ACLI
Financial Security for Life

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Submitted Electronically *via* https://regulations.gov

The Honorable Xavier Becerra
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The Honorable Lisa Gomez
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The Honorable Janet L. Yellen
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cc: Cam Clemmons, CMS, Geraldine Doetzer, CMS, Elizabeth Schumacher, EBSA, Rebecca Miller, EBSA

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

The American Council of Life Insurers ("ACLI") appreciates the opportunity to provide comments on behalf of our member companies regarding the regulation proposed by the Department of Health and Human Services, Department of Labor, and the Department of the Treasury (collectively "Departments") regarding Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance ("NPR").

ACLI does not engage in policy or advocacy with respect to short-term, limited duration insurance ("STLDI"), and therefore, we do not have any comments on the provisions of the NPR related to STLDI. However, ACLI does engage in policy and advocacy regarding supplemental benefits including Hospital and Other Fixed Indemnity (collectively "Fixed Indemnity"), as well as Specified Disease or Illness ("Specified Disease") and Accident Insurance; therefore, our comments are limited to the provisions of the NPR that impact these benefits. As discussed in detail below, we have serious concerns with provisions of the NPR that will have a detrimental impact on the affordability and access to Fixed Indemnity benefits. These benefits supplement comprehensive medical insurance and provide vital consumer protections by helping to pay for out-of-pocket expenses associated with medical events that are not covered by comprehensive medical insurance. The changes proposed in this NPR related to supplemental benefits will harm the very consumers the NPR seeks to protect. For decades, consumers have relied on these products that provide valuable benefits to help pay for out-of-pocket expenses associated with health events. However, the NPR's proposed changes are unnecessarily destructive to their benefit design and tax treatment, greatly reducing their value to those that rely on these benefits for financial protection.

Summary of Concerns

The NPR proposes several fundamental changes to the structure of Fixed Indemnity benefits that will severely undermine the availability of benefits and financial protection provided to consumers by the benefits.

- The Departments have identified specific issues with the marketing and sales of the products mentioned in this proposed regulation. While we agree that state regulators, federal authorities, insurers, and others can and should work together to stop the improper marketing of insurance products, the NPR would not achieve that outcome. This is a matter appropriately resolved by state insurance regulators.

- We are very concerned that the significant changes to Fixed Indemnity benefit structure proposed in the NPR would: 1) leave policyholders who have purchased these benefits in good faith without the coverage on which they rely; 2) greatly diminish the financial protection value of the benefits for consumers; and 3) decrease opportunity for utilization of benefits.

- The Departments seek to redefine statutory criteria establishing Fixed Indemnity benefits; however, we believe the Departments exceed their statutory authority by proposing unprecedented changes to regulatory requirements that are not based on a plain reading of the enabling statues or consistent with legal precedent that has analyzed these laws.

- The tax provisions of the NPR as written would significantly alter the tax treatment of all types of supplemental benefits that we represent to the detriment of those that use these benefits and to employers who offer the benefits to employees.

- We are concerned with the Departments' request for comments regarding Specified Disease benefits. For the reasons stated herein, we recommend that the Departments not move forward with proposed regulations for Specified Disease benefits.

I. Fixed Indemnity and Specified Disease Insurance Provide Valuable Protection for Americans Who Are Sick or Injured

Fixed Indemnity and Specified Disease coverages provide benefits to help bridge what can be an insurmountable financial gap between benefits a comprehensive health plan pays and the total costs faced when an individual experiences a health event that requires medical treatment and/or services. Specifically, Fixed Indemnity and Specified Disease benefits reduce financial hardship for individuals caused by copays, deductibles, coinsurance, and other out-of-pocket costs. Unfortunately, the changes proposed in the NPR would significantly undermine the availability of benefits and consumers' ability to utilize the benefits, thereby severely limiting consumers' ability to financially protect themselves and their families and exposing them to greater financial liability caused by health events. This outcome is contrary to the goals of the states and the federal government with insurance regulation and public policy relative to health insurance. As proposed, the NPR would likely reduce the availability and the value of these products to consumers, the vast majority of whom value the products and view them favorably.

Millions of working Americans and their families rely on Fixed Indemnity and Specified Disease benefits for financial protection from out-of-pocket costs associated with health events. Tellingly, 57% of Americans cannot afford a $1,000 emergency expense[1] and 41% of Americans have some sort of debt created by medical or dental expenses. [2] A recent survey by Morning Consult shows that over 80% of consumers that have salaries between $50,000 and $100,000 value these supplemental insurance products to protect their household budgets and want federal policymakers to protect their availability.[3] ACLI's member companies serve industries including retail, K-12 education, hospitals and nursing homes, municipalities, agriculture, and construction, among many other industry types with a wide range of income levels.

The value to consumers of the benefits targeted in this NPR is additionally illustrated by the following nationwide data from 2022:

- nearly 8.2 million lives insured by Fixed Indemnity insurance;
- over 17.2 million lives insured by Specified Disease (e.g. cancer) insurance;
- 61,885 employers offering group Fixed Indemnity products;
- 96,274 employers offering group Specified Disease products;
- 1,522,841 individual Fixed Indemnity policies sold through the worksite (79% of total individual policies); and
- over 4.3 million Specified Disease policies sold through the worksite (84% of total individual policies).[4]

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[1] Bankrate, *Bankrate's 2023 Annual Emergency Savings Report*, (June 23, 2023) available at: https://www.bankrate.com/banking/savings/emergency-savings-report/.

[2] Lunna Lopez, Audrey Kearney, Alex Montero, Liz Hamel and Mollyann Brodie, *Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills*, KFF, June 16, 2022 available at: https://www.kff.org/health-costs/report/kff-health-care-debt-survey/.

[3] Morning Consult, nationwide survey of 2,201 adults, August 10 – 13, 2023.

[4] *AHIP-ACLI-BCBSA 2023 Survey: Fixed Indemnity & Specified Disease Plans*, (September 7, 2023) available at: AHIP-ACLI-BCBSA 2023 Survey: Fixed Indemnity & Specified… - AHIP.

Also, in 2022, consumer complaints were filed with state insurance departments relating to Fixed Indemnity coverage on only .0003% of policies/certificates and only .0002% of Specified Disease policies/certificates.[5] These complaints were related to any matter, not necessarily confusion about the products or the benefits offered.[6]

A 2022 survey of customers who have Fixed Indemnity, Specified Disease, and/or Accident benefits found that beneficiaries consider their supplemental benefits to be highly valuable in shielding them from financial worries and protecting their household budgets when they are sick or injured:

- 92% to 99% overall satisfaction rate depending on the product type;
- 91% felt their Supplemental plan gave them peace of mind;
- 91% felt the plan was there when they needed it;
- 90% believe they receive value for their monthly premium; and
- 89% agreed that purchase of the plan was a valuable investment in protecting them financially.[7]

Fixed Indemnity and Specified Disease products have for decades been offered to consumers through their employer either as individual or group coverage. Depending on the employment setting, coverage is offered as employer paid, voluntary, or a combination thereof. These worksite and employer-based offerings of coverage have generated remarkably few consumer complaints, as noted above, to insurers or state insurance regulators relating to the scope of coverage, claim handling, benefits provided, or other matters. Further, employers value the ability to offer this type of coverage to employees as it improves their benefit offering, provides financial protection to employees, and helps attract and retain employees.[8]

The high degree of employee and employer satisfaction with Fixed Indemnity and Specified Disease coverage is due to: 1) well trained brokers and agents offering the coverage in the worksite; 2) clear and accurate explanations of the coverage being provided to employers and employees prior to sale; 3) excellent customer service for employees when they file a claim or otherwise need assistance relating to their coverage; 4) excellent customer service to employers relating to administration of and premium collection for the coverage; and 5) ongoing communication with insured employees to remind them of benefits provided and ease of filing claims.

With worksite and employer-based offerings of Fixed Indemnity and Specified Disease coverage, an employer and often their human resources and/or employee benefits personnel first evaluate which coverage will be offered to employees, including the plan design. Thus, as with most employer-sponsored benefits, the employer is a gatekeeper who decides which products can be offered to employees. Employers who want to attract and retain good employees strive to provide their employees with valuable benefit offerings through the worksite or group policies. Because of an employer's role in the decision to offer such coverage, the Departments' concerns with deceptive marketing are nearly nonexistent with worksite and group sales. ACLI maintains that the

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[5] *Id.*
[6] *Id.*
[7] Global Strategy Group, *Measuring Satisfaction With Supplemental Insurance*, (February 23, 2022) available at: https://www.ahip.org/documents/AHIP-Supplemental-Insurance-Deck-032422.pdf (surveyed holders of Hospital and Other Fixed Indemnity, Specified Disease/Critical Illness, and Accident-only policies).
[8] *See* LIMRA-EY 2023 Workforce Benefits Study (2023).

NPR would diminish the value of Fixed Indemnity and Specified Disease coverage, and therefore, will decrease employers' likelihood of making the coverage available to employees.

Individuals, businesses of all sizes, unions, and state and local governments purchase Fixed Indemnity and Specified Disease products for their employees and union members. Millions of Americans are currently covered by these policies, and the NPR would significantly decrease or even eliminate their choice to continue receiving the valuable coverage they currently have in place.

II. The Proposed Standards Harm Americans by Eliminating Coverage They Count On

The changes proposed in this NPR related to the benefits allowed under Fixed Indemnity products will harm the very consumers the NPR seeks to protect. For decades, people have relied on Fixed Indemnity products that provide valuable benefits to help them pay for out-of-pocket expenses associated with health events. However, the NPR's unrealistic and unnecessary benefit design requirements will render them of greatly reduced value to those that rely on them for financial protection. The NPR prohibits Fixed Indemnity benefits from being paid based on "*services or items received, 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, and not on any other basis (such as on a per-item or per-service basis)*." The purported purpose of this change is to protect consumers from being misled about the differences between comprehensive medical coverage and Fixed Indemnity coverage. However, the practical effect of these requirements will be to eliminate many traditional Fixed Indemnity benefits that working Americans can use to help pay for out-of-pocket expenses not covered by comprehensive medical insurance.

