

INSURANCE DIVISION[191]

Adopted and Filed Emergency After Notice

Rule making related to short-term limited-duration health insurance policies

The Insurance Division hereby amends Chapter 35, “Accident and Health Insurance,” and Chapter 36, “Individual Accident and Health—Minimum Standards and Rate Hearings,” Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code chapters 505 and 514D and 83 FR 38212.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code chapters 505 and 514D and 83 FR 38212.

Purpose and Summary

This rule making implements, in whole or in part, a final rule issued by the Internal Revenue Service, Department of the Treasury; the Employee Benefits Security Administration, Department of Labor; and the Centers for Medicare and Medicaid Services, Department of Health and Human Services, found at 83 FR 38212 (new HHS rule).

The new HHS rule extends the permissible policy term periods for short-term limited-duration health insurance policies to up to 12 months (increased from three months). The new federal rule also allows such plans to be renewable for a period of up to three years. Prior to this new HHS rule, these plans were not renewable for periods beyond three months. The new HHS rule was published in the Federal Register on August 3, 2018, and became effective on October 2, 2018.

The amendments adopt a minimum standard of benefits for short-term limited-duration health insurance policies, in response to the new HHS rule, and require certain other consumer protections. These amendments also allow for the Insurance Division’s administration of short-term limited-duration health insurance in response to the new HHS rule.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on January 16, 2019, as **ARC 4242C**. A public hearing was held on February 8, 2019, at 11 a.m. at the Division’s offices on the fourth floor of Two Ruan Center, 601 Locust Street, Des Moines, Iowa. Three persons attended the public hearing. Ten public comments were received. No changes from the Notice have been made.

Reason for Waiver of Normal Effective Date

Pursuant to Iowa Code section 17A.5(2)“b”(1)(b), the Insurance Division finds that the normal effective date of this rule making, 35 days after publication, should be waived and the rule making made effective on February 20, 2019, because the Insurance Division finds that the availability and affordability of health insurance is critical for the greater public interest and that the necessity of ensuring that short-term limited-duration coverage has appropriate consumer protections requires adoption of these amendments.

Adoption of Rule Making

This rule making was adopted by the Insurance Division on February 20, 2019.

Fiscal Impact

This rule making may have some fiscal impact to the State of Iowa, in that an increase in the number of these plans being sold would increase the amount of premium tax funds collected by the State from the issuing companies. While the expected fiscal impact is unknown because the number of plans that will be sold by the issuing companies is unknown, the Insurance Division does not expect a large fiscal impact from the amount of premium tax funds collected.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

The Insurance Division's general waiver provisions of 191—Chapter 4 apply to these rules.

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making became effective on February 20, 2019.

The following rule-making actions are adopted:

ITEM 1. Amend rule **191—35.23(509)**, definition of “Creditable coverage,” as follows:

“*Creditable coverage*” means health benefits or coverage provided to an individual under any of the following:

1. to 10. No change.
11. A short-term ~~limited-duration~~ limited-duration policy.

ITEM 2. Amend rule **191—35.23(509)**, definition of “Health insurance coverage,” as follows:

“*Health insurance coverage*” or “*Health health insurance plan*” means benefits consisting of health care provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as health care under a hospital or health service policy or certificate, hospital or health service plan contract, or health maintenance organization contract offered by a carrier.

1. No change.
2. “Health insurance coverage” does not include benefits provided under a separate policy as follows:

- Limited scope dental or vision benefits.
 - Benefits for long-term care, nursing home care, home health care, or community-based care.
 - Short-term ~~limited-duration~~ limited-duration insurance.
 - Any other similar, limited benefits as provided by rule of the commissioner.
 - Stop loss insurance coverage.
3. No change.
 4. No change.
 5. No change.

ITEM 3. Rescind the definition of “Short-term limited duration insurance” in rule **191—35.23(509)** and adopt the following **new** definition in lieu thereof:

“*Short-term limited-duration insurance*” means health coverage provided pursuant to a contract with an issuer that has an expiration date 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.

ITEM 4. Adopt the following **new** subrule 36.4(17):

36.4(17) “*Short-term limited-duration insurance*” means health coverage provided pursuant to a contract with an issuer that has an expiration date 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.

ITEM 5. Adopt the following **new** subrule 36.6(11):

36.6(11) *Short-term limited-duration insurance coverage.*

a. “Short-term limited-duration insurance coverage” provides coverage up to an aggregate maximum of not less than \$500,000 for each initial or renewal policy term and shall include a minimum of all of the following services subject to the approved policy terms, limitations and exclusions:

- (1) Daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;
- (2) Miscellaneous hospital services, including emergency room services;
- (3) Surgical services;
- (4) Anesthesia services;
- (5) In-hospital medical services;
- (6) Out-of-hospital care consisting of physicians’ services rendered on an ambulatory basis, and through telemedicine by remote diagnosis and treatment of patients by means of telecommunications technology, where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic X-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician;
- (7) In-hospital registered nurse services;
- (8) Convalescent nursing care;
- (9) Diagnosis and treatment by a radiologist or physiotherapist;
- (10) Rental of special medical equipment, as defined by the insurer in the policy;
- (11) Artificial limbs or eyes, casts, splints, trusses or braces;
- (12) Treatment for functional nervous disorders, mental and emotional disorders and substance use disorders; and
- (13) Out-of-hospital prescription drugs and medications.

