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September 11, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

The Honorable Lisa Gomez
Assistant Secretary, EBSA
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
1111 Constitution Avenue NW
Washington, DC 20224

Submitted electronically via regulations.gov

RE: Proposed Regulations on Short-Term, Limited-Duration Insurance, Independent Non-coordinated Excepted Benefits Coverage; and Tax Treatment of Certain Accident and Health Insurance (REG-120730-21, CMS-9904-P) — AHIP Comments

Dear Secretary Becerra, Assistant Secretary Gomez, and Deputy Commissioner O'Donnell:

Every American deserves access to affordable, comprehensive, high-quality coverage and care. AHIP appreciates the opportunity to provide comments on the proposed rules from the Departments of Labor, Health and Human Services, and the Treasury ("Departments") affecting short-term, limited duration insurance (STLDI) plans and supplemental health insurance benefits, published July 12, 2023, in the *Federal Register*. AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day.

The foundation of that high-quality health coverage is comprehensive, major medical health insurance provided by an employer; purchased through an Exchange; or through enrollment in a public program such as Medicare, Medicaid or CHIP. In addition to comprehensive health insurance coverage, millions of Americans choose supplemental insurance coverage such as hospital indemnity and fixed indemnity health insurance to meet additional health care and financial needs. These supplemental insurance products, valued by employers and employees alike, fill different personal needs and are subject to stringent oversight and regulations.

AHIP requests the Departments not finalize the hospital and fixed indemnity rules as proposed, as they would make supplemental health insurance policies more expensive while ultimately providing hardworking Americans fewer benefits and less overall value. The proposed rule would exceed the Departments' statutory authority and result in millions of Americans no longer having affordable access to fixed indemnity or hospital indemnity insurance – inevitably causing financial stress for households during difficult times – while not protecting people consumers from the harms of misleading marketing detailed in the Preamble.

We share the Departments' stated goal of promoting access to high-quality, affordable, comprehensive coverage. In addition to comprehensive health coverage, many employers and employees choose to offer or purchase supplemental (voluntary) health insurance benefits. We have serious concerns about any regulatory proposal that would make it more difficult or more expensive for employers to offer supplemental benefits and, in turn, for Americans to benefit from them. Employers offer supplemental benefits, including fixed indemnity insurance, because these benefits augment the value to an American with comprehensive health insurance and support employees' financial and overall wellbeing.

We instead recommend states remain the primary regulator of these products, focusing on regulatory actions that address improper, misleading, or fraudulent marketing. Incidents of improper or aggressive marketing or inappropriate bundling demand a focus on those marketing practices and deceitful actors, rather than a complete market restriction that upends longstanding business practices.

The proposed rule would deprive hardworking families of existing benefits that are legal, effective, highly valued, and well-liked. Supplemental health benefits are popular, and Americans want to continue to be able to choose these benefits. A 2023 survey from AHIP, the Blue Cross Blue Shield Association, and the American Council of Life Insurers found that responding carriers provide nearly 8.2 million people with hospital or other fixed indemnity insurance, with another 17.2 million people choosing specified disease insurance, either through a group or individual policy.[1] A 2022 survey conducted by Global Strategy Group on behalf of AHIP found that 92 percent of respondents surveyed were satisfied with their fixed indemnity insurance and 97 percent said service from their fixed indemnity insurance provider was excellent or good.[2] These products are commonly chosen by Americans because they provide additional financial protection by helping cover out-of-pocket costs for specified services. In that 2022 survey, 90 percent of respondents said their supplemental plan helps pay for needed critical medical expenses and eases concerns about preserving financial security.

[1] https://www.ahip.org/documents/Joint-Trade-Survey-Fixed-Indemnity-and-Specified-Disease.pdf
[2] https://www.ahip.org/documents/AHIP-Supplemental-Insurance-Deck-032422.pdf

We agree those considering the purchase of supplemental insurance must be fully informed about their purpose, duration, and limitations. Just as it is important for Americans and employers to continue to have fixed indemnity and hospital indemnity coverage as an affordable, viable option for supplemental coverage, it is imperative that the problem of "bad actors" and misleading marketing is addressed. People must clearly understand the coverage they are selecting and not be pressured into making a purchase decision based on deceptive or aggressive marketing tactics. People should be able to choose the products that they want and that meet their needs, rather than enrolled because of inappropriate bundling of different coverage types. AHIP has strongly supported efforts, including those by the National Association of Insurance Commissioners (NAIC), to prevent these tactics and make it more difficult for fraudulent actors to target hardworking people. **We urge the Departments to identify ways to curb the bad actors without regulations that are so broad as to undermine access to affordable, legitimate, and valued supplemental health insurance benefits.**

Changes to the Tax Treatment of Employment-based Accident and Health Plans
The proposed rules include a change to federal 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 or other fixed indemnity and specified disease or illness excepted benefit plans. Under the proposed rule, all benefits paid under pre-tax funded, employment-based policies must be reported as income and subject to both income and payroll taxes as wages.

