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Submitted Electronically

Centers for Medicare & Medicaid Services
United States Department of Health and Human Services
Attention: CMS-9904-P
P.O. Box 8010
Baltimore, Maryland 21244-8010

Re: Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance [CMS-9904-P]

To Whom It May Concern:

On July 12, 2023, the Departments of Treasury, Labor, and Health and Human Services ("the Departments") published in the *Federal Register* a proposed rule entitled, "Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance" ("proposed rule"). This document proposes to amend the definition of short-term, limited-duration insurance; to amend the requirements for hospital indemnity or other fixed indemnity insurance; and to amend the tax treatment of certain benefit payments in fixed amounts received under employer-provided accident and health plans. In addition, the Departments seek comment on coverage only for a specified disease or illness that qualifies as excepted benefits and level-funded plan arrangements. The Health Benefits Institute (HBI) appreciates the opportunity to comment on the proposed rule.

HBI is a policy organization supported by agents, brokers, insurers, employers, benefit platforms and others seeking to protect the ability of consumers to make their own healthcare financing choices. We support policies that expand consumer choice and control, promote industry standards, educate consumers on their options and foster high quality health outcomes through transparency in healthcare prices, quality, and the financing mechanisms used to pay for care.

HBI's detailed comments are outlined below. These comments align with our shared objectives of promoting consumer choice and accessibility to affordable, quality healthcare coverage. While we commend the Departments for actively seeking comprehensive input regarding the proposed amendments, as described in our comments below, we have serious concerns about many of the proposals in the proposed rule. On balance, if finalized many of the changes would serve to eliminate important coverage options that millions of consumers rely on today, increasing the number of uninsured and resulting in fewer Americans having access to affordable health insurance coverage that meets their needs.

We look forward to engaging with the Departments, including offering further clarification on these comments and providing additional perspectives on the issues that resonate with our members if needed.

Proposed Changes to Short-Term, Limited Duration Insurance (STLDI)

For over two decades, short-term, limited duration insurance (STLDI) has served as a vital, affordable insurance option for many Americans. STLDI fills a critical gap for individuals who are between jobs, those waiting for employer-sponsored insurance to begin, or who are otherwise in need of temporary coverage. The affordability of STLDI is one of its most appealing features. For many consumers, especially those for whom COBRA continuation coverage is too costly, who do not qualify for large subsidies under the ACA, or who miss the marketplace Open Enrollment Period, STLDI is often the only viable alternative to going uninsured. Consumer satisfaction with STLDI is generally high, as these plans offer a range of coverage options that can be tailored to individual needs. STLDI's focus on affordability and customization not only enhances consumer choice but also empowers individuals to take control of their healthcare needs.

The Departments propose to reinterpret the terms "short-term" and "limited-duration" for purposes of STLDI to mean a coverage expiration date not more than three months after the effective date of the final rule and no longer than four months in total, including any renewals or extensions. The Departments also propose that renewals or extensions would include short-term, limited duration policies sold by the same issuer to the same policyholder within 12 months of the original effective date, including the total number of consecutive or nonconsecutive dates of coverage.

States are in the best position to oversee and regulate STLDI

The Departments should recognize that states, not the federal government, are best positioned to regulate STLDI. The 2018 final rule on STLDI sets a minimum federal floor similar to the one set by earlier HIPAA regulations that were in place for nearly two decades. The current federal floor gives states the flexibility to regulate and govern these plans in a manner that best suits their individual markets and consumer needs. In prior rulemaking, the Departments have rightly recognized that states, rather than the federal government, are in the best position to oversee and regulate their own insurance markets. Yet, if finalized as proposed, this rule would impose a one-size-fits all federal approach on the entire country that effectively removes any meaningful state flexibility.

As the Departments point out, since the issuance of the 2018 rule, half of the states have taken action to regulate STLDI in some fashion. This demonstrates the clear ability and willingness of states to effectively regulate these products in their own markets and the lack of a need for new federal regulation. States with less competitive insurance markets where a wide choice of ACA-regulated coverage is not available, for example, may see an advantage in retaining STLDI with a duration of up to 12 months as an option for their consumers—a key reason why half of states have not placed new restrictions on the sale or terms of STDLI.

Furthermore, HBI membership reports very low consumer complaint volume for STLDI products. In the 18-month time period from January 2022 – June 2023, a large short-term medical program of approximately $60 million in annual premiums and 19,200 average in force members over the time period received a total of 40 complaints to the various state departments of insurance—an average complaint rate of 0.012% of monthly subscribers. This indicates a very high (99%+) satisfaction ratio for short-term medical plan consumers in direct contradiction to the Departments' assertions in the proposed rule regarding STLDI.

States have also innovated in this area to make more affordable products available to their citizens. Two states, Idaho and Rhode Island, have taken steps to require STLDI to cover pre-existing conditions, to cover the same categories of health benefits that other nongroup plans must cover, and have made other changes to make STLDI a more attractive alternative for those who cannot afford or cannot otherwise purchase ACA-regulated plans. The actions of these two states, whose market dynamics, political makeups, and populations are very different, illustrate the critical need to continue to allow states to innovate and craft solutions for their

unique market circumstances. The proposed rule would eliminate appropriate state flexibility, harming consumers in Idaho, Rhode Island, and the half of states who have chosen to keep STLDI options available to their residents.

The National Association of Insurance Commissioners (NAIC), representing the chief insurance regulators in all 50 states, the District of Columbia, and the 5 U.S. territories, has consistently asserted that states should be the primary regulators of their insurance markets. In their letter dated August 9, 2016, in response to the Departments' previous proposal to limit the definition of STLDI to 3 months, the NAIC emphasized that federal interference often leads to unintended consequences and may not effectively address underlying issues.[1] The NAIC strongly disagreed with the Departments' proposal in 2016 to limit STLDI to a three-month period, arguing that such a limit would reduce consumer options and could do more harm than good. They pointed out that the proposed rule provided no data to support the premise that a three-month limit would protect consumers or markets. Instead, the NAIC suggested focusing on educating consumers about the limitations of STLDI.[2] The same is true today.

Since the Departments' issuance of the 2016 and 2018 rules, NAIC and its members have taken numerous actions to increase transparency and education around alternative plans like STLDI, hospital indemnity plans, and other fixed indemnity plans. As discussed further below in our comments on hospital indemnity and other fixed indemnity plans, in 2019 NAIC updated its guidance and model act for supplementary and short-term health insurance minimum standards with the goal of standardizing terms, increasing public education, and eliminating confusing or misleading provisions in these forms of coverage.[3] One of the most important recent steps has been to improve data collection on STLDI and hospital indemnity or fixed indemnity plans. Recently, the NAIC updated its Market Conduct Annual Statement (MCAS) standards to require the submission extensive new information on STLDI and hospital indemnity or other fixed indemnity plans, including the data set forth in Table 1 below.[4]

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[1] NAIC comment letter on the Departments' June 10, 2016, proposed rule: "Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance." August 9, 2016 https://content.naic.org/sites/default/files/government-affairs-testimony-letter-hhs-short-term-duration.pdf.

[2] Ibid.

[3] NAIC, "Supplementary and Short-Term Health Insurance Minimum Standards Model Act," https://content.naic.org/sites/default/files/inline-files/MDL-170_0.pdf.

[4] NAIC, "Other Health Insurance Market Conduct Annual Statement Data Call & Definitions," https://content.naic.org/sites/default/files/inline-files/MCAS%20Data%20Call%20Other%20Health%202023.0.1.pdf

Table 1. Selected MCAS "Other Health Insurance" Data Collection

Product Type	Market	Data Collected
Accident only Hospital/surgical/medical expense Hospital/other fixed indemnity Specified disease/critical illness	Individual Trusts/associations Group	• Premiums • Covered lives • Applications and denials • Cancellations • Rescissions • Claims paid, amounts, and denials • Complaints received (both from consumers and DOIs) • Lawsuits • Marketing and sales practices

Regulators who are closely tied to health insurance markets know that information needs to be gathered over a period of time to be properly validated and understood. States need time to be able to review the data and appropriately regulate their markets. The MCAS process not only collects extensive data on the plans, but also uses that data to find outliers, a sort of early regulatory warning system. The Departments have no regulatory authority to collect this data, no ability to analyze the data, and no ability to take regulatory action. In appropriate deference to state activity, the Departments should continue to rely on states and, at a minimum, should not move forward with these regulations until states have been able to collect sufficient data to properly inform policy decisions on these products. In light of these and other concerns raised by this letter, the Departments should not move forward with finalizing the proposed rule at this time.