The proposed drastic limitations on plan designs will decrease opportunity for utilization of benefits, and thereby, decrease the financial protection value to consumers as explained below. As a result, consumers will have less access to Fixed Indemnity benefits and more consumers will be forced to manage out-of-pocket expenses from health events from their personal savings or incur healthcare-related debt.

In 2013, the National Association of Insurance Commissioners ("NAIC") commented to the Departments regarding the value of allowing variable benefit amounts in Fixed Indemnity coverage. The NAIC stated:

> *[S]tate regulators believe hospital and other fixed indemnity coverage with variable fixed amounts based on service type could provide important options for consumers as supplemental coverage. Consumers who purchase major medical insurance that meets the definition of "minimum essential coverage" may still wish to buy fixed indemnity coverage to help meet out-of-pocket medical and other costs. Policies with variable fixed amounts have proven to be popular and we see no reason they should be eliminated as options for supplemental coverage. We ask that you reconsider your position on this issue.*

We agree with the NAIC. Prohibiting Fixed Indemnity benefits from paying based on "services or items received", "severity of illness or injury", "other characteristics particular to a course of treatment received", and "not on any other basis (such as on a per-item or per-service basis)" other than "per day (or per other time period) of hospitalization or illness", as the NPR proposes to do would eliminate virtually all ability for Fixed Indemnity coverage to provide customers with

variable fixed indemnity benefits that are better tailored to assist with their likely out-of-pocket costs associated with health events. Examples of variation in the likely out-of-pocket burden depending on severity of illness or acuity of care include the need for air versus ground ambulance, admission to an intensive care unit instead of an observation hospital bed, or a diagnosis of skin cancer versus one of pancreatic cancer.

Preventing Fixed Indemnity coverage from including varying benefit amounts for hospitalization, illnesses, services, and treatments only hurts customers by reducing the number of benefits permitted, and thereby, limiting their opportunity to utilize coverage. Additionally, the proposed benefit limitations do not recognize advancements in medicine and technology, which have resulted in a higher number of less invasive treatments, many of which do not require hospitalization. The inability to take this into account by varying benefits would result in the removal of benefits for non-invasive procedures, which are valuable to consumers and help reduce the financial burden of receiving healthcare.

The NPR would also negatively impact in-force coverage by removing benefits from customers who have paid premiums for this insurance and relied on access to existing benefits available under their Fixed Indemnity coverage. The NPR will force carriers to either risk their products losing excepted benefit status under federal and state law, or to break promises to customers that coverage cannot be changed or cancelled so long as premiums are paid. This is a fundamental contractual promise many carriers make to provide customers with assurance of the financial protection they purchase. We do not oppose issuing updated disclosures to in-force customers. However, in the event the NPR moves forward, we strongly request that the proposed benefit changes not be applied to coverage that is in-force prior to the required application date of the provisions.

An additional, harmful result of the NPR would be drastically limiting customers' opportunity to utilize Fixed Indemnity benefits. Analysis conducted by ACLI's members on common plan designs available in the market today, approximately 80% of the benefits provided by these plans will potentially no longer be available to consumers if the NPR becomes law. This is because benefits could only be *"paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, $100/day)"*, therefore, many valued benefits for items, services, and different types of hospital confinement or illness would not be permitted. This decreased opportunity for utilization of benefits harms consumers because they will lose access to benefits that help pay for out-of-pocket expenses when health events occur and have existed in Fixed Indemnity products for decades. There is ample evidence that increasing out-of-pocket costs associated with medical care harms Americans by increasing their amount of financial debt.[9]

To help quantify the adverse financial impact of the proposed rule on consumers, ACLI engaged Milliman to assist with assessing the expected actuarial impact of the NPR changes on Fixed Indemnity plans, using two illustrative plan designs meant to broadly represent typical plan designs that are available in the market. Plan A is illustrative of a streamlined benefit design largely focused on hospitalization elements, and Plan B is illustrative of a broader Fixed Indemnity benefit offering. If the proposal rule is implemented, the financial support provided by Plans A and B would be

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[9] Lunna Lopez, Audrey Kearney, Alex Montero, Liz Hamel and Mollyann Brodie, *Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills*, KFF, (June 16, 2022) available at: https://www.kff.org/health-costs/report/kff-health-care-debt-survey/.

reduced by 77% and 82%, respectively.[10] This means that for every $1,000 in benefits that would currently be payable under Plan A, only $230 would be payable if the NPR becomes law. Likewise, for every $1,000 in benefits that would currently be payable under Plan B, only $120 would be payable if the NPR becomes law. The following example helps put the impact of the NPR into context for how it actually impacts policyholders.

Suppose that, in addition to comprehensive medical coverage, an individual is covered by Fixed Indemnity Plan B. Under current law, if the individual received $10,000 from Plan B to help pay for out-of-pocket costs associated with a medical event (e.g., loss of income, childcare, transportation, and deductible and coinsurance under a major medical policy), under the NPR, the individual would only receive $1,200. This means that the individual would need to rely on savings or incur health care related debt to help pay for up to $8,800 in benefits that would have been provided under Plan B prior to the NPR changes.

Although the above example is for illustrative purposes only and results could vary based on a particular individual's situation, the example helps highlight that people in less stable or more stressed financial situations may be more adversely impacted by the NPR changes.

Based on this analysis, ACLI concludes that the limited type of Fixed Indemnity benefits permitted under the NPR would significantly reduce consumers' opportunity to utilize their benefits and have an adverse financial impact.

Additionally, analysis by ACLI members demonstrates that the benefit limitations proposed in the NPR would distort the correlation between benefits paid by Fixed Indemnity coverage and financial protection of consumers. This result occurs in different ways whether benefit amounts remain the same, decrease, or increase. For example, if the benefit for hospital confinement in traditional Fixed Indemnity coverage remains at $150 per day and no benefits for services, items, or type of hospitalization are permitted, then a consumer would have little to no financial protection for most out-of-pocket expenses that would be incurred during a serious health event. In 2021, the average cost of a hospital stay was approximately $2,883 per day.[11] Currently, consumers enjoy a higher level of financial protection to help cover the high costs associated with hospitalization that are not covered by comprehensive medical insurance.

If the benefit for hospital confinement in Fixed Indemnity coverage decreased, the harm to consumers would be greater as less financial protection would be provided. Similarly, if the benefit for hospital confinement in Fixed Indemnity coverage is increased to $5,000 per period of confinement to compensate for most other Fixed Indemnity benefits not being permitted, then a customer may often be paid a benefit that was greater than out-of-pocket expenses incurred during a health event. Further, more expensive Fixed Indemnity coverage may be unaffordable for middle-and lower-income earners. We suggest that either outcome is harmful to consumers and contrary to sound public policy for health insurance coverage.

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[10] Ashlee Borcan, FSA, MAAA, Jennifer Howard, FSA, MAAA, *Actuarial Impact on Fixed Indemnity Plans of Tri-Agency Rule Proposal*, (September 2023) available at: [Actuarial impact on fixed indemnity plans of Tri-Agency rule proposal (milliman.com)](milliman.com).

[11] *Hospital Adjusted Expenses per Inpatient Day*, KFF, 2021 available at: https://www.kff.org/health-costs/state-indicator/expenses-per-inpatient-day/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

III. The Federal and State Regulatory Framework Has Consistently Defined Fixed Indemnity Insurance as Excepted Benefits

The current regulatory framework provides ample governance of excepted benefits products, including Fixed Indemnity insurance.

A. Federal Law Has Recognized Excepted Benefits Since 1996

Since Congress enacted the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), health insurance products which meet specific criteria have been regulated as excepted benefits.[12] In enacting HIPAA, Congress explicitly recognized that excepted benefit coverage is different from comprehensive medical coverage and is not subject to the same regulatory standards. This recognition by Congress was reinforced by excepted benefit coverage being excluded from federal requirements that apply to comprehensive health coverage enacted since HIPAA, including in the Mental Health Parity and Addiction Equity Act ("MHPAEA"), Patient Protection and Affordable Care Act of 2010 ("ACA"), and No Surprises Act ("NSA").[13] In *Central United Life Insurance Company v. Burwell*, the U.S. Court of Appeals for the District of Columbia stated "[e]ver 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."[14] As such, since 1996, individual and group health insurance products that satisfy excepted benefit requirements are excluded from federal and state laws applying to health products that provide comprehensive health coverage.

Under federal law, group and individual excepted benefits include health coverage that satisfies requirements of "one or more (or any combination thereof) of the following categories:" 1) benefits not subject to the requirements; 2) limited benefits; 3) independent, noncoordinated benefits; or 4) supplemental benefits. Specific types of excepted benefits are permitted under each category; however, federal law specifically allows for excepted benefit coverage to include combinations of benefits from different categories.[15]

The independent, noncoordinated category of excepted benefits coverage includes Fixed Indemnity and Specified Disease insurance.[16]

B. State Law Establishes Robust Regulation of Excepted Benefits

In the United States, the states have primary regulatory authority over insurance products sold within their borders. Federal law does not establish standards for the filing and approval of excepted benefit insurance products, insurance rates, marketing practices, or many other aspects of insurance regulation. However, federal law does provide a framework for states to follow relative to regulation of excepted benefits.[17] Accordingly, all states have enacted laws defining specific requirements that insurers must satisfy that are applicable to excepted benefit products.