AHIP opposes this substantial change in long-standing IRS policy. The tax changes are both a departure from operative statutory language and a significant shift in tax policy that imposes new taxes on working Americans and new burdens on employers. **We urge the Department and the IRS to rescind this proposal in its entirety.**

Short-term, Limited Duration Insurance Plans
The Departments propose revisions to existing regulations affecting STLDI. We agree that "short-term" and "limited duration" should mean just that – coverage for a brief period of time when comprehensive coverage may not be available. Short-term products can help fill gaps in coverage, but are not intended to serve as a substitute for long-term, comprehensive health insurance coverage. **We support finalizing the proposal to limit STLDI to a coverage expiration date not more than 3 months after the effective date of the final rule and no longer than 4 months in total, including renewals or extensions.**

Americans must have clear, understandable, and accessible notices about these time limits and other key information that distinguishes STLDI from comprehensive health insurance and ensures they are making an informed choice. **We support the Departments' proposed changes to improve consumer notice requirements that include prominent display and information directing potential buyers to healthcare.gov, or employer-provided coverage.**

Our attached detailed comments and recommendations are centered around our shared goal of expanding the number of Americans enrolled in comprehensive, affordable health insurance. We ask that in proceeding with rulemaking, the Departments ensure millions of Americans are not needlessly prevented from accessing affordable supplemental health insurance options.

Sincerely,

Jeanette Thornton
Executive Vice President, Policy & Strategy
AHIP

Detailed Comments on the Proposed Regulations

I. Short-Term Limited Duration Insurance (26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103)

Definitions

The Departments propose to reinterpret the terms "short-term" and "limited-duration" for purposes of Short-Term Limited Duration Insurance (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 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.

The availability of STLDI coverage provides an option for some consumers when they experience brief periods of time when comprehensive health insurance may not be available. It should be viewed as a product that can fill in gaps between periods when not enrolled in coverage under comprehensive health insurance, particularly if a Special Enrollment Period is not available, such as when changing jobs, temporarily unemployed, during employer waiting periods, or other similar coverage transitions.

Short-term plans are not meant to provide comprehensive, long-term health insurance coverage, nor are they to replace comprehensive health insurance, and that intention is reflected in Federal law. The *Public Health Service Act* (PHSA) and the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) have considered short-term, limited duration coverage as a type of individual coverage, but not as individual health insurance coverage or a HIPAA Excepted Benefit. In addition, states retain authority over whether to permit short-term plans in their markets and may impose additional restrictions or disclosure requirements that are stricter than Federal law.

Short-term plans are not a replacement for comprehensive coverage, and AHIP supports policies to expand access to affordable coverage options for all Americans. To facilitate access to short-term, limited duration coverage when appropriate as a bridge between comprehensive coverage sources, AHIP supports the Departments' proposal to allow the permitted duration of short-term policies to extend to four months in total, including renewals. This will allow individuals adequate time to navigate gaps in comprehensive coverage and appropriately access short-term policies if they choose.

Recommendations:

- **Support the Departments' proposal to allow the permitted duration of short-term policies to extend to four months, including renewals.**

- **Support the calculation of policies sold by the same issuer to the same policyholder within 12 months of the original effective date.**

RFI on Sales and Marketing Practices
The Departments raise concerns about deceptive marketing practices and consumer confusion about short-term, limited duration coverage, and seek comment on ways to help consumers distinguish between types of coverage and state efforts to protect consumers.

Notice Requirements
The Departments propose changes to the notice content and specifications to include:
- prominent display in written and electronic format,
- a website link and telephone number for HealthCare.gov or State Exchange website and/or State Department of Insurance contact information if applicable, and
- reminders about employer-sponsored coverage eligibility.

Appropriate notice and disclosure requirements are critical to ensuring that consumers understand the type of coverage they are purchasing, what specific benefits it includes, any exclusions or limitations, and any benefit and cost-sharing limits that may apply. These notices should clearly communicate that short-term plans are not subject to individual market health insurance regulations and do not provide comprehensive coverage. We do have concerns about the utility of including state-specific information on the notices and that this information may be confusing to consumers. Overall, AHIP believes that the Departments' proposed changes will improve consumer transparency about short-term, limited-duration coverage and supports these changes.

Recommendations:
- **Support unambiguous consumer notice requirements for short-term, limited duration insurance coverage.**
- **Finalize proposed changes to notice requirements to include prominent display, HealthCare.gov information, and employer-sponsored coverage reminders.**

Short-Term, Limited Duration Insurance Sold Through Associations
The Departments requested comment on what steps, if any, can be taken to support state oversight of short-term, limited duration coverage sold to or through associations.

Existing data on short-term plans is limited and difficult to compare, particularly when coverage is sold through associations. States should review existing state requirements for short-term plans sold through associations to ensure they are subject to the same laws and regulations and explore additional ways to capture data on all short-term policies sold to the residents of each state to ensure a level playing field.

Recommendations:

- **States should review existing state requirements for short-term plans sold through associations and explore additional ways to capture data on short-term plans available in their state.**

Applicability Dates

The Departments propose a bifurcated approach to applicability dates for new and existing short-term, limited duration coverage. Existing coverage sold or issued before the effective date of the final rules, including renewals or extensions, would continue to follow the current Federal definition, while new coverage sold or issued after the effective date of the final rules would be subject to the revised definitions proposed by the Departments. Additionally, the proposed notice requirements would apply to all new policies sold or issued on or after the final rule's effective date, but would only apply to existing policies in connection with required notices provided upon renewal or extension of existing policies.

AHIP supports robust transparency and consumer information about short-term, limited duration coverage, and appreciates the Departments' consideration of transitional periods for policies currently in effect. However, the applicability dates of the final rule should allow issuers sufficient time to update systems, processes, vendors, and other administrative tasks to comply with updated requirements. This includes updated notices or materials which may require additional state Department of Insurance review and approval. Extending the applicability date for the notice requirements from 75 to 90 days from the effective date of the final rule will allow issuers to communicate with states about updated processes and materials and obtain any necessary approvals.