The Departments have not laid out a reasonable justification for the proposed rule

There is scant evidential basis presented in the proposed rule to justify the heavy-handed federal action contemplated by the Departments. The Departments cite the "low value that STLDI provides to consumers when used as a substitute for comprehensive coverage" while providing little basis for this assertion, nor offering any quantitative data providing insight on the

magnitude of this perceived issue. For example, the Departments provide no survey or other data on the number of consumers enrolling in STLDI plans as a substitute for marketplace coverage or the number of consumers who mistakenly enroll in STLDI under the misapprehension that STLDI represents a lower-cost equivalent to a marketplace plan. Instead, the Departments offer only anecdotes and hypothetical concerns. However, as related in the previous section, states are now moving to collect this data, which is a critical prerequisite to any additional federal or state regulation.

The proposed rule repeatedly cites media articles and blog posts labeling STLDI as "junk insurance" and "problematic," in support of the view that any insurance coverage that is not subject to the ACA's requirements is substandard. Such characterizations are not only unhelpful and inaccurate, but indicate prejudgment and undermine the Departments' mandate to carry out their responsibilities under the PHSA. As the Departments have previously recognized, "short-term, limited-duration insurance plays an important role in providing temporary valuable health coverage to individuals who would otherwise go uninsured. [STLDI] can also provide a more affordable, and potentially desirable, coverage option for some consumers, such as those who cannot afford unsubsidized coverage in the individual market."[5]

Federal law and regulation considers STLDI to be health insurance, as do federal survey instruments like the American Community Survey and the Current Population Survey.[6] The nonpartisan Congressional Budget Office (CBO) has also found STLDI to meet the definition of health insurance for purposes of its projections and estimates of the number of insured Americans. In rejecting Senator Tammy Baldwin's (D-WI) request to recharacterize STLDI as not meeting the definition of health insurance, CBO concluded that, like coverage that is subject to the ACA's nongroup insurance requirements, STLDI "covers high-cost medical events and includes coverage for services provided by physicians and hospitals."[7] Importantly, CBO also found that "[m]ost of the available evidence about STLDI suggesting that it does not constitute health insurance comes from the time before the 2018 rule took effect," that is, while the 2016 rule limiting STLDI to 3-months or less was still in effect. CBO noted that, while the STLDI

[5] See 83 FR 38217.
[6] See, for example 46 CFR 144.103 ("Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage, individual health insurance coverage, and *short-term, limited-duration insurance*." [emphasis added]).
[7] Congressional Budget Office, letter to Senator Tammy Baldwin, September 25, 2020, https://www.cbo.gov/system/files/2020-09/56622-Baldwin.pdf

coverage that was limited to 3-months or less by the 2016 rule "tended to provide coverage for only emergency care and not to provide coverage for preexisting conditions or preventive care," STLDI issued pursuant to the 2018 rule—which allowed initial STLDI terms of up to 12 months—tended to be more comprehensive coverage and to offer a broader array of services than the plans issued under the 2016 rule.

The primary source of the Departments' assertion that STLDI coverage poses significant risks to consumers appears to be blog posts from a single organization (the Commonwealth Fund, which is cited no less than eight times in the preamble to the proposed rule); however, again this organization's studies report only anecdotal concerns about consumer risks. Furthermore, the Departments' examples of specific individuals harmed by these plans are based on media stories, for which the full facts and final disposition of the cases are not provided. Actual data on enrollment numbers and other unbiased data are necessary to determine the real impact on marketplace enrollment and provide a substantive basis upon which to make the sweeping policy changes contemplated by the proposed rule.

ACA coverage is still unaffordable and is not attractive to many Americans

The Departments seek to distinguish STLDI from "comprehensive coverage," a term which is not defined in statute or regulation. The Departments define "comprehensive coverage" as coverage "subject to the Federal [sic] consumer protections and requirements established under chapter 100 of the Internal Revenue Code (Code), part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and title XXVII of the PHS Act, such as the prohibition of exclusions for preexisting conditions, the prohibition on health status discrimination, the requirement to cover certain preventive services without cost sharing, and many others."

But individual market plans subject to the ACA's consumer protections are in fact often characterized by high deductibles, unaffordable premiums, and narrow networks, making them unaffordable or otherwise unappealing to millions of Americans. The Departments themselves cite a 2022 national survey conducted by the Commonwealth Fund that found 44 percent of individuals with coverage purchased through the ACA-regulated individual market were

considered "underinsured," meaning their coverage did not provide them with affordable access to healthcare despite it being characterized as "comprehensive coverage" by the Departments.[8,9]

While the Departments suggest that increased accessibility and affordability of ACA-regulated individual market coverage since the publication of the 2018 final rules somehow reduces or eliminates the need for STLDI as an option for consumers, access to affordable coverage is still far from universal—and is decreasing for some segments of the population. In 2023, unsubsidized premiums increased on average between 2.2 percent and 4.7 percent compared to the previous year.[10] Today, an unsubsidized 60-year-old couple (non-smoking) seeking to purchase the lowest-cost bronze Qualified Health Plan in their area could pay premiums upwards of $3,000 per month and face maximum out-of-pocket costs of $18,200—putting this coverage out of reach for all but the wealthiest consumers.[11]

Preliminary rate filings for 2024 suggests that rates will continue to rise at a rate higher than overall inflation in the Consumer Price Index (CPI); initial analysis of 320 insurers across the 50 states in DC showed a median proposed premium increase of 6 percent, with almost a quarter of insurers proposing increases over 10 percent.[12] Some states will experience even more significant increases. In Virginia, the end of a state reinsurance program established in 2023 portends estimated premium increases of over 25 percent for residents.[13]

The availability of premium tax credits largely shielded consumers from rate increases in 2023, and the expansion of subsidies under the American Rescue Plan Act (ARPA) has also improved affordability of marketplace coverage for those who qualify for subsidies. However, the availability of expanded subsidies is only temporary and is not guaranteed beyond 2025. Should the temporary increased subsidies under ARPA be allowed to expire, premium costs will spike for marketplace enrollees of all ages and all income levels. Among lower-income individuals

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[8] The survey defined an individual as "underinsured" if they were insured all year but at least one of the following applied: (1) out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 10 percent or more of household income; (2) out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 5 percent or more of household income for individuals living under 200 percent of the federal poverty level ($27,180 for an individual or $55,500 for a family of four in 2022); or (3) the deductible constituted 5 percent or more of household income.

[9] "The State of U.S. Health Insurance in 2022: Findings from the Commonwealth Fund Biennial Health Insurance Survey," Commonwealth Fund, 2022.

[10] "How ACA Marketplace Premiums Are Changing by County in 2023," Kaiser Family Foundation, 2022.

[11] For example, a 60-year-old couple (non-smoking) living in Cabell County, WV would pay $2,961 per month for the lowest-cost bronze plan; the same couple living in La Paz County, AZ would pay $2,351 per month, while if the couple lived in Marion County IL, they would pay $2,447 per in monthly premiums.

[12] "How much and why 2024 premiums are expected to grow in Affordable Care Act Marketplaces," Peterson-KFF Health Systems Tracker, 2023.

[13] Ibid.

who would see subsidy reductions, for example, a single individual making $30,000 (232 percent of the poverty level) would see their monthly premium more than double for an annual increase of $1,320.[14] Because the ARPA also extended subsidies to those with incomes above 400 percent of the federal poverty level, the elimination of the temporary increased subsidies would cause dramatic premium hikes. For example, a typical 60-year-old couple making $75,000 (430 percent of the poverty level) could see monthly marketplace premiums *more than triple*—an annual premium increase of roughly $16,000.[15] Consequently, the continued availability of STLDI will be important to preserving desperately needed coverage options for individuals whose circumstances may change as a result of changing policies and market conditions.

The proposed three-month/four-month limit for STLDI is too brief and will harm consumers

The proposed limitations on the duration of STLDI plans are misaligned with the actual needs of Americans. These restrictions fail to account for the realities of unemployment durations, job search timelines, and the unique circumstances that lead individuals to opt for STLDI plans in the first place. Federal standards for STLDI should, at a minimum, seek to accommodate the average length of unemployment or job search, understanding that many Americans experience much longer periods between jobs or without coverage. This shows a clear need for federal policy to be flexible and to allow a range of coverage options such as STLDI to be available when people need them. Yet, in the name of protecting consumers, the proposed rule would harm consumers by removing options for coverage.

The average duration of a job search greatly exceeds three months, making STLDI a practical solution for maintaining coverage during periods of unemployment. Yet once again, the Departments provide little evidentiary basis for the proposal to limit STLDI to have an expiration date of no more than three months following the effective date and no longer than four months in total.