b. If the short-term limited-duration insurance coverage establishes a separate out-of-pocket maximum for the prescription drug benefit, the short-term limited-duration insurance coverage shall contain a deductible, coinsurance and copayment out-of-pocket maximum for all benefits for each covered person, excluding prescription drug services, that shall not exceed \$5,000 multiplied by the number of months of coverage and not in excess of \$20,000 for the full policy term of any duration, and the separate prescription drug benefit shall have a deductible, coinsurance and copayment out-of-pocket maximum separate from the other required services that shall not exceed \$2,500 multiplied by the number of months of coverage and not in excess of \$10,000 for the full policy term of any duration.

c. If the short-term limited-duration insurance coverage integrates a prescription drug benefit into the plan design, the deductible, coinsurance and copayment out-of-pocket maximum for each covered person for all medical and prescription drug coverage shall not exceed \$7,500 multiplied by the number of months of coverage and not in excess of \$30,000 for the full policy term of any duration.

d. After 180 days of coverage, short-term limited-duration insurance coverage that has an initial policy term or has been renewed or extended beyond 180 days in duration shall also provide preventative and wellness services subject to deductibles, coinsurance and copayments, including

annual routine office visits, immunizations, mammography examinations, prostate-specific antigen blood tests and Papanicolaou tests.

e. Short-term limited-duration insurance shall not contain preexisting condition exclusions that exceed the initial policy term. Any renewable short-term limited-duration insurance shall be guaranteed renewable.

f. Short-term limited-duration insurance shall have an expiration date specified in the policy.

g. All short-term limited-duration policies shall contain the notices required of short-term limited-duration insurance as set forth in the Public Health Service Act, 45 CFR Section 144.103.

h. All short-term limited-duration insurance shall contain a free-look period of not less than ten days after the insured receives the policy during which the insured may cancel the insurance. If the insurance is so canceled, all fees and premiums paid shall be promptly refunded and the insurance shall be voided as if the policy had not been issued. Notice of the free-look period shall be prominently displayed on the first page of the policy.

(1) For the purposes of this paragraph, the policy shall be determined to be received by the insured as follows:

1. Pursuant to Iowa Code section 554D.117 if received electronically; and
2. Four days after the policy is postmarked for delivery if sent in the mail.

(2) For the purposes of this paragraph, the insured may cancel the insurance by giving notice to the insurance company, agent, broker or other representative in any manner, including but not limited to via electronic notice or by telephone.

i. All applications for short-term limited-duration insurance shall contain clear and unambiguous questions designed to ascertain the health condition of the applicant and identify any preexisting conditions.

ITEM 6. Adopt the following **new** subrule 36.7(13):

36.7(13) *Short-term limited-duration insurance coverage.*

a. Outline of coverage. An outline of coverage, in the form prescribed below, shall be issued in connection with any short-term limited-duration insurance, as set forth in subrule 36.6(11). This outline of coverage must be provided in addition to the notices required by paragraph 36.6(11) "g." The items included in the outline of coverage must appear in the sequence prescribed below, and Section A must be in at least 14-point type or, if electronic, of equivalent prominence:

[COMPANY NAME]

SHORT-TERM LIMITED-DURATION INSURANCE COVERAGE
OUTLINE OF COVERAGE

[If coverage begins before January 1, 2019, the following notice shall appear in at least 14-point type or, if electronic, of equivalent prominence:]

A. 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" 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.

[If coverage begins on or after January 1, 2019, the following notice shall appear in at least 14-point type or, if electronic, of equivalent prominence:]

A. 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.

B. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

C. [A brief specific description of the benefits, including dollar amounts, contained in this policy. The description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or copayment or other out-of-pocket cost provisions applicable to the benefits described. The description of benefits shall also clearly state any applicable provider network requirements including but not limited to distinctions in cost provisions for in-network and out-of-network providers.]

D. [A description of any other policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in Section C, above, including but not limited to any preexisting condition exclusions for policies.]

E. [A description of policy provisions regarding renewability or continuation of coverage, including any reservation of right to change premiums.]

b. Application for coverage for short-term limited-duration insurance. All applications for short-term limited-duration policies shall contain the notice prescribed below, which shall be in at least 14-point type or, if electronic, of equivalent prominence. One signed copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer.

STATEMENT TO APPLICANT BY ISSUER [PRODUCER, BROKER OR OTHER REPRESENTATIVE]:

Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under this policy. This could result in a denial or delay of payment of benefits. If you wish to purchase a short-term limited-duration policy, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

ALSO NOTE THAT, 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.

(Signature of Producer, Broker or Other Representative of the Company)
[Typed Name and Address of Producer, Broker or Other Representative]

The above "Statement to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

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