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[12] *See* 42 U.S.C. §300gg-21, 29 U.S.C. §1191a, and 26 USC §9831.
[13] 42 U.S.C. §300gg-26; 26 USC §9812; 29 U.S.C. §1185a; Pub. L. 111-148 (2010); Pub. L. 111–152 (2010); IRC §9816.
[14] *See Cent. United Life Ins. Co. v. Burwell*, 827 F.3d 70 (D.C. Cir. 2016).
[15] *See* 42 U.S.C. §300gg-91(c).
[16] *See* 42 U.S.C. §300gg-21(c)(2), 29 U.S.C. §1191a(c)(2), 26 USC §9831(c)(2).
[17] *See e.g., How To Modernize And Improve The System Of Insurance Regulation In The United States*, Fed. Ins. Office (2013).

States generally adhere closely to the federal framework, though some states establish additional criteria that are further intended to distinguish excepted benefit products from comprehensive medical coverage. Examples of additional state requirements include prominent consumer disclosures that the benefits provided are supplemental and do not provide comprehensive medical insurance, annual insurer certifications to the state insurance commissioner that the coverage is offered and marketed as supplemental health insurance and not a substitute for "primary" health insurance, and restricting issuance of coverage to only customers who have underlying health insurance coverage. Should the NPR be adopted as written, all U.S. jurisdictions would be required to amend existing laws and regulations governing these products to align with the requirements.

C. The NAIC Sets National Standards for Excepted Benefit Regulation

The NAIC is a body of state insurance regulators that sets national standards for insurance regulation with input from consumer advocates and insurers. NAIC Models may then be enacted by state legislatures and regulators. The NAIC continuously works to protect consumers from misleading marketing and unfair trade practices and to set appropriate benefit requirements for excepted benefit coverage.

The NAIC's Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (Model 171) establishes standards for regulation of excepted benefit products. Model 171 has been implemented in whole or in part by a majority of states.[18] The NAIC is currently working on updating Model 171 with the concerns stated in the NPR's preamble in mind. The updates to Model 171 are consistent with current federal law; and include new requirements for consumer disclosures, benefit design, and sales practices that extend beyond existing federal requirements.

Further, the NAIC's Improper Marketing of Health Insurance Working Group ("Working Group") is charged with:

> *Coordinat[ing] with regulators, both on a state and federal level, to provide assistance and guidance monitoring the improper marketing of health plans, and coordinat[ing] appropriate enforcement actions, as needed, with other NAIC Committees, task forces, and working groups.*

The Working Group is actively pursuing revisions to the NAIC's Model Unfair Trade Practices Act (Model 880) that will include new definitions, regulatory authority, and requirements for marketing of supplemental health insurance products, including Fixed Indemnity coverage. These changes reflect the NAIC's recognition that when there is consumer confusion about these products, deceptive marketing, rather than product design, is the primary cause. Similarly, the Departments express concerns in the NPR about inappropriate marketing of Fixed Indemnity products and indicate that is a reason for the current proposals. ACLI puts forth that efforts by the NAIC's Working Group and state insurance regulators will address the Departments' concerns with inappropriate marketing of Fixed Indemnity products and add valuable enforcement tools for state regulators to punish bad actors. Therefore, the Fixed Indemnity proposals in the NPR are unnecessary and should not move forward.

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[18] *See, NAIC Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Model Act (Model 171)*, 1999.

IV. The Proposal Exceeds Federal Rulemaking Authority

The authority for federal regulation of Fixed Indemnity products is provided through statutes initially passed by Congress in 1996 with HIPAA and retained in subsequent legislation enacting new federal health coverage mandates. The enabling statutes state that independent, noncoordinated benefits qualify as excepted benefits if the following requirements are met:

1. *The benefits are provided under a separate policy, certificate, or contract of insurance;*
2. *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;*
3. *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. (Emphasis added).*[19]

A. Fixed Indemnity Benefits Must be Paid with Respect to an Event

As the statutory language clearly states, independent, noncoordinated excepted benefits must be "paid with respect to an event"; however, there are no other benefit criteria limitations specified or reasonably implied from the enabling language. Limitations such as restricting benefits to "per day" or prohibiting benefits for "services or items received", "severity of illness or injury", or "other characteristics particular to a course of treatment received" are not stated in the statute or reasonably implied. Rather, the term "with respect to an event" in plain language broadly encompasses any health-related "event", including treatments, services, procedures, and diagnosis. In the context of Fixed Indemnity insurance, "with respect to an event" necessarily has this meaning as any other meaning would be inconsistent with the purpose for Fixed Indemnity benefits which is to provide financial protection to customers relating to medical events generating out-of-pocket medical expenses. This purpose for Fixed Indemnity benefits has existed for decades and has been recognized by Congress and state insurance regulators.

Further, federal statutes dealing with health coverage define "medical care" and "essential health benefits" as consisting of health care "items and services," requiring Fixed Indemnity benefits to supplement related expenses to effectively support consumers.[20] Similarly, the term "medical care" is defined as amounts paid for "the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body", and "amounts paid for transportation primarily for and essential to medical care."[21] Even the term "hospitalization" itself is considered an "item" or "service" under the ACA.[22] As these definitions illustrate, for Fixed Indemnity benefits to effectively supplement and provide financial protection to customers for healthcare-related out-of-pocket expenses, the benefits necessarily must be permitted for expenses arising from medical treatments, procedures, services, and items.

In evaluating a previous effort by the U.S. Department of Health and Human Services ("HHS") to redefine the criteria for Fixed Indemnity coverage to qualify as an excepted benefit under federal law, the Court of Appeals for the District of Columbia in *Central United Life Insurance Company v. Burwell* held that HHS exceeded its authority. The Court concluded in *Central United Life*:

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[19] *See* 42 U.S.C. §300gg-21(c)(2), 29 U.S.C. §1191a(c)(2), 26 USC §9831(c)(2).
[20] *See* 42 USC §300gg-91.
[21] *See id.*
[22] *See* 42 U.S. Code § 18022(b).

Nothing in the [Public Health Service Act ("PHSA")] suggests Congress left any leeway for HHS to tack on additional criteria.[23] *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."*[24] *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. Chevron, 467 U.S. at 842; see also Ry. Labor, 29 F.3d at 671 (en banc) (rejecting an argument that Step One is satisfied "any time a statute does not expressly negate the existence of a claimed administrative power" as "flatly unfaithful to the principles of administrative law . . . and refuted by precedent").*

Thus, where Congress exempted all such conforming plans from the PHSA's coverage requirements, HHS, with its additional criterion, exempts less than all. Disagreeing with Congress's expressly codified policy choices isn't a luxury administrative agencies enjoy.[25]

The District Court in *Central United Life* explicitly noted that per service benefits are permitted under current law, opining:

The Court recognizes that more severe injury or illness may require more visits or longer periods of disability and thereby increase the amount of benefits paid under a fixed indemnity plan, and does not decide here whether fixed indemnity insurance has always necessarily included benefits paid on a per-service basis. But no matter what "fixed indemnity insurance" means at its margins, any attempt to define that phrase in a way that imports wholly foreign concepts is not an act of definition as this Court understands it.[26]

As the Court stated, the Departments do not have authority to redefine the meaning of Fixed Indemnity coverage by importing "wholly foreign concepts", such as prohibiting paying benefits based on "services or items received", "severity of illness or injury", or "other characteristics particular to a course of treatment received" and limiting benefits to being paid "per day (or per other time period)."

We believe the proposed restriction on Fixed Indemnity benefits covering "services or items received", or varying benefits by "severity of illness or injury" or "other characteristics particular to a course of treatment received" and restricting benefits to being paid "per day (or other period of time)" is without statutory authority and contravenes the federal court rulings in *Central United Life*. The proposed limitations and restrictions on benefits permitted do more than redefine the statutory language enabling Fixed Indemnity excepted benefits. Rather, the Departments' proposal seeks to amend the clear statutory criteria for Fixed Indemnity benefits, which is a right only reserved for

[23] *See* 42 U.S.C. 6 § 300gg-91(c)(3) (defining "excepted benefits" for fixed indemnity plans).
[24] IRC. § 5000A(f)(3).
[25] *See Cent. United Life Ins. Co. v. Burwell*, 827 F.3d 70 (D.C. Cir. 2016).
[26] *See Cent. United Life, Inc. v. Burwell,* 128 F. Supp. 3d 321 (D.D.C. 2015).

Congress.[27] Similarly, the District Court in *Central United Life* stated in regard to an HHS proposed regulation for excepted benefits, "[m]ost likely, HHS intended only to amend the *regulatory* criteria because of course only Congress can amend its statutes. But it's more accurate—and fatally so—to say HHS's rule proposed to 'amend' the PHSA itself."[28]

Based on the forgoing, if the Departments continue to keep Fixed Indemnity in scope for this rulemaking, we encourage the Departments to remove the proposed restriction on paying benefits based on "services or items received", "severity of illness or injury" or "other characteristics particular to a course of treatment received" and remove the proposed limitation for benefits to be paid "per day (or per other time period)."

B. Noncoordination Definition Is Meant to Regulate Employer Behavior and Is Inappropriately Applied to Insurers

The Departments propose a new example to illustrate the meaning of the "no coordination" requirement under federal law for Fixed Indemnity coverage. Proposed Example #3 states:

> *(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 elected together. The benefit packages are not subject to a formal coordination of benefits arrangement.*
>
> *(2) Conclusion. Even if the other conditions in paragraph (c)(4)(ii) of this section are satisfied, the second benefit package's insurance policy does not qualify as an excepted benefit under this paragraph (c)(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.*

ACLI is concerned that this example establishes new criteria for Fixed Indemnity coverage to qualify as an excepted benefit by redefining the meaning of there being "no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor."[29] Further, we are concerned that the example is intended to regulate insurer behavior; however, in reality regulates consumer behavior.