Recommendation:

- **Extend the applicability date of notice requirements from 75 days to 90 days after the effective date of the final rule.**

II. Request for Information on Level-Funded Plans

AHIP 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, and a majority of respondents to a recent AHIP survey say that their employer-

sponsored coverage gives them financial peace of mind.[3] Many small employers face additional challenges in providing competitive benefit packages and have less resources than large employers to absorb rising health care costs. Level-funded plans are one option that small employers may consider when determining whether they can offer health insurance coverage.

Overview of Level-Funded Plans

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 managing and monitoring the performance of their benefit plans are not likely to be good candidates for level-funding with stop-loss. Some AHIP members report that in their experience, small employers who are moving to level funded plan arrangements previously offered grandfathered plans under the *Affordable Care Act* (ACA) and were not previously included in the ACA fully-insured small group market. Other AHIP members shared that some small employers who enter into level-funded plan arrangements return to ACA fully-insured small group coverage when their claims utilization increases.

Level-Funded Plan Structure and Operation

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. Level-funded plans can provide coverage that is comparable to small group, fully-insured or self-insured coverage. Some level-funded plans also choose to comply with state-mandated benefits, even though they are generally not required to do so.

Level-funded plans purchase stop-loss insurance coverage from an insurance carrier. Stop-loss insurance provides coverage for an employer who chooses to level-fund their health plan by providing a maximum limit on the employer's liability for a single member or from higher than anticipated overall utilization from all members. Stop-loss insurance does not insure the individual members of the plan.

A group health plan's TPA and stop-loss carrier typically 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. TPAs 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

[3] AHIP, "New Survey: Consumers Say Comprehensive Employer-Provided Coverage Vital to Their Financial Peace of Mind" https://www.ahip.org/news/press-releases/new-survey-consumers-say-comprehensive-employer-provided-coverage-vital-to-their-financial-peace-of-mind

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 encouraging the use of lower-cost or high-quality sites of care. It is the responsibility of the plan sponsor to determine how the returned funds are used and can be utilized for the benefit of participants, such as through taxable refunds, discounts on future premiums, or upgrading plan coverage.

Administrative costs are similar to those found in fully insured plans, including the costs of services 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 TPA and stop-loss carrier.

Compliance with ACA and Federal Regulations

Level-funded group health plans are regulated by several federal agencies including the Departments, as well as 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. Level-funded plan designs must comply with ACA and other federal market reforms that apply to self-insured group health plans, 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, 2021* (CAA), and other applicable statutes and regulations. At the same time, there are state insurance regulations and some federal regulations that only apply to fully-insured markets, such as Essential Health Benefits, and do not apply to level-funded arrangements.

Stop-Loss Coverage and State Oversight

Stop-loss insurance is not medical insurance, but it provides protection against catastrophic or unpredictable financial losses for the employer. 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 employers. Groups and their benefit advisors select the specific 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 considering 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.

Role of Agents, Brokers, and TPAs

Agents, brokers, and 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 health care spending reporting, and fiduciary and compliance duties under ERISA.

III. Hospital and Other Fixed Indemnity Excepted Benefit Insurance (26 CFR 54.9831-1, 29 CFR 2590.731-1 – 2590.732, 45 CFR 146.145, and 45 CFR 148.220)

The proposed rule addresses hospital and other fixed indemnity excepted benefits coverage and, in the preamble, raises questions about and seeks additional information on specified disease or illness excepted benefit coverage. In the detailed comments that follow, AHIP provides information about the coverage these policies provide and the value of that coverage to consumers, why the Departments' proposed rules exceed their statutory authority, and the regulation of these policies and issuers of these policies by the states.

Additionally, we provide specific recommendations in response to the proposed changes to the requirements for hospital or other fixed indemnity plans to retain their classification as HIPAA Excepted Benefits, address the proposed changes to the tax treatment of benefits paid from accident and health insurance plans, and respond to the Departments' requests for comment on whether new requirements should be issued for specified disease or illness excepted benefits products.

Consumer Satisfaction with Hospital Indemnity or Other Fixed Indemnity and Specified Disease or Illness Excepted Benefit Products

Supplemental health insurance policies, such as hospital or other fixed indemnity and specified disease or illness excepted benefit coverages, are chosen by tens of millions of Americans seeking protection against the financial impact of medical treatment. Both coverages generally pay benefits in a fixed dollar amount not based on the amount of medical expenses incurred,[4] and payment is not coordinated with benefits under other types of coverage.

[4] Some states allow specified disease or illness excepted benefit coverage to pay benefits on an expense-incurred basis.

Benefits under hospital and other fixed indemnity excepted benefit policies are typically paid directly to the individual, who is free to use the money for any purpose. Funds often pay for the cost of transportation, lodging, childcare, rent or mortgage, as well as out-of-pocket costs for health care. In this way, these policies provide financial protection against costs associated with medical treatments that are not covered by comprehensive major medical insurance coverage.

Hospital or other fixed indemnity excepted benefit coverage pays a fixed dollar amount based on a medical event, such as hospitalization or a doctor visit, and may pay different amounts on a per day or per-event basis. Specified disease or illness excepted benefit coverage pays benefits when a beneficiary suffers from one or more covered illnesses or diseases. Some specified disease coverage may pay an initial lump sum, a fixed amount, or benefits based on expenses incurred, for the covered illnesses or diseases for hospitalization, hospital services, surgical procedures, nonsurgical treatments, and recovery care. Some specified disease policies may also provide a death benefit.

