point type the following:

THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH FEDERAL REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR POLICY CAREFULLY TO MAKE SURE YOU UNDERSTAND WHAT THE POLICY DOES AND DOESN'T COVER. IF THIS COVERAGE EXPIRES OR YOU LOSE ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE.

* * * * *

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ 9. The authority citation for part 146 is revised to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg-1 through 300gg-5, 300gg-11 through 300gg-23, 300gg-91, and 300gg-92).

■ 10. Section 146.125 is amended by revising the last sentence to read as follows.

§ 146.125 Applicability dates.

* * * Notwithstanding the previous sentence, the definition of "short-term, limited-duration insurance" in § 144.103 of this subchapter applies [DATE 60 DAYS AFTER DATE OF PUBLICATION OF THE FINAL RULE IN THE FEDERAL REGISTER].

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

■ 11. The authority citation for part 148 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg-63, 300gg-91, and 300gg-92), as amended.

■ 12. Section 148.102 is amended by revising the section heading and the last sentence of paragraph (b) to read as follows:

§ 148.102 Scope and applicability date.

* * * * *

(b) * * * Notwithstanding the previous sentence, the definition of "short-term, limited-duration insurance" in § 144.103 of this subchapter is applicable [DATE 60 DAYS AFTER DATE OF PUBLICATION OF THE FINAL RULE IN THE FEDERAL REGISTER].

[FR Doc. 2018-03208 Filed 2-20-18; 8:45 am]

BILLING CODE 4150-28-P; 4510-29-P; 6325-64-P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

RIN 0648-BG83

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Reef Fish Fishery of the Gulf of Mexico; Amendment 36A

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notification of availability; request for comments.

SUMMARY: The Gulf of Mexico (Gulf) Fishery Management Council (Council) has submitted Amendment 36A to the Fishery Management Plan for the Reef Fish Resources of the Gulf of Mexico (Reef Fish FMP) for review, approval, and implementation by NMFS. Amendment 36A would require owners or operators of federally permitted commercial Gulf reef fish vessels landing any commercially caught, federally managed reef fish from the Gulf to provide notification prior to landing and to land at approved locations; require shares of red snapper individual fishing quota (IFQ) (RS-IFQ) program and groupers and tilefishes IFQ (GT-IFQ) program from non-activated accounts to be returned to NMFS for redistribution; and allow NMFS to hold back a portion of IFQ allocation at the start of the fishing year in anticipation of a commercial quota reduction. The purpose of Amendment 36A is to improve compliance and increase management flexibility in the RS-IFQ and GT-IFQ programs, and increase the likelihood of achieving optimum yield (OY) for reef fish stocks managed under these programs.

DATES: Written comments on Amendment 36A must be received by April 23, 2018.

ADDRESSES: You may submit comments on the amendment identified by "NOAA-NMFS-2017-0060" by either of the following methods:

- **Electronic Submission:** Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to www.regulations.gov/#!docketDetail;D=NOAA-NMFS-2017-0060, click the "Comment Now!" icon, complete the required fields, and enter or attach your comments.

- **Mail:** Submit written comments to Peter Hood, NMFS Southeast Regional Office, 263 13th Avenue South, St. Petersburg, FL 33701.

Instructions: Comments sent by any other method, to any other address or individual, or received after the end of the comment period, may not be considered by NMFS. All comments received are a part of the public record and will generally be posted for public viewing on www.regulations.gov without change. All personal identifying information (e.g., name, address, etc.), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. NMFS will accept anonymous comments (enter "N/A" in the required fields if you wish to remain anonymous).

Electronic copies of Amendment 36A may be obtained from www.regulations.gov or the Southeast Regional Office website at http://sero.nmfs.noaa.gov/sustainable_fisheries/gulf_fisheries/reef_fish/2017/A36A_comm_IFQ/am36Aindex.html. Amendment 36A includes an environmental assessment, fishery impact statement, regulatory impact review, and Regulatory Flexibility Act analysis.

FOR FURTHER INFORMATION CONTACT: Peter Hood, NMFS Southeast Regional Office, telephone: 727-824-5305, or email: peter.hood@noaa.gov.

SUPPLEMENTARY INFORMATION: The Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) requires each regional fishery management council to submit any FMP or amendment to NMFS for review and approval, partial approval, or disapproval. The Magnuson-Stevens Act also requires that NMFS, upon receiving a plan or amendment, publish an announcement in the **Federal Register** notifying the public that the FMP or amendment is available for review and comment.

Amendment 36A to the Reef Fish FMP was prepared by the Council and, if approved, would be implemented by NMFS through regulations at 50 CFR