

INTERNAL REVENUE BULLETIN



HIGHLIGHTS OF THIS ISSUE

Bulletin No. 2018-11
March 12, 2018

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

ADMINISTRATIVE

Rev. Proc. 2018-20, page 427.

This revenue procedure extends the safe harbor set forth in Rev. Proc. 2010-28, 2010-34 I.R.B. 270, concerning the application of Internal Revenue Code sections 7702 and 7702A, to life insurance contracts that have mortality guarantees based on the 2017 Commissioners' Standard Ordinary Mortality Tables or any other prevailing commissioners' standard tables that extend beyond age 100 and that may continue in force after the day on which the insured individual attains age 100. The safe harbor applies to life insurance contracts that are intended to qualify as life insurance contracts and avoid characterization as modified endowment contracts, or MECs, under section 7702A, provided the contract complies with certain testing methodologies set out in the revenue procedure. Rev. Proc. 2010-28 modified and superseded.

fit, it is exempt from the Public Health Service Act's (PHS Act) individual-market requirements because it is statutorily excluded from individual health insurance coverage. The proposed regulations expand the potential maximum coverage period by 9 months, consistent with the definition in the 2004 HIPAA final regulations.

EXCISE TAX

T.D. 9830, page 423.

These final regulations provide rules for the definition of covered entity for purposes of the fee imposed by section 9010 of the Affordable Care Act.

EMPLOYEE PLANS

Notice 2018-11, page 425.

This notice sets forth updates on the corporate bond monthly yield curve, the corresponding spot segment rates for February 2018 used under § 417(e)(3)(D), the 24-month average segment rates applicable for January 2018, and the 30-year Treasury rates. These rates reflect the application of § 430(h)(2)(C)(iv), which was added by the Moving Ahead for Progress in the 21st Century Act, Public Law 112-141 (MAP-21) and amended by section 2003 of the Highway and Transportation Funding Act of 2014 (HATFA).

REG-133491-17, page 430.

These proposed regulations contain proposals to amend the definition of short-term limited duration insurance (STLDI) for purposes of its exclusion from the definition of individual health insurance coverage. Although STLDI is not an excepted bene-

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Introduction

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

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

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

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

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

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.

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

Part II.—Treaties and Tax Legislation.

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

Part III.—Administrative, Procedural, and Miscellaneous.

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

Part IV.—Items of General Interest.

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

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

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Part I. Rulings and Decisions Under the Internal Revenue Code of 1986

T.D. 9830

DEPARTMENT OF THE TREASURY

Internal Revenue Service 26 CFR Part 57

Health Insurance Providers Fee

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Final regulations and removal of temporary regulations.

SUMMARY: This document contains final regulations that provide rules for the definition of a covered entity for purposes of the fee imposed by section 9010 of the Patient Protection and Affordable Care Act, as amended. The final regulations supersede and adopt the text of temporary regulations that provide rules for the definition of a covered entity. The final regulations affect persons engaged in the business of providing health insurance for United States health risks.

DATES: *Effective Date:* The final regulations are effective February 22, 2018.

FOR FURTHER INFORMATION CONTACT: Rachel S. Smith at (202) 317-6855 (not a toll-free number).

SUPPLEMENTARY INFORMATION:

Background

Section 9010 of the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-148 (124 Stat. 119 (2010)), as amended by section 10905 of PPACA, and as further amended by section 1406 of the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (124 Stat. 1029 (2010)) (collectively, the Affordable Care Act or ACA) imposes an annual fee on covered entities that provide health insurance for United States health risks. All references in this preamble to section 9010 are references to section 9010 of the ACA. Section 9010 did not amend the Internal Revenue

Code (Code) but contains cross-references to specified Code sections. Unless otherwise indicated, all other references to subtitles, chapters, subchapters, and sections in this preamble are references to subtitles, chapters, subchapters, and sections in the Code and related regulations. All references to “fee” in this preamble are references to the fee imposed by section 9010.

On November 27, 2013, the Department of the Treasury (Treasury Department) and the IRS published final regulations (TD 9643) relating to the health insurance providers fee in the **Federal Register** (78 FR 71476). On February 26, 2015, the Treasury Department and the IRS published temporary regulations (TD 9711) relating to the health insurance providers fee in the **Federal Register** (80 FR 10333). A notice of proposed rulemaking (REG-143416-14) cross-referencing the temporary regulations was published in the **Federal Register** in the same issue (80 FR 10435). The temporary regulations provided further guidance on the definition of a covered entity for the 2015 fee year and subsequent fee years.

The Treasury Department and the IRS received two written comments with respect to the notice of proposed rulemaking. No public hearing was requested or held. After considering the public written comments, the final regulations adopt the proposed regulations without change and the temporary regulations are removed.

