September 11, 2023

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Acting Secretary Julie Su
U.S. Department of Labor
200 Constitution Ave NW
Washington, DC 20210

Secretary Janet Yellen
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Dear Secretaries Becerra and Yellen, and Acting Secretary Su,

UnitedHealthcare (UHC) is pleased to respond to the 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* (the Proposed Rule) issued by the Departments of Health and Human Services, Labor, and the Treasury (the Departments). We are also responding to the requests for information regarding specified disease excepted benefits coverage and level-funded plan arrangements.

UHC is dedicated to helping people live healthier lives and making the health system work better for everyone by simplifying the health care experience, meeting consumer health and wellness needs, and sustaining trusted relationships with care providers. In the United States, UHC offers the full spectrum of health benefit programs for individuals, employers, and Medicare and Medicaid beneficiaries, and contracts directly with more than 1.3 million physicians and care professionals, and 6,500 hospitals and other care facilities nationwide.

We appreciate the opportunity to provide recommendations on providing quality, affordable coverage options to consumers. The Proposed Rule limits the short-term limited duration insurance (STLDI) contract period to three months with one additional month renewal period and restricts how fixed indemnity excepted benefits (FI benefits) can be provided. We believe these changes are not in the best interest of consumers and will lead to loss of coverage and financial hardship. Allowing more affordable coverage options in the commercial market helps to achieve universal coverage. The Departments should work to reduce barriers to care, not unduly restrict access to affordable coverage options.

STLDI and FI benefits are beneficial coverage options

STLDI and FI benefits provide affordable, consumer-responsive, innovative health care coverage with high member satisfaction. Recent surveys found that over 90 percent of consumers are satisfied with their FI benefits and short-term coverage.[1]

STLDI typically covers a range of medical and pharmaceutical benefits and provides consumers with a flexible, reasonable option to bridge the gap between the loss of other coverage such as an employer sponsored group health plan and the Open Enrollment Period (OEP) for a new employer plan or through a health insurance Marketplace. Also, UHC STLDI plans have a large provider network. Enrollees can access an extensive network of health care professionals, with 1.5 million physicians and other health care professionals and approximately 7,000 hospitals and other facilities.[2]

FI benefits serve the needs of a wide spectrum of consumers in both the individual and group markets. These benefits are typically provided on a first-dollar basis (i.e., no deductible) and help consumers manage a broad array of costs associated with illnesses and injuries, including medical treatment expenses, lost income, travel expenses, and childcare costs. Consumers typically use FI benefits to fill gaps that may exist in other coverage such as high deductibles, and purchase these benefits to supplement ACA Marketplace coverage as well as Medicare and employer group plans.

Restricting STLDI and FI products will disadvantage consumers

Limiting both STLDI and FI benefits will negatively impact consumers because it will lead to loss of coverage, cause financial challenges, and decrease consumer choice. Restricting STLDI coverage to three months (as opposed to the current term of up to 12 months) with a one month renewal will lead to coverage losses. As stated above, sometimes people become uninsured and need a solution to bridge them to the next OEP. These coverage gaps can last more than three months as proposed by the Departments - almost 37 percent of Americans can be unemployed for 15 weeks or greater.[3] A four month contract term is insufficient to meet the needs of consumers who experience a loss of comprehensive coverage and need time to find new affordable coverage options.

Restricting STLDI coverage and FI benefits will also cause financial hardship for consumers. ACA Marketplace coverage can be expensive for higher-income families who do not qualify for federal subsidies, and Marketplace or employer coverage can have higher cost-sharing obligations. STLDI and FI benefits are affordable alternatives or supplements to coverage. A survey demonstrated that over 60 percent of respondents cited affordability as the primary factor that led them to choose a short-term plan.[4] Another survey found that 90 percent of supplemental insurance enrollees felt that their coverage helped to pay for critical medical expenses.[5]

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[1] https://www.ahip.org/news/press-releases/new-survey-millions-of-americans-say-supplemental-insurance-plans-deliver-financial-peace-of-mind; eHealth Short Term Consumer Survey (Feb. 2019)
[2] UnitedHealth Group Annual Form 10-K for year ended 12/31/21
[3] U.S. Bureau of Labor Statistics, https://www.bls.gov/news.release/empsit.t12.htm
[4] eHealth Short Term Consumer Survey (Feb. 2019)
[5] https://www.ahip.org/news/press-releases/new-survey-millions-of-americans-say-supplemental-insurance-plans-deliver-financial-peace-of-mind

In addition, ACA enhanced subsidies expire at the end of 2025 absent Congressional action. Before the enhanced subsidies were renewed in 2022, HHS estimated that three million people could lose coverage if the subsidies were not extended.[6] This potential scenario could arise again in 2026. The Proposed Rule would decrease affordable choices for consumers during a time when premiums may rise for many due to a lack of subsidies.

