STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

Janet T. Mills
Governor

Eric A. Cioppa
Superintendent

Bulletin 438

Short-Term, Limited-Duration Policies and Limited Benefit Policies

(Supersedes Bulletin 431)

This Bulletin outlines some of the key requirements under federal and state law for limited benefit health insurance policies and for short-term, limited-duration health insurance policies ("STLD" or "short-term coverage"), including recently-enacted changes to Maine's law governing STLD policies, such as a requirement for coverage to be sold through an in-person encounter and a requirement for policies to terminate by the end of the calendar year in which they are sold. As discussed in more detail later in this Bulletin, these types of policies do not need to comply with the Affordable Care Act (ACA) requirements for comprehensive health plans. When sold to Maine residents, they are subject to Maine law, but the applicable state laws are different from the state laws governing comprehensive health plans. This Bulletin replaces Bulletin 431, which provided guidance on the applicable requirements for STLD policies under prior Maine law.

Although STLD and limited benefit policies are sometimes confused with one another, they are not the same, and they are exempt from ACA requirements for different reasons. **Limited benefit policies** provide specialized types of coverage, including dental, vision, accident-only, specified-disease, and fixed-indemnity policies. They are optional in nature and are not designed to substitute for comprehensive health plans, so it would not be appropriate to impose requirements that are designed to ensure a full range of benefits or to ensure that they are available to all consumers. The purpose of **short-term, limited-duration policies,** on the other hand, is to serve as a temporary substitute for comprehensive health plans, most commonly when the policyholder is between jobs. Accordingly, the benefit design is similar, with the differences reflecting the adverse selection risks associated with temporary coverage and the limited resources available to many consumers who buy short-term policies.

Recent Short-Term Coverage Legislation

In June of 2019, "An Act Regarding Short-term, Limited-duration Health Plans," P.L. 2019, ch. 330, was enacted and signed into law. In addition to changing the statutory terminology from "short-term policies" to "short-term, limited-duration policies," to mirror the federal laws governing the same types of coverage,[1] the 2019 legislation also imposes several new requirements, discussed below, that that will apply to all STLD coverage with effective dates on and after January 1, 2020 that is offered or issued to Maine consumers. The law took effect on September 19, 2019, but does not apply to STLD policies already in force or to any new 2019 policies.

Term of Coverage (24-A M.R.S. § 2849-B(1)): The legislation changes the definition from "an individual, nonrenewable policy issued for a term that is less than 12 months" to "an individual, nonrenewable policy issued for a term that does not extend beyond December 31st of the calendar year in which the policy is issued."

Disclosure Requirements (24-A M.R.S. §§ 2849-B(8)(A), (F), and (G)): Federal regulations currently require all STLD applications and contracts to contain the following disclosure in at least 14-point type:

> This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.[2]

The 2019 legislation will also require the following additional disclosures to be provided by the carrier or producer at the time STLD coverage is offered to any Maine consumer, again in 14-point type or larger, and also to be made available to the public on the carrier's website:

> (1) A summary of plan benefits, limits and exclusions in a standardized format similar to the format required for a qualified health plan under the federal Affordable Care Act that is specific to the exact policy being offered for purchase in this State, including, but not limited to, information about the circumstances in which covered benefits may be subject to balance billing and examples of how charges may be applied toward any cost sharing under the policy and billed to the individual policyholder; and
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> (2) A comparison of the short-term, limited-duration policy to a qualified health plan in the terms, benefits and conditions of the policy, any exclusions, medical loss ratio requirements or the provisions of guaranteed renewal and continuity of coverage.

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[1] Maine's law was enacted in 1995, a year before HIPAA.

[2] 45 CFR § 144.103, definition of short-term, limited-duration insurance at ¶ 3.

Carriers must prepare these policy-specific disclosures for each short-term policy they offer in Maine (including, as discussed further below, any association group policy that has been approved for sale in Maine), and these disclosures must be provided by each producer offering that policy in Maine. The standardized format for the summary of plan benefits, limits, and exclusions is attached to this Bulletin as an Appendix.

In addition, the carrier, or a producer acting on the carrier's behalf, must also disclose at the time of purchase, at the time of policy expiration, and on the first day of November if the policy is in effect during an ACA open enrollment period:

> That the policy does not qualify as "minimum essential coverage" under the ACA and does not qualify enrollees for an ACA special enrollment period when the policy terminates. The carrier or producer must also provide the dates of the next ACA enrollment period and the website address and toll-free telephone number for the Exchange.