Explanation of Provisions

The temporary regulations provided that, for the 2015 fee year and each subsequent fee year, an entity qualified for an exclusion under section 9010(c)(2) if it qualified for an exclusion either for the entire data year ending on the prior December 31st or for the entire fee year beginning on January 1st. The temporary regulations also generally imposed a consistency requirement that bound an entity to its original selection of either the data year or the fee year (its test year) to determine whether it qualified for an exclusion under section 9010(c)(2) for the 2015 fee year and each subsequent fee year.

Next, the temporary regulations imposed a special rule for any entity that uses the fee year as its test year. Finally, the temporary regulations provided that a controlled group must report net premiums written only for each person who is a controlled group member at the end of the day on December 31st of the data year and that would qualify as a covered entity in the fee year if it were a single-person covered entity (that is, not a member of a controlled group).

The Treasury Department and the IRS received two written comments in response to the proposed and temporary regulations. Both commenters agreed with the approach described in the proposed and temporary regulations. One commenter suggested that the final rules add three additional requirements. First, the commenter suggested that entities seeking to claim the non-profit exemption described in section 9010(c)(2)(C) and § 57.2(b)(2)(iii) of the Health Insurance Providers Fee Regulations be required to file a Form 8963, “Report of Health Insurance Provider Information,” or similar report indicating its exempt status for either the data year or the fee year. Second, the commenter suggested that such entities claiming exempt status for the fee year should also file a year-end statement certifying that they maintained their exempt status through the end of the fee year. The Treasury Department and the IRS received similar comments prior to issuing the final regulations. The preamble to TD 9643 (78 FR 71476) explains that the Treasury Department and the IRS declined to adopt commenters’ suggestions to require an entity qualifying for an exclusion to report its net premiums written because section 9010(g)(1) applies only to covered entities. Furthermore, imposing additional filing requirements for only certain entities is contrary to Executive Order 13789, which directs the Treasury Department to reduce tax regulatory burdens. Imposing additional filing requirements for only certain entities is also contrary to Executive Order 13765, which directs the executive branch to minimize the regulatory burden of the ACA specifically. Therefore, we decline to adopt the commenter’s suggestions.

Third, the commenter suggested that any entities that fail to remain exempted for the full duration of the fee year should be subject to a fee assessment at the end of the year. The final regulations do not adopt this suggestion. Section 57.6(c) of the Health Insurance Providers Fee Regulations provides that the IRS will not alter fee calculations on the basis of information provided after the end of the error correction period. Section 9010(g)(2) and § 57.3(b)(1) of the Health Insurance Providers Fee Regulations impose a penalty on covered entities that fail to timely submit Form 8963 without reasonable cause. It is possible that if an entity fails to remain exempted for the full duration of the fee year, such entity will be subject to a penalty provided for by the existing statutory and regulatory framework. An additional fee assessment for such entities is not necessary.

Special Analyses

Certain IRS regulations, including these, 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. Because the final regulations do not impose a collection of information on small entities, the Regulatory Flexibility Act (5 U.S.C. chapter 6) does not apply. Pursuant to section 7805(f) of the Code, the temporary regulations that preceded the final regulations was submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on its impact on small business.

Drafting Information

The principal author of these final regulations is Rachel S. Smith, Office of the Associate Chief Counsel (Passthroughs and Special Industries). However, other personnel from the Treasury Department

and the IRS participated in their development.

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Adoption of Amendments to the Regulations

Accordingly, 26 CFR part 57 is amended as follows:

PART 57 – HEALTH INSURANCE PROVIDERS FEE

Paragraph 1. The authority citation for part 57 continues to read in part as follows:

Authority: 26 U.S.C. 7805; sec. 9010, P. L. 111–148 (124 Stat. 119 (2010)). * * *

Par. 2. Section 57.2 is amended by revising paragraphs (b)(3) and (c)(3)(ii) as follows:

§ 57.2 Explanation of terms.

* * * * *

(b) * * *

(3) *Application of exclusions*—(i) *Test year*. An entity qualifies for an exclusion described in paragraphs (b)(2)(i) through (iv) of this section if it so qualifies in its test year. The term *test year* means either the entire data year or the entire fee year.

(ii) *Consistency rule*. For purposes of paragraph (b)(3)(i) of this section, an entity must use the same test year as it used in its first fee year beginning after December 31, 2014, and in each subsequent fee year. Thus, for example, if an entity used the 2014 data year as its test year for the 2015 fee year, that entity must use the data year as its test year for each subsequent fee year.

(iii) *Special rule for fee year as test year*. For purposes of paragraph (b)(3) of this section, any entity that uses the fee year as its test year but ultimately does not qualify for an exclusion described in paragraphs (b)(2)(i) through (iv) of this section for that entire fee year must use the

data year as its test year for each subsequent fee year.

* * *

(c) * * *

(3) * * *

(ii) A person is treated as being a member of the controlled group if it is a member of the group at the end of the day on December 31st of the data year. However, a person's net premiums written are included in net premiums written for the controlled group only if the person would qualify as a covered entity in the fee year if the person were not a member of the controlled group.

