

# DEPARTMENT OF INSURANCE

## OFFICE OF THE COMMISSIONER

Statutory Authority: 18 Delaware Code, Sections 311 and 1720; 18 Delaware Code Chapters 33, 35 and 36; 29 Delaware Code, Chapter 101, and in response to 26 CFR 54.9833-1, 29 CFR 2590.736, 45 CFR 146.125 and 45 CFR 148.120

(18 Del.C. §§311 & 1720; 18 Del.C. Chs. 33, 35 & 36; 29 Del.C. Ch. 101 & in response to 26 CFR 54.9833-1, 29 CFR 2590.736, 45 CFR 146.125 and 45 CFR 148.120)

### PROPOSED

### PUBLIC NOTICE

#### 1320 Minimum Standards for Short-Term, Limited Duration Health Insurance Plans

##### A. Type of Regulatory Action Required

Proposed New Regulation

##### B. Synopsis of Subject Matter of the Regulation

Short-term, limited duration (STLD) health insurance has long been offered to individuals through the non-group market and through associations. The product was originally designed for people who experience a temporary gap in health insurance coverage. Unlike other products that are considered "limited benefit" or "excepted benefit" policies (cancer-only or hospital indemnity that pay a fixed dollar benefit per inpatient stay), STLD health insurance policies are sometimes advertised as providing "major medical" coverage.

STLD policies are distinguishable from other comprehensive major medical policies in that they only provide coverage for a limited term, typically less than 365 days, and, as the name implies, are not renewable. Thus, an individual who bought an STLD and then becomes seriously ill has historically been unable to renew coverage when the policy ends.

STLD policies also have other significant limitations, including the types of services covered, and caps on the maximum claims-paid amounts. Additionally, pursuant to an exemption in the federal Affordable Care Act (ACA), STLD policies are exempt from the market rules that apply to most major medical health insurance policies sold to individuals in the non-group market, including rules that prohibit medical underwriting, pre-existing condition exclusions, and lifetime and annual limits. They are also exempt from the ACA's minimum coverage standards.

In 2017, Congress reduced the ACA's individual mandate tax penalty, (the requirement that individuals have minimum essential health coverage or face a tax penalty) to \$0, beginning in 2019. It is possible that this change could lead more consumers to contemplate purchasing STLD policies.

On August 3, 2018, the federal government issued a rule that will apply to STLD health insurance policies sold on or after October 2, 2018. See 83 Fed. Reg. 38212 (the Final Rule). The Final Rule would extend the period during which plans can be sold from three to 12 months and would allow for consecutive renewal of short-term policies. The relaxation in renewal requirements allows consumers to enroll in the policies for a period arguably longer than "short term" and may re-enroll in the policies for an indefinite period of time.

Although the intent of the Final Rule is to grant consumers more affordable coverage alternatives than are offered through state health insurance marketplaces, the more "affordable" coverage comes with less actual coverage. Specifically, consumers who purchase these plans may face limited benefit offerings, significant out-of-pocket costs, the risk of plan cancellation due to pre-existing conditions, and possible deceptive advertising practices. A producer's duty of competence includes ensuring that consumers considering these policies are fully advised of the terms, benefits, and limitations of the coverage.

The Final Rule expressly describes short-term coverage as "a type of health insurance coverage that was primarily 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 (emphasis added)." *Id.* at 38213.

STLD health insurance policies are not considered minimum essential coverage for purposes of satisfying the ACA individual mandate. *Id.* at 38213 and 38225.

Increased sales of these plans to younger, healthy people is expected to draw thousands of healthy consumers out of Delaware's Health Insurance Marketplace (HIM) risk pool, leading to an unhealthy risk mix and subsequent increases in marketplace health insurance premiums.

The sale of these plans can begin on October 1, 2018, which is 60 days after the Final Rule was issued. Therefore, states, including Delaware, have a short window within which to implement consumer protections, as the sale of these short-term policies could begin later this year.

The Final Rule specifically states that "states generally remain free to adopt . . . other standards as they see fit." *Id.* at 38225.

Elsewhere in this edition of the *Register of Regulations*, the Department published an emergency order by which it adopted new 18 **DE Admin. Code** 1320 - Minimum Standards for Short-Term, Limited Duration Health Insurance Plans, to ensure that carriers offering STLD health insurance plans comply with minimum consumer protection and notification standards so as to partially prevent the erosion of the stability of Delaware's HIM and to protect Delaware consumers from being potentially misled into purchasing a STLD health insurance plan without being fully informed of its coverage limits or applicability.