Example #3 indicates that prohibited "implied coordination" exists even when there is no explicit coordination of benefits provision and that prohibited coordination can exist based on an

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[27] See *Cent. United Life Ins. Co. v. Burwell*, 827 F.3d 70 (D.C. Cir. 2016), (stating "HHS described its rule as an attempt to "*amend* the criteria for fixed indemnity insurance to be treated as an excepted benefit." 79 Fed. Reg. at 30253 (emphasis added)).
[28] *See* Id. at 73.
[29] *See* 42 U.S.C. §300gg-21(c)(2), 29 U.S.C. §1191a(c)(2), IRC §9831(c)(2).

employers' decision to offer two or more health plans to employees. Specifically, Example #3 states that prohibited coordination exists when an employer (customer) offers two health coverage benefit packages to employees, and one package "*includes benefits only for preventive services and excludes benefits for all other services"* and a *"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 Departments' conclusion is that this arrangement is prohibited coordination "*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,"* therefore, the second package does not qualify as Fixed Indemnity coverage.

We assert that the Departments incorrectly define the meaning of the statutory "no coordination" requirement by applying the requirement to employer (consumer) behavior, rather than to regulate insurer behavior.[30] Further, adding a criterion that is based solely on customer behavior or actions is unworkable and impermissible as discussed in *Central United Life*. Under the Departments proposed Example #3, an insurer could offer a valid Fixed Indemnity product to employees under a group plan then at some later point the plan sponsor could offer additional coverage to employees that would render the Fixed Indemnity coverage non-compliant with excepted benefit requirements. There is no practical way for insurers to know whether they are offering a Fixed Indemnity product that complies under this interpretation of non-coordination. Also, the example contradicts established state product filing requirements for Fixed Indemnity coverage in that policies and certificates do not include every potential benefit that may be excluded from coverage. As the Court stated in *Central United Life*, the proposed "no coordination" requirements are an "attempt to regulate consumers under a provision directed at providers [insurers]" and "confirms the [Departments'] rule was an act of amendment, not interpretation."[31]

V. The NPR Fails to Meet Standards for Rulemaking Required by Courts and Federal Administrative Standards

When federal agencies create new regulations for the purpose of interpreting law, courts and administrative standards require that: 1) the regulation must be supported by substantial evidence; 2) agencies must consider reasonable alternatives to proposed policy including explaining why other approaches were rejected; and 3) agencies must consider the costs as well as the benefits imposed by the regulation. Further, if federal agencies fail to satisfy any of these elements, courts have held that the agency action creating new regulations is arbitrary and capricious.[32] Additionally, administrative standards require proposed regulations to identify a compelling public need.[33]

ACLI asserts that the NPR's provisions relating to Fixed Indemnity insurance are arbitrary and capricious as the proposed regulations do not establish a compelling public need, are not supported with substantial evidence, policy alternatives to the restrictions were not considered,

[30] *See Cent. United Life Ins. Co. v. Burwell*, 827 F.3d 70 (D.C. Cir. 2016).
[31] *See, id*. at 74.
[32]*Spirit Airlines, Inc. v. United States Dep't of Transp*., 997 F.3d 1247, 1255 (D.C. Cir. 2021) (quoting *Am. Radio Relay League, Inc. v. FCC*, 524 F.3d 227, 242 (D.C. Cir. 2008))(referring to the requirement to consider alternatives; *Genuine Parts Co. v. EPA*, 890 F.3d 302, 307, 312 (D.C. Cir. 2018) (citing *Butte Cty. v. Hogen*, 613 F.3d 190, 194 (D.C. Cir. 2010) and *Ctr. For Auto Safety v. Fed. Highway Admin.*, 956 F.2d 309, 314 (D.C. Cir. 1992)(referring to the requirement for substantial evidence); *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co*., 463 U.S. 29, 54 (1983) (referring to the requirement to consider costs as well as benefits).
[33] Exec. Order No. 12866, 58 C.F.R. 51735 (October 4, 1993); *see also* Exec. Order No. 13563 76 C.F.R. 3821 (January 21, 2011).

and a reasonable cost-benefit analysis was not considered. Instead, the proposed regulations are based on vague, anecdotal, and inaccurate information regarding Fixed Indemnity coverage, which does not meet the required standards federal agencies must meet.

A. The NPR Fails to Provide Substantial Evidence or Identify a Compelling Public Need to Justify Federal Rulemaking

Agencies are required to provide more than a scintilla of evidence to support rulemaking.[34] As discussed in detail below, the Departments fail to meet this required evidentiary standard in the NPR. In addition to providing substantial evidence, agencies must identify a compelling public need that the regulation is intended to address as well as assess the significance of the problem[35] and show a likelihood that the action taken will be effective.[36] Decisions made by agencies should be based on the "best reasonably obtainable scientific, technical, economic, and other information concerning the need for, and consequences of, the intended regulation."[37] In 2023, President Biden reaffirmed these principles in an Executive Order.[38] The NPR relies heavily on anecdotal evidence and news articles and blog posts rather than the best reasonably obtained evidence, such as peer-reviewed studies or hard data. It also does not demonstrate how the proposed changes would be effective in addressing the underlying issue. Therefore, the NPR fails to demonstrate a compelling need and fails to include substantial evidence to support the stated problem.

1. The NPR Fails to Demonstrate a Compelling Public Need for Regulatory Action

The stated purpose of the NPR is to "more clearly distinguish [Fixed Indemnity insurance] from comprehensive medical coverage and increase consumer awareness of coverage options that include the full range of Federal consumer protections,"[39] with the ultimate goal of addressing the concern that consumers are purchasing Fixed Indemnity products as a substitute for comprehensive medical coverage.[40] This concern stems from the relatively rare instances of fraudulent marketing tactics where Fixed Indemnity policies are marketed as an alternative to comprehensive coverage and the limited nature of the product is not explained.[41] However, the NPR fails to provide any evidence that consumers are purchasing Fixed Indemnity policies to substitute comprehensive medical coverage at a rate or frequency that would justify federal rulemaking or that the provisions restricting the structure of Fixed Indemnity insurance is the appropriate response to the concern.[42] This concern represents a very small percentage of the market and complaints on fixed indemnity products and are very low relative to the millions of individuals covered.[43] The NPR itself identifies only one consumer who erroneously believed they

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[34] *FPL Energy Maine Hydro LLC v. FERC*, 287 F.3d 1151, 1160 (D.C. Cir. 2002).
[35] *See* executive orders cited *infra* note 27.
[36] OMB Circular A-4 3, 4 (September 17, 2003).
[37] Exec. Order No. 12866 at 51736.
[38] Exec. Order No. 88 C.F.R. 14904, 21879 (April 6, 2023).
[39] Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance, 88 Fed. Reg. 44604 (proposed July 12, 2023) (to be codified at 26 C.F.R. pts. 1, 54; 29 C.F.R. pt. 2590; 45 C.F.R. pts. 144, 146, 148).
[40] *See id*. at 44605.
[41] *Id.* at 44607.
[42] *Id.* at 446707 n.100 (The articles the NPR cites to contain no data and rely on interviews with regulators from 4 states and the District of Columbia. There is no evidence to show the problem is widespread); 44620 (providing no evidence for the HHS's view that fixed indemnity products closely resemble comprehensive coverage and confuse consumers).
[43] *AHIP-ACLI-BCBSA 2023 Survey: Fixed Indemnity & Specified Disease Plans*, (September 7, 2023) available at: AHIP-ACLI-BCBSA 2023 Survey: Fixed Indemnity & Specified… - AHIP. Of all Fixed Indemnity policies/certificates sold, .0003% had complaints in 2022, which are not limited to confusion about the products or benefits offered.

had comprehensive medical coverage.[44] Additionally, the NPR does not address the data that shows an all-time low in the rate of people in the U.S. who are uninsured.[45]

Further, the Departments fail to prove the significance of the perceived problem by showing virtually no data and referencing vague reports and articles which, even taken together, do not demonstrate a compelling public need to warrant federal rulemaking. Moreover, the NPR fails to distinguish between STLDI and Fixed Indemnity insurance, which are two very different types of insurance. In fact, only Fixed Indemnity insurance is an excepted benefit and is designed to provide financial protection to consumers by providing benefits to help reduce the impact of out-of-pocket expenses associated with health events. In contrast, STLDI is a form of primary medical coverage with a short duration and is not an excepted benefit. This distinction is essential in understanding why anecdotes and data regarding STLDI cannot be extrapolated to also describe or apply to Fixed Indemnity insurance. The Departments' reliance on information about STLDI to justify a compelling need for Fixed Indemnity regulations is inaccurate, misplaced, and meritless, and indeed serves only to conflate and confuse two separate types of products and issues.

For example, the NPR asserts that consumers covered by STLDI and Fixed Indemnity insurance face high out-pocket-costs and limitations on coverage for treatment related to COVID-19.[46] However, the support for this assertion only considered STLDI.[47] Additionally, the discussion in the preamble of the NPR regarding negative impacts of both STLDI and Fixed Indemnity products on ACA risk pools used data solely limited to STLDI.[48] The NPR inappropriately extrapolates that the negative impacts on ACA risk pools posed by STLDI potentially extends to Fixed Indemnity products; [49] however, the differences between the two types of products are such that assertions made about STLDI cannot appropriately be applied to fixed indemnity insurance.