* * * * *

§ 57.2T [Removed]

Par. 3. Section 57.2T is removed.

Par. 4. Section 57.10 is amended by revising paragraph (b) to read as follows:

§ 57.10 Effective/applicability date.

* * * * *

(b) *Paragraphs (b)(3) and (c)(3)(ii) of § 57.2*. Paragraphs (b)(3) and (c)(3)(ii) of § 57.2 apply on February 22, 2018.

§ 57.10T [Removed]

Par. 5. Section 57.10T is removed.

Kirsten Wielobob,
Deputy Commissioner for Services and Enforcement.

Approved: February 15, 2018.

David J. Kautter,
Assistant Secretary of the Treasury (Tax Policy).

(Filed by the Office of the Federal Register on February 22, 2018, 11:15 a.m., and published in the issue of the Federal Register for February 26, 2018, 83 F.R. 8173)

Part III. Administrative, Procedural, and Miscellaneous

Update for Weighted Average Interest Rates, Yield Curves, and Segment Rates

Notice 2018–11

This notice provides guidance on the corporate bond monthly yield curve, the corresponding spot segment rates used under § 417(e)(3), and the 24-month average segment rates under § 430(h)(2) of the Internal Revenue Code. In addition, this notice provides guidance as to the interest rate on 30-year Treasury securities under § 417(e)(3)(A)(ii)(II) as in effect for plan years beginning before 2008 and the 30-year Treasury weighted average rate under § 431(c)(6)(E)(ii)(I).

YIELD CURVE AND SEGMENT RATES

Generally, except for certain plans under section 104 of the Pension Protection Act of 2006 and CSEC plans under § 414(y), § 430 of the Code specifies the minimum funding requirements that apply

to single-employer plans pursuant to § 412. Section 430(h)(2) specifies the interest rates that must be used to determine a plan’s target normal cost and funding target. Under this provision, present value is generally determined using three 24-month average interest rates (“segment rates”), each of which applies to cash flows during specified periods. To the extent provided under § 430(h)(2)(C)(iv), these segment rates are adjusted by the applicable percentage of the 25-year average segment rates for the period ending September 30 of the year preceding the calendar year in which the plan year begins.¹ However, an election may be made under § 430(h)(2)(D)(ii) to use the monthly yield curve in place of the segment rates.

Notice 2007–81, 2007–44 I.R.B. 899, provides guidelines for determining the monthly corporate bond yield curve, and the 24-month average corporate bond segment rates used to compute the target normal cost and the funding target. Consistent with the methodology specified in Notice 2007–81, the monthly corporate bond yield curve derived from December

2017 data is in Table 2017–12 at the end of this notice. The spot first, second, and third segment rates for the month of December 2017 are, respectively, 2.33, 3.55, and 4.11.

The 24-month average segment rates determined under § 430(h)(2)(C)(i) through (iii) must be adjusted pursuant to § 430(h)(2)(C)(iv) to be within the applicable minimum and maximum percentages of the corresponding 25-year average segment rates. For plan years beginning before 2021, the applicable minimum percentage is 90% and the applicable maximum percentage is 110%. The 25-year average segment rates for plan years beginning in 2016, 2017, and 2018 were published in Notice 2015–61, 2015–39 I.R.B. 408, Notice 2016–54, 2016–40 I.R.B. 429, and Notice 2017–50, 2017–41 I.R.B. 280, respectively.

24-MONTH AVERAGE CORPORATE BOND SEGMENT RATES

The three 24-month average corporate bond segment rates applicable for January 2018 without adjustment for the 25-year average segment rate limits are as follows:

Applicable Month	24-Month Average Segment Rates Without 25-Year Average Adjustment		
	First Segment	Second Segment	Third Segment
January 2018	1.81	3.68	4.53

Based on § 430(h)(2)(C)(iv), the 24-month averages applicable for January 2018, adjusted to be within the applicable minimum and maximum percentages of the corresponding 25-year average segment rates, are as follows:

For Plan Years Beginning In	Applicable Month	Adjusted 24-Month Average Segment Rates		
		First Segment	Second Segment	Third Segment
2016	January 2018	4.43	5.91	6.65
2017	January 2018	4.16	5.72	6.48
2018	January 2018	3.92	5.52	6.29

30-YEAR TREASURY SECURITIES INTEREST RATES

Generally for plan years beginning after 2007, § 431 specifies the minimum funding requirements that apply to multiemployer plans pursuant to § 412. Sec-

tion 431(c)(6)(B) specifies a minimum amount for the full-funding limitation described in § 431(c)(6)(A), based on the plan’s current liability. Section 431(c)(6)(E)(ii)(I) provides that the interest rate used to calculate current liability for this purpose must be no more than 5 percent

above and no more than 10 percent below the weighted average of the rates of interest on 30-year Treasury securities during the four-year period ending on the last day before the beginning of the plan year. Notice 88–73, 1988–2 C.B. 383, provides guidelines for determining the weighted