These disclosure requirements will apply to coverage offered for issuance in 2020 even if the sales activity is conducted in 2019. Although the plan summary and QHP comparison are not mandatory for policies taking effect in 2019, producers and carriers should consider providing substantially similar disclosures for all new 2019 policies as one best practice that could aid in complying with their general legal and professional obligations to provide accurate information to customers and refrain from deceptive or misleading sales practices.

Replacements of STLD Coverage (24-A M.R.S. § 2849-B(8)(B)): Currently, short-term policies must be nonrenewable, and the combined term of all successive short-term policies may not exceed two years. This limit applies regardless of whether the successive policies are issued by the same carrier or by different carriers, and consumers applying for short-term coverage must disclose all prior short-term policies and their duration. The amended law adds the further requirement that at least a full year must elapse between the termination of an STLD policy and the effective date of any new STLD policy.

Face-to-Face Sales Contact Required (24-A M.R.S. § 2849-B(8)(C)): Carriers and producers will be prohibited from issuing short-term coverage that is subject to the 2019 legislation "unless it has been sold through an in-person encounter." One frequently asked question is whether videophone or videoconference technology can be used to satisfy this requirement. It cannot. The producer and consumer must meet in the same physical location.

Sales During Open Enrollment Periods (24-A M.R.S. § 2849-B(8)(D)): All STLD policies subject to the 2019 legislation that are marketed or sold during an ACA open enrollment period must terminate at the end of the calendar year in which they are sold. In particular, this means that 2020 STLD policies cannot be marketed during the open enrollment period for comprehensive 2020 health plans.

Assessment of Eligibility for ACA Subsidies (24-A M.R.S. § 2849-B(8)(E)): The carrier, or a producer acting on the carrier's behalf, must assess each STLD applicant's eligibility for premium tax credits and cost-sharing reductions, and must provide an estimate of the applicant's net cost for a qualified health plan after applying any applicable advance premium tax credits or cost-sharing reductions.

STLD and Limited Benefit Policies: Consumer Protection Issues

Carriers and producers offering short-term or limited benefit coverage must make sure that consumers understand that these types of policies are not subject to the same consumer protections as state and federal law require for comprehensive health plans, including the following:

Guaranteed Issue and Community Rating (Federal Public Health Service Act (PHSA) §§ 2701–2702; 24-A M.R.S. §§ 2736-C(2), (3), & (11)): Carriers issuing comprehensive health plans must make all their plans available to anyone living in the plan's service area who applies for coverage during the annual open enrollment period or any applicable special enrollment period to which the applicant might be entitled. The prices charged for the coverage cannot take the applicant's health status or claims experience into account – an individual's premium for a plan can only vary on the basis of his or her age and geographic location. By contrast, there is no restriction on insurers' ability to "underwrite" STLD or limited benefit policies – *i.e.,* to pick and choose which applicants they accept or deny based on the carrier's own judgment – or to charge higher premiums based on the carrier's evaluation of a policyholder's risk.

Guaranteed Renewal (PHSA § 2703; 24-A M.R.S. § 2850-B): Once a comprehensive health plan is in force, carriers must offer renewal each subsequent year, unless the policyholder moves out of the plan's service area or the carrier stops doing business in the policyholder's service area. Changes to premium rates or to the terms of coverage are subject to regulatory review and must apply on a uniform basis to all similarly situated policyholders.[3] STLD plans may not be renewed at all, and limited benefit plans may be terminated or rerated at the carrier's discretion when they expire, unless the terms of the policy provide some type of contractual protection against nonrenewal or rerating.

Subsidies (ACA §§ 1401–1402; Internal Revenue Code § 36B; 24-A M.R.S. §§ 3951–3962): Consumers with income between 100% and 400% of the federal poverty level (FPL), and who are not eligible for employer-sponsored or governmental coverage, are eligible for advance premium tax credits to reduce the cost of buying a qualified health plan (QHP) on the ACA Exchange. If their income is between 100% and 250% of FPL, they are also eligible for cost sharing reductions, which lower the deductibles and coinsurance that would otherwise be charged for Silver-level QHPs. In addition, comprehensive individual health insurance plans receive subsidized reinsurance through the Maine Guaranteed Access Reinsurance Association (MGARA). This lowers carriers' claims costs, which lowers the premiums for those plans. None of these programs is available for STLD or limited benefit policies.

Annual and Lifetime Limits (PHSA § 2711; 24-A M.R.S. § 4320): Comprehensive health plans may not set lifetime limits on the benefits they provide, and may not set annual dollar limits on any essential health benefits. These restrictions do not apply to short-term or limited benefit policies.