2. The NPR Fails to Provide Substantial Evidence Supporting the Need for Regulatory Action

The Departments express concern throughout the preamble of the NPR about inappropriate marketing tactics by sellers of Fixed Indemnity insurance.[50] However, the Departments fail to provide any substantial evidence, and their justification does not meet the evidentiary standard set forth in case law, that the marketing and sales practices are widespread or that consumers who are unaware of the limitations of Fixed Indemnity coverage represent a significant portion of the market. An article referenced in the NPR provides examples of four consumers who were misled about their coverage.[51] This article also references employers offering "skinny" medical plans alongside Fixed Indemnity coverage, however many of the internet links provided in the report as support for the assertions are no longer available.[52] The article repeatedly cites to one insurer to illustrate problems with Fixed Indemnity coverage and the NPR cites to a different article as support for extensive variable benefit structures in Fixed Indemnity plans that also only refers to the same insurer.[53]

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[44] 88 Fed. Reg. at 44608.
[45] Dreher, Arielle, "Uninsured Rate Hit Record Low in Early 2023, CDC Says," (August 3, 2023) available at: [Uninsured rate hit all-time low in early 2023 (axios.com)](https://www.axios.com).
[46] 88 Fed. Reg. at 44607.
[47] *Id.* at n. 96.
[48] *Id.* at 44608-09.
[49] *Id.* at 44609.
[50] *Id.* at 44607.
[51] *Id.* at 44608 n. 101.
[52] *Id.*
[53] *Id.*, at 44621 n. 171

It is wholly inappropriate to extrapolate that a single insurer's practices are representative of the market of carriers that offer Fixed Indemnity coverage. Also, the insurer cited has a very limited market share, files products in a small number of states, and has a model for Fixed Indemnity products that is very different from those Fixed Indemnity products typically filed by insurers and approved by state regulators throughout the country. Another article referenced by the NPR as evidence for the Departments' concerns about inappropriate marketing of these products relies on anecdotal evidence from regulators in four states and the District of Columbia, but provides no data, and the article's discussion with the regulators was not limited to Fixed Indemnity insurance.[54]

The NPR also fails to cite any comprehensive, peer-reviewed study as support for a compelling public need that justifies extensive federal regulatory changes or the creation of a dual federal/state regulatory scheme as would result under this NPR. In fact, the assertions throughout the preamble of the NPR rely on very little data specific to Fixed Indemnity insurance. The sweeping regulatory changes and federal pre-emption of state regulatory functions proposed in this regulation should not be based on such limited research. The Departments failed to meet the standard to provide substantial evidence and to rely on the best reasonably obtained information.

3. The NPR Fails to Demonstrate that Rulemaking Would Be Effective

The Departments identified the inappropriate marketing of Fixed Indemnity coverage as the public need addressed in the NPR. However, no part of the NPR seeks to regulate the marketing of Fixed Indemnity coverage, and the Departments fail to show that the proposed changes would be effective in addressing this stated public need. The NPR acknowledges that Fixed Indemnity benefits serve best as a supplement to comprehensive coverage.[55] The concern the NPR attempts to address relates only to the marketing of Fixed Indemnity coverage as an alternative to comprehensive medical coverage. The NPR asserts that there is a heightened risk to the individual ACA market due to the decision in the *Central United Life* case and change to the "individual shared responsibility" payment under the *Tax Cuts and Jobs Act of 2017*[56], but does not elaborate as to the particular nature of the potential risk. Further, the stated risk is only identified when the sale of Fixed Indemnity coverage involves inappropriate marketing.[57]

The NPR also concludes that consumers enrolled in STLDI are more likely to be subjected to higher out-of-pocket costs than they would be had they enrolled in comprehensive coverage.[58] When making a similar point with Fixed Indemnity benefits, the regulation states,". . . consumers who enroll in fixed indemnity benefits coverage *as an alternative* to comprehensive coverage bear similar risk and exposure to significant out-of-pocket costs . . . ."[59] This highlights that the concern is not with the products themselves, but with how the products are used by consumers. Also, STLDI coverage is intended to pay for primary healthcare services and treatments; in contrast, Fixed Indemnity coverage is intended to provide consumers with fixed benefits to help pay for out-of-pocket expenses that are not covered by comprehensive medical coverage. Again, the NPR fails to provide any evidence that consumers purchase Fixed Indemnity products as an alternative to comprehensive medical coverage frequently or that they do so when Fixed Indemnity Insurance

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[54] *Id.* at 44607 n. 100, at 44623 n. 182.
[55] *Id.* at 44606-07.
[56] 47 Pub. Law 115-97.
[57] *Id.* at 44609.
[58] *Id.* at 44606.
[59] *Id.* (emphasis added).

is properly marketed or sold. In fact, as stated above, the rate of people who do not have comprehensive medical insurance in the U.S. is at an all-time low.[60]

Eliminating financial protection benefits from Americans who rely on them to protect their household budgets from continually rising out-of-pocket healthcare costs, as would be required under this NPR, is not the answer to the Departments' valid concern with improper marketing which is caused by a few bad actors who market Fixed Indemnity plans as an alternative to comprehensive insurance. Indeed, the ACLI agrees that improper marketing behavior needs to be addressed regardless of the small portion of the market it represents. However, instead of the NPR, the state-based regulatory system should address the improper marketing of these products. If implemented as drafted, the NPR would not address the problem of improper marketing and presentation of Fixed Indemnity benefits to the public, instead creating more problems and harm to be borne by consumers. Bad actors would still misrepresent Fixed Indemnity coverage to consumers using the same methods they currently use today. Instead, the NPR will have the unintended consequences of leaving even more people unprotected from financial debt arising out of a health event.

Data supports the conclusion that addressing misleading marketing practices would more effectively address the problems identified by the Departments. A recent Georgetown University "secret shopper" study by the Center for Health Insurance Reforms supports the argument that the changes in the NPR to the product design would be ineffective in addressing the marketing problem. The secret shopper study created consumer profiles for two hypothetical consumers who have lost Medicaid eligibility and are seeking inexpensive medical insurance, and then fielded 20 calls, limited to one state, seeking different types of limited benefits.[61] The study was able to identify two fixed indemnity plans that were improperly presented to the secret shopper, but noted that, in most cases, not enough information was provided to identify the type of plan.[62] The study also found that representatives provided false and misleading information including misleading comparisons between limited benefits and comprehensive coverage.[63] Out of all 20 calls, only two written documents were provided and only one in its entirety.[64] Since the problem identified was the improper and misleading presentation of products, most of which were not clearly identifiable as Fixed Indemnity products, the changes in the NPR specific to Fixed Indemnity benefits would not have protected the two hypothetical consumers from being misled on the products being presented to them.

The Departments failed to provide substantial evidence that the identified misleading marketing practices are widespread and justify a need for federal rulemaking. They also failed to provide a reasoned analysis that the proposed provisions would be effective in addressing the problem.

B. The NPR Fails to Consider Appropriate Regulatory Alternatives

Federal agencies are mandated to consider available regulatory alternatives, including not regulating, and to only promulgate regulations when necessary, for example where there is a

[60] See infra note 40.

[61] Schwab, Rachel and JoAnn Volk, "The Perfect Storm: Misleading Marketing of Limited Benefit Products Continues as Millions Losing Medicaid Search for New Coverage," 3, (August 2023) available at: Perfect Storm Misleading Marketing(7.31.23).pdf | Powered by Box.

[62] *Id.* at 4.

[63] *Id.* at 4-5.

[64] *Id.* at 5.

compelling public need.[65] Current OMB Circular A-4, issued as guidance on Executive Order 12866, includes an examination of alternative approaches in its list of key elements for a good regulatory analysis.[66] In evaluating the choices, an agency should prioritize flexibility and freedom of choice for the public[67] while ensuring that the regulations "impose the least burden on society including, individuals, businesses of differing sizes, and other entities (including small communities and governmental entities) . . ."[68] The NPR is inconsistent with these principles and runs afoul of these requirements, which were reaffirmed by President Biden earlier this year.[69]

The NPR fails to consider any alternatives to regulation, nor does it consider alternative approaches to resolving the identified public need relating to improper marketing of Fixed Indemnity coverage. This lack of consideration is especially problematic because the Departments have identified a marketing problem, as outlined above, but are attempting to address it through restrictions on the products themselves, without completing a full regulatory analysis of alternative approaches. There are several alternative considerations the Departments could have considered, as follows:

- More appropriate options to address the fraudulent marketing and inappropriate presentation of these products by a small number of actors. There was no discussion in the preamble of the NPR of involving other federal agencies such as the Federal Trade Commission ("FTC"), the Federal Communications Commission, and the Department of Justice or working with the NAIC or state regulators to enforce laws prohibiting such fraudulent mis-marketing. State regulators have been working with these federal agencies to identify and penalize bad actors. A recent example is the FTC action against Benefytt Technologies which resulted in $100 million in refunds.[70]

- Only requiring a new consumer notice as an alternative to adding restrictions on the product design for Fixed Indemnity insurance.

- Deferring to state regulatory activity or working with the states. The NAIC's "Improper Marketing of Health Insurance Working Group" is in the process of amending the NAIC Model Unfair Trade Practices Act. This will give states more authority to regulate lead generating entities, a small number of which have been identified as perpetrators of improper marketing practices. The NPR does not acknowledge the appropriate role of the states in regulating the marketing and sales of these products, and instead asserts federal preemption of state regulatory authority over these benefits and products. The NPR creates federal minimum standards that go far beyond those used to determine whether benefits meet the legal requirements for excepted benefit status. It also leaves no decision-making authority to the states to modify the standards to assure the continued availability and affordability of these benefits, which is a fundamental responsibility of state regulators.