The Department is therefore concurrently proposing new 18 **DE Admin. Code** 1320 - Minimum Standards for Short-Term, Limited Duration Health Insurance Plans with the purpose of permanently codifying the regulations that are the subject of the Commissioner's Emergency Order adopting these same regulations.

Any person may file written comments, suggestions, briefs, and compilations of data or other materials concerning the proposed new regulation. Any written submission in response to this notice and relevant to the proposed new regulation must be received by the Department of Insurance no later than 4:30 p.m., 3<sup>rd</sup> day, December, 2018 by mailing to:

Delaware Department of Insurance  
Attn.: Leslie W. Ledogar, Esq., Regulatory Specialist  
Docket No. 3909-2018  
841 Silver Lake Boulevard  
Dover, DE 19904

Comments may also be emailed to [leslie.ledogar@state.de.us](mailto:leslie.ledogar@state.de.us).

The Department of Insurance does not plan to hold a public hearing on the proposed new regulation. The proposed new regulation appears below and can also be viewed at the Department of Insurance website at <http://insurance.delaware.gov/information/proposedregs/>.

## **1320 Minimum Standards for Short-Term, Limited Duration Health Insurance Plans**

### **1.0 Purpose**

1.1 The purpose of this regulation is to:

- 1.1.1 Ensure that any short-term, limited duration health insurance policy that is offered in this state complies with certain minimum requirements;
- 1.1.2 Set forth the requirements on producers and agents who offer short-term health insurance policies to this State's consumers; and
- 1.1.3 Provide for full disclosure and notice in the sale of short-term, limited duration health insurance policies, as defined in this regulation.

### **2.0 Authority**

This regulation is issued pursuant to the authority vested in the Commissioner pursuant to 18 Del.C. §311, 18 Del.C. §1720, 18 Del.C. Chs. 33, 35 and 36, 29 Del.C. Ch. 101 and in response to 26 CFR 54.9833-1, 29 CFR 2590.736, 45 CFR 146.125 and 45 CFR 148.120.

### **3.0 Applicability and Scope**

- 3.1 This regulation shall apply to short-term, limited-duration health insurance coverage offered for sale in this state. The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.
- 3.2 This regulation shall not apply to:
  - 3.2.1 Medicare supplement policies subject to 18 Del.C. Ch. 34; or
  - 3.2.2 Long-term care insurance policies subject to 18 Del.C. Ch. 71.

### **4.0 Definitions**

The following words and terms shall have the following meaning unless the context clearly indicates otherwise:

"Carrier" means any entity that provides health insurance in this State. Carrier includes an insurance company, health service corporation, managed care organization and any other entity providing a plan of health insurance or health benefits subject to State insurance regulation. Carrier also includes any third-party administrator or other entity that adjusts, administers or settles claims in connection with health insurance.

"Certificate" means a statement of the coverage and provisions of a policy of either individual or group accident and sickness insurance, which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached to the policy.

"Commissioner" means the Delaware Insurance Commissioner.

"Direct response solicitation" means a communication through a sponsoring or endorsing entity or individually through mail, telephone, the internet or other mass communication media.

"Health care services" means any services or supplies included in the furnishing to any individual of medical care, or hospitalization or incidental to the furnishing of such care or hospitalization, as well as the furnishing to any individual of any and all other services for the purpose of preventing, alleviating, curing or healing human illness, injury, disability or disease.

"Short-term, limited duration health insurance" means health insurance coverage provided pursuant to a contract with a health carrier that has an expiration date specified in the contract that is less than or equal to 3 months after the original effective date of the contract and has a duration of no longer than 3 months in total.

## **5.0 Minimum Policy Standards**

- 5.1 No carrier shall advertise, sell or otherwise offer for sale or cause to be offered for sale a policy that it purports to be a short-term, limited duration health insurance policy, unless that policy meets the definition of short-term, limited duration health insurance policy as defined in Section 4.0 of this regulation and the policy meets the following minimum standards:
- 5.1.1 The policy may not be issued for a period longer than three months;
  - 5.1.2 The three-month policy term limit set in subsection 5.1.1 is a single occurrence limit and may not be effectively extended by issuing the same policy for successive back-to-back terms or by issuing a different short-term, limited duration policy to the same policy holder more than once in any given year;
  - 5.1.3 The carrier shall apply the same underwriting standards to all applicants, regardless of whether they have previously been covered by short-term, limited duration health insurance;
  - 5.1.4 The policy contains the notice required in federal law as dictated in Section 6.0 of this regulation; and
  - 5.1.5 The policy shall be offered at a rate that has an actuarially expected loss ratio of at least 60 percent.
- 5.2 Every carrier who offers a short-term, limited duration health insurance policy shall obtain the approval of the terms and conditions of that policy from the Commissioner before such policy may be offered for sale in this state.
- 5.3 The Commissioner reserves the right to reject for approval a short-term, limited duration health insurance policy that, in the opinion of the Commissioner, is unjust, unfair, or unfairly discriminatory to the policyholder, a person insured under the policy, or to a beneficiary of the policy.