Supplemental health insurance products provide millions of Americans with protection against the financial impact of complex treatment for medical conditions. In a 2023 industry survey conducted jointly with the American Council of Life Insurers and the Blue Cross Blue Shield Association, AHIP found that responding carriers provide nearly 8.2 million people with hospital or other fixed indemnity insurance, with another 17.2 million people choosing specified disease insurance, either through a group or individual policy. Significantly, most policies, whether individual or group policies, were purchased at the worksite – almost 80 percent of hospital and other fixed indemnity and 84 percent of critical illness or specified disease insurance.[5]

For working-age Americans, employers are making more of these types of voluntary benefit plans available to employees, affording them the opportunity to choose from a variety of plan options and select those that best meet their needs. Additionally, many seniors purchase hospital or other fixed indemnity and specified disease or illness excepted benefits plans, because they view these plans as a valuable addition to the various types of Medicare coverage. Regardless of age, Americans who choose these products report high levels of satisfaction. Ninety-two percent say they are satisfied with their hospital or other fixed indemnity coverage, and 97 percent report satisfaction with their specified disease or illness coverage.[6]

In addition to high satisfaction levels, the same survey found that 97 percent of individuals with hospital or other fixed indemnity coverage (and 99 percent of those with specified disease or

[5] The joint AHIP-ACLI-BCBSA industry survey included 39 insurers offering fixed indemnity and specified disease policies, but not all insurers offering these products, and these numbers may be understated. https://www.ahip.org/resources/ahip-acli-bcbsa-2023-survey

[6] According to a survey carried out by Global Strategy Group on behalf of AHIP in January-February 2022: https://www.ahip.org/resources/ahip-supplemental-plans-survey-results

illness coverage) rate the service received from their supplemental insurer as either excellent or good. Overall, beneficiaries' satisfaction stems from the high quality of service and the peace of mind supplemental health insurance products provide. Approximately 9 in 10 supplemental health insurance policyholders report that they are satisfied with the services and benefits covered by their plan, with the value they receive for their premiums, and with the affordability of their plan.

Together, the high consumer satisfaction rates for both hospital and other fixed indemnity and specified disease or illness excepted benefit coverages indicate that policyholders value the services and benefits provided by these plans and prioritize the financial peace of mind these coverages bring to their families.

The Departments' Proposals Exceed Their Authority Under Applicable Federal Statutes Governing Hospital or Other Fixed Indemnity Excepted Benefits

The proposed rules for both individual and group hospital and "other fixed" indemnity policies would, among other things, restrict benefit payments to a fixed dollar amount per day (or other period of time) of hospitalization or illness and prohibit such payments from taking account of: (i) the actual or estimated amount of expenses incurred; (ii) the services or items received; (iii) the severity of illness or injury experienced by a covered participant or beneficiary; or (iv) other characteristics particular to a course of treatment received by a covered participant or beneficiary. The proposed rule also makes clear that to qualify as "HIPAA-excepted," it must not pay on any other basis (such as on a per-item or per-service basis).

As explained below, these proposed changes either ignore or render as mere surplusage express statutory language governing "other fixed indemnity" products and other provisions governing the design and treatment of such products in a variety of contexts. Accordingly, these proposals exceed the agencies' statutory authority.

Excepted benefits are defined under federal law to include hospital indemnity or "other fixed indemnity" policies.[7] To maintain "excepted benefit" status, and not be subject to federal regulation as comprehensive major medical health insurance coverage, these policies must meet three conditions described in the statute: (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" any other health insurance coverage; and (c) the "benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under" any other health insurance coverage.[8]

[7] 42 U.S.C. §§ 300gg-91(c)(3) (Public Health Service Act (PHSA) § 2191); 300gg-21(c)(2) (PHSA § 2721).
[8] Id. § 300gg-21(c)(2)(A)-(C).

Historically, these products have generally been offered on a per event basis consistent with the statute (*e.g.*, per doctor's visit or hospital stay) and with varying payment amounts. Moreover, nothing in the PHSA or the ACA (which retained the HIPAA statutory excepted benefits criteria) permits the Departments to add additional criteria for hospital 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.

Courts have made it clear this excepted status may not be limited through regulation to less than *all* policies encompassed under the statutory requirements. (*See, e.g., Central United Life Insurance v. Burwell*, 827 F.3d 70, 73 (D.C. Cir 2016) (making it clear the Department did not have authority to establish enrollment in Minimum Essential Coverage (MEC) as a required criterion for individual fixed indemnity policies, stating "where Congress exempted all such conforming plans from the PHSA's coverage requirements, HHS, with its additional criterion, exempts less than all.")

The D.C. Circuit in *Central United* was clear when it observed:

> "Nothing in the PHSA suggests Congress left any leeway for HHS to tack on additional criteria. *See* 42 U.S.C. § 300gg-91(c)(3) (defining "excepted benefits" for fixed indemnity plans). Nor do any subsequent amendments to it. The ACA, in fact, endorses the PHSA's definition—it excludes the "excepted benefits ... described in" the PHSA from what counts as "minimum essential coverage." 26 U.S.C. § 5000A(f)(3). At no point does the ACA give even the slightest indication the definition of "excepted benefit" was suddenly debatable; rather, the Act doubled down on the PHSA's existing requirements. Ever since it first carefully defined what counts as an "excepted benefit" in 1996, Congress has never changed course or put its original definition in any doubt. Where the text is as clear as it is here, "that is the end of the matter."[9]

The Departments' proposed rule for hospital indemnity or other fixed indemnity policies does exactly what the *Central United* court declared they could not: adding criteria not required by statute. Here, as in *Central United*, "Congress has never changed course or put its original definition in any doubt."[10] As a result, in this proposal the Departments "lack[ed] authority to demand more of fixed indemnity providers than Congress required…"[11]