For example, while the Departments claim that they "reflected on instances when individuals may experience a temporary gap in coverage," they apparently considered only two, highly limited examples–a college student waiting until the fall to enroll in new coverage and a teacher who changes jobs between school years. Yet the length of summer break is in no way representative of how the broader economy works. In fact, according to Department of Labor

[14] "Health Premiums Will Rise Steeply for Millions if Rescue Plan Tax Credits Expire," Center on Budget and Policy Priorities, 2022.
[15] Ibid.

data, the average length of unemployment in the US currently stands at 20.6 weeks–over two months longer than the proposed maximum term of the initial STLDI contract and over one month longer than the proposed total allowable duration including renewals and extensions. As recently as 2011, the average length of unemployment was a full 40.5 weeks, while during the COVID-19 public health emergency, the average length of unemployment spiked to 32 weeks.[16] According to the popular career website Zippia.com, the average length of a job search is five months.[17]

HBI's membership, which includes a number of issuers and marketers of STLDI coverage, reports that the average duration of STLDI is just over seven months.[18] This highlights the fact that consumers have a need for STLDI coverage much longer than three or four months as contemplated by the proposed rule. In addition, since the average duration of enrollment is seven months, this evidence indicates that a significant percentage of consumers remain enrolled in their STLDI plan longer than the average. Data from this HBI member organization indicates that about two-thirds of the enrollment continue past the third month, while over 60 percent continue past the fourth month of coverage. Over the past 18 months, nearly half of enrollees purchased initial durational coverage of 364 days, the maximum allowable under current federal rules. The proposed rule would subject consumers to either not having coverage for periods beyond four months, or in the case where the consumer seeks coverage from a different carrier for an additional four months, potentially being subject to medical underwriting, deductibles, copays, and other out-of-pocket expenses for those additional months.

Moreover, STLDI offers a lifeline for those who miss the Marketplace Annual Open Enrollment Period and do not qualify for a Special Enrollment Period (SEP). Consider the case of Sarah, a 28-year-old freelancer who missed the Open Enrollment window due to a hectic work schedule. She didn't qualify for an SEP because she had no significant life changes like marriage, childbirth, or loss of other coverage. Sarah opted for an STLDI plan, which not only provided her with immediate coverage but was also affordable. The plan's 12-month duration was particularly beneficial as it covered her until the next Open Enrollment Period, saving her from the risk of being uninsured for an extended period.

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[16] U.S. Bureau of Labor Statistics, Average Weeks Unemployed [UEMPMEAN], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/UEMPMEAN, August 27, 2023.
[17] Zippia. "15+ Incredible Job Search Statistics [2023]: What Job Seekers Need To Know" Zippia.com. Feb. 27, 2023, https://www.zippia.com/advice/job-search-statistics/.
[18] This member reported data for a large marketing organization with approximately $60 million in annual premiums.

In addition, should Sarah be diagnosed with a serious illness while enrolled in an STLDI plan with a 364-day initial term, as currently allowed by federal regulations, she would be able to remain in her plan at least until the next Open Enrollment Period; under the Departments' proposed 3-month limit, if Sarah were newly diagnosed with a condition while enrolled in STLDI plan that is not renewable, she may be left uninsured until the next Open Enrollment Period if she does not qualify for an SEP.

Finally, HBI members report that there is no contractual definition that exists today defining a one-month extension. Therefore, there is no rational basis for the Departments proposal to limit STLDI to three months of initial coverage and a one-month extension rather than simply providing for four months of coverage. This proposal is unnecessarily complex and will likely create administrative confusion and impose additional costs. Depending on how the Departments intend to implement the proposed provisions, consumers could be further exposed to additional deductibles or cost sharing for the extension period.

There is no evidence that the current standard is harming the ACA risk pool

The Departments have not provided evidence to support the claim that the existing definition of STLDI negatively impacts premiums or the risk pool in the ACA-regulated individual market. While the Departments cite a 2020 Milliman study to justify limiting STLDI and hospital indemnity or other fixed indemnity plans due to risk pool concerns,[19] a more recent 2023 study by the American Academy of Actuaries contradicts this conclusion. The Academy does not cite STLDI or hospital indemnity or other fixed indemnity plans as significant factors driving premium increases for the 2024 plan year. Furthermore, a 2023 study by the Kaiser Family Foundation reveals that the number of people enrolled in non-ACA-regulated coverage has dropped from 5.7 million in 2015 to an estimated all-time low of only 1.2 million today.[20] This decline has occurred despite Congress "zeroing out" the ACA's individual mandate penalty, which was still in effect in 2015.[21] Given the latest data, rather than the outdated and selective sources relied on

[19] See Dane Hansen and Gabriela Dieguez, "The impact of short-term limited-duration policy expansion on patients and the ACA individual market," Milliman, February 2020 https://www.lls.org/sites/default/files/National/USA/Pdf/STLD-Impact-Report-Final-Public.pdf

[20] Kaiser Family Foundation, "Already at Record High, ACA Marketplace Enrollment Could Increase Further," September 7, 2023, https://www.kff.org/private-insurance/press-release/already-at-record-high-aca-marketplace-enrollment-could-increase-further/.

[21] See Rachel Fehr, Daniel McDermott, and Cynthia Cox, "Individual Insurance Market Performance in 2019," ("[D]espite absence of the mandate penalty, data indicate that the individual market has not become significantly less healthy. These new data from 2019 offer further evidence that the individual market is stable even without a

by the Departments in the preamble, it is evident that concerns about the risk pool do not provide a valid basis for the proposed rule.

The Departments impermissibly substitute their views for the views of Congress in the proposed rule

The exclusion of STLDI from the definition of individual market health insurance (and the ACA's requirements on individual market coverage) was intentional by Congress, not an oversight or mistake. Congress has acted to ensure the availability of comprehensive coverage, but also has repeatedly and intentionally chosen to allow alternative plan options to exist alongside more comprehensive coverage, including renewable STLDI (with an initial contract term of up to 12 months).[22] The proposed rule will effectively do what Congress has chosen not to do by eliminating an affordable option for millions of Americans.

It is also worth noting that, in the wake of several significant healthcare-related actions taken over the last several years in response to the pandemic, Congress has had multiple opportunities to regulate or restrict STLDI but declined to do so. For instance, the Families First Coronavirus Response Act (FFCRA); the Coronavirus Aid, Relief, and Economic Security (CARES) Act; and the No Surprises Act all dealt with critical aspects of health insurance and the individual market. These federal laws touch on various elements relevant to private health insurance coverage in general and individual market coverage in particular, such as coverage requirements, consumer protections, and emergency healthcare provisions. Yet, in none of these legislative actions did Congress choose to include provisions that would limit or regulate STLDI. This omission is not accidental, but rather represents a deliberate choice by Congress to allow STLDI to continue alongside ACA-regulated plans as alternative products. The proposed rule, therefore, not only contradicts the legislative intent but in reality seeks to accomplish what Congress has deliberately refrained from doing for over two decades.

Finally, there is no statutory authority allowing the Departments to take action against private insurance entities for the purpose of protecting ACA-regulated exchange markets from real or imagined adverse selection, nor can the Departments point to any authority allowing them to make alternative insurance products less flexible, flexible, or available to consumers in

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mandate penalty…") https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2019/.

[22] As the Departments said in the 2018 rule: "Indeed, when the federal regulations for short-term, limited-duration insurance were first implemented in 1997, short-term, limited-duration insurance was considered to be health insurance coverage with a period of coverage that was less than 12 months, as under the proposed rule. That standard was in place for nearly two decades without objection." See 83 FR 38216.

order to steer them into the government's preferred health insurance products. As discussed in more detail below in this comment letter, the case of *Central United Life Insurance Co. v Burwell* challenges the Departments' assertions of statutory authority in this area.

Notice Requirements

The Departments propose several modifications to the notice content and specifications for STLDI plans. These changes include requirements for prominent display in both written and electronic formats, the inclusion of a website link and telephone number for HealthCare.gov or the relevant State Exchange website, and State Department of Insurance contact information where applicable. Additionally, the Departments propose adding reminders about eligibility for employer-sponsored coverage.

While clear and comprehensive notice and disclosure requirements are important, these notices must be carefully crafted to avoid confusion. Furthermore, the proposed federal notice requirements could potentially conflict with existing state regulations on the language or placement of such notices. States have their own unique insurance landscapes and consumer protection laws, and their existing notice requirements may already be as prominent, complete, and detailed as the proposed federal requirements. To avoid unnecessary duplication or contradiction, states should be permitted to maintain their existing notice language, provided it meets or exceeds the federal standards in terms of prominence, completeness, and detail.

Applicability and Effective Date

The Departments propose a dual approach to the applicability dates for new and existing short-term, limited-duration coverage. Under this approach, existing policies sold or issued before the final rule's effective date, including any renewals or extensions, would continue to operate under the current Federal definition. In contrast, new policies sold or issued after the effective date would be subject to the Departments' revised definitions. The proposed notice requirements would be applicable to all new policies sold or issued on or after the effective date and would extend to existing policies only in the context of required notices provided upon their renewal or extension.