Preexisting Condition Exclusions (PHSA § 2704; 24-A M.R.S. § 2850): Comprehensive health plans may not exclude preexisting conditions from coverage. Carriers are not restricted from imposing preexisting condition exclusions in specific-disease, hospital indemnity, or accidental injury policies. The prohibition against preexisting condition exclusions does apply to other types of limited benefit medical insurance and to STLD policies. However, as discussed above, these types of policies are

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[3] If approved by the Superintendent, changes in coverage could involve the discontinuance of a particular plan and its replacement with a different plan that provides comparable protection.

subject to medical underwriting, so that carriers have the right to deny issuing the policy, or to charge higher premiums to applicants with preexisting conditions or other medical risk factors. As part of the underwriting process, carriers may ask applicants about their health history. If an applicant makes a misrepresentation about a preexisting condition, and subsequently files a claim, the carrier could be able to rescind coverage and deny the claim

Minimum Coverage Standards

Comprehensive individual health policies are subject to minimum benefit requirements under both federal law – the "essential health benefit" requirements of the ACA[4] – and state law – the "mandated benefits" in Chapter 33 of the Maine Insurance Code. These requirements are interrelated, because the ACA essential health benefit package is based on a state-specific "benchmark plan" that includes all state mandated benefits and any other benefits expressly required by the ACA, and sets detailed minimum levels of coverage for various services. There is also an overall minimum actuarial value, which measures the average amount of covered services that are paid by the carrier, as compared to the cost sharing that the consumer is required to pay as deductibles, copayments, and coinsurance. Plans are classified by "metal levels" as Bronze, Silver, Gold, or Platinum depending on their actuarial values.

There are no restrictions on cost sharing for STLD or limited benefit policies, nor are they required to provide the ACA essential benefit package. Because limited benefit policies are, by nature, limited, they are likewise generally exempt from the mandated benefit requirements of the Maine Insurance Code.[5] Short-term policies, on the other hand, are intended to provide the same general type of coverage as permanent health insurance policies, and are subject to most requirements of Maine law other than the ones discussed earlier in this Bulletin. Two specific questions the Bureau has received are whether maternity benefits and behavioral health benefits are required. Maternity benefits are not required in STLD policies. Although they are part of the ACA essential health benefit package, they are not independently mandated by state law for individual coverage. Mental health benefits, including coverage for substance use disorders, are now required for STLD policies, under legislation enacted in 2019 that made Maine's mental health coverage requirements consistent across all sectors of the medical insurance market (other than limited benefit policies).[6]

The Bureau has developed a checklist of form filing requirements for STLD policies that specifies which mandated benefits apply. A link to this checklist, as well as links to similar checklists for the various types of limited benefit policies, may be found at the following page:

https://www.maine.gov/pfr/insurance/licensees/insurance-companies/insurers/life-and-health-checklists/life-and-health-non-qhp-checklists

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[4] PHSA § 2707(a), incorporated into Maine law at 24-A M.R.S. § 4320-D.

[5] 24-A M.R.S. § 704(2).

[6] 24-A M.R.S. § 2749-C, as amended by P.L. 2019, ch. 5.

Association Policies and Other Group Coverage

Carriers, producers, and consumers need to be aware that coverage issued to Maine consumers through associations and other discretionary groups is not exempt from the requirements of Maine law, even if the master group policy is issued in another state. Before coverage under out-of-state group policies may be offered in Maine, the certificates must be filed for approval and the carrier must demonstrate that the association or other master policyholder meets the requirements to be an acceptable group policyholder under Maine law.[7] In particular, the 2019 STLD legislation discussed earlier, like most of Maine's minimum health insurance requirements, expressly applies to certificates of coverage as well as policies issued to Maine residents.

However, these group filing requirements do not apply to employment-based coverage under *bona fide* single-employer policies unless specifically requested by the Superintendent.[8] This exception is not relevant for STLD policies, because the ACA requires all group health insurance policies to be guaranteed renewable, but limited benefit policies are not considered "group health insurance" for this purpose and therefore may be offered by employers on a supplemental basis.

Disclosures for Limited Benefit Policies

Limited benefit policies do not provide major medical coverage, and it should go without saying that carriers and producers should not represent or suggest that they can substitute for major medical coverage. Bureau of Insurance Rule 755 establishes thirteen different categories of limited benefit policies and prescribes specific disclosures that must be provided for each category. Adequate disclosure is particularly important for types of limited benefit policies, such as fixed indemnity policies, that might raise a significant risk of confusion. For example, while a hospital indemnity policy and a comprehensive health plan both pay benefits if a covered person is hospitalized, the hospital indemnity benefit does not reimburse the cost of care. Instead, it pays a predefined amount, set in advance, regardless of how much the hospitalization costs. Consumers being offered these types of policies, or other limited benefit policies that they might consider buying as an alternative to comprehensive health plans, need to have clear notice, similar to the notice required for STLD coverage, that ACA protections do not apply, that the policy does not qualify as "minimum essential coverage" under the ACA, and that it does not qualify enrollees for an ACA special enrollment period when the policy terminates.[9] This disclosure is in addition to the disclosures mandated by Rule 755, which does not address ACA requirements because it was adopted before the ACA was enacted.