[9] *Central United Life Ins. Co. v. Burwell*, F.3d 70, 73 (D.C. Cir. 2016).
[10] Id. at *2
[11] Id. at *3

The Departments' Proposals Improperly Depart From Decades of Previous Regulatory Guidance Governing Hospital or Other Fixed Indemnity Excepted Benefits

The newly proposed criteria for benefit payments for fixed indemnity products are inconsistent with the Departments' decades-long treatments of these products. Prior to FAQ 11, published by the Departments in January 2013, the term "event" was understood to include both per-service and per-period triggers. The Departments' proposed change to the term "event" is a significant shift in how the long-standing regulation has been interpreted, relied upon, and enforced. Neither the ACA nor any other statutory changes have occurred to alter that status. This fact underscores the significance of the proposed change and why it is contrary to statute.

Also of concern is the Departments' reinterpretation related to variation in benefit amounts. Before and after adoption of the 2013 regulations related to excepted benefits, insurers, state insurance regulators, and the Departments have all shared a common interpretation of the allowed payment provisions, which does not exclude policies that pay event-based benefits or those that pay varying amounts for different types of services.[12]

States, who are the primary regulators of the business of insurance, and who have primary enforcement authority under the PHSA have consistently approved hospital or other fixed indemnity policies that pay event-based benefits and allow variation in payments based on services.[13] This proposed rule creates entirely new, non-statutory requirements for these products which would cause widespread market disruption and essentially eliminate the vast majority of hospital or other fixed indemnity insurance designs which have been offered and purchased by consumers for decades.

Recommendation:

- **For the reasons articulated above, we believe the Departments should not finalize these rules as proposed.**

The States Exercise Appropriate Regulatory Authority Over the Relevant Products

The states are and have long been the primary authority for regulation of health insurance, including hospital and other fixed indemnity insurance and specified disease or illness insurance. The PHSA recognizes this authority, and the ACA did not change this authority for these

[12] 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.

[13] 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.").

products.[14] 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 investigations and market conduct examinations and impose fines and order compliance as necessary to enforce the requirements. In addition, each state insurance department has a division for the reporting and investigation of fraud, improper marketing, and other market abuses. States remain the closest to both the consumer and the sales channels and should be entrusted with the necessary oversight of these products and their marketing.

To guide state regulation, the National Association of Insurance Commissioners (NAIC) has adopted a model act (Model #170, the *Supplementary and Short-Term Health Insurance Minimum Standards Model Act*) for accident and sickness insurance, is currently in the process of updating the corresponding regulation (Model #171, the *Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act*), and has also adopted a model regulation (Model #40, the *Advertisements of Accident and Sickness Insurance Model Regulation*) that specifically addresses the advertisement of these products. Many states have adopted or follow the model acts and regulations, providing a regulatory framework for these products. Models #170 and #171 contain minimum policy standards and disclosure requirements, as well as an outline of coverage, and other provisions designed to inform consumers of the limited nature of these coverages.

Additionally, states are the primary licensing and enforcement authorities for the activities of agents and brokers (collectively, "producers"). Here, too, the NAIC maintains and periodically updates the Producer Licensing Model Act (Model # 218), which provides a framework for states' licensing structures and rules related to the payment of commissions, and also places requirements on insurers to report when producers' contracts are terminated, included when a contract is terminated for cause.

And as explained in the next section, the NAIC has been actively engaged with relevant stakeholders in identifying NAIC model laws and regulations that need updating to address various marketing-related concerns raised in connection with these products.

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 appropriately to protect each state's citizenry.

[14] 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.")

Recommendation:

- **The Departments should defer to the states' regulation of the design of hospital or other fixed indemnity insurance plans.**

Addressing Improper Marketing to Protect Consumers

AHIP's members are committed to ensuring consumers can find and purchase health insurance coverages that fit their needs at a price they can afford. Our members offer plans that provide robust benefits for individuals and families at every stage of life, including plans that offer supplemental benefits that are structured to enhance – but not replace – major medical coverage. The products offered by our members serve a valuable purpose in the market and have satisfactorily met the needs of consumers for decades.

We are aware that some articles detail claims of bad actors preying on consumers by providing misleading or outright false information about the insurance plan, coverage, and benefits being purchased. We want to be clear: AHIP and our members condemn such fraudulent behavior, and we commit to working in partnership with federal and state regulators to ensure robust consumer protections in the insurance market.

AHIP's member companies do not want their supplemental health insurance plans sold to unwitting consumers under false pretenses. These instances of fraud cost insurers money, time, reputation among consumers, and relationships with regulators who investigate these consumer complaints. While it may seem counterintuitive, insurers do not profit when their products are sold in these schemes. Insurers lose the cost of the commission paid to the producer and the administrative costs of underwriting and issuing the policy. For low-premium supplemental plans, it can take several years to recoup the costs of issuing the plan.

The increase in the use of internet lead generators is an area of concern highlighted in a recent July 2023 GAO Report. Lead generators are generally not licensed insurance agents or brokers and are not appointed with an insurance carrier. These entities capture the contact information of parties interested in purchasing insurance coverage and sell them to the agents or carriers they contract with. Interestingly, the GAO report noted only one fixed indemnity carrier indicated using an online lead generator.[15]

AHIP and our members are actively engaged in the ongoing work of the NAIC Improper Marketing of Health Insurance Working Group ("the Working Group"). This group, formed in July 2021, has begun the process of identifying NAIC model laws and regulations that need updating to address the use of lead generators in the purchase of health insurance plans. Additionally, the Working Group coordinates regularly with state and federal regulators to provide assistance and guidance monitoring the improper marketing of health plans, and

[15] https://www.gao.gov/products/gao-23-106034, pg 31

coordinates appropriate enforcement actions among the states and in partnership with the federal government.