While the Departments' consideration of transitional periods for currently active policies is appreciated, it is crucial to ensure that the final rule's applicability dates provide issuers with adequate time to make necessary adjustments. This involves updating systems, processes, and vendor relationships, as well as revising notices or materials that may require additional state Department of Insurance review and approval. For both the short-term medical as well as fixed

indemnity market changes, HBI membership reports that typical turnaround times from initial filing of product or rate changes to final approvals by all states are six to nine months, depending on the time of year and whether submissions coincide with the process for submitting rates for qualified health plans (QHPs). When the time needed to update administration and rating systems, processes, and vendor relationships is added, the total timeline is far in excess of the 75-day proposed implementation timeline.

While HBI urges the Departments to withdraw the proposed rule in its entirety, should the Departments finalize this aspect of the proposed rule, we request that the Departments extending the applicability date for the notice requirements to 180 days from the final rule's effective date. While still likely insufficient for some states, this timeline would offer issuers minimal additional time to coordinate with states on updated processes and materials, and to secure any required approvals.

Hospital Indemnity or Other Fixed Indemnity Excepted Benefits Proposals

Millions of middle-income Americans depend on voluntary supplemental insurance products, such as hospital indemnity and other fixed indemnity insurance, to provide financial help with added expenses incurred during and incident to medical problems. Distinct from lost wages, for which disability income insurance provides coverage, hospital indemnity and other fixed indemnity benefits provide coverage for the additional expenses individuals and families face when the individual or a family member requires treatment for a covered illness or medical condition. A few examples of these extraordinary expenses include added childcare expense (due to loss of caregiver), transportation and lodging expenses, home upkeep (repairs, lawn, snow removal, and other functions of daily life that the patient or family members may not be able to provide). Hospital indemnity and other fixed indemnity products may also bridge the financial gap between their comprehensive health plan coverage and the total out-of-pocket expenses they incur during hospitalization or when diagnosed with serious illnesses like cancer. These additional costs can include copays, deductibles, and coinsurance. These expenses can be especially burdensome for lower-income Americans who may have limited or no paid leave and insufficient savings.

Hospital indemnity or other fixed indemnity insurance pays a fixed-dollar benefit that is triggered by a healthcare "event." This benefit is paid directly to the policyholder and is not related to medical expenses incurred. The benefits are commonly used by policyholders to pay

for indirect medical costs and non-medical expenses directly caused by the triggering healthcare event.

The proposed rule marks a significant departure from established federal law. Notably, the last three major congressional actions related to health insurance—HIPAA in 1996, the ACA in 2010, and the No Surprises Act in 2020—all allowed the market for these supplemental products to continue without interruption.

The Departments, without offering any empirical evidence, assert that consumers are confused by "deceptive marketing." However, state insurance regulators have received few complaints regarding consumer confusion surrounding hospital indemnity or other fixed indemnity coverage or consumers mistaking these plans for comprehensive medical coverage. For decades, these regulators have effectively overseen these products and their marketing under existing state laws.

The Departments' proposal, rather than targeting a small and unrepresentative sample of bad actors, would unjustly strip states of their regulatory authority. It would effectively eliminate traditional supplemental insurance products that state regulators have approved for decades and that consumers highly value.

These supplemental plans are not only popular among individuals with employer-sponsored coverage but are also frequently used by other individuals with minimum essential coverage. Individuals enrolled in a silver plan through the marketplace will face an average deductible of over $4,000, money that is not in savings and not available to most Americans. Even seniors enrolled in Medicare Advantage plans need to finance higher cost sharing. These supplemental plans when sold through state licensed insurance companies and state licensed insurance agents help consumers finance these unexpected medical costs.

The Departments' one-size-fits-all approach would needlessly harm these consumers in the name of protecting the ACA-regulated individual market. Moreover, the supplemental policies impacted by the Departments' proposal often come with a "guaranteed renewable" clause, allowing consumers to maintain their existing benefits provided premiums are paid. The proposal would effectively nullify this crucial protection, potentially leaving millions without coverage.[23]

[23] It is worth noting that Medicare and Medicare Advantage serve as effective models of coverage, allowing consumers to opt in or out of supplemental plans at reasonable prices. This is particularly relevant as out-of-pocket healthcare costs continue to rise, outpacing both the Consumer Price Index and wage growth. Hospital indemnity or fixed indemnity products offer a customizable solution to offset these rising costs.

Additionally, the proposal would increase taxes on small businesses and hard-working Americans. Reversing a tax treatment in place for over six decades, the benefits from these supplemental policies would become subject to taxation as wage income if the premiums are paid pre-tax through an employer's cafeteria plan, subject to an increase in FICA taxes for both the employee and the employer.[24]

In summary, the Departments' overreaching approach in the proposed rule would significantly increase Americans' exposure to medical debt and medical bankruptcy, effectively eliminating their ability to secure additional financial protection through these supplemental products.

States have the primary responsibility for regulating insurance markets

As discussed above in our comments on STLDI, state insurance regulators hold the primary responsibility for regulating insurance markets and ensuring consumers are protected. State regulators must retain the flexibility to determine whether, and under what conditions, hospital indemnity or fixed indemnity plans are appropriate for their state. Blanket action at the federal level may not be effective in addressing the underlying issues identified by the Departments and is more likely to have unintended consequences that limits choice and harms consumers.

The states are and have long been the primary authority for regulation of both hospital indemnity and other fixed indemnity insurance. The Public Health Service Act (PHSA) recognizes this authority, and the ACA did not change this authority for these products.[25] Current state law already regulates these products as "supplementary" insurance. The Departments make this proposal despite the successful regulation by the states and state regulators' ongoing support for maintaining "per service" benefit payments.[26]

State regulation includes robust consumer protections and the active enforcement of those protections. Consumer protections include requirements for policy provisions, filing and approval of policy forms, outlines of coverage, marketing, and advertising. State insurance departments monitor compliance with these requirements through consumer complaint

[24] We note that such a change in federal tax structure might also create additional state tax burdens on employers and employees.
[25] 42 U.S.C. § 300gg-61(a); 65 Fed. Reg. 45,786, 45,787 (1999) ("States are the primary regulators of health insurance coverage in each State.")
[26] See NAIC August 2016 letter commenting on the proposed regulations on Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance.

investigations and market conduct examinations, the MCAS process previously mentioned and may impose fines and order compliance as necessary to enforce requirements. In addition, all state insurance departments have a division for the reporting and investigation of fraud, improper marketing, and other market abuses.

To guide state regulation, the NAIC has adopted a model act (Model #170) for accident and sickness insurance, is currently in the process of updating the corresponding regulation (Model #171) and has also adopted a model regulation (Model #40) that specifically addresses the advertisement of these products. (It is also noteworthy the NAIC first adopted Models #170 and #171 in 1975—21 years before HIPAA was enacted and 35 years prior to the enactment of the ACA.) Many states have adopted or follow the longstanding NAIC model acts and regulations, providing a regulatory framework for these products. Models #170 and #171, which have been frequently updated, contain minimum policy standards, disclosure requirements, as well as an outline of coverage, and other provisions designed to inform consumers of the limited nature of these coverages.

Continuing to recognize the primacy of state regulation of these insurance products and markets allows the flexibility necessary for states to quickly adapt to changing market conditions and tailor state responses appropriate to protect each state's citizens. In deference to appropriate and comprehensive state regulation, the Departments should not move forward with finalizing proposals affecting hospital indemnity or other fixed indemnity plans.

The Departments provide insufficient factual and legal basis for the proposed rule

Once again, the Departments assert significant risks to consumers from hospital indemnity or fixed indemnity excepted benefits coverage without providing appropriate supporting evidence that would justify federal action. Cited sources are heavily anecdotal; one blog post cited by the Departments admits that the authors "are not aware of systematic data on fixed indemnity coverage in the individual or group market."[27] Mere anecdotal evidence is not sufficient justification for federal action on an important issue primarily regulated by the states. Another source cited by the Departments to support claims of misleading marketing draws conclusions from a statistically insignificant sample of only twenty secret shopper phone calls

[27] "Fixed Indemnity Coverage is a Problematic Form of 'Junk' Insurance," U.S.C-Brookings Schaeffer Initiative for Health Policy, 2020.

made in a single state (Texas).[28] Instead of anecdotal evidence, AHIP and ACLI recently surveyed their members and found that the over 4.7 million fixed indemnity members filed 2,432 complaints in 2022[29].

Rather than taking federal, nationwide action, such examples have typically been addressed by state regulators, whose intimate knowledge of their insurance markets enables them to more effectively investigate issues and, if warranted, take appropriate enforcement action or promulgate additional regulations if necessary.