¹Pursuant to § 433(h)(3)(A), the 3rd segment rate determined under § 430(h)(2)(C) is used to determine the current liability of a CSEC plan (which is used to calculate the minimum amount of the full funding limitation under § 433(c)(7)(C)).

average interest rate. The rate of interest on 30-year Treasury securities for December 2017 is 2.77 percent. The Service determined this rate as the average of the

daily determinations of yield on the 30-year Treasury bond maturing in November 2047. For plan years beginning in January 2018, the weighted average of the

rates of interest on 30-year Treasury securities and the permissible range of rates used to calculate current liability are as follows:

<i>Treasury Weighted Average Rates</i>		
For Plan Years Beginning In	30-Year Treasury Weighted Average	Permissible Range 90% to 105%
January 2018	2.84	2.56 to 2.98

MINIMUM PRESENT VALUE SEGMENT RATES

In general, the applicable interest rates under § 417(e)(3)(D) are segment rates

computed without regard to a 24-month average. Notice 2007–81 provides guidelines for determining the minimum present value segment rates. Pursuant to that notice, the minimum present value seg-

ment rates determined for December 2017 are as follows:

<i>Minimum Present Value Segment Rates</i>			
Month	First Segment	Second Segment	Third Segment
December 2017	2.33	3.55	4.11

DRAFTING INFORMATION

The principal author of this notice is Tom Morgan of the Office of the Associ-

ate Chief Counsel (Tax Exempt and Government Entities). However, other personnel from the IRS participated in the development of this guidance. For further

information regarding this notice, contact Mr. Morgan at 202-317-6700 or Tony Montanaro at 202-317-8698 (not toll-free numbers).

Table 2017-12									
Monthly Yield Curve for December 2017									
<i>Derived from January 2017 Data</i>									
<i>Maturity</i>	<i>Yield</i>	<i>Maturity</i>	<i>Yield</i>	<i>Maturity</i>	<i>Yield</i>	<i>Maturity</i>	<i>Yield</i>	<i>Maturity</i>	<i>Yield</i>
0.5	1.83	20.5	3.94	40.5	4.13	60.5	4.20	80.5	4.23
1.0	1.98	21.0	3.95	41.0	4.14	61.0	4.20	81.0	4.24
1.5	2.12	21.5	3.96	41.5	4.14	61.5	4.20	81.5	4.24
2.0	2.23	22.0	3.97	42.0	4.14	62.0	4.20	82.0	4.24
2.5	2.33	22.5	3.98	42.5	4.14	62.5	4.21	82.5	4.24
3.0	2.41	23.0	3.98	43.0	4.15	63.0	4.21	83.0	4.24
3.5	2.49	23.5	3.99	43.5	4.15	63.5	4.21	83.5	4.24
4.0	2.56	24.0	4.00	44.0	4.15	64.0	4.21	84.0	4.24
4.5	2.64	24.5	4.00	44.5	4.15	64.5	4.21	84.5	4.24
5.0	2.71	25.0	4.01	45.0	4.15	65.0	4.21	85.0	4.24
5.5	2.79	25.5	4.02	45.5	4.16	65.5	4.21	85.5	4.24
6.0	2.86	26.0	4.02	46.0	4.16	66.0	4.21	86.0	4.24
6.5	2.94	26.5	4.03	46.5	4.16	66.5	4.21	86.5	4.24
7.0	3.02	27.0	4.03	47.0	4.16	67.0	4.21	87.0	4.24
7.5	3.09	27.5	4.04	47.5	4.16	67.5	4.22	87.5	4.24
8.0	3.17	28.0	4.04	48.0	4.17	68.0	4.22	88.0	4.24
8.5	3.24	28.5	4.05	48.5	4.17	68.5	4.22	88.5	4.24
9.0	3.30	29.0	4.05	49.0	4.17	69.0	4.22	89.0	4.24
9.5	3.36	29.5	4.06	49.5	4.17	69.5	4.22	89.5	4.25
10.0	3.42	30.0	4.06	50.0	4.17	70.0	4.22	90.0	4.25
10.5	3.47	30.5	4.07	50.5	4.17	70.5	4.22	90.5	4.25

Table 2017-12
Monthly Yield Curve for December 2017
Derived from January 2017 Data