During the NAIC's 2023 Summer Meeting in Seattle, Washington, the Working Group approved its first amendments to an NAIC model law (Model #880, the Unfair Trade Practices Act). When these amendments are ultimately approved by the NAIC and adopted by the states, state laws will, for the first time, formally recognize the role that lead generators play in the purchase of health insurance products, subject lead generators to the same trade requirements placed on insurers and producers, and require lead generators to maintain marketing and performance records for the current year and the preceding two years. AHIP supported the approval of these amendments and worked closely with the Working Group to propose additional language to refine and strengthen the new requirements.

The Working Group's activities have appropriately focused on entities, including lead generators, that mislead consumers about the insurance products they purchase. These include interstate and state-federal collaboration to hold fraudulent actors accountable. Additionally, AHIP members have partnered with state insurance regulators to target fraudulent actors' use of their trademarked logos and products.

Unfortunately, the Departments' currently proposed rules fail to address or discuss lead generation and/or the entities that engage in the harmful activities highlighted throughout the preamble as examples of improper marketing. Rather than address the problematic activities of individual bad actors, the proposed rules will instead undermine the value of or potentially remove these valuable insurance products from the market that millions of Americans rely on for protection against the total cost of illness or injury. Without addressing bad actors who will continue to prey on unwary consumers, this rule in its current form will simply dilute the value of these products and do nothing to solve the underlying problem.

"Income Replacement"

Throughout the preamble of the proposed rules, the Departments refer to fixed indemnity health insurance plans as "income replacement." AHIP disagrees with this categorization. Fixed indemnity plans are most appropriately referenced as a type of supplemental health insurance. Benefits paid under these policies require the occurrence of a medical event or the receipt of a health service as a payment trigger. Policyholders have the discretion to utilize these benefits as they see fit. The Departments have referred to fixed indemnity plans as "income replacement" only once, in FAQ Part XI,[16] but not in the footnoted references for the justification for using the label.[17]

[16] https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xi.pdf
[17] 62 FR 16903 (April 8, 1997) and 79 FR 15818 (July 8, 2014)

Hardworking Americans purchase hospital or other fixed indemnity policies as a supplement to their comprehensive major medical plans to cover costs related to their health care that they do not have the savings or income to cover. According to the Departments' jointly released (with the Consumer Financial Protection Bureau) request for information on medical payment products, in addition to recent research on medical billing, about half of American adults are not able to cover a medical bill exceeding $500.[18,19] Studies examining the financial capabilities of Americans to cover potential health care 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, time missed from work, and childcare. This is where products like fixed indemnity plans play a valuable role: to help cover out-of-pocket costs for care and to cover health-related costs that major medical health insurance does not pay. These plans can help policyholders alleviate or avoid medical debt when used in conjunction with comprehensive major medical plans. The label "supplemental health insurance" is appropriate for hospital and other fixed indemnity excepted benefits plans, while "income replacement" fails to accurately describe these products' structure and function as a complement to comprehensive major medical health insurance. (AHIP also notes that some insurance products, such as disability income insurance, are intended for use as wage or income replacements.)

Recommendation:

- **The Departments should refer to hospital or other fixed indemnity plans as supplemental health insurance, rather than "income replacement."**

Per-Period Basis Fixed Payment Standard

Fixed indemnity plans play an important role for patients facing substantial costs related to treatment for a serious injury or illness, including out-of-pocket expenses for medical care and other costs that major medical insurance does not cover, such as childcare, transportation, and time missed from work. These expenses are of particular concern for lower income Americans who may not have the income or savings to cover all expenses.

AHIP shares the Departments' concerns about fixed indemnity plans being bundled and marketed to mislead consumers into believing that these plans are comprehensive major medical plans. This is a deceptive marketing practice. Fixed indemnity plans must not be offered, marketed, and sold as comprehensive major medical plans or as an alternative to, or substitute for, major medical plans. The way to address this practice is with strong enforcement against the

[18] https://www.federalregister.gov/documents/2023/07/12/2023-14726/request-for-information-regarding-medical-payment-products

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

use of such marketing practices. So long as fixed indemnity coverage is offered, marketed, and sold as "supplementary" insurance, it meets the requirement to be an "excepted benefit."

As we have noted, AHIP's view is that regulation of specific benefits structures is most appropriately left to the states, as is oversight and regulation of appropriate marketing and other contract terms and conditions. Ultimately, a complete prohibition on per-item or per-service benefits in the individual market does a disservice to consumers, especially lower income Americans who often rely during difficult challenges on the financial security that fixed indemnity plans provide.

Recommendation:

- **AHIP requests the Departments not finalize the Per-Period Basis Fixed Payment Standard as proposed.**

Prohibitions on Benefit Variance

The proposed rules would further require that hospital or other 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."

AHIP agrees that hospital or other fixed indemnity plans should not be marketed or bundled to be offered, marketed, and sold as comprehensive major medical health insurance. However, consideration of the severity and/or level of care is required to ensure the plans provide the appropriate value to members. Hospital or other fixed indemnity coverages are purchased as a safety net from unanticipated out of pocket medical expenses and to help with unanticipated costs for incidental expenses related to prolonged medical care. Certainly, the need for that protection varies based upon the severity of and course of treatment for the relevant medical event. Prohibiting variability in benefits based upon those factors prevents consumers from being able to purchase appropriate value and protection for themselves.