STLDI is not harming the ACA

The Departments express concerns about potential negative effects STLDI has on the risk pools for individual health insurance coverage, citing data from 2018-2020. It can be difficult to estimate the impact of STLDI on the ACA Marketplaces at this time due to factors such as the COVID-19 pandemic and rising health care costs and inflation that affected market dynamics. Average benchmark Marketplace premiums have generally decreased since that time and are still not as high as they were in that 2018-2020 period.[7] Marketplace enrollment did not grow while previous STLDI restrictions were in place (i.e., the 3 month Obama Administration standard), but now has record high enrollment of over 16 million people in 2023 under the current 12 month standard.[8] Based upon these two critical facts and with 26 states allowing an initial STLDI term of 12 months, STLDI seems to have limited impact on the growth and sustainability of the ACA Marketplace.[9]

STLDI's limited impact on the ACA Marketplaces can also be seen in state studies. A recent report from Wisconsin's Office of the Commissioner of Insurance evaluating the utilization and impact of STLDI in the Wisconsin market found that these products have limited impact on the ACA individual Marketplace, and many residents who enroll in STLDI use them as a bridge to other coverage.[10]

In addition, the Proposed Rule's regulatory risk impact analysis estimates a minimal impact on the ACA Marketplace from limiting STLDI coverage to no more than four months as opposed to the current term of up to 12 months, with an extension or renewal not to exceed 36 months. The analysis shows a shift in enrollment to Marketplace coverage of 60,000 individuals for each year in the period 2026 – 2028 with a resulting decrease in gross premiums of 0.5 percent per year.[11] The total migration to the Marketplace risk pool of 180,000 over the three years is approximately 1 percent of the 16 million consumers enrolled in these plans in 2023.

Instead of limiting coverage options, we urge the Departments to allow consumers the ability to purchase coverage that best meets their needs. Current STLDI and FI excepted benefits options provide an important and valuable coverage option serving the needs of a wide spectrum of consumers.

Attached are additional technical comments and recommendations on the Proposed Rule.

We appreciate the opportunity to comment on the Proposed Rule and look forward to working with the Departments to provide quality, affordable coverage that best meets consumer needs.

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[6] arp-ptc-sunset-impacts-03-22-22 Final.pdf (hhs.gov)
[7] Average Marketplace Premiums by Metal Tier, 2018-2023 | KFF
[8] Marketplace Enrollment, 2014-2023 | KFF
[9] State-by-state-short-term-health-insurance (healthinsurance.org)
[10] STLDP Report Final May 2023.pdf (wi.gov)
[11] Table 2: Estimated Effects of the Provisions of Provisions Regarding STLDI on Enrollment to and Gross Premiums for Individual Health Insurance Coverage Purchased on an Exchange and on Federal Spending on the PTC, 88 FR 44641.

Thank you for your thoughtful consideration of our comments. Please do not hesitate to contact me if you have any questions.

Sincerely,

John W. Cosgriff
Chief Executive Officer
UnitedHealthOne

UnitedHealthcare Comments
Short-Term Limited Duration Insurance Proposed Rule

Overview – Short Term Limited Duration Insurance and Fixed Indemnity Excepted Benefits

Short-term, limited-duration insurance (STLDI) and fixed indemnity excepted benefits plans exist to serve and support critically important market needs, and provide coverage to a wide array of consumers. These plans have effectively fulfilled consumer needs long before they entered the federal regulatory lexicon as part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

While UHC agrees that STLDI and fixed indemnity excepted benefits are not intended to provide comprehensive benefits comparable to individual or group coverage subject to the Affordable Care Act (ACA), the fact that they do not provide these types of benefits does not mean they do not offer meaningful benefits to consumers, nor that they should be severely restricted. Unfortunately, that would be the likely effect of the Proposed Rule if implemented as drafted. In this regard, we believe that the Departments fundamentally misunderstand and misstate the purpose and impact of STLDI and fixed indemnity excepted benefits, and are proposing to impose restrictions that will ultimately disadvantage consumers who rely on such plans as part of their health benefits coverage portfolio.

As noted in the preamble to the Proposed Rule, STLDI typically provides consumers with an inexpensive option to bridge gaps in coverage. This is especially true for those without a qualifying life event that would permit a special enrollment period, who cannot afford COBRA, or are only eligible for an unsubsidized Marketplace plan. Consumers with coverage gaps also may include individuals between jobs, students taking time away from school, independent contractors, and those subject to waiting periods prior to employer group coverage effective dates. These consumers would lose a medical plan choice if the Proposed Rule is implemented that today could provide coverage for more than four months.

Consumers express broad satisfaction with fixed indemnity coverage and the critically important supplemental benefits it provides.[1] Fixed indemnity benefits are typically provided on a first-dollar basis (i.e., no deductible, co-pay, or co-insurance) and provide benefits without regard to any other coverage the consumer may maintain (i.e., there is no coordination or reduction in fixed benefits based on other coverage). As such, many consumers purchase fixed indemnity excepted benefits as a supplement to ACA individual and group market coverage or Medicare and may utilize fixed indemnity plans to supplement and help fill coverage gaps, such as out-of-pocket expenses owed under coverages with deductibles, copays, or coinsurance.

