THE NEW ENGLAND COUNCIL

September 11, 2023

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

The Honorable Lisa M. Gomez
Assistant Secretary
Employee Benefits Security
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

Douglas W. O'Donnell
Deputy Commissioner for Services and Enforcement
Internal Revenue Service
U.S. Treasury Department
1500 Pennsylvania Ave, NW
Washington, DC 20220

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

**Submitted electronically via** www.regulations.gov

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

On behalf of The New England Council and our Financial Services Committee, I wanted to thank you for the opportunity to provide comments on the above-referenced Proposed Rule published in the Federal Register on July 12, 2023, at 88 FR 44596 by the Departments of Health and Human Services, Labor and Treasury (collectively, the "Departments").

The New England Council's mission is to support public policy that promotes economic growth and a high quality of life throughout New England. With that in mind, our members have significant concerns with the Departments' Proposed Rule applicable to hospital indemnity and other fixed indemnity excepted benefits and with the tax changes Proposed by the Treasury

Department. These portions of the Proposed Rule will significantly restrict cost-effective financial protection insurance options that have been available to individual consumers for decades and continue to be popular today. The Proposed Rule will also subject policyholders to new taxes on the benefits received under the impacted policies. We believe the Proposed Rule is contrary to law and congressional intent and goes well beyond the Departments' statutory authority. We share the Departments' concerns that consumers should understand the nature of the health coverage products they buy, however oppose the proposals overreach and ask it be withdrawn.

Many insurance companies, including several New England Council members, offer insurance policies that are commonly referred to in the marketplace as "supplemental products" or "supplemental benefits". The term supplemental is used to distinguish these policies from major medical coverage. Supplemental products are not designed as primary medical coverage or a substitute for such coverage. Rather, supplemental products recognize that individuals experiencing an accident, sickness, or injury face many out-of-pocket costs that major medical plans are not designed to cover. A key attraction of supplemental products is that they pay money directly to the policyholder, who can then use the benefits as they consider best, whether to offset the impact of deductibles and copayments or for other financial needs, such as for respite care giving. These policies do not make payments directly to providers or facilitate such payment (e.g., do not offer medical payment cards for use with providers). The Departments propose to significantly reduce the availability of this protection; and, to the extent products remain available under the Proposed Rule subject policyholders to taxation on the benefits.

Federal law has long been cognizant of excepted benefits and left their regulation to the states. Our member's supplemental products are what Congress referred to in HIPAA as "independent, noncoordinated" excepted benefits. This class of excepted benefits includes hospital indemnity and other fixed indemnity excepted benefits as well as specified disease or illness excepted benefits (e.g., cancer-only coverage). Under the statutory standard established by Congress, supplemental products are called "excepted" benefits because Congress has intentionally "excepted" these benefits from federal health coverage mandates that apply to primary medical coverage. The federal requirements for these products to qualify as excepted benefits were first established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Congress has kept these same requirements in place without change each and every time that Congress has added new federal health mandates since HIPAA. Since insurance is regulated by the states, hospital indemnity policies are designed and offered only in accordance with the statutes and regulations of the states/territories where they are issued.

The Departments' proposals regarding hospital indemnity and other fixed indemnity excepted benefits will be harmful to consumers by severely reducing the availability of cost-effective options that have long been available for individuals who need additional financial protection for expenses major medical insurance does not cover - the exact purpose of supplemental products.

The Proposed Rule contains two parts.

- First, the Departments propose two new requirements for hospital indemnity and other fixed indemnity coverage to qualify as an excepted benefit in both the group and individual market by (a) changing what it means to provide a "fixed benefit" and (b) proposing a new interpretation of the "noncoordination" requirement.

With respect to the first proposed change, under the statutory standard established by Congress, benefits under these excepted benefit products must be fixed in amount, that is, the benefit paid under the plan is triggered by the occurrence of a covered medical event but cannot be based on the amount of medical expenses incurred with respect to that event. Currently, in both the individual and group markets, the amount of the benefit may vary based on the particular medical event without being considered expenses incurred coverage. Current group market regulations provide that the benefit must also be limited to a specific time period; individual market regulations allow per period and/or per service benefit payments. Varying the fixed payment based on the particular medical event, such as the specific type of hospitalization (e.g., emergency room, hospital confinement, rehabilitation facility, or intensive care unit) is the common form for these policies. This approach provides the most value to consumers and reflects the fact that different medical events present different financial risks. The Proposed Rule would prohibit this type of benefit structure, essentially limiting these policies to one specific benefit, such as $100 per day for a stay in a rehabilitation facility as the only benefit.