Recommendation:

- **AHIP recommends the Departments not finalize these prohibitions and allow insurers to appropriately structure benefits for significant events, such as a stay in a hospital's intensive care unit or needing use of an air ambulance, and distinguish them from less significant events, such as an outpatient hospital procedure or transport via ground ambulance.**

Payments to Health Care Providers

While the proposed rules do not include proposals specific to the payment of benefits directly to health care providers under hospital or other fixed indemnity health insurance, AHIP is providing insight from our members about payments to providers. As we understand the current market, a

substantial majority of hospital or other fixed indemnity plans pay benefits only to the policyholder. In some plan designs, a policyholder may choose to go through the available process to assign payment to a provider, although we understand there is limited use of this process.

AHIP would oppose a blanket ban on assignment of payments to providers. However, we could be supportive of a ban on plan structures that *only* pay providers while still allowing consumers the flexibility to choose to assign payment to providers.

Notice Requirements
AHIP believes that consumers must have a clear understanding of the products they are considering for purchase, and we support strong notice requirements for all supplemental health insurance products. We have joined with other industry representatives to work with NAIC consumer representatives and state regulators to draft disclosure language that we believe is clearer than 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 is proposed to 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."

The language in Model #171 was written to distinguish between hospital indemnity plans and other types of fixed indemnity plans.

Recommendations:

- **AHIP recommends the Departments use the final verbiage adopted and approved by the NAIC for Model #171, which includes clear descriptions of the features of fixed indemnity insurance plans. Alternatively, the Departments could require that the notice mirror the most recent version of the notice in NAIC Model #171.**
- **AHIP supports the inclusion of the second paragraph of the proposed notice, which directs consumers looking for comprehensive major medical health insurance to the Marketplace or their employer and directs complaints about the fixed indemnity product to the relevant state Department of Insurance.**
- **While AHIP does not support a requirement to include the contact information for each state Department of Insurance (DOI), we recommend that the Departments consider the inclusion of the NAIC's online directory of state DOIs, available at naic.org.**

Noncoordination Requirements

While the proposed rules do not include a change in the regulatory text for the noncoordination requirements, the Departments proposed a new example (proposed Example 3) that represents a reinterpretation of the requirements. Although the example is added only to the group market rule, the new interpretation would apply in both the individual and group markets.

AHIP is concerned about the inclusion of this new reinterpretation in the examples, rather than through proposed changes in the regulatory text. The Departments' including this new policy only in the examples has generated questions and uncertainty, creating a new unclear standard not defined elsewhere in the rules.

The preamble states that proposed Example 3 is just one illustrative example. How would the new reinterpretation be applied in other situations? All health plans, no matter how robust, have exclusions such as deductibles and co-payments, and do not necessarily cover all medical treatments. What type(s) of group health plans may an employer offer in addition to a hospital or other fixed indemnity plan and still meet the noncoordination standard? The Departments do not provide any guidance on these issues.

AHIP is concerned that this proposal could severely restrict employers' ability to offer hospital and other fixed indemnity excepted benefit plans to their employees and could severely undermine the role of excepted benefits as supplemental health insurance coverage.

Recommendation:

- **AHIP opposes the inclusion of proposed Example 3 and recommends the Departments exclude it from the final rules.**

Applicability Dates

New Policies

For new hospital or other fixed indemnity health insurance policies sold in both the individual and group markets, AHIP 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. In order for new individual and group policies 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 or other fixed indemnity plans to be sold in the state. Additionally, AHIP notes that some state legislatures do not meet annually, meaning it could take more than one year for those states to pass minimum standards legislation and fully implement the new requirements.
- 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 product marketing materials 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 as DOIs are not staffed to handle the volume of submissions for a complete overhaul of a longstanding industry product. **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 or other fixed indemnity products will be delayed as states prioritize QHPs in time for open enrollment.**

If states are not able 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 fixed indemnity policies, leaving consumers without access to a popular supplemental health insurance product.

Existing Policies
Individual Market. In the individual market, fixed indemnity policies are most often sold on a *guaranteed renewable* basis. When an insurance contract is marketed and sold as guaranteed renewable, as long as 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, AHIP 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.

Recommendation:

- **AHIP recommends that existing policies sold on a guaranteed renewable basis should be and should remain exempt from the requirements of the proposed rules. Such an exemption would allow customers who like their fixed indemnity plans to keep them.**

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

Recommendation:

- **AHIP recommends that the proposed rules' effective date for existing contracts in the group market apply only to contracts renewed after January 1, 2027. This would allow existing contracts and contracts subject to CBAs or other similar contractual**

agreements to continue through their predetermined end dates, after which the benefit structures would be required to conform to the finalized rules.

IV. Request for Information: Specified Disease or Illness Plans

AHIP appreciates the opportunity to offer comments in response to the Departments' request for information (RFI) about specified disease or illness policies. As we have noted previously, these policies have extremely high rates of overall consumer satisfaction (97 percent), as well as high rates of satisfaction with the service received from their provider (99 percent). Across all supplemental health insurance plans (fixed indemnity, specified disease, and accident policies), approximately 9 in 10 policyholders report that they are satisfied with the services and benefits covered by their plan, with the value they receive for their premiums, and with the affordability of their plan.[20]

As with hospital and other fixed indemnity health insurance, AHIP believes that specified disease or illness 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 or other fixed indemnity plans, which as we explain above would exceed the Departments' statutory authority. We do not believe that specified disease or illness products would see an increase in interest or purchase as a result of the proposed rules, if they are finalized. Our members report that many specified disease or illness 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 or illness 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.