Fixed indemnity plans offer dedicated funding that can be used to assist consumers with a broad array of costs associated with illnesses and injuries, including such things as medical treatment, travel, and childcare. In the group market, employers may offer fixed indemnity excepted benefits as a means to provide some health benefits to seasonal or part-time workers who might otherwise be ineligible for the employer's group medical coverage.

[1] A recent survey indicates 92 percent of respondents were satisfied with their fixed indemnity coverage. AHIP, *Measuring Satisfaction with Supplemental Benefits,* February 23, 2022 accessed at: https://www.ahip.org/news/press-releases/new-survey-millions-of-americans-say-supplemental-insurance-plans-deliver-financial-peace-of-mind

Purported Regulatory Justification for STLDI and Fixed Indemnity Restrictions

The Departments cite two concerns with STLDI and fixed indemnity excepted benefits: (i) the potential negative impact on the individual insurance market risk pool (in the case of STLDI), and (ii) consumers mistakenly purchasing STLDI or fixed indemnity coverage instead of comprehensive coverage. We address both of these concerns in more detail below.

Fundamentally, we do not believe that either basis justifies these types of sweeping, market-disrupting regulatory changes that will result in consumers losing coverage with high satisfaction and that they would prefer to keep. This is particularly true when weighed against the overwhelming public policy that favors inclusion of these types of products as choices in the market, the fact that states have effectively regulated these products for decades.

Impact on Risk Pools

The preamble to the Proposed Rule references two studies which purportedly stand for the proposition that healthier consumers will purchase STLDI, rather than ACA Marketplace coverage, resulting in a significant negative impact on the individual insurance market risk pool. Both reports focused on a limited timeframe, making it difficult to draw statistically valid conclusions which would justify this type of sweeping rulemaking.

In this regard, the Milliman report looked only at a one-year sample – 2020 projected rate increases from health insurer submitted rate requests – and the Commonwealth Fund report only cited data from 2018–2020. In addition to the short timeframe covered by these reports, it is important to note that this period saw a number of developments, including Medicaid expansion, increases in Marketplace subsidies, rising health care cost trends, and the COVID-19 pandemic, that impacted market dynamics and pricing, making it difficult to isolate the effects of STLDI coverage. In fact, the studies themselves indicate other factors in addition to state limits on STLDI may have impacted composition of the individual market risk pool, such as the repeal of the individual mandate penalty, differences in open enrollment rules, and Marketplace outreach and enrollment efforts.[2]

We also note the regulatory risk impact analysis which the Departments rely on as justification for the Proposed Rule, projects only minimal impacts resulting from limiting STLDI coverage to no more than four months, as opposed to the current term of up to 12 months. The analysis shows a shift in enrollment to Marketplace coverage of only 180,000 individuals for the period 2026 – 2028, with a speculative resulting decrease in gross ACA premiums of only 0.5% per year.[3] In other words, even assuming a best-case scenario as relied on by the Departments, it will only have a *de minimis* impact of 0.5% on ACA premiums. Maintaining the current, longer

[2] According to the Milliman study, excluding California (which has a state-specific individual mandate penalty), there was "a weighted average rate impact of 0.6% among states with restrictions on STLD policies" compared to other states indicating a minimal impact on the market risk pool. Hansen, Dane and Dieguez, Gabriela, *The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,* Milliman February 2020, p. 18, accessed at: https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market

[3] Table 2: Estimated Effects of the Provisions of Provisions Regarding STLDI on Enrollment to and Gross Premiums for Individual Health Insurance Coverage Purchased on an Exchange and on Federal Spending on the PTC, 88 FR 44641.

STLDI duration of up to 12 months, therefore, has limited, if any, impact on the viability and financial stability of the ACA Marketplaces which have enrollment of 16 million as of 2023.[4]

Consumer Transparency

We agree that consumers should have a clear understanding of their benefits and any coverage limits when purchasing STLDI and fixed indemnity excepted benefits coverage. Misleading marketing and lack of transparency are not in the best interests of either consumers or health insurers. As discussed below, we support the consumer notice requirements in the proposed rule as the best approach to achieve this goal.

We believe consumers have the right to purchase coverage that best meets their needs, including a full range of STLDI and fixed indemnity excepted benefits options. Instead of unduly restricting access to these products, the Departments and the state regulatory authorities should focus their oversight efforts on any entities intentionally deploying misleading marketing tactics, and work with stakeholders to promote consumer awareness of the types of different coverages that are available to them.

Short-Term Limited Duration Insurance

Contract Term Duration

The Proposed Rule shortens the STLDI contract period to three months with one additional month renewal period. We believe this shortened timeframe is not in the best interests of consumers and will have the unintended consequence of leaving some consumers without any available coverage options.

In the preamble to the Proposed Rule, the Departments indicate the three-month contract term was chosen because of a belief that most consumers need STLDI for only a temporary period, such as between jobs or during a break between coverage under a student health insurance policy. Our documented experience, which is consistent with data published by the US Bureau of Labor Statistics, is that many consumers experience coverage gaps longer than the three months contemplated in the Proposed Rule, even with the allowance of a potential additional month renewal period.