[65] *Spirit Airlines* F.3d at 1255 (quoting *Am. Radio Relay League* F.3d at 242); *see also* Exec. Order No. 12866 at 51735, 51736; Exec. Order No. 13563 at 3821.
[66] Circular A-4, 2 (September 17, 2003).
[67] Exec. Order No. 13563 at 3822.
[68] Exec. Order No. 12866 at 51736.
[69] Exec. Order No. 14904 at 21879.
[70] *FTC Action Against Benefytt Results in $100 Million in Refunds for Consumers Tricked into Sham Health Plans and Charged Exorbitant Junk Fees*, FTC Press Release, (August 8, 2022) available at: https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-action-against-benefytt-results-100-million-refunds-consumers-tricked-sham-health-plans-charged.

- Congress, through its passage of the McCarran-Ferguson Act and subsequent amendments, continues to conclude that the states, by virtue of their proximity and responsibility to consumers and expertise, are best suited to regulate the business of insurance as a critically important part of the nation's economy. In passing the ACA, Congress explicitly recognized the status of excepted benefits as health coverage that is exempt from HIPAA and ACA requirements (HIPAA excepted benefits) and therefore properly regulated by the states. At several points in the preamble of the NPR, the Departments purport to permit the federal government the authority to exercise enforcement authority over insurers by stating that they will "closely examine as part of potential enforcement actions" whether insurers' fixed indemnity products are in compliance with the minimum standards they have established for qualification as a HIPAA excepted benefit. This purported authority to exercise enforcement actions creates a dual regulatory structure and undermines the regulatory integrity and enforcement authority of state insurance regulators. No federal laws alter the jurisdiction of the states over, and responsibility for, insurance regulation; nor enable the dual federal and state regulation of insurance companies' market conduct, minimum standards, and solvency. Therefore, the lack of recognition of the role of states in regulating these products and the provisions of the NPR usurping state regulatory authority over Fixed Indemnity are inappropriate, subject to challenge, and do not meet the requirement that the Departments must initiate a process to determine whether states have failed in their role as insurance regulators to enforce federal standards prior to taking action. Again, the NPR failed to consider deferring to state regulatory activity or working with the states.

- Coordinating with the working group under the NAIC Accident and Sickness Insurance Minimum Standards Subgroup which has been reviewing and updating the minimum standards for products including fixed indemnity for a few years by working with various stakeholders. The Departments did not consider waiting to address Fixed Indemnity products until the new Other Health Market Conduct Annual Statement data (a new data call that the NAIC has developed to gather annual data on Supplemental Benefits and STLDI products) is received and analyzed by states in 2024. This data would have provided crucial information to federal regulators regarding products that they do not actively regulate and approve.

As the NPR fails to meet the requirement to consider alternatives to the insurance policy restrictions proposed, it also fails to meet the requirement to provide a reasoned explanation for the rejection of such alternatives. Several alternatives should have been considered prior to taking action that would usurp the role of the states in regulating insurance and require contractual promises to consumers to be vacated. The NPR is arbitrary and capricious for failing to consider less burdensome and intrusive alternatives that would meet the stated goal of protecting consumers from fraudulent marketing without harming consumers and infringing on the states' regulatory role.

C. The Departments Failed to Conduct an Appropriate Regulatory Impact Analysis

An agency must consider the costs and benefits of its proposed rulemaking. It is arbitrary and capricious when an agency has "entirely failed to consider an important aspect of the problem [or] offered an explanation that runs counter to the evidence before the agency."[71] An agency "cannot

[71] *Genuine Parts Co.* 890 F.3d at 312 (quoting *State Farm* 463 U.S. at 43).

ignore evidence that undercuts its judgment; and [they] may not minimize such evidence without adequate explanation.[72] The opinions of those who would be affected should be sought throughout the rulemaking process – not just in the final stages.[73] While there is no one-size-fits-all approach to good regulatory analysis, the NPR does not provide a proper cost-benefit analysis to justify the cost impacts, most of which are not included in the regulatory impact analysis. It entirely failed to consider the costs to consumers providing no evidence that Fixed Indemnity insurance is beneficial to consumers such as was recognized by CMS in a proposed regulation in 2014.[74] The 2014 final regulation also recognized that limiting choice in Fixed Indemnity insurance could harm consumers.[75] The Departments ignored this evidence with no explanation and failed to consider the harm the NPR could cause consumers, especially those who are currently covered by Fixed Indemnity insurance. The Departments provided no explanation for this change in position, which is itself "a reason for holding an interpretation to be an arbitrary and capricious change . . . ."[76]

The summary of impacts fails to include any analysis on benefits that would be lost and/or premiums increased for Americans who currently have Fixed Indemnity policies or certificates.[77] It fails to consider that the restrictions the NPR would impose would likely render the products either unaffordable or without value, which affects consumers who may want to purchase these products in addition to those who are already covered.[78] Much of the data in Tables 1 and 2 in section VII (B)(2) of the NPR is limited to STLDI.[79] The NPR also provides no data in the discussion related to the number of affected entities and the Departments note that they are unaware of any way to determine the number of individuals enrolled in fixed indemnity coverage.[80]

The Departments could have sought this information from insurers or ACLI and other trade associations in order to come to an estimate consistent with the requirement in Circular A-4 to seek opinions of affected stakeholders who will have special knowledge of the issues.[81] The agencies would have learned that approximately 8,163,560 people are covered by Fixed Indemnity benefits.[82] The Departments seek this information in comments, but Circular A-4 instructs that a good regulatory impact analysis will not wait until the final stages to engage with stakeholders.[83]

In the discussion on benefits, the NPR assumes that consumers will switch from Fixed Indemnity insurance to comprehensive medical coverage. But there is no basis for this assumption, nor recognition that many currently covered are already enrolled in comprehensive coverage.[84] As discussed above, there is also no evidence that the NPR's provisions related to Fixed Indemnity insurance would lead to an increase in enrollment in comprehensive medical coverage. Another benefit asserted in the NPR's preamble is the likely reduction in out-of-pocket expenses and medical debt/bankruptcy.[85] However, the NPR does not explain that, when purchased as

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[72] *Genuine Parts Co.* 890 F.3d at 312.
[73] Circular A-4 at 3.
[74] 79 FR 15807, 15819 (March 21, 2014).
[75] 79 FR 30240, 30256 (May 27, 2014).
[76] *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 222 (2016) (quoting *National Cable & Telecommunications Assn. v. Brand X Internet Services*, 545 U.S. 967, 981 (2005)).
[77] *Id.* at 44639-41.
[78] *Id.*
[79] *Id.* at 44640-41.
[80] *Id.* at 44643.
[81] Circular A-4 at 3.
[82] *AHIP-ACLI-BCBSA 2023 Survey: Fixed Indemnity & Specified Disease Plans*, (September 7, 2023) available at: AHIP-ACLI-BCBSA 2023 Survey: Fixed Indemnity & Specified… - AHIP.
[83] Circular A-4 at 3.
[84] 88 Fed. Reg. at 44643.
[85] *Id.* at 44644.

supplements to comprehensive medical insurance as intended, Fixed Indemnity insurance actually reduces out-of-pocket expenses and helps prevent medical debt/bankruptcy.[86]

The NPR fails to address the costs associated with the proposed restrictions to Fixed Indemnity insurance or which benefits currently enjoyed by Americans would become unaffordable or lose value.[87] In fact, consumers are overwhelmingly satisfied with Fixed Indemnity coverage and do not want to lose their benefits that provide financial protection and peace of mind as shown above.

Although the NPR acknowledges that consumers have purchased these products in reliance on requirements that allow for more value than the requirements here, that acknowledgement is only in relation to the effective date, and the analysis does not extend further.[88] For example, the cost impact on existing customers is not analyzed.[89] Similarly, an analysis into the impact of insurers being forced to break contracts with their customers is not included. Fixed Indemnity insurance is often either noncancelable or guaranteed renewable meaning that in both cases, the insurer cannot change the benefits of the policy and the policy renews as long as the premiums are paid on time. For noncancelable policies, the insurer cannot change the premium, as well. There is no contemplation of these contractual obligations in the NPR and how it would harm consumers, who have been paying premiums expecting certain benefits, to have their contracts broken.

In this sense, the NPR would create the problem it purports to address. Consumers who purchased a product with a certain understanding of the benefits would be left either with a product offering less benefits or no product at all if they cannot afford the premium increases required to create a valuable product that complies with the regulation. In either case, policyholders would not receive the coverage they thought they had purchased due to the restrictions that would be imposed by the federal government. These consumers are left out of the discussion around costs completely.[90]

Although reduction of medical debt is mentioned as a benefit of the proposed NPR,[91] the potential for a rise in medical debt due to consumers either losing coverage completely or losing benefits is not discussed as a cost, thus failing to consider the people the regulation purports to protect.[92] A survey found that 100 million Americans experience healthcare debt.[93] Medical debt can negatively affect health by causing individual to delay or avoid medical care because of the cost, and can force people to sacrifice essentials like groceries, and deplete savings.[94] Another study found that private health insurance leaves a lot of costs uncovered and can offer little protection against high

[86] *Id.*
[87] *Id.* at 44640, 44644.
[88] 88 Fed. Reg. at 44647.
[89] *Id.* at 44640, 44644.
[90] 88 Fed. Reg. at 44644.
[91] *Id.*
[92] *Id.* at 44640, 44644.
[93] Lopes, Lunna and Audrey Kearny, Alex Montero, Liza Hamel, and Mollyann Brodie, "Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills," (June 2022) available at: Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills | KFF.
[94] Himmelstein, David and Samuel Dickman, Danny McCormick, et. al., "Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US," (September 2022) available at: Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US | Health Policy | JAMA Network Open | JAMA Network.

bills.[95] Middle income earners have the highest rate of medical debt at 23.5%.[96] Of those middle income earners, people of color experience a higher level of medical debt.[97]

With comprehensive insurance leaving high costs uncovered, it is not surprising that many middle-income earners turn to Fixed Indemnity insurance to help cover those costs. Removing the option harms those people. A survey targeting adults with annual incomes between $50,000 and $100,000 found that 83% say that supplemental insurance benefits are valuable and 85% believe the federal government should protect access to them.[98] That same survey found that 89% see value in having the option to protect themselves and their households from medical expenses that could cause financial hardship and 38% describe out-of-pocket medical expenses as a financial hardship.[99]

The restrictions the NPR would impose on the products would remove benefits in a best-case scenario. Most likely they would make the products less available to many who rely on them or may wish to purchase them. Given rising medical debt, desire from consumers for options for financial protection from medical debt, and the satisfaction rates of consumers who are covered by Fixed Indemnity insurance; the NPR should have factored in the loss of benefits and availability of the products into the cost benefits analysis.