With respect to the second change, excepted benefits are often referred to as "supplemental" because they are not designed or intended as major or primary medical coverage but "supplement" primary medical coverage with an additional layer of financial protection. Employers of all sizes often offer hospital indemnity or other fixed indemnity excepted benefits along with other employee benefits, including comprehensive medical coverage. The proposed changes to the "noncoordination" rules would raise serious risks that these excepted benefits could no longer be offered by any employer that offers major medical coverage (or, in the individual market, by an insurer that also offers major medical coverage). This proposal essentially turns current law and practice on its head, by restricting the ability of individuals to have both major medical coverage and excepted benefit coverage.

- Second, a separate rule proposed by the Treasury Department would change the long-standing tax treatment of fixed indemnity health insurance when the premium is paid on a pre-tax basis (either by direct employer contributions or by pre-tax employee salary reduction contributions). This change in tax treatment for fixed indemnity health coverage would specifically apply to hospital indemnity and other fixed indemnity and specified disease or illness excepted benefit coverage.

Under current law, when premiums for fixed indemnity health coverage are paid for on a pre-tax basis, then the benefits are tax-free to the extent of the individual's unreimbursed related medical expenses. Only any "excess benefit" is taxable, that is, any benefit in excess of such unreimbursed medical expenses.

Under the proposal, however, when premiums are paid on a pretax basis, the entire benefit would be taxable regardless of the amount of the individual's unreimbursed medical expenses. In addition, the preamble indicates that the benefits would also be subject to employment taxes (such as FICA taxes).

The Treasury Department describes the tax changes in the Proposed Rule as a "clarification". Our members believe this is a complete misstatement; the proposed changes reverse what has been clear tax treatment for decades. If the Proposed Rule is finalized,

individuals who purchase fixed indemnity coverage on a pre-tax basis, including hospital indemnity and other fixed indemnity excepted benefits, will face increased income taxes. In addition, new employment liability would arise for employees and their employers, including small businesses. If the proposal is finalized, some employers, not wishing to expose their employees to taxation on the full indemnity benefit, may offer these benefits on an after-tax basis only; this also is an increase in taxes compared to current law. Some employers, particularly smaller employers, may decide not to make the benefits available at all, thus reducing the availability of this type of additional financial protection.

The Departments do not limit the application of their proposals prospectively; rather, they would also apply to existing policies. With respect to existing policies, the Proposed Rule is retroactive, interfering with current contract rights (most of the impacted coverage is issued on a guaranteed renewable basis) and imposing new taxes on benefit arrangements that have long been in place.

In addition to causing negative impact on consumers, including increased taxes, the Proposed Rule is contrary to the relevant statutory provisions. In each of these provisions, the Departments overstep their regulatory authority.

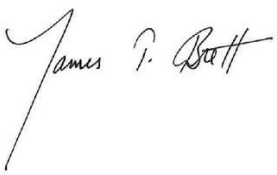
These aspects of the Proposed Rule should be withdrawn. Further, the Departments should conform the group market rule to the current individual market rule and allow payments to vary based by service and/or by period. At the least, the Departments should make it clear that in the group market payments that vary based on the service and that also have a time period are permitted.

The Departments also propose a notice requirement with respect to hospital indemnity and other fixed indemnity excepted benefits. Our members do not oppose consumer notice A notice, we believe would cure the Departments' concern about consumer confusion without the broad negative impacts on consumers who wish to have this type of additional financial protection.

Finally, while not proposing a change to the requirements for specified disease or illness coverage to qualify as an excepted benefit, the Departments include a request for information asking for detailed information on such coverage. This indicates that the Departments may consider similar changes to those benefits as well. For the reasons presented here, applying the Proposed Rule (or other new restrictions) on specified disease or illness excepted benefits would have a similar negative impact on consumers and would also be contrary to law and congressional intent, unconstitutional, and go well beyond the Departments' statutory authority.

Thank you for your consideration of our position, we look forward to furthering our engagement with the Agencies and Congress on this matter. If you have any questions regarding this issue, please contact Griffin Doherty at (781) 223-6420 or gdoherty@newenglandcouncil.com.

Sincerely,



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