<i>Maturity</i>	<i>Yield</i>								
11.0	3.52	31.0	4.07	51.0	4.18	71.0	4.22	91.0	4.25
11.5	3.57	31.5	4.08	51.5	4.18	71.5	4.22	91.5	4.25
12.0	3.61	32.0	4.08	52.0	4.18	72.0	4.22	92.0	4.25
12.5	3.65	32.5	4.08	52.5	4.18	72.5	4.22	92.5	4.25
13.0	3.68	33.0	4.09	53.0	4.18	73.0	4.22	93.0	4.25
13.5	3.71	33.5	4.09	53.5	4.18	73.5	4.23	93.5	4.25
14.0	3.74	34.0	4.10	54.0	4.18	74.0	4.23	94.0	4.25
14.5	3.77	34.5	4.10	54.5	4.19	74.5	4.23	94.5	4.25
15.0	3.79	35.0	4.10	55.0	4.19	75.0	4.23	95.0	4.25
15.5	3.81	35.5	4.11	55.5	4.19	75.5	4.23	95.5	4.25
16.0	3.83	36.0	4.11	56.0	4.19	76.0	4.23	96.0	4.25
16.5	3.85	36.5	4.11	56.5	4.19	76.5	4.23	96.5	4.25
17.0	3.86	37.0	4.11	57.0	4.19	77.0	4.23	97.0	4.25
17.5	3.88	37.5	4.12	57.5	4.19	77.5	4.23	97.5	4.25
18.0	3.89	38.0	4.12	58.0	4.20	78.0	4.23	98.0	4.25
18.5	3.90	38.5	4.12	58.5	4.20	78.5	4.23	98.5	4.25
19.0	3.91	39.0	4.13	59.0	4.20	79.0	4.23	99.0	4.25
19.5	3.92	39.5	4.13	59.5	4.20	79.5	4.23	99.5	4.25
20.0	3.93	40.0	4.13	60.0	4.20	80.0	4.23	100.0	4.25

26 CFR 601.601 Rules and regulations.
(Also Part I, §§ 7702 and 7702A.)

Rev. Proc. 2018-20

SECTION 1. PURPOSE

This revenue procedure provides a safe harbor concerning the application of §§ 7702 and 7702A of the Internal Revenue Code (the “Code”) to life insurance contracts that (1) have mortality guarantees based upon prevailing commissioners’ standard tables² that extend beyond age 100, such as the 2001 Commissioners’ Standard Ordinary Mortality Tables (“2001 CSO tables”) and the 2017 Commissioners’ Standard Ordinary Mortality Tables (“2017 CSO tables”), and (2) may continue in force after the day on which the insured individual (“the insured”) attains age 100. This revenue procedure modifies and supersedes Rev. Proc. 2010-28, 2010-34 I.R.B. 270, to provide for application of the safe harbor described in Rev. Proc. 2010-28 to life insurance contracts that have mortality guarantees based

upon not only the 2001 CSO tables, but also upon the 2017 CSO tables and any other prevailing commissioners’ standard tables that extend beyond age 100.

SECTION 2. BACKGROUND

.01 Section 7702 defines the term “life insurance contract” for purposes of the Code. Section 7702(a) provides that a “life insurance contract” is any contract that is a life insurance contract under the applicable law, but only if such contract either (1) meets the cash value accumulation test of § 7702(b), or (2) both meets the guideline premium requirements of § 7702(c) and falls within the cash value corridor of § 7702(d).

.02 A contract meets the cash value accumulation test of § 7702(b) if, by the terms of the contract, the cash surrender value of the contract may not at any time exceed the net single premium that would have to be paid at that time to fund future benefits under the contract.

.03 A contract meets the guideline premium requirements of § 7702(c) if the sum of the premiums paid under the contract does not at any time exceed the guideline premium limitation as of that time. The guideline premium limitation as of any date is the greater of the guideline single premium, or the sum of the guideline level premiums to that date. The guideline single premium is the premium that would be required on the date the contract is issued to fund the future benefits under the contract. The guideline level premium is the level annual premium, computed on the same basis as the guideline single premium but with a lower interest rate, that would be required on the date the contract is issued to fund the future benefits under the contract.

.04 A contract falls within the cash value corridor of § 7702(d) if the death benefit under the contract at any time is not less than the applicable percentage, as determined under the table set forth in § 7702(d)(2), of the cash surrender value.

²Section 13517 of Public Law 115-97 amended §§ 807(d) and 7702(f)(10) of the Code. References in this revenue procedure to “prevailing commissioners’ standard tables” refer to the term as defined in § 807(d)(5) for taxable years beginning on or before December 31, 2017, and as defined in § 7702(f)(10) for taxable years beginning after December 31, 2017.

Under that table, the applicable percentage for an insured with an attained age of 95 is 100 percent.

.05 Section 7702(e) provides computational rules that must be used for purposes of § 7702, other than for purposes of applying the cash value corridor. In particular, under § 7702(e)(1)(B) the maturity date (including the date on which any death benefit is payable) under a contract is deemed to be no earlier than the day on which the insured attains age 95, and no later than the day on which the insured attains age 100. Section 1.7702-2 of the Income Tax Regulations provides guidance on determining the attained age of the insured for this purpose.