Although many Americans are unemployed for a period of five weeks or less (34 percent), 29 percent can be unemployed for up to 14 weeks, and almost 37 percent for 15 weeks or greater.[5] These gaps in employment do not include any waiting period for coverage under a group health plan or Marketplace. While young adults have the highest uninsured rate among all Americans, this is generally a result of comprehensive coverage not being affordable, their ineligibility for

[4] Marketplace enrollment has increased steadily since inception from slightly over 8 million in 2014 to 16 million in 2023, with significant growth in the last three years (all while the current STLDI standard of up to 12 months was in effect). Kaiser Family Foundation, *Marketplace Enrollment 2014-2023 Trend Graph,* accessed at: Marketplace Enrollment, 2014-2023 | KFF

[5] US Bureau of Labor Statistics, Economic News Release, *Table A-12 Unemployed Persons by Duration of Unemployment,* seasonally adjusted data for July 2023 accessed at: https://www.bls.gov/news.release/empsit.t12.htm

such coverage, or they simply did not see the need for such coverage as "young invincibles",[6] – issues that are not addressed by severely restricting access to STLDI as a coverage option.

Consumer needs and desires for their insurance coverage are as diverse as the American population itself depending on their individual situation. Given these widely varying requirements, there is no "one size fits all" solution, and we believe that consumers themselves are best positioned to determine the length of STLDI coverage they need. In this regard, according to a 2019 survey, 19 percent of respondents intended to keep coverage for 3 months or less, 27 percent were keeping their coverage for 4 – 6 months, 24 percent intended to keep coverage between 7 and 12 months, and 30 percent were keeping coverage for more than 1 year.[7] We also note that individual states have primary oversight responsibility for their insurance markets and may legislate shorter periods, as they do now, to fit their local markets.[8]

UHC recommends continuing to empower American consumers to make coverage decisions based on their individual needs and maintaining the current duration term for STLDI of up to 12 months to permit consumers access to medical benefits during times when comprehensive ACA eligible coverage is not available, or not affordable if not subsidized. Limiting access to these products by restricting the contractual durational term will disrupt the market and negatively impact consumers who rely on STLDI coverage to meet their health care coverage needs.

STLDI Coverage Renewals

The Proposed Rule allows only one month of additional STLDI coverage beyond the initial three-month contract term. As discussed above, we believe four months is insufficient to meet the diverse needs of most consumers who purchase STLDI to cover a gap in comprehensive coverage. Consumers should have the flexibility to choose how long they wish to have STLDI coverage based on their individual situations and subject to applicable state limits.

Applying these restrictions on STLDI renewals forces consumers who need coverage for more than four months to apply for coverage from another carrier, where they may be subject to new health-based underwriting, pre-existing condition limits, and cost-sharing requirements. None of these requirements would apply if they were permitted to keep their original policy beyond a four-month maximum duration as proposed.

Ensuring the ability of consumers to maintain existing STLDI for longer than four months provides consumers greater protection but does not limit their ability to end their coverage earlier than the original contract duration if they desire. Regardless of the contractually stated maximum duration (currently up to 12 months), most - if not all - STLDI carriers permit consumers to end their coverage effective as of the last day for which premiums have been paid.

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[6] Cha, Amy and Cohen, Robin, *Reasons for Being Uninsured Among Adults Aged 18 – 64 in the United States, 2019,* Centers for Disease Control and Prevention, September 2020 accessed at: https://www.cdc.gov/nchs/products/databriefs/db382.htm

[7] eHealth, *Short-Term Consumer Survey,* February 2019, accessed at: https://news.ehealthinsurance.com/_ir/68/20191/eHealth%20Short-Term%20Consumer%20Survey%20February%202019.pdf

[8] Health Insurance.org, *Duration and Renewals of 2023 Short-Term Medical Plans by State,* accessed at: state-by-state-short-term-health-insurance (healthinsurance.org)

We believe a longer renewal term should be available for those individuals who need access to health benefits but are unable to find affordable comprehensive coverage options. UHC recommends that the Departments keep the current regulatory structure permitting the renewal of STLDI coverage for up to three years.

Applicability Dates

We appreciate the Departments recognition that consumers with existing STLDI coverage should be permitted to continue with that option through the end of any contract term or renewal periods as specified in their agreement with the issuing health insurer. Minimizing market disruption for consumers is an important consideration that serves the needs of consumers. However, we have significant concerns with the applicability period for any changes to the STLDI contract term and duration, as well as the consumer notices.

The Proposed Rule provides that the STLDI changes, including the updated consumer notice, are applicable 75 days after the final rule is published in the Federal Register. As the Departments are aware, STLDI is primarily regulated by states which typically require both premium rates and any contract language in the product forms to be submitted for review and approval by state departments of insurance prior to use. We also note that some states require marketing materials and brochures to be filed and approved. The current federal consumer disclosure is not required on marketing materials, and including the notice will add implementation time to update these materials and file them with state regulators where applicable.