October 10, 2019

Eric A. Cioppa
Superintendent of Insurance

NOTE: This Bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties, or privileges, nor is it intended to provide legal advice. Readers should consult applicable statutes and rules and contact the Bureau of Insurance if additional information is needed.

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[7] 24-A M.R.S. § 2412(1-A).

[8] Employee leasing companies or PEOs are not considered single-employer policies under Maine law, so they are subject to the same mandatory filing requirements as employer associations and multiple-employer trusts.

[9] For hospital indemnity policies and other fixed indemnity policies, Bulletin 396 had formerly set forth similar notice requirements. However, the language of those notices is obsolete due to the repeal of the ACA's "individual mandate" tax penalties, and Bulletin 396 has been withdrawn.

Appendix — Template for Summary of Short-Term Limited-Duration Coverage

Short-term, Limited-duration Policy — Summary of Plan Benefits, Limits, and Exclusions

What this Plan Covers & What You Pay For Covered Services

[insert insurance company name]: [insert plan name]
Coverage Period: [insert dates]

The Summary of Plan Benefits, Limits, and Exclusions document shows how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, [insert contact information]. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see www.healthcare.gov/sbc-glossary/.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$**	
Are there services covered before you meet your deductible?		
Are there other deductibles for specific services?	**$**	
What is the out-of-pocket limit for this plan?	**$**	
What is not included in the out-of-pocket limit?		
What is the annual dollar limit on benefits?	**$**	
Are there other annual dollar limits for specific services?		
Will you pay less if you use a network provider?		
Do you need a referral to see a specialist?		

(Form adapted from the federal Summary of Benefits and Coverage Standard Format Template, available at www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html)

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness			
	Specialist visit			
	Preventive care/screening/ immunization			
If you have a test	Diagnostic test (x-ray, blood work)			
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].com	Generic drugs			
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (*e.g.,* ambulatory surgery center)			
	Physician/surgeon fees			
If you need immediate medical attention	Emergency room care			
	Emergency medical transportation			
	Urgent care			
If you have a hospital stay	Facility fee (*e.g.,* hospital room)			
	Physician/surgeon fees			

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services			
	Inpatient services			
If you are pregnant	Office visits			
	Childbirth/delivery professional services			
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care			
	Rehabilitation services			
	Habilitation services			
	Skilled nursing care			
	Durable medical equipment			
	Hospice services			

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)
• • •

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)
• • •

Your Grievance and Appeal Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, visit http://www.maine.gov/pfr/insurance/consumers or call 1-800-300-5000.

Does this plan provide Minimum Essential Coverage under the federal Affordable Care Act? [Yes/No] Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

——To see examples of how this plan might cover costs for a sample medical situation, see the next section.——

[* For more information about limitations and exceptions, see the plan or policy document at [www.insert.com].]

Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Having a Baby (9 months of in-network pre-natal care and a hospital delivery)	
■ **The plan's overall deductible**	**$**
■ **Specialist *[cost sharing]***	**$**
■ **Hospital (facility) *[cost sharing]***	**%**
■ **Other *[cost sharing]***	**%**

This EXAMPLE includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds, blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$**
In this example, you would pay:	
Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total you would pay:	**$**
The total the plan would pay:	**$**

Managing type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	
■ **The plan's overall deductible**	**$**
■ **Specialist *[cost sharing]***	**$**
■ **Hospital (facility) *[cost sharing]***	**%**
■ **Other *[cost sharing]***	**%**

This EXAMPLE includes services like:
Primary care physician office visits
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$**
In this example, you would pay:	
Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total you would pay:	**$**
The total the plan would pay:	**$**

Simple Fracture (in-network emergency room visit and follow up care)	
■ **The plan's overall deductible**	**$**
■ **Specialist *[cost sharing]***	**$**
■ **Hospital (facility) *[cost sharing]***	**%**
■ **Other *[cost sharing]***	**%**

This EXAMPLE includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$**
In this example, you would pay:	
Cost Sharing	
Deductibles	$
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$
The total you would pay:	**$**
The total the plan would pay:	**$**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.