V. 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-

[20] https://www.ahip.org/resources/ahip-supplemental-plans-survey-results

based accident and health insurance plans, which include hospital or other fixed indemnity and specified disease or illness excepted benefit 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 only the benefits paid under these policies that exceed the cost of medical care should be reported as income by the policyholder.[21] Under the proposed rule, by contrast, all benefits paid under pre-tax funded, employment-based policies must be reported as income and subject to both income and, according to the preamble, payroll taxes as wages (FICA and FUTA).

AHIP opposes this change in long-standing IRS policy and disputes the notion that these changes are a mere "clarification." The tax changes are both a departure from operative statutory language and a significant shift in tax policy that imposes new taxes on working Americans and new burdens on employers.

IRS Code section 105(b) states that gross income does not include amounts "paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him for the medical care (as defined in section 213(d))." This statutory exclusion applies to amounts paid to reimburse a taxpayer for medical care expenses. There is nothing in the statute that indicates that the entire plan or policy must only pay medical expense reimbursements for the exclusion to apply to any portion of the benefits. To require otherwise would be inconsistent with the plain text of the statute.

This view has long been reflected in corresponding guidance and regulations. For example, current regulations recognize this by stating that the exclusion applies "only to amounts which are paid specifically to reimburse the taxpayer for expenses incurred by him for the prescribed medical care" but "does not apply to amounts which the taxpayer would be entitled to receive irrespective of whether or not he incurs expenses for medical care," and "section 105(b) is not applicable to the extent that such amounts exceed the amount of the actual expenses for such medical care." (emphasis added)[22]

In addition, in Rev. Rul. 69-154, the IRS ruled that, where the premiums are not taxed, only the "excess indemnification" is taxable and states that Treas. Reg. § 1.105-2 "provides that section 105(b) of the Code is not applicable to the extent that such amounts exceed the amount of the actual expenses for such medical care." (emphasis added); *see also* Rev. Rul. 2002-80 and Rev. Rul. 2002-43. And, most recently in June 2023, the IRS said a wellness indemnity payment under a fixed indemnity health insurance policy is included in the employee's gross income to the extent the employee does not have any unreimbursed out-of-pocket medical expenses related to the payment. CCA 202323006; see also CCA 201719025.

[21] 1956-1 CB 63, 70; T.D. 6169
[22] 26 CFR § 1.105-2

Application to Major Medical Plans
We note that the IRS previously proposed a similar change requiring legislation in the Fiscal Year 2023 and 2024 President's Budget request and accompanying explanations of revenue proposals ("the Greenbook").[23] 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 through regulations.

Moreover, the proposed change would result in a tax increase on hardworking Americans, including lower income workers. Policyholders who choose to have policy premiums deducted on a pre-tax basis would experience a new tax on the benefits they receive, while policyholders who choose to have premiums deducted on an after-tax basis would also experience a tax increase due to higher net wages, which had previously been reduced by the ability to deduct premiums on a pre-tax basis. These individuals may not have savings to cover unexpected health care-related costs, 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. Accident and health policies provide 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.

Further, if the proposed change is finalized, insurance providers and employers would face increased administrative burdens with limited time to adapt, 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.

Impact on Employer-Sponsored Major Medical Health Plans
The proposed regulation states:

> *Any amounts received under* a fixed indemnity plan treated as an excepted benefit under section 9832(c)(3), or *any plan that pays amounts regardless of the amount of section 213(d) medical care expenses actually incurred*, are not payments for medical care under section 105(b) and are included in the employee's gross income under section 105(a). (emphasis added).

The preamble requests comments on whether additional clarification is needed regarding how the proposed regulation would apply to types of benefits provided through employment-based accident or health insurance (where the premiums are paid on a pre-tax basis) other than fixed indemnity or specified disease excepted benefits coverage, including incentives offered through

[23] 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

wellness programs, where the insurance, those programs, or both provide benefits without regard to the amount of medical expenses incurred.

It is very common for comprehensive major medical plans to make limited taxable payments that are not tied to the amount of Code section 213(d) medical expenses incurred. For example, travel benefits above the Code's limits (e.g., over $50/night for hotel or where the underlying medical care is not provided by a physician in a hospital or similar setting, fertility benefits for same sex couples, MLR rebates, and wellness incentives). AHIP is concerned that the broad language in the proposed regulation could be read to say that the Code section 105(b) exclusion does not apply to any payments made by a comprehensive major medical plan, even those for Code section 213(d) medical care, if the plan pays any amounts that are not tied to the amount of Code section 213(d) medical expenses incurred. In other words, all payments under such a plan would be taxable.

Recommendations:

- **Because the IRS lacks statutory authority to make the proposed change, AHIP recommends the IRS rescind this proposal in its entirety.**
- **If the rule is finalized as proposed, AHIP recommends that Treasury and IRS make clear in the final regulation that this "any amounts" rule does not apply to comprehensive major medical plans, and that such plans can treat amounts paid for Code section 213(d) medical care as excludable under Code section 105(b).**
- **In response to the question about whether additional clarification is needed regarding how the proposals would apply to wellness program incentives, we believe that the existing legislative and regulatory framework already appropriately addresses the tax treatment of wellness incentives such that no additional clarification is needed.**
- **In response to the question about whether specific timing requirements should be included for substantiation, AHIP recommends against such requirements. Policyholders often file and receive benefits under these policies during times of serious illness or following injuries. Adding arbitrary timing requirements during a time of substantial personal hardship is unnecessary.**