In our experience it takes a minimum of three months for states to complete such reviews, with many states taking additional time, sometimes 12 months or longer. This review period is in addition to the significant time it will take to design and price new benefit structures prior to submission to a state for approval and for implementing the plans on the insurer's administrative systems. These steps are in addition to work required of insurance agents and brokers on marketing the new STLDI products after state approvals, which is critically important for consumer protection.

Requiring the changes to be implemented in 75 days will result in a period of time where no new STLDI coverage will be available because neither health insurers nor their state-regulatory counterparts can complete this lengthy process within this time period. We do not believe it is in the best interest of consumers to completely shut down the STLDI market while health insurers work with state regulatory authorities to implement the new standards.

The same problem exists with respect to updating the consumer notice for existing coverage which must be provided for any renewals. Existing STLDI contracts are extended at the request of the consumer throughout the calendar year, and it will be extremely challenging, if not impossible, to get the notice language approved by states, where required, in time to meet the 75-day deadline.

UHC recommends that the Departments apply any new STLDI requirements, including the consumer notices, to newly issued and renewed STLDI policies beginning 12 months after the date the final rule is published in the Federal register.

Fixed Indemnity Excepted Benefits

As indicated above, fixed indemnity coverage is an important and valuable coverage option serving the needs of a wide spectrum of consumers in both the individual and group markets. Fixed indemnity benefits are typically provided on a first-dollar basis (i.e., no deductible, co-insurance, or co-pays), and provide benefits in addition to any other coverage the consumer may maintain (i.e., no coordination or reduction in fixed benefits based on other coverage). Many consumers support access to fixed indemnity[9] and use these excepted benefits to supplement ACA individual and group coverage and Medicare and fill gaps in coverage, such as deductibles or other cost-sharing.[10] As noted, consumers express broad satisfaction with their coverage.[11]

Statutory Authority to Regulate Fixed Indemnity Excepted Benefits

Fixed indemnity coverage has historically been regulated by the states and has provided valuable supplemental protection for consumers for decades.[12] In the individual market, from the time fixed indemnity products first entered the Federal regulatory lexicon as part of HIPAA in 1996, insurers could provide benefits on a "per-service" basis (i.e., $100 per office visit; $50 per prescription, etc.), on a "per-period" basis (i.e., $500 per day of hospital confinement) or some combination of both.[13] The ACA did not change any of the existing federal regulatory structure around fixed indemnity products, and many individual market fixed indemnity products provide a robust combination of both "per-service" and "per-period" benefits.

In the individual market, the Departments propose to prohibit the ability of insurers to provide fixed indemnity benefits on a "per-service" basis, and instead limit the coverage to only "per-period" benefits. The net effect of this would be that any per-service benefits ($100 per office visit, etc.) would be prohibited, and only daily hospital benefits would be permissible (i.e., $500 per day of hospital confinement).

In other words, even though these types of fixed indemnity plans are fully permissible under HIPAA, and these governing rules were not modified or amended by the ACA, the Departments

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[9] According to a consumer survey by Morning Consult for the American Council of Life Insurers (ACLI), 89% of adults with incomes between $50,000 and $100,00 believe such coverage is an important option to protect against financial hardship. Morning Consult, *Supplemental Insurance Benefits Survey,* August 2023 accessed at: PowerPoint Presentation (acli.com)

[10] Beginning in 2024, the out-of-pocket maximum limits for single and family coverage are $9,450 and $18,900, respectively. Centers for Medicare and Medicaid Services. *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2024 Benefit Year*, December 12, 2022, accessed at: https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf

[11] According to a recent industry survey, the ratio of consumer complaints in 2022 per fixed indemnity policy/certificate was 0.0003 percent. Americas Health Insurance Plans, American Council of Life Insurers, and Blue Cross Blue Shield Association, *2023 Survey: Fixed Indemnity & Specified Disease Plans* ("2023 Survey") accessed at: Joint-Trade-Survey-Fixed-Indemnity-and-Specified-Disease.pdf (ahiporg-production.s3.amazonaws.com)

[12] Insurers began selling fixed indemnity insurance policies in Wisconsin in 1892 and in Arkansas beginning in 1959. *See* Brief of the States of Wisconsin, Arkansas, Louisiana, Michigan, Nebraska, Oklahoma, Texas, South Carolina, Texas, Utah, and West Virginia, *Central United Life Ins. Co. v. Burwell* (D.C. Cir. February 29, 2016) (No. 15-5310) at 14.

[13] *See:* 42 U.S.C. § 300gg-91(c)(3).

propose to prohibit an entire class of "per-service" benefits, including "other fixed indemnity insurance" meaning that daily hospital indemnity benefits would likely be the only permissible coverage. This change negates statutory language authorizing "other fixed indemnity insurance,"[14] limits consumer choice, and leaves consumers with fewer insurance coverage alternatives at a time when every option should be on the table.

Even under a hospital indemnity plan, as revised by the Proposed Rule, only "per day" reimbursement would be allowed, meaning that the host of other services that are provided during a hospital confinement – such as surgery, radiology, medications, and testing – could not be reimbursed, as they are reimbursed on a "per-service" basis, and not on a "per-period" basis.