Isolated incidents have occurred where certain consumers may have received misleading or inaccurate information regarding insurance plans, coverage, or benefits. It is important to emphasize that issuers of hospital indemnity or other fixed indemnity plans have no interest in their products being misrepresented to consumers and certainly do not profit from it in any way. Contrary to some assertions, deceptive marketing and sales practices are highly detrimental to insurers both financially and reputationally. Such incidents, even if they are without merit, can incur costs and reputational damage for insurers in the form of the need for increased underwriting, administrative investigations, and loss of trust and goodwill by consumers, distributors, and regulators. Given the relatively low premiums charged for supplemental plans, the time required to recover these increased underwriting and marketing costs can take an extended period of time to recoup, even up to several years. It should be acknowledged by the Departments that insurers have strong incentives to ensure their products are accurately represented in the market.

Excepted benefits are defined under federal law to include hospital indemnity or other fixed indemnity policies, provided the benefits are not coordinated with a group health plan.[30] If these policies meet the three requirements set out in statute, they are treated as excepted benefits and are not subject to federal regulation as comprehensive, major medical health insurance coverage under the PHSA: (a) the "benefits are provided under a separate policy;" (b) there is "no coordination between the provision of such benefits and any exclusion of benefits under" a group health plan by the same sponsor; and (c) the "benefits are paid with respect to an

[28] "Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period," Center on Health Insurance Reforms at Georgetown University, 2021.
[29] Joint-Trade-Survey-Fixed-Indemnity-and-Specified-Disease.pdf (ahiporg-production.s3.amazonaws.com)
[30] 42 U.S.C. §§ 300gg-91(c)(3) (Public Health Service Act (PHSA) § 2191); 300gg-21(c)(2) (PHSA § 2721).

event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor."[31]

This exemption may not be limited through regulation to less than *all* policies encompassed under the statutory requirements. The court in *Central United Life Insurance v. Burwell* made clear the Department did not have authority to establish enrollment in Minimum Essential Coverage (MEC) as a required criterion for individual hospital indemnity or other fixed indemnity policies: "[t]hus, where Congress exempted all such conforming plans from the PHSA's coverage requirements, HHS, with its additional criterion, exempts less than all. Disagreeing with Congress's expressly codified policy choices isn't a luxury administrative agencies enjoy."

Before and after the enactment of the ACA, these products have generally been offered on a per event basis consistent with the statute – *e.g.*, benefits triggered by a healthcare event such as a doctor's visit or hospital stay – and with varying payment amounts. Nothing in the PHSA or the ACA (which did not amend this section or regulate excepted benefits criteria) permits the Departments to add additional criteria for group hospital indemnity or other fixed indemnity insurance to qualify as excepted benefits—including a per day or other time period requirement and restrictions on providing different amounts of payment based on the type of item or service provided. So long as the three statutory conditions are satisfied, the plan qualifies as an excepted benefit.

New criteria for non-coordinated excepted benefit hospital indemnity or other fixed indemnity policies adds requirements not contemplated by the statute and exceeds the Departments' statutory authority and discretion. Under well-settled principles of administrative law, courts apply a two-step analysis to determine whether agencies have overreached their statutory mandate. The first question is always whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, the agency must give effect to the unambiguously expressed intent of Congress. If Congress has not directly addressed the precise question at issue, the question is whether the agency's regulation is based on a permissible construction of the statute.[32]

This is the exact line of reasoning adopted by the D.C. Circuit in *Central United* when a federal regulation attempted to amend the criteria for hospital indemnity or other fixed indemnity insurance in the individual market to be treated as an excepted benefit by requiring

[31] Id. § 300gg-21(c)(2)(A)-(C).
[32] *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

that the plan be "provided only to individuals who have … minimum essential coverage."[33] Here, as in *Central United*, "Congress has never changed course or put its original definition in any doubt."[34] As a result, in this proposal the Departments lack authority to demand more of hospital indemnity or other fixed indemnity providers than Congress required."[35]

The Departments' proposal presents a radical shift in how a longstanding statute has been interpreted, relied upon, and enforced. Prior to the ACA, the statutory term "event" was understood to always include both per-service and per-period triggers. Neither the ACA nor any other statute changed that common understanding. This underscores the significance of the proposed change and why it is contrary to the statute. Further, the newly proposed criteria for excepted benefits are inconsistent with the Departments' decades-long treatment of these products. The proposed rule would create entirely new, non-statutory requirements that would cause widespread market disruption for a product that has been offered to and purchased by consumers for many years.

Before and following enactment of the excepted benefits statute, insurers, state insurance regulators, and the Departments have shared a common interpretation of the exception for hospital indemnity or other fixed indemnity policies: it does not exclude policies that pay event-based benefits or those that pay varying amounts for different types of services.[36] These new proposed requirements would essentially eliminate the vast majority of hospital indemnity or other fixed indemnity insurance designs offered in the market today.

States have consistently approved policies that pay event-based benefits and allow variation in payments based on service as fixed indemnity or hospital indemnity policies, in line with their responsibilities as primary regulators of the business of insurance and primary enforcers under the PHSA.[37]

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[33] *Central United Life Insur. Co. v. Burwell*, No. 15-5310, 2016 WL 3568084, at *1 (D.C. Cir. Jul. 1, 2016).
[34] Id. at 2.
[35] Id. at 3.
[36] Even the D.C. Circuit, in the *Central United* decision, described fixed indemnity with a "per event" trigger: "Among the excepted benefits listed in the PHSA is a form of insurance known as "fixed indemnity." Id. § 300gg-91(c)(3)(B). As their label suggests, these policies pay out a fixed amount of cash upon the occurrence of a particular medical event. For instance, if a policyholder visits a hospital or purchases prescription drugs, the provider pays out a predetermined amount, which the policyholder is then free to use however she chooses." *Central United* at *1*.
[37] See 42 U.S.C. § 300gg-61(a); 65 Fed. Reg. 45,786, 45,787 (1999) ("States are the primary regulators of health insurance coverage in each State.").

The Departments lack legal authority to limit payments of hospital indemnity or other fixed indemnity benefits to a "per period" basis

Federal statutory authority (HIPAA and ACA) does not employ the terms "per day," or "per period," or "per service" for fixed indemnity benefit amounts. Federal statutory law uses the broader term "events."[38] The phrase "event" is a reference to the various healthcare events that would trigger cash benefit payments under hospital indemnity or other fixed indemnity insurance for uncovered economic expenses. The plain meaning of the phrase "event" would broadly encompass any health-related item or service such as surgery, an emergency room visit, a doctor visit, or the writing of a prescription.

Federal statutes (both HIPAA and the ACA) define "medical care" and "essential health benefits" as consisting of healthcare "items and services." The term "services" is used to describe medical care. The proposed prohibition on a "per service" benefit payment would result in the denial of cash benefit payments to policyholders for many healthcare "events" that are classified as "services."[39]

The HIPAA interim federal rules issued immediately following the enactment of HIPAA used the phrase "per day" only as an example of what is hospital indemnity or other fixed indemnity coverage (*e.g.*, "for example, $100 per day").[40] The HIPAA final rules expanded on the example that it "must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100 per day)".[41] This 2004 amendment remains as the current group market regulation. The preamble explanation for the 2004 amendment does not include any expressed intention to prohibit "per service" based benefit payments.[42]

Furthermore, nowhere in the current federal statute or regulations does any text state that *only* "per day (or other period)" based payments can be utilized as the exclusive basis of benefit payments. In fact, federal regulations have always expressly allowed for payments to be made on either a per period or per service basis. This has been the law since HIPAA's enactment in 1996.

The Departments' proposed ban on "per service" benefits is without statutory authority and contravenes the appellate court's ruling in *Central United*. The states are the primary regulators of insurance and are adequately and appropriately regulating these products, and

[38] See ERISA Section 705(c)(2); PHSA Section 2721(d)(2).
[39] See ERISA Section 706(a)(1)-(2); PHSA Section 2791(a)(1)-(2); and ACA Section 1302(b).
[40] See *Federal Register* of April 8, 1997.
[41] See FR December 30, 2004.
[42] See 69 FR 78720 at 78735.

federal agencies such as the Federal Trade Commission (FTC) and Federal Communications Commission (FCC) are adequately and appropriately regulating any improper interstate marketing of these products.

In light of these legal concerns and other reasons stated in this comment letter, HBI recommends that the Departments withdraw this proposal.