.06 Section 7702A(a) provides that a life insurance contract is a modified endowment contract (“MEC”) if the contract is entered into on or after June 21, 1988, and fails to meet the 7-pay test, or is received in exchange for a contract that is a MEC. A contract fails to meet the 7-pay test if the accumulated amount paid under the contract at any time during the first 7 contract years exceeds the sum of the net level premiums that would have to be paid on or before such time if the contract were to provide for paid-up future benefits (including death benefits) after the payment of 7 level annual premiums. Under § 7702A(c)(1)(B), the determination of the 7 level annual premiums generally is made by applying the computational rules of § 7702(e), including the rule requiring a deemed maturity date no earlier than the day on which the insured attains age 95 and no later than the day on which the insured attains age 100.

.07 The 2017 CSO tables became the prevailing commissioners’ standard tables on January 1, 2017. For tax purposes, the 2017 CSO tables generally must be used for purposes of applying the reasonable mortality charge requirements of § 7702(c)(3)(B)(i) with regard to contracts issued on or after January 1, 2020. *See* Notice 2016-63, 2016-45 I.R.B. 683. Either the 2001 CSO tables or the 2017 CSO tables may be used for contracts issued on or after January 1, 2017, and before January 1, 2020. *Id.* The 2001 CSO tables generally must be used for purposes of applying the reasonable mortality charge requirements of § 7702(c)(3)(B)(i) with regard to contracts issued on or

after January 1, 2009, and before January 1, 2017. *Id.*

.08 Unlike the 1958 Commissioners’ Standard Ordinary Mortality Tables (“1958 CSO tables”) and the 1980 Commissioners’ Standard Ordinary Mortality Tables (“1980 CSO tables”), the 2001 CSO tables and 2017 CSO tables extend to age 121. As a result, an increasing number of issuers now develop contracts that may continue in force beyond age 100, even though the qualification of a contract as a life insurance contract (and as a MEC) under §§ 7702 and 7702A is tested using computational rules that deem the contract to mature between the day on which the insured attains age 95 and the day on which the insured attains age 100.

.09 The 2001 CSO Maturity Age Task Force of the Taxation Section of the Society of Actuaries (“Task Force”) recommended a series of computational rules for compliance with the requirements of §§ 7702 and 7702A in a manner that is actuarially sound in the case of contracts that may continue in force beyond age 100. *See 2001 CSO Implementation Under IRC Sections 7702 and 7702A*, 2 Taxing Times 23 (May 2006).

.10 Notice 2009-47, 2009-24 I.R.B. 1083, proposed a safe harbor drawn from the recommendations of the Task Force, with modifications. Specifically, the notice addressed the application of §§ 7702 and 7702A to a contract that may continue in force after the day on which the insured attains age 100. The notice also requested comments on related matters.

.11 The Treasury Department and the Internal Revenue Service (“IRS”) subsequently determined that it was in the interest of sound tax administration to adopt the safe harbor that was proposed in Notice 2009-47, with modifications, in the form of a revenue procedure. Rev. Proc. 2010-28 adopted, with modifications, the safe harbor testing methodologies proposed in Notice 2009-47 for life insurance contracts that (1) have mortality guarantees based upon the 2001 CSO tables, and (2) may continue in force after the day on which the insured attains age 100. Rev. Proc. 2010-28 did not address the other issues on which comments were requested in Notice 2009-47.

.12 Following the issuance of the 2017 CSO tables, the Treasury Department and

the IRS have determined that it is in the interest of sound tax administration to extend the safe harbor adopted in Rev. Proc. 2010-28 to life insurance contracts that (1) have mortality guarantees based upon prevailing commissioners’ standard tables that extend beyond age 100, such as the 2001 CSO tables and the 2017 CSO tables, and (2) may continue in force after the day on which the insured individual attains age 100.

SECTION 3. APPLICATION

.01 *In general.* The IRS will not challenge the qualification of a contract as a life insurance contract under § 7702, or assert that a contract is a MEC under § 7702A, if the contract satisfies the requirements of those provisions using all of the Age 100 Safe Harbor Testing Methodologies of section 3.02 of this revenue procedure.

.02 *Age 100 Safe Harbor Testing Methodologies.* The Age 100 Safe Harbor Testing Methodologies are as follows:

(a) All determinations under §§ 7702 and 7702A (other than the cash value corridor) assume that the contract will mature by the day on which the insured attains age 100, notwithstanding that the contract specifies a later maturity date (such as by reason of using prevailing commissioners’ standard tables that extend beyond age 100).

(b) The net single premium determined for purposes of the cash value accumulation test under § 7702(b), and the necessary premiums determined for purposes of § 7702A(c)(3)(B)(i), assume an endowment on the day on which the insured attains age 100.

(c) The guideline level premium determined under § 7702(c)(4) assumes premium payments through the day on which the insured attains age 99.