Against this dearth of statutory authority, the Departments should also consider their prior regulatory history and experience with regard to fixed indemnity excepted benefits. In 2013, the Departments proposed (and ultimately implemented) a series of changes applicable to the individual fixed indemnity market, including a notice requirement, as well as requirement that individuals attest they maintained underlying minimum essential coverage (MEC) as a precondition to purchasing a fixed indemnity plan.[15]

As discussed in the preamble to the Proposed Rule, the statutory authority to implement the MEC attestation was ultimately challenged in court in *Central United Life Ins. Co. v. Burwell*.[16] In that case, the United States Court of Appeals for the District of Columbia expressly found that the Department of Health and Human Services (HHS) had "colored outside the lines" of what is allowed under federal law for fixed indemnity, and hence invalidated the MEC attestation requirement.

As is pertinent to the individual market fixed indemnity changes in the Proposed Rule, the Court of Appeals noted that the ACA's market reforms, while "sweeping", did not modify or amend the existing treatment of excepted benefits (including fixed indemnity).[17] While noting that "[a]gencies may act only when and how Congress lets them,"[18] the Court of Appeals in *Central United* expressly stated that the Public Health Service Act (of which both HIPAA and the ACA are part) "only defined [two] criteria" for fixed indemnity plans to have "excepted benefit" status: the plan, namely: "(1) the insurance plans must be 'provided under a separate policy, certificate, or contract of insurance,' and (2) they must be 'offered as independent, noncoordinated benefits.'"[19]

The Court expressly held that "so long as these [two] conditions are met, the plan qualifies as an excepted benefit" under federal law.[20] Citing to the United States Supreme Court's decision in *Chevron USA, Inc. v NRDC,*[21] the Court concluded that "[e]ver since it first carefully defined what counts as a 'excepted benefit' in 1996, Congress has never changed course or put its

[14] 42 U.S.C. 300gg-91(c)(3)(B)
[15] 83 FR 38212.
[16] *Central United Life Ins. Co. v. Burwell*, 827 F.3d 70 (D.C. Cir. 2016).
[17] *Id.* at 72.
[18] *Id.* at 73.
[19] *Id.* at 72., citing to 42 U.S.C. § 300gg-91(c)(3)(B) [emphasis added].
[20] *Id.* at 73. [emphasis added].
[21] 467 US 837 (1984)

original definition in any doubt."[22] As such, it held that "[w]here the text is clear as it is here, 'that is the end of the matter.'"[23]

Applying the express statutory requirements applicable to fixed indemnity, with the controlling authority of *Central United*, it is clear that the Departments' regulatory authority is limited to only requiring that fixed indemnity be provided under (i) a separate policy, certificate or contract of insurance, and (ii) be provided on an independent, noncoordinated basis. Because the Departments lack any such statutory authority for prohibiting "per-service" benefits in addition to "per-period" benefits, we believe the fixed indemnity requirements should be withdrawn.

Prior Proposed (and Withdrawn) Fixed Indemnity Regulations

After the decision in *Central United* was final, the Departments proposed a regulation that was similar to the instant proposal, and which would have imposed "per day" benefit requirements and eliminated "per service" benefits.[24] A number of interested parties, including state regulators and the National Association of Insurance Commissions opposed this "per day" proposal in the individual market on a number of grounds, including (i) the lack of statutory authority, citing to *Central United*; (ii) the significant market disruption that the rule would cause; (iii) the fact that this would eliminate fixed indemnity coverage as had been offered for decades; and (iv) the elimination of this type of coverage from the market would reduce consumer choice and the vibrancy of the insurance market. As a result of these well-reasoned objections, the Departments did not implement the previously proposed "per-period" standard in the individual market,[25] and the individual market has continued to function and been effectively regulated by the states.

All of these concerns remain valid, and as such we oppose the proposed revisions. Instead, we recommend that the Departments continue to follow the statutory standard that has been in place since HIPAA was enacted in 1996.

Group Market Fixed Indemnity Excepted Benefits

The Proposed Rule additionally limit the flexibility to provide fixed indemnity coverage in the group market. In particular, the Departments are proposing to further define when such benefits are impermissibly "coordinated" with other coverage:

> (C) *Example 3*— (*1*) *Facts.* An employer sponsors a group health plan that provides two benefit packages. The first benefit package includes benefits only for preventive services and excludes benefits for all other services. The second benefit package provides coverage through an insurance policy that pays a fixed dollar amount per day of hospitalization for a wide variety of illnesses that are not preventive services covered under the first benefit package. The two benefit packages are offered to employees at the same time and can be selected together. The benefit packages are not subject to a formal coordination of benefits arrangement.

[22] *Central United Life supra* at 74.
[23] *Id.* at 74 (citing *Chevron* 467 US 842).
[24] Departments of Health and Human Services, Labor, and the Treasury, *Expatriate Health Plans and Other Issues* (June 10, 2016) 81 FR 38019.
[25] 81 FR 75316.