Income replacement is not the purpose of hospital or other fixed indemnity plans or specified disease products

Throughout the preamble of the proposed rule, the Departments refer to hospital indemnity or other fixed indemnity health insurance plans as "income replacement." HBI disagrees with this categorization. Hospital indemnity or other fixed indemnity plans are most appropriately referenced as a type of supplemental health insurance, as any benefits paid require a health event or the receipt of a health service as a trigger and do not function on a reimbursement basis. As previously discussed herein, benefits provided by fixed indemnity products are intended to cover added expenses incurred during medical encounters. Existing disability income policies already serve that purpose but do not allow for the added costs covered by hospital indemnity or other fixed indemnity insurance.[43] It would be counterproductive and destructive to disqualify hospital indemnity or other fixed indemnity products from regulatory recognition by misrepresenting their purpose.

Consumers purchase hospital indemnity or other fixed indemnity policies as a supplement to their comprehensive major medical plans to cover costs related to their healthcare that they may not have the savings or income to cover. According to recent research on medical billing, about half of American adults are not able to cover a medical bill exceeding $500.[44] Studies examining the financial capabilities of Americans to cover potential healthcare bills generally do not consider patients' or families' ability to pay for the additional costs of sickness or injury that health providers do not bill and major medical health insurers do not pay—such as costs for transportation to and from treatment and childcare. This is where products like hospital

43 For this discussion, it is useful to reference how disability income products work. For these products, the payment trigger is typically loss of income due to inability to work. However, these products do not require any loss of income from work to pay benefits. Disability income plans also cover individuals who may not even be working at the time, such as children, retirees, or unemployed individuals. Hence, the term "income replacement" is an erroneous oversimplification of how these products work and the benefits they provide to consumers, which extend far beyond mere replacement of income from time spent away from work due to illness, injury, or disability.

44 https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/#:~:text=Main%20takeaways%20include%3A,putting%20off%20due%20to%20cost.

indemnity or other fixed indemnity plans play an invaluable role to help cover out-of-pocket costs for care and other health-related costs that major medical health insurance does not cover. These plans can help policyholders alleviate or avoid medical debt and bankruptcy when used in conjunction with comprehensive major medical plans. The label "supplemental health insurance" is appropriate for these types of plans, while "income replacement" fails to accurately describe these products' structure and function as a complement to comprehensive major medical health insurance.

Prohibitions on benefit variance

The proposed rules would further require that fixed indemnity benefits be paid "regardless of [...] severity of illness or injury experienced by a covered participant or beneficiary, or other characteristics particular to a course of treatment received by a covered participant or beneficiary."

Consideration of the severity and/or level of care is still required to ensure the plans match appropriate benefits to amounts of added costs incurred by members. For instance, the hospital or fixed indemnity benefit paid where a member suffers a broken arm should relate to the likely added costs members incur in such a case. On the other hand, the added costs most often incurred when a family member undergoes long-term treatment for cancer would, in general, be far greater. Specific recognition of diagnosis and severity are integral to preserving the value of fixed indemnity insurance to consumers.

Coordination of Benefits

Noncoordination means that the "excepted benefit" plan may not expressly provide any benefit that is expressly excluded under the group health plan. The effect of this condition is to ensure that supplementary insurance products are not interdependent and a substitute for providing benefits expressly excluded in the primary plan. The prohibited coordination must be real and explicit, not imagined or implied.

Fixed indemnity plans do not provide benefits for specific medical expenses incurred. Instead, specific medical events trigger cash benefit payments that are used to pay for uncovered out-of-pocket expenses for medical items or services and non-medical expenses directly caused by the healthcare event such as transportation, lodging, or other out-of-pocket costs.

The Departments' proposal disregards nearly 30 years of unchallenged understanding about Congress's intentions for the "noncoordination" component of the hospital indemnity or other fixed indemnity benefits definition. In Example (3) under "Special rules relating to group health plans," the proposed rule asserts that a product which provides hospital indemnity or other fixed indemnity benefits for services would "coordinate" if the group plan sponsor has other group health plan coverage which did not provide benefits for those same services. This purported interpretation of the statute is a wholesale reconstruction of its meaning.

There are three requirements making up the "noncoordination" component of hospital indemnity or other fixed indemnity coverage. The first requirement clarifies that the fixed indemnity coverage must stand on its own (*i.e.*, the hospital indemnity or other fixed indemnity benefits are not a part of a traditional major medical policy). As part of HIPPA, this definitional requirement caused traditional group health plans to comply with HIPAA with regard to all facets of the health plan, even where some of the plan benefits were nominally "fixed." The second requirement is that the standalone policy, certificate, and/or contract providing such fixed benefits (referring back to the standalone policy, certificate, and/or contract) does not "coordinate" with any exclusions of another plan of the plan sponsor, which is to say that coverage/benefits under the standalone policy, certificate, and/or contract *cannot be conditioned upon or otherwise take into consideration* the existence of an exclusion in the other plan. This understanding is the only rational understanding of the "noncoordination" language. This is because all insurance is intended to fill holes or gaps (i.e., exclusions). If insurance coverage does not "coordinate" in that sense, then the coverage fails in its fundamental purpose. Moreover, the second requirement, properly understood, is an obvious corollary of the third requirement, which is that the fixed indemnity coverage must pay benefits even if another plan also pays benefits. Read as a whole, all three requirements require "noncoordination," because the fixed indemnity coverage must always pay without regard to provisions in other coverage, the lack of provisions in other coverages, or the existence or non-existence of other coverage.

Finally, the Departments' proposed language on noncoordination lacks specificity and could create significant confusion in the market. Should the Departments choose to finalize these provisions, it could create unintended consequences and could limit beneficial innovation by insurers to offer supplemental products to consumers. In addition, the Departments' related proposal to eliminate assignment of benefits represents an overreach and presents no benefits to consumers.

Notice Requirements

HBI agrees with the Departments that consumers should have a clear understanding of products prior to purchase and supports notice requirements for all supplemental health insurance products. However, HBI supports draft disclosure language prepared by industry representatives, NAIC consumer representatives and state regulators in lieu of the first paragraph of the proposed and alternative notices included in the proposed rules. The disclosures would be required to be included next to the signature on any application or enrollment forms and on the first page of policies and certificates. The language will be included in the final draft of NAIC Model #171, the Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act, and reads as follows:

> (3) For hospital indemnity coverage, the application, policy, and certificate must include a disclosure statement that reads as follows: "This [policy] [certificate] pays fixed dollar benefits as a result of a covered hospitalization due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."
>
> **Drafting Note:** The words "fixed dollar benefits" should be prominent.
>
> (4) For other fixed indemnity coverage, the application, policy, and certificate must include a disclosure statement that reads as follows: "This [policy] [certificate] pays fixed dollar benefits as a result of covered events due to a sickness or injury. The benefit amounts are not based on the cost of your medical expenses. These benefits are designed to be paid to the [policyholder] [certificate holder]. They are not intended to be paid directly to providers. This [policy] [certificate] is not major medical insurance and does not replace it. Read the description of benefits provided along with your [enrollment form /application] carefully."

This language is preferrable to the Departments' proposed notice language and reflects the careful consideration of industry, consumer groups, and state regulators.

New Policies and Applicability Dates

For new hospital indemnity or other fixed indemnity health insurance policies sold in both the individual and group markets, HBI is concerned that the proposed applicability dates of 75

days following the publication of the final rule will not allow sufficient time for state legislatures, state regulators, and insurers to implement the new requirements and have products on the market ready for purchase. The effect of these delays would, at very least, prohibit sales of hospital indemnity or other fixed indemnity products of any sort to new enrollees for an undetermined period. The recognized value of hospital indemnity or other fixed indemnity insurance coverage would be lost.

For new individual and group policies conforming with the new requirements to be sold by that time, the following events would need to occur:

- State legislatures would need to pass new minimum standards laws that conform to the new requirements for both the individual and group markets. Minimum standards may include additional requirements or restrictions for hospital indemnity or other fixed indemnity plans to be sold in the state. Additionally, we note that some state legislatures do not meet annually, meaning that it could take more than one year for those states to pass minimum standards legislation and fully implement the new requirements.
- State Departments of Insurance (DOIs) would need to propose, finalize, and implement minimum standards regulations.
- Insurance carriers would need to work internally with benefits experts, actuaries, and accountants to develop new products that are based on sound accounting and actuarial principles and are appealing to individual consumers and employers.
- Insurance carriers would need to submit proposed products to state DOIs for review and approval. Some states also require that any marketing materials for a product be submitted for review and approval.
- State DOIs would need to review and approve insurance carriers' submissions. Given that every carrier will need to re-file every product in the individual and group markets, backlogs will develop in every state. If submissions coincide with the process for submitting rates for qualified health plans (QHPs) in the individual major medical market, review and approval for new hospital indemnity or fixed indemnity products may be delayed as states prioritize QHPs in time for open enrollment.

If states are unable to implement the new rules and insurers are not able to file and receive approval for new products by the 75-day deadline, insurers will be unable to sell any hospital

indemnity or other fixed indemnity policies, leaving consumers without access to a popular supplemental health insurance product.