(d) Under § 7702(c)(2)(B), the guideline level premiums accumulate through a date no earlier than the day on which the insured attains age 95 and no later than the day on which the insured attains age 99. Thereafter, premium payments are allowed and are tested against the guideline premium limitation, but in determining the guideline premium limitation the sum of the guideline level premiums does not change after the day on which the insured attains age 100.

(e) In the case of a contract issued or materially changed within fewer than 7 years of the day on which the insured attains age 100, the net level premium under § 7702A(b) is computed assuming level annual premium payments over the number of years between the date on which the contract is issued or materially changed and the date on which the insured attains age 100.

(f) In the case of a contract issued or materially changed within fewer than 7 years of the day on which the insured attains age 100, the sum of the net level premiums increases until the day on which the insured attains age 100. Thereafter, the sum of the net level premiums does not increase, but premium payments are allowed and are tested against this limit for the remainder of the 7-year period.

(g) In the case of a contract that (i) is not subject to § 7702A(c)(6) and (ii) is issued or materially changed within fewer than 7 years of the day on which the insured attains age 100 and thereafter has a reduction in benefits, the reduction in benefits rule of § 7702A(c)(2) applies for 7 years from the date of issue or the date of the material change. In the case of a contract that is subject to § 7702A(c)(6) (generally, a contract with more than one insured), the rule of § 7702A(c)(6) concerning reductions in benefits applies as long as the contract remains in force whether or not the contract is issued or

materially changed fewer than 7 years before the day on which the insured attains age 100.

(h) A change in benefits under (or in other terms of) a life insurance contract that occurs on or after the day on which the insured attains age 100 is not treated as a material change for purposes of § 7702A(c)(3) or as an adjustment event for purposes of § 7702(f)(7). Thus, necessary premium testing under § 7702A(c)(3)(B)(i) ceases on the day on which the insured attains age 100.

.03 *No inference.* No adverse inference should be drawn with respect to the qualification of a contract as a life insurance contract under § 7702, or its status as not a MEC under § 7702A, merely by reason of a failure to satisfy all of the requirements of this section 3. Furthermore, this revenue procedure neither answers nor comments on any issue raised in Notice 2009–47 that is not specifically covered by the safe harbor in this revenue procedure.

SECTION 4. EFFECT ON OTHER DOCUMENTS

Rev. Proc. 2010–28 is modified and superseded.

SECTION 5. EFFECTIVE DATE

This revenue procedure is effective February 23, 2018.

SECTION 6. DRAFTING INFORMATION

The principal author of this revenue procedure is Kathryn M. Sneade of the Office of Associate Chief Counsel (Financial Institutions & Products). For further information regarding this revenue procedure, contact Kathryn M. Sneade at (202) 317-6995 (not a toll-free number).

Section 7702.—Life insurance contract defined.

Safe harbor for purposes of applying computational rules of § 7702(e) for life insurance contracts that (1) have mortality guarantees based upon prevailing commissioners' standard tables that extend beyond age 100 and (2) may continue in force after the day on which the insured individual attains age 100. *See* Rev. Proc. 2018–20, page 427.

Section 7702A.—Modified endowment contract defined.

Safe harbor for purposes of applying computational rules of § 7702A(c)(1)(B) for life insurance contracts that (1) have mortality guarantees based upon prevailing commissioners' standard tables that extend beyond age 100 and (2) may continue in force after the day on which the insured individual attains age 100. *See* Rev. Proc. 2018–20, page 427.

Part IV. Items of General Interest

DEPARTMENT OF THE TREASURY Internal Revenue Service

DEPARTMENT OF LABOR Employee Benefits Security Administration

DEPARTMENT OF HEALTH AND HUMAN SERVICES Short-Term, Limited-Duration Insurance

REG-133491-17

AGENCIES: 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/cciiio) 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 Web site as soon as possible after they have been received: <http://www.regulations.gov>. Follow the search instructions on that Web site 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)³, 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 1996,⁴ the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,⁵ the Newborns' and Mothers' Health Protection Act,⁶ the Women's Health and Cancer Rights Act,⁷ the Genetic Information Nondiscrimination Act of 2008,⁸ the Children's Health Insurance Program Reauthorization Act of 2009,⁹ Michelle's Law,¹⁰ and the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (PPACA).¹¹

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".¹² 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 ap-

plicable individuals must maintain minimum essential coverage or pay the individual shared responsibility payment.¹³ On December 22, 2017, the President signed tax reform legislation into law.¹⁴ 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,¹⁵ it is exempt from the PHS Act's individual-market requirements because it is not individual health insurance coverage.¹⁶ Section 2791(b)(5) of the PHS Act provides "the 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."¹⁷

³Pub. L. 104-191, 110 Stat. 1936 (August 21, 1996).

⁴Pub. L. 104-204, 110 Stat. 2944 (September 26, 1996).

⁵Pub. L. 110-343, 122 Stat. 3881 (October 3, 2008).

⁶Pub. L. 104-204, 110 Stat. 2935 (September 26, 1996).