(*2*) *Conclusion.* Even if the other conditions in paragraph (b)(4)(ii) of this section are satisfied, the second benefit package's insurance policy does not qualify as an excepted benefit under this paragraph (b)(4) because the benefits under the second benefit package are coordinated with an exclusion of benefits under another group health plan maintained by the same plan sponsor (that is, the preventive-services only benefit package). The conclusion would be the same even if the benefit packages were not offered to employees at the same time or if the second benefit package's insurance policy did not pay benefits associated with a wide variety of illnesses.[26]

The mere offering of two different benefit packages to the same group of employees is not a basis for concluding they are "coordinated" and is not supported by the statute which establishes the following standards for noncoordinated excepted benefits:

- The benefits are provided under a separate policy, certificate, or contract of insurance.
- There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor.
- Such benefits are paid with respect to an 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 or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.[27]

In this example, employees are free to select one or both of the benefit packages and the fact that one package does not pay for a specified item or service does not automatically trigger payment under the second benefit package. There is no expectation of coordination between the two options.

Following the Departments' theory that the absence of specific benefits in one coverage choice that may be available under the second coverage means the two options are coordinated, how comprehensive must the coverage be under first option be before it is no longer considered coordinated with the fixed indemnity excepted benefits? For example, if an employer offers a comprehensive group health plan that does not cover certain prescription drugs or experimental treatments, is the employer prohibited from offering fixed indemnity excepted benefits because that coverage could be applied to those items or services excluded by the group plan? Are employers similarly prohibited from offering a high deductible health plan alongside fixed indemnity excepted benefits?

In fact, fixed indemnity excepted benefits can provide an important supplement to group health plan coverage to help pay for deductibles, co-payments, and co-insurance and other medical expenses that are not reimbursed by the group plan. As noted, in 2024 group health plans can impose a maximum out-of-pocket amount of $9,450 for self-only coverage and $18,900 for other than self-only coverage.[28] Group plan sponsors should have the ability to offer fixed indemnity excepted benefits to help employees with these out-of-pocket expenses and other costs.

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[26] Proposed 45 CFR §146.145(b)(4)(iii)(C) [emphasis added].

[27] 42 USC §300gg-21(c)(2).

[28] Centers for Medicare and Medicaid Services. *Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required*

UHC recommends the Departments follow the statutory definition of noncoordinated excepted benefits and provide group plan sponsors with the flexibility to offer fixed indemnity coverage alongside other benefit packages.

Applicability Dates

The new standards and consumer notices for fixed indemnity excepted benefits are intended to be effective 75 days after publication of the final rule in the Federal Register. As discussed above in response to the STLDI proposal, we believe this is insufficient time for health insurers and group plan sponsors to make the necessary policy updates, obtain state approvals, and issue and market new products, let alone implement system and technology changes. For these reasons, we recommend that the Departments implement any changes applicable to fixed indemnity excepted benefits, including the consumer notices, for policy and plan years beginning on or after 12 months from the publication of the final rule.

We do not support the proposal to apply the new requirements to existing fixed indemnity excepted benefits for policy and plan years beginning on or after January 1, 2027. In this regard, most of these plans contain "per service" benefits that cannot be readily modified or amended to a "per period" basis. Moreover, many of these plans are contractually non-cancellable or guaranteed renewable individual and group contracts that cannot be unilaterally changed or cancelled. Modifying current benefit structures to comply with the "per period" reimbursement proposal would not only create significant operational challenges for health insurers and plan sponsors but it would also be extremely disruptive to consumers, many with long-standing coverage who have had consistent benefits for decades. We recommend that existing coverage issued prior to the effective date of any new regulation be grandfathered and permitted to continue based on the terms and conditions in place at the time the coverage was issued..

Taxation on Fixed Indemnity Excepted Benefits

The Treasury Department is clarifying in the Proposed Rule that payments from a hospital indemnity or other fixed indemnity excepted benefits where the premiums are paid pre-tax by an employer under Internal Revenue Code Section 106 are considered taxable income to the employee.[29] This change is applied beginning with the later of the date of publication of the final rule in the Federal Register or January 1, 2024. Given the accounting and operational changes that may need to be adopted by employers and their service providers, we ask that the new requirements are made effective with tax years beginning on or after January 1, 2025, to give group plan sponsors and their service providers time to make the changes and to be consistent with other regulatory changes that have been applied on a tax year basis.

Consumer Notices

As discussed above, UHC agrees consumers benefit from notice provisions that clearly set out the differences with ACA Marketplace coverage. We support the consumer notice language in the proposed rule for STLDI and fixed indemnity excepted benefits which we believe clearly communicates to consumers the potential limits on their coverage and where they can obtain

Contribution Percentage for the 2024 Benefit Year, December 12, 2022, accessed at: https://www.cms.gov/files/document/2024-papi-parameters-guidance-2022-12-12.pdf

[29] Proposed 26 CFR §1.105-2(a).

information and access to ACA coverage.[30] That said, there are several disclosure clarifications we ask the Departments to consider with regard to the consumer notice:

- We recommend an edit to the title of the notices. Using the phrase "Important Notice – Please Read Carefully" will better catch the attention of consumers and inform them that this is important information they should consider prior to making a decision.