Existing Policies - Individual Market

In the individual market, hospital indemnity or other fixed indemnity policies are most often sold on a guaranteed renewable basis. When an insurance contract is marketed and sold as guaranteed renewable, provided the policyholder pays their premiums, the contract remains in effect and the benefits cannot change. In some plan designs, the policyholder essentially "pre-funds" the contract by paying a higher premium initially in order to pay a lower premium later (though this is not a universal structure).

As proposed, the requirement to implement the changes for existing policies in the individual market by 2027 would require insurance carriers to violate state contract laws and break contractual promises made to policyholders when their plans were purchased. Beyond the clear conflict with well-established contract law, this proposal would result in significant negative impacts on consumers, who will lose their current robust benefits, which they have continued to find valuable and necessary for their financial protection. Further, if they choose to purchase a new policy, the underwriting for that policy will have to account for their increased age(s), as well as any medical conditions experienced or developed since the original policy was underwritten. Their new policies will likely cost them more, while ultimately providing fewer benefits and less overall value.

For these reasons, HBI strongly opposes the application of the new rules to existing policies sold on a guaranteed renewable basis. Changing the implementation date will not fix this problem.

Existing Policies - Group Market

In the group market, hospital indemnity or other fixed indemnity contracts are generally conditionally or optionally renewable, with timelines that vary in duration. HBI notes that some contracts are subject to collective bargaining agreements (CBAs) that may stretch beyond the proposed 2027 effective date. Requiring those employers to break their CBAs to comply with the new rules is unfair to the workers who rely on their labor organizations to represent them in contract negotiations.

Tax Treatment: Payments from Accident and Health Policies (26 CFR 1.105-2)

The proposed rules include a change to federal tax regulations from the Department of the Treasury and the Internal Revenue Service (IRS) related to the tax treatment of employment-based accident and health insurance plans, which include hospital indemnity or other fixed indemnity and specified disease plans. Under current law, if premiums for these policies are paid by an employer or by the employee with dollars that are excluded from their gross income, then benefits paid under these policies that exceed the cost of medical care should be reported as income by the policyholder.[45] Under the proposed rule, all benefits paid under employment-based polices must be reported as income and subject to both income and payroll taxes (FICA and FUTA are mentioned in the preamble).

HBI opposes this change in long-standing IRS policy and disputes the notion that these changes are a mere "clarification." The tax changes are a significant shift in tax policy that imposes new taxes on working Americans with new burdens on employers. The IRS has previously proposed a similar legislative change in the Fiscal Year 2023 and 2024 President's Budget request and accompanying explanations of revenue proposals ("the Greenbook").[46] Congress has not chosen to implement this requested policy change, and congressional inaction does not grant the Department and the IRS the authority to legislate in its place.

The proposed change would result in a tax increase on hard working Americans, including lower income workers who may have little or no paid leave from work or who may not have savings to cover all expenses, including out-of-pocket expenses under their comprehensive major medical policy. In some instances, the benefits paid in response to an injury or serious illness may shift the policyholder and their household into a higher tax bracket, which could result in an even larger tax increase for that family. Supplemental insurance provides these individuals with financial peace of mind when they are facing a serious injury or illness, and the proposed change makes that peace of mind more expensive and for some, may place it out of reach altogether.

Payouts from other, similar forms of insurance such as life insurance proceeds are not usually taxed. Life insurance proceeds are available to pay for funerals and other related expenses. Similarly, proceeds from fixed indemnity excepted benefits, including hospital indemnity coverage, should not be taxed as income because, regardless of whether such

[45] 1956-1 CB 63, 70; T.D. 6169
[46] FY 2023: https://home.treasury.gov/system/files/131/General-Explanations-FY2023.pdf
FY 2024: https://home.treasury.gov/system/files/131/General-Explanations-FY2024.pdf

payments are used to pay for medical expenses or other out-of-pocket expenses, they do not make the taxpayer better off financially.

Furthermore, changing the tax treatment of hospital indemnity or other fixed indemnity coverage bears little or no relationship to the Departments' stated goal of distinguishing hospital indemnity or other fixed indemnity coverage from comprehensive coverage. Rather, this proposal represents an inappropriate use of the tax code to promote the Departments' preferred coverage, at the expense of millions of consumers who are benefitting from these supplemental policies. Further, if the proposed change is finalized, insurance providers and employers would face increased administrative burdens, and the proposed rule is unclear as to how the proposed change will be implemented, particularly with respect to payroll tax amounts owed by employers and employees.

Because the IRS lacks statutory authority to make the proposed change and because the proposal breaks the Administration's commitment not to raise taxes on individuals who make less than $400,000 annually, HBI recommends the IRS rescind this proposal in its entirety.

Request for Information on Level-Funded Plans

HBI appreciates the opportunity to provide additional information on level-funded plans, how they operate, the current oversight and regulation of level-funded plans, and the role that agents, brokers, third-party administrators (TPAs), and other benefits advisors and professionals serve with respect to small employer health coverage. Employer-sponsored coverage provides affordable, high-quality coverage options for more than 180 million Americans and their families. Many small employers face additional challenges to provide competitive benefit packages with large employers and have fewer resources to absorb rising healthcare costs. Level-funded plans provide a viable option for small employers to consider when determining whether they can offer health insurance coverage to their workforce.

Small employers may choose to pursue level-funded plan arrangements for a variety of reasons, including costs, employee recruitment and retention, risk tolerance, ability to provide uniform benefits across states, and other factors. Employers who are unwilling or unable to take on level-funding risk, additional compliance requirements, or employers who would prefer to be less involved in the management and monitoring the performance of their benefit plans are not likely to be good candidates for level-funding with stop-loss. In addition, some HBI members report that many small employers who are moving to level-funded plan arrangements previously

offered grandfathered plans under the ACA and were not previously included in the ACA fully-insured small group market.

Level-funded plan designs must comply with many ACA and other federal market reforms, including prohibitions on lifetime and annual limits, out-of-pocket maximums and cost-sharing limits, prohibitions on preexisting condition exclusions, coverage of dependents to age 26, coverage of preventive care without cost sharing, claims appeal requirements, the Transparency in Coverage Rules, the No Surprises Act provisions included in the Consolidated Appropriations Act of 2021 (CAA), and other applicable statutes and regulations.

The proposed rule focuses on a number of issues around level-funded plans and seeks guidance on regulation of level-funded plans. It is important to note that most employers who offer coverage do so regardless of the employer mandate. This is especially true for small businesses – defined as those with fewer than 50 employees – who are not subject to the employer mandate. These small employers face all of the same benefit restrictions that are applied to the individual market but without the subsidies and the mandate to provide coverage. As a result, it has become more and more expensive for employers to provide coverage. The small employer market is already in a death spiral with rising costs and many small employers eliminating health insurance coverage for their employees. This shrinking market has forced more employees into the individual market. The self-funded health market provides a more affordable option for large employers and level funding provides a way for small employers to access the same advantages. Eliminating level funding will merely exacerbate the crisis in the small employer market.

Level-funded plans are a simplified version of other self-funded plans. All self-funded plans have three components: an administrator, stop-loss insurance, and a claims account. The administrator is paid through a fee and controls the checkbook by paying claims and calculating the amount of money an employer must remit to cover costs. Employers also purchase stop-loss insurance to limit the risks both in aggregate and to limit the risk of any one employee who has a single very expensive health event. Finally, the employer is responsible for paying all claims before the reinsurance contract begins to pay. The only differences between level-funded plans and other self-funded insurance plans is that the costs are sent to a single entity to simplify accounting, and the employer is required to pay a fixed amount that reflects the entire risk of their claims account for the year

Level-funded plans are primarily bought by small businesses and offer a lifeline for the declining market. They allow increased flexibility in plan design which helps lower premiums.

Coverage is only offered on a whole-group basis; in other words, all employees are covered or none. If small businesses lose access to level-funded plans, employers who are enrolled in the plans will drop coverage, and employees will move to the individual market.

Level-funded plans have now been available for decades. The *American Medical Security Inc. v. Barlett* which was one of the first versions upholding level-funded plans was decided by the Fourth Circuit in 1997:

> While we recognize that self-funded plans may not be providing Maryland residents with the range of benefits mandated by state law and that such plans' benefits may not always be as secure as those offered by regulated insurance companies, the remedy for any such deficiency must be requested of Congress. When ERISA preempted state law relating to ERISA-covered employee benefit plans, it may have created a regulatory gap, but Maryland is without authority to fill that gap. See Greater Washington Bd. of Trade, 506 U.S. at 130-31, 113 S.Ct. at 583-84 (D.C. workers' compensation provision requiring the provision of benefits in proportion to covered benefits of ERISA plan "relates to" and is therefore preempted by ERISA); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504, 525, 101 S.Ct. 1895, 1907, 68 L.Ed.2d 402 (1981) ("even indirect state action bearing on [ERISA plans] may encroach upon the area of exclusive federal concern"). This is not to say that Maryland may not regulate stop-loss insurance policies. Such regulation is clearly reserved to the states. See 15 U.S.C. § 1012(a) (The "business of insurance, and every person engaged therein, shall be subject to the laws of the several states"); 29 U.S.C. § 1144(b)(2) (ERISA does not preempt "any law of any State which regulates insurance" unless it deems a plan to be "an insurance company"). But because the Maryland regulation before us attempts to mandate the benefits that certain self-insured plans may offer, we affirm the judgment of the district court.