⁷Pub. L. 105-277, 112 Stat. 2681-436 (October 21, 1998).

⁸Pub. L. 110-233, 122 Stat. 881 (May 21, 2008).

⁹Pub. L. 111-3, 123 Stat. 64 (February 4, 2009).

¹⁰Pub. L. 110-381, 122 Stat. 4081 (October 9, 2008).

¹¹The Patient Protection and Affordable Care Act, Pub. L. 111-148, was enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, was enacted on March 30, 2010.

¹²282 FR 48385.

¹³The eligibility standards for exemptions can be found at 45 CFR § 155.605. Section 5000A of the 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.

¹⁴Pub. L. 115-97, 131 Stat. 2054.

¹⁵Sections 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.

¹⁶The 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).

¹⁷Sections 733(b)(4) of ERISA and 2791(b)(4) of the PHS Act provide that group health insurance coverage means "in connection with a group health plan, health insurance coverage offered in connection with such plan." Sections 733(a)(1) of ERISA and 2791(a)(1) of the PHS Act provide that a group health plan is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents (as defined under the terms of the plan) directly, or through insurance, reimbursement, or otherwise. There is no corresponding provision excluding 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.

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.”¹⁸

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)¹⁹ 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”.²⁰ 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)).²¹

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 (“MINI-

MUM ESSENTIAL COVERAGE”) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON’T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.²²

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 Act²³ (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”.²⁴

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”²⁵, 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-

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

¹⁹Note, 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.

²⁰81 FR 38019.

²¹81 FR 38019, 38032-33.

²²82 FR 38032.

²³Pub. L. 99-272, 100 Stat. 82 (April 7, 1986).

²⁴81 FR 75316.

²⁵82 FR 26885.

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.²⁶ Further, in 2018, about 26 percent of enrollees (living in 52 percent of counties) have access to just one insurer in the Exchange.²⁷ 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 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 apprises 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, 2017.²⁸ 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

²⁶See 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>

²⁷See 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/>

²⁸81 FR 75318 through 75319.

rule.²⁹ 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 benefit³⁰), 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) (regarding supplemental coverage excepted benefits).³¹ Given that the applicability date for the amendments to those sections has passed, it is no longer necessary to mention the “future” applicability date.³² 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).³³

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.

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)³⁴ 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.

²⁹This 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.

³⁰See footnote 14.

³¹The 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).

³²The applicability date for these amendments (policy years and plan years beginning on or after January 1, 2017) remains unchanged.

³³The applicability date for these amendments (policy years beginning on or after January 1, 2017) remains unchanged.

³⁴The Departments are using data on APTC as an approximation of premium tax credits since this is the data that is available for 2017.

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

Table 1: Accounting Table

Benefits:					
Qualitative:					
<ul style="list-style-type: none"> • 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:					
<ul style="list-style-type: none"> • 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	High Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$96 million	\$168 million	2017	7 percent	2019
	\$96 million	\$168 million	2017	3 percent	2019
Quantitative:					
<ul style="list-style-type: none"> • Transfer from the Federal government to enrollees in individual market plans in the form of increased APTC payments. 					
Qualitative:					
<ul style="list-style-type: none"> • 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.³⁵

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 Pub. L. 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,

³⁵National 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.

limited-duration policy was approximately \$124 compared to \$393 for an unsubsidized PPACA-compliant plan.³⁶ 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.³⁷ 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 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 Pub. L. 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 Pub. L. 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.³⁸ 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

³⁶<http://www.npr.org/sections/health-shots/2017/01/31/512518502/sales-of-short-term-insurance-plans-could-surge-if-health-law-is-relaxed>

³⁷The 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>

³⁸See 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>.

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 Ex-

change 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 esti-

mated 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 premiums³⁹ 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
\$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 in-

clude 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

³⁹Percent Premium Increase = (Total Enrollment-(Morbidity(75%)*Number Switching))/(Total Enrollment-Number Switching)

million or less.⁴⁰ The Departments believe that few, if any, insurance companies selling comprehensive health insurance 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,⁴¹ 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 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 pro-

posed 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.

* * * * *

Kirsten B. Wielobob,
*Deputy Commissioner for Services and
Enforcement
Internal Revenue Service.*

⁴⁰“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.

⁴¹Available at <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

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.

(Filed by the Office of the Federal Register on February 20, 2018, 8:45 a.m., and published in the issue of the Federal Register for February 21, 2018, 83 F.R. 7437)

**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 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 April 23, 2018.

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as “rulings”) that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the new ruling holds that it applies to both A

and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the new ruling does more than restate the sub-

stance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.

ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
F.R.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel’s Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.

PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z—Corporation.

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¹A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2017–27 through 2017–52 is in Internal Revenue Bulletin 2017–52, dated December 27, 2017.

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¹A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2017-27 through 2017-52 is in Internal Revenue Bulletin 2017-52, dated December 27, 2017.

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