- The consumer notice must be "displayed prominently on the first page (in either paper or electronic form, including on a website) of the policy, certificate, or contract of insurance, and in any marketing, application, and enrollment materials (including reenrollment materials) provided to individuals at or before the time an individual has the opportunity to enroll (or reenroll) . . . ."[31] States will often require pre-approval of any materials including renewal notices if there is any language added to the prior approved insurance document. We ask that insurers have the flexibility to provide the consumer notice required on the renewal of existing coverage on a separate document and not on the face page of the renewal.

- The Departments should clarify how the notice should be displayed in situations where there may be a conflict with state disclosure requirements (e.g., Illinois and Indiana require their state specific STLDI disclosures to be displayed in addition to the federal notice).[32] Given state notice provisions and the federal requirement to place the notice on the *first page* of all materials in 14-point type, it may be impossible to include both state and federal disclosures.

- We do not believe health insurers should be held responsible for the display of notices on websites that they do not control. Insurers may receive consumer inquiries from a variety of sources, including generalized marketing by non-affiliated entities, and carriers may not be aware of or have any control over whether the consumer notice is present on a particular website.

- The Departments ask whether the consumer notices should specify a telephone number and a link to the State Exchange's website if the STLDI or fixed indemnity excepted benefits are offered in a state that does not use *HealthCare.gov* for Marketplace coverage. We would note that consumers accessing the *HealthCare.gov* website are automatically redirected to a link for the state website if Marketplace coverage is provided through a State Marketplace and, as a result, providing state contact information on the notice is not necessary.

Request for Information – Specified Disease Excepted Benefits

The preamble to the Proposed Rule includes a request for information regarding specified disease excepted benefits coverage. As noted by the Departments, specified disease excepted benefits "provides a cash benefit related to the diagnosis or the receipt of items or services related to the treatment of one or more medical conditions specified in the insurance policy,

[30] We do not support the "alternative" notice language which does not materially improve the information provided to consumers.
[31] Proposed 45 CFR §§144.103 and 148.220.
[32] *See e.g.:* Kentucky Insurance Department Bulletin 2018-02 (October 18, 2018), Ohio Insurance Department Bulletin 2018-05 (October 24, 2018), 215 ILL Comp. Stat. 190/15, IND Code 27-8-5.9, VT. Code R. I-2018-03

certificate, or contract of insurance."[33] For decades (including pre-HIPAA) these excepted benefits have provided valuable coverage and been effectively regulated at the state level.

Specified disease plan designs vary but as noted, typical plans provide either lump sum benefits on the diagnosis of the covered illness or disease, or expense-incurred benefits for treatment of the specified diseases. In many cases, consumers purchase specified disease coverage as a supplement to other comprehensive medical coverage, including the ACA individual and group market coverage and Medicare.

We are unaware of any broad regulatory concerns related to the marketing, sale or utilization of specified disease products, nor of the products themselves.[34] We would also note that should the Departments propose to regulate specified disease excepted benefits, the statutory basis for regulation would be based on the same limited statutory authorization applicable to fixed indemnity. The only requirements Congress authorized for specified disease coverage is that it be provided on an independent, noncoordinated basis.[35] That has been the sole federal requirement applicable to individual specified disease coverage since HIPAA was enacted in 1996. From our perspective, that statutory standard – combined with state regulation – has worked well for the past 27 years since HIPAA was enacted in 1996, as there have been no material regulatory issues to our knowledge. Therefore, we recommend no changes to the existing statutory standards.

Request for Information – Level-funded Plan Arrangements

The Departments are requesting feedback related to level-funded plan arrangements (i.e. employer sponsored self-insured group health plan combined with state regulated stop loss coverage). While we do not have access to industry wide data, we can advise that UHC administered level funded plans have grown in popularity because they allow small employers the ability to access group benefit plan options typically only available to large employers. The employer sponsored group health plans associated with level funded arrangements are subject to HIPAA, ACA, and other federal consumer protection laws applicable to large employer sponsored self-insured plans. These federal protections include, among other things, annual out-of-pocket maximums, ERISA claims and appeal procedures, and prohibitions on pre-existing condition exclusions. Moreover, plan participants are required to receive all the same plan disclosure requirements about their benefits (Summary of Benefits and Coverage, Summary Plan Descriptions, etc.).

We believe availability of level funded plan arrangements are very beneficial for many small employers and their enrollees and the Departments should continue to preserve this valued benefit option.

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[33] 88 FR 44603.

[34] According to a recent industry survey, the ratio of consumer complaints in 2022 per specified disease policy/certificate was 0.0002 percent. Americas Health Insurance Plans, American Council of Life Insurers, and Blue Cross Blue Shield Association, *2023 Survey: Fixed Indemnity & Specified Disease Plans* ("2023 Survey") accessed at: Joint-Trade-Survey-Fixed-Indemnity-and-Specified-Disease.pdf (ahiporg-production.s3.amazonaws.com)

[35] 42 U.S.C. § 300gg-91(c)(3).