Based on a plain reading of *AMS v. Bartlett*, the Departments lack the authority to ban level-funded plans or to restrict level-funded employer sizes. Absent congressional action, we see no authority to set new attachment points that would effectively ban access to the stop-loss insurance needed for these arrangements. Worse, ill-advised changes will not only invite litigation, but will limit access to employer-based coverage and likely increase the uninsured rate.

States regulate the underlying stop-loss insurance as part of the McCarren-Ferguson Act's longstanding statutory framework. And states have taken various steps in regulating the underlying stop-loss insurance plans for small employers around minimum attachment points,

disclosures, and other rules. We do not believe substantive action is necessary and will merely interfere with state regulatory authority.

Small employers work closely with TPAs, stop-loss carriers, brokers, benefits advisors, and other professionals to design their plan's benefits and estimate their expected costs as a plan sponsor. Many level-funded plans provide coverage that is comparable to small group fully-insured or self-insured coverage. Some level-funded plans also comply with state-mandated benefits, even though they are not required to do so.

The plan's third-party administrator and stop-loss carrier use proprietary rating algorithms to set costs. Expected claims costs need to be determined using the specific stop-loss deductible and self-funded plan benefits. Service providers manage funds separately for each plan sponsor. If the full year costs for each plan sponsor's claims are less than the funded amount, a portion of the excess funds are returned to the plan sponsor. Employers and employees share in the cost savings if the plan's design generates savings—for example, by driving utilization to lower-cost or high-quality sites of care. It is the responsibility of the plan sponsor to determine how the refunds are used for the benefit of participants, through taxable refunds, discounts on future premiums, or upgrading plan coverage.

Administrative costs are similar to those found in fully insured plans, covering items such as claims administration, customer service, broker compensation, and network access. Administrative costs will vary based upon the services provided and the expense structures of the third-party administrator and stop-loss carrier.

Section 403 of ERISA requires plan sponsors to establish a trust for plan assets and participant contributions. Under a longstanding Department of Labor (DOL) policy, DOL will not enforce the trust requirement upon participant contributions under certain conditions: (i) the participant contributions are applied only to the payment of premiums for certain fully-insured benefits, (ii) the participant contributions are made under a cafeteria plan, or (iii) benefits are paid solely out of the general assets of the employer (DOL Technical Release 92-01). Any changes to this technical bulletin that would reinstate enforcement of the ERISA section 403 trust requirement for participant contributions and plan assets would impact all self-funded plan sponsors in considerable ways. As the plan is self-funded, in level-funding it is up to the plan sponsor and their tax advisor as to how best to treat any plan funds.

Level-funded group health plans are regulated by several federal agencies including DOL, the Treasury, HHS, and the Equal Employment Opportunity Commission (EEOC). Most self-funded plans are subject to ERISA, which has a set of rules around disclosure, fiduciary controls,

claims and appeal rules, and reporting requirements and failure to comply with these rules can bring potential civil and criminal penalties.

Stop-loss insurance is not medical insurance, but it provides protection against catastrophic or unpredictable financial losses. Therefore, stop-loss insurance falls under state jurisdiction and is also subject to state regulation based on group size and other restrictions. Many states require stop-loss carriers to set an annual aggregate attachment point at a defined percentage of expected claims. In order to come up with a credible estimate of expected claims, stop-loss insurers use risk rules to determine the allowable attachment points available to the group. Groups and their benefit advisors select the stop-loss attachment point that fits their risk tolerance and is within the stop-loss carrier's allowed limits. Aggregate attachment points are determined as the expected claims below the specific attachment point plus additional margin taking into account the self-funded benefit plan provisions. Some states have also implemented stop-loss disclosure requirements to be provided in the sales process to promote additional transparency.

Stop-loss protects the employer by providing maximum liability for a single member or from higher than anticipated overall utilization. Stop-loss does not insure the individual members of the plan.

Agents, brokers, and third-party administrators (TPAs) play an important role in ensuring that small employers understand the components of level-funded plans and know that they must comply with applicable regulations as a plan sponsor, including the risks and benefits of purchasing this type of product and the possible consequences and liabilities related to self-funded arrangements.

Many TPAs offer customer reporting or tools to assist plans with compliance, monitor changes, and communication with plan participants. This includes requirements under the ACA and CAA, such as applicable consumer protections, benefit mandates, Summary of Benefits and Coverage (SBC) requirements, section 6055 and 6056 reporting, prescription drug and healthcare spending reporting, fiduciary and compliance duties under ERISA, and more.

Request for Information on Specified Disease Plans

HBI appreciates the opportunity to offer comments in response to the Departments' request for information (RFI) about specified disease policies. As with hospital indemnity or other fixed indemnity health insurance, HBI believes that specified disease plans are best and most appropriately regulated by state insurance regulators, and we strongly oppose any potential

federal regulatory changes to specified disease plans, particularly any changes that would mirror the proposed rules' changes to hospital indemnity or other fixed indemnity plans. We do not believe that specified disease products would see an increase in interest or purchase as a result of the proposed rules, if they are finalized. Many specified disease policyholders specifically seek out their policies because they have a family history of certain illnesses or because their financial wellbeing could be substantially damaged if they were diagnosed with a covered illness.

Unfortunately, we are not aware of any data sources that provide information and data on specified disease policies, the numbers of policies and certificates in force, characteristics and demographics of policyholders, and common structures (including when benefits are paid and common exclusions/limitations). We are not aware of plan designs that employ or require the use of a network of providers. Additionally, plan structures vary widely; a single carrier may offer policies that pay upon diagnosis but also offer other policies that pay on receipt of treatment for covered illnesses (or other policy variations). This variation is the result of consumer demands in both the individual and group markets, as well as variation among states in their permitted benefit designs.

In the current market, specified disease coverage provides supplemental coverage for diseases that are serious and expensive to treat, such as cancer, heart disease, and strokes. Unfortunately, health insurance doesn't come close to covering the full cost of treating these serious medical conditions. In addition to high deductibles and other cost sharing, treating the condition can involve travel, require additional nonmedical and medical assistance, and other issues. Specified disease coverage provides consumers with additional resources to cover those unplanned expenses. Consumers usually purchase this coverage to protect themselves after seeing someone – often a relative – suffer from one of the named conditions and with an understanding that the consumer purchasing the plan is at higher risk to be diagnosed with the condition.

Specified disease coverage is sold by licensed insurers and through licensed insurance agents. Once issued, specified disease plans continue unless the plan is cancelled by the consumer unless fraud occurs. Specified disease plans are subject to insurance department rate and form review. State insurance departments have specific laws and rules including in some cases limits on the number of diseases that may be covered.

The Department's request for information in the preamble includes specific questions around specified disease coverage, the most important of which is what is the impact on specified disease coverage if the NPRM is adopted as written. In other words, if NPRM upends

consumer access to hospital and fixed indemnity plans, will consumers seek alternative coverage to meet those needs?

We would note that the NAIC will be requiring insurers to file a Market Conduct Annual Statement on "Other Health" products which includes specified disease coverage. This data will be necessary to properly assess specified disease and other products. Any federal action on specified disease coverage would be potentially duplicative and harmful to states' traditional oversight of these plans.

It remains our firm contention that any final rule issued by the Departments should not finalize the proposed hospital and fixed indemnity changes. We are hopeful that lawsuit will be unnecessary, and that any final rule will better protect consumer access to products used to finance the high-cost sharing included in all ACA plans. As a result, we expect to see no impact on the sale of specified disease plans.

Conclusion

HBI appreciates the opportunity to provide input on these proposed rules, which have far-reaching implications for both consumers and the insurance industry. We believe that a collaborative dialogue between all stakeholders is essential for crafting regulations that truly serve the public interest.

We look forward to continuing this important discussion and are committed to contributing constructively to the rulemaking process. Thank you for your attention to these critical issues. Should you have any questions or require further clarification on any of the points raised in our comments, please do not hesitate to contact jpwieske@thehealthbenefitsinstitute.org.

Sincerely,

JP Wieske
Executive Director