The NPR proposes to protect consumers, but the cost-benefit analysis completely excludes costs to consumers and fails to provide evidence for stated benefits of the NPR. The Departments provided no analysis showing that limiting the availability of these products is beneficial to consumers, which is contrary to assertions provided in prior rulemaking. It is arbitrary and capricious to propose such restrictive provisions without properly considering how consumers could be harmed and ignoring evidence that Fixed Indemnity insurance is beneficial to consumers.

VI. The NPR's Applicability Dates are Unworkable and Would Place an Undue Burden and Unaccounted-For Costs on State Insurance Regulators and Insurers

The Departments propose bifurcated applicability dates for the proposed Fixed Indemnity regulations. Should the Fixed Indemnity proposals in the NPR be finalized, the Departments propose that changes to payment standards and the non-coordination requirement be applicable as soon as 75 days after the final regulations are published in the Federal Register (the "Effective Date"). Further, the Departments propose applicability as follows:

1. For policies sold or issued on or after the regulation Effective Date, the changes would apply in plan years (for group market policies) and coverage periods (for individual market policies) beginning on or after the Effective Date; and
2. For policies sold or issued before the Effective Date, the changes would apply in plan years and coverage periods beginning on or after January 1, 2027.

Separate from the timelines outlined above, the proposed notice requirement would apply to all Fixed Indemnity coverage, regardless of when issued, in plan years (for group market policies) and coverage periods (for individual market policies) beginning on or after the Effective Date.

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[95] *Id.*
[96] Murdock, Kylie and Joshua Kendall, David Kendall, "Medical Debt Hits the Heart of the Middle Class," (August 2023) available at: Medical Debt Hits the Heart of the Middle Class – Third Way.
[97] *Id.*
[98] "Supplemental Insurance Benefits Survey" at 5.
[99] *Id.* at 6, 10.

A. Application to Policies Issued on or After the General Effective Date

If, contrary to our recommendations, the NPR relative to Fixed Indemnity coverage is finalized, more lead time than 75 days will be required for issuers and employers to comply with the requirements proposed for new policies. Issuers would need time to evaluate product offerings and premium rates as well as revise forms and refile policies with states for approval (a process that typically takes many months), and design and implement internal system technology to ensure that systems are prepared to properly handle the new products. Employers will also need time to re-evaluate benefit package options and prepare enrollment materials. In most cases policy forms and employer benefit programs are set out (and communicated) months, or even years, in advance. We also note that the form and rate filing process is costly both for insurers and state regulators. The costs of this work will be substantial since it requires the refiling and review of all versions of Fixed Indemnity products by all insurers and regulators in all states. These costs have not been acknowledged or accounted for in the NPR, in violation of Administrative Procedures Act ("APA") requirements.[100]

B. Application to Policies Issued Before the General Effective Date

Fixed Indemnity excepted benefits policies are generally sold to individuals on a "guaranteed renewable" or "non-cancellable" basis. This means that as long as the policyholder continues to pay premiums, the issuer cannot cancel the policy or make changes to benefits or premium amounts. In the case of group coverage, policies are often sold with rate guarantees in place that also contractually bind the insurer to the originally offered premiums or benefits unless requested by the policyholder. The NPR proposes to apply each of the benefit and tax treatment changes to all in-force and new policies. This proposal would result in insurers breaching the contract they have with the policyholder in order to comply with the NPR. Beyond the negative impact to consumers, agencies lack the authority to effect this type of retroactive change without express authorization from Congress.[101] The Departments have not been given that specific authority relative to Fixed Indemnity coverage.[102] Therefore, we request that in-force policies be exempted from the requirements of the finalized rule.

Should the NPR relative to Fixed Indemnity coverage be finalized contrary to our recommendations, we request that new requirements for payment standards and non-coordination not apply to coverage issued after January 1, 2027 ("Recommended Effective Date"). Similarly, we request that the notice requirement for all individual and group coverage, regardless of when issued or sold, not apply until the Recommended Effective Date. There are currently strong notices required in most states and consistency in effective dates will create less administrative burden for state regulators and those making the extensive product changes required in this NPR.

VII. The NPR Imposes a Tax Increase on Policyholders and Small Businesses and May Reduce the Availability of Financial Protection Options

For a more detailed discussion of ACLI's comments related to the tax portion of the NPR please refer to Appendix A. ACLI's comment letter incorporates Appendix A.

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[100] 5 U.S.C. §§ 551–559.

[101] *Cox v. Kjakazi*, 2023 U.S. App. Lexis 19399 (D.C. Cir. July 29, 2023), at *15 (citing *Bowen v. Georgetown Univ. Hosp*., 488 U.S. 204, 208 (1988)).

[102] ERISA § 707, Code § 9086 and PHS Act § 2792 authorize the agencies to issue regulations as necessary to carry out the federal health care requirements; however, those sections do not authorize retroactive changes.

The NPR also seeks to apply new tax requirements to employees and employers for customers who pay premium for Fixed Indemnity and/or Specified Disease and certain similar coverage that qualifies as an independent, noncoordinated excepted benefit under Internal Revenue Code ("IRC") § 9832(c)(3) ("NCBs") with pre-tax funding. ACLI is concerned that imposing new taxes on employees and employers will have a significant, detrimental effect on employees' ability to purchase Supplemental Health products and employers' willingness to offer the coverage.

Although the U.S. Department of the Treasury ("Treasury") and the Internal Revenue Service ("IRS") refer to the NPR as a "clarification," the changes are a drastic departure from current law, resulting in a tax increase on individuals receiving Supplemental Health[103] benefits. Currently, policyholders are taxed only on NCB benefits to the extent they exceed an individual's medical expenses ("the excess benefit rule"), and NCB benefits are not wages for payroll tax purposes. The NPR would recharacterize the full amount of NCB benefits as wages and impose income and payroll taxes. Individuals receiving NCB benefits will have recently experienced a serious health-related event and should not have an increased tax liability. Additionally, if fixed NCB are subject to payroll taxes, employers will be less likely to offer NCB coverage.

A. Tax Avoidance Schemes Should be Addressed Directly

The life insurance industry shares the concerns of Treasury and the IRS regarding arrangements that are marketed as supplemental coverage and purport to avoid reporting and imposition of income and payroll taxes. NCB insurance, however, is very different from the product used in recent tax avoidance schemes yet would be subject to the NPR. The IRS should continue to address abusive arrangements through targeted guidance, public outreach, and enforcement action, not through an overly broad regulation with far-reaching consequences for millions of Americans who rely on NCB insurance to protect them from the unexpected costs of medical events.

B. The Excess Benefit Rule Has Been in Effect for More than 60 Years

The NPR is a departure from more than 60 years of law and formal and informal guidance. The IRS and Treasury have repeatedly affirmed the "excess benefit rule," (defined in Appendix A page 3) in regulations, revenue rulings, private letter rulings, IRS publications, and Presidential budget proposals. The NPR would arbitrarily eliminate the excess benefit rule for NCB insurance, increasing taxes on policyholders who have recently suffered an unplanned health-related event, and incurred out-of-pocket expenses that are not covered by comprehensive medical insurance.

C. The NPR Arbitrarily Presumes that NCB Insurance Benefits Are Not Used to Pay for Medical Expenses and Do Not Qualify for the Exclusion Under IRC §105(b)

The NPR states that 100% of any NCB benefit is taxable because NCB insurance is not reimbursement for medical expenses. This is an inaccurate view. While NCB policies may not be marketed as paying for medical expenses and may not base payment of benefits on expenses incurred for medical care, the health-related events covered by NCB insurance, such as cancer, heart attacks, and hospitalizations, invariably give rise to medical expenses that are not covered by

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[103] While we use the term "NCB" throughout our comments, the NPR generally refers to policies that pay a fixed benefit on the occurrence of a medical event as "fixed indemnity." Many kinds of noncoordinated benefits including fixed indemnity, hospital indemnity, specified disease, and accident only insurance meet that definition. See IRC §9832(c)(1)(A);(c)(3);Treas. Reg. §54.9831-1(c)(2)(i),(c)(4).

comprehensive medical insurance, such as co-pays, travel costs, special clothing, household modifications, out of network providers, and experimental or investigative medical treatments. The indemnity benefits issued under an NCB policy may be used for whatever the insured person wishes, including to pay medical expenses not covered by comprehensive major medical insurance. Further, any policy benefits that are not used to pay medical expenses are subject to income tax.

D. The NPR is Contrary to Congressional Intent

Over the past 60 years, Congress has repeatedly revisited the rules applicable to employer-paid health insurance without making changes that would make NCB benefits fully taxable. Treasury and the IRS propose to change this decades-long tax treatment, where Congress has clearly left the longstanding rule for the taxation of excess reimbursements for medical expenses intact. Such a fundamental change to the rule that would impact an entire market should only be affected legislatively.