## **6.0 Disclosure and Notice Requirements**

- 6.1 Except as provided in subsection 6.2, a carrier shall, at time of sale, enclose with every short-term, limited duration health insurance policy an outline of coverage of such policy delivered or issued for delivery in this state, in accordance with the following:
- 6.1.1 If the sale of a policy occurs through an agent, the outline of coverage shall be delivered to the applicant at the time of application or to the certificate holder at the time of enrollment;
  - 6.1.2 If the sale of a policy occurs through direct response solicitation, the outline of coverage shall be delivered no later than in conjunction with the issuance of the policy or delivery of the certificate;
  - 6.1.3 If the outline of coverage required in this section is not delivered at the time of application or enrollment, the advertising materials delivered to the applicant or enrollee shall contain all the information required in subsection 6.1;
  - 6.1.4 If the outline of coverage is delivered to the applicant or enrollee at the time of application or enrollment, the carrier shall collect an acknowledgment of receipt or certificate of delivery of the outline of coverage and the carrier shall maintain evidence of the delivery; and
  - 6.1.5 If coverage is issued on a basis other than as applied for, an outline of coverage properly describing the coverage or contract actually issued shall be delivered with the policy or certificate to the applicant or enrollee.
- 6.2 An outline of coverage for short-term, limited duration health insurance shall not be required to be delivered by the carrier if the certificate contains a brief description of:
- 6.2.1 Benefits;
  - 6.2.2 Provisions that exclude, eliminate, restrict, limit, delay or in any other manner operate to qualify payment of the benefits;
  - 6.2.3 Non-renewability provisions; and
  - 6.2.4 The notice requirements as provided in subsection 6.5.

- 6.3 Coverage outlines provided pursuant to subsection 6.1 shall include:
- 6.3.1 A statement identifying the applicable category or categories of coverage;
  - 6.3.2 A description of the principal benefits and coverage provided;
  - 6.3.3 A statement of the exceptions, reductions and limitations;
  - 6.3.4 A statement that the policy is not renewable; and
  - 6.3.5 A statement that the outline is a summary of the policy or certificate issued or applied for and that the policy or certificate should be consulted to determine governing policy provisions.
- 6.4 With respect to a policy having a coverage start date before January 1, 2019, a carrier shall display prominently in the application materials provided in connection with enrollment a notice, in at least 14 point type, that includes the following language in the following format:
- : 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).
  - : Be sure to check your policy carefully to make sure you are aware of any **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.
  - : 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.
- 6.5 With respect to policies having a coverage start date on or after January 1, 2019, a carrier shall display prominently in the application materials provided in connection with enrollment a notice, in at least 14 point bolded type, that includes the following language:
- : 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).
  - : Be sure to check your policy carefully to make sure you are aware of any **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.
  - : This coverage is **NOT "MINIMUM ESSENTIAL COVERAGE."** If you don't have minimum essential coverage for any month in 2019 or thereafter and the penalty for not having minimum essential coverage is more than the 2018 amount of \$0, 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.

## **7.0 Requirements for Replacement**

- 7.1 Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and sickness insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.
- 7.2 Upon determining that a sale will involve replacement, a carrier, other than a direct response carrier, or its agent, shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in subsection 7.3. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the carrier. A direct response carrier shall deliver to the applicant upon issuance of the policy, the notice described in subsection 7.4. In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.
- 7.3 The notice required by subsection 7.2 for a carrier, other than a direct response carrier, shall provide, in substantially the following form:

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**  
According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (insert Company Name) Insurance Company. For your own information and protection, you should be aware of

and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under the policy you are replacing with this policy.

(2) You may wish to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, 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, re-read it carefully to be certain that all information has been properly recorded.

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

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant's Signature)

7.4 The notice required by subsection 7.2 for a direct response carrier shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (insert Company Name) Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under the policy you are replacing with this policy.

(2) You may wish to secure the advice of your present carrier or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

(Company Name)

**8.0 Severability**

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the Regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

**9.0 Effective Date**

This regulation shall take effect 10 days after final publication in the Delaware Register of Regulations.

**22 DE Reg. 371 (11/01/18) (Prop.)**