E. NCB Benefits Are Not Disability Income Payments

Benefits under disability income policies are triggered by an absence from and inability to work and are a replacement for earned income. In contrast, NCB benefits are not income replacement. The policies pay based on specific health-related events, such as a hospital stay or a diagnosis of a specified disease (such as cancer). NCB benefits cover individuals who may not be employed and pay benefits even if a policyholder continues working after a health-related medical event or has disability coverage. This is because medical related out-of-pocket expenses that NCB benefits may help cover are unrelated to an individual's employment or earnings status.

F. NCB Benefits Are Not Wages for Purposes of Income Tax Withholding or the Federal Insurance Contributions Act ("FICA") or Federal Unemployment Tax Act ("FUTA") Tax

The NPR presumes that NCB benefits are subject to payroll taxes without proposing underlying regulatory changes to impose wage treatment on NCB benefits. Indemnity benefits issued by third-party insurance companies in the event of a triggering medical condition are not wages within the plain meaning of the term. Furthermore, there is a longstanding distinction between insured and uninsured employer health plans that is reflected in the Internal Revenue Code, Treasury Regulations, and the applicable legislative history. Additionally, Temporary Treasury Regulation §32.1 was promulgated without notice and comment with the intention that it apply to disability payments and is not valid as applied to NCB benefits.

G. Information Reporting Guidance on Fixed Indemnity Benefits Would Be Helpful

If Treasury and the IRS agree that longstanding guidance on NCB benefits should not be changed, insurance companies would benefit from direction as to how NCB benefits should be reported. There is no form available that permits insurance companies to indicate that an NCB benefit payment may not be taxable, subject to the excess benefits rule. Additionally, if Treasury and the IRS impose wage treatment on NCB benefits, a framework similar to the framework for third-party sick pay will need to be established to report NCB benefits. We believe such a framework is impossible here because, unlike disability payments that are taxable based on how they are funded, NCB benefits are taxable based on the extent to which the benefits exceed otherwise

unreimbursed expenses the individual may have. Neither employers nor insurers have access to this information.

H. The Proposed Applicability Date Is Unworkable and Would Impermissibly Impact the Taxation of Insurance Contracts Already in Force

The proposed applicability date of these significant tax changes is unworkable because it would impact policies that were purchased with the expectation that benefits paid by a policy purchased on a pre-tax basis would be taxable only to the extent that they exceed a policyholder's unreimbursed medical expenses. Additionally, many employers have already made decisions about plan offerings for 2024, based on the assumption that benefits under the policies would not be subject to FICA or FUTA tax or payroll withholding and reporting.

Furthermore, if the NPR is finalized, contrary to our recommendations, insurance companies and employers will need time to implement systems and administrative changes. With 2024 only three months away, the necessary changes cannot be implemented in the time frame proposed.

VIII. Recommendations

In summary and for the reasons described throughout this letter, ACLI makes the following requests and recommendations regarding the NPR.

A. ACLI Supports Disclosures and Suggests the Notice in the NPR Allow for State Flexibility

ACLI strongly supports disclosures for HIPAA excepted benefit products to explain the limited nature and distinguish these products from comprehensive medical insurance. The NAIC Accident and Sickness Insurance Minimum Standards Subgroup, through its work on the model minimum standards regulation for Supplemental Benefits and Short-Term Limited Duration Insurance ("Model 171"), is developing new disclosure language for each type of Supplemental Benefits included in their minimum standards model regulation. The Model 171 disclosure language is being drafted through the coordinated effort of multiple stakeholders representing both the insurance industry and consumers. Countless hours were spent choosing language that would assure a potential purchaser understands the benefit limits and accurately describes the coverage in easy-to-understand terms. For months, state regulators have been reviewing and revising disclosure language presented by the industry and consumer representatives. We suggest that the NPR include an option in the final regulation that gives state regulators the flexibility to substitute their preferred notice and disclosure language for federally prescribed language.

We also strongly suggest removing the alternative notice with the headline "WARNING." The use of "WARNING" is misleading and could be interpreted to mean that the coverage purposely avoids standards that must be met for comprehensive coverage when it is exempted from those standards. Using "WARNING" also inappropriately implies that the coverage is harmful to consumers and could even endanger them. There is nothing dangerous or harmful about the products themselves. Millions of Americans benefit from the financial protection these products provide when they experience a significant health event and the peace of mind the products provide. The intent of the notice is to ensure that consumers understand that this coverage should not replace comprehensive coverage. The intent should not be to imply that the products are inherently dangerous or harmful.

Additionally, the statement in the alternative notice "[i]t is not intended to cover the cost of your care" is misleading because even comprehensive coverage does not cover all costs of care. It could also be confusing because insureds can use the benefits for copays, deductibles, or out of network physicians which could be interpreted by consumers as cost of care.

State regulators are experienced with Fixed Indemnity insurance and are better positioned to create accurate disclosures that are easily understood by the consumers in their states.

B. Remove the Proposed Provisions Related to Fixed Indemnity Benefit Limitations from the Final Regulation

- The NPR's prohibitions on providing Fixed Indemnity benefits based on "services or items received" or by "severity of illness or injury" or "other characteristics particular to a course of treatment received" in both the individual and group markets should be removed from the regulation. Please see section II above for details on why this request is being made.

- The proposed requirement applying to individual Fixed Indemnity coverage that limits benefits to being paid "per day (or other period of time)" should be removed. Please see section II above for details supporting this request.

- The new example of prohibited "coordination" which appears to prohibit an employer from offering policies to employees that have any exclusions that are covered benefits or benefit triggers in a different policy offered by the employer should be removed. This section is meant to regulate employers through interpretation of a statute that regulates insurers.

C. Should the NPR Relating to Fixed Indemnity Coverage Be Finalized, the Implementation Dates for New Policies Should Be Extended to the Recommended Effective Date for Payment Standards, Non-coordination, and Consumer Notice Requirements, and Should Not Apply to In-Force Business. Please See Section VI for Details Supporting This Request

D. Provisions Related to Fixed Indemnity Benefits, Product Structure, and the Non-coordination Definition Should NOT Be Extended to Specified Disease Insurance

For the reasons described above, we strongly recommend that none of the benefit restrictions or "examples" of those restrictions should be applied to Specified Disease benefits. Because the Departments sought input through a request for comments and no language or description of provisions related to the minimum standards for Specified Disease were included in the NPR, we recognize that the Departments would be required to propose a new set of regulations implementing such changes to Specified Disease benefits and cannot under the APA add such language to the final regulation without a new formal notice of NPR and comment period distinct from the notice and comment period associated with CMS-9904-P.

With that said, we strongly assert that such a new rulemaking should not be pursued. These products offer vital financial protection for people who are facing a severe life crisis. Denying them access to Specified Disease benefits is decidedly not in their best interest. Specified Disease coverage is well regulated by state insurance departments and federal interference with the state regulatory structure for Specified Disease products will bring the same unnecessary and negative

outcomes for consumers that have been described throughout this letter related to Fixed Indemnity benefits.

E. The Applicability Dates Should Be Changed

Should the Departments deny our request that the NPR provisions related to Fixed Indemnity benefits, product structures and non-coordination definition be removed from the final regulation, we request that the applicability date for new products be the Recommended Effective Date. This will allow insurers and state regulators the appropriate time to refile and approve products, and to update all marketing materials associated with the required product changes. Existing products should not be subject to these rules.

Should the Departments deny our request that the proposed tax treatment changes not be included in the final regulation we recommend that, if a final rule is adopted in 2023, an applicability date that is not earlier than tax years beginning on or after January 1, 2025. If the rule were finalized in 2024, then it should be applied no earlier than tax years beginning on or after January 1, 2026.

Conclusion

As articulated in this letter, we share the Departments' concern about the risk of improper marketing and presentation of Fixed Indemnity products to consumers as a form of primary medical coverage. We have and will continue to work with appropriate state and federal policymakers to identify and root out these negative elements in the best interest of our member companies and their clients. However, the changes proposed by the NPR will not address this marketing and sales problem. Instead, the NPR requires substantive, destructive changes to the underlying products, and are not a viable means to address the marketing issue. As noted in survey data cited in this comment letter, Americans value and need the financial protections afforded by these products, as uncovered health-related expenses soar and household budgets tighten. Removing their access to these valued products in an attempt to address marketing and sales practices will be an unpopular and negative outcome for the people the Departments want to protect.

Through this NPR, the Departments impose sweeping regulatory changes without Congressional consideration or direction and without legal authority from enabling statutes. The new interpretations of existing laws governing excepted benefits represent substantive regulatory and policy changes that were not contemplated by Congress, exceed the statutory authority that Congress granted the Departments, and ignores the authority granted to state regulators to regulate these products. Given the serious and far-reaching consequences the proposed regulations would have on the continued existence of popular and financially protective Fixed Indemnity insurance products, we strongly recommend that all provisions related to those products be removed from the finalized version of this regulation.

Thank you for your consideration of these comments. Please do not hesitate to contact us if you have questions or want to discuss our requests and recommendations.

Sincerely,

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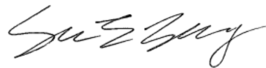

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ACLI
Financial Security for Life

Appendix

Tax Treatment and Substantiation Requirements for Amounts Received from Fixed Indemnity Insurance and Certain Other Arrangements

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The NPR Imposes a Tax Increase on Policyholders and Small Businesses and May Reduce the Availability of Financial Protection Options

Policyholders will face a tax increase: Policyholders relied on current and longstanding rules that only benefits in excess of their unreimbursed medical expenses would be subject to tax. If the NPR is finalized, 100% of their benefits would be subject to tax regardless of the amount of their unreimbursed expenses. Further, the U.S. Department of the Treasury ("Treasury") and the Internal Revenue Service ("IRS") indicate that FICA and FUTA taxes would apply, when FICA and FUTA taxes have never previously applied to these amounts and there is no valid rule subjecting the benefits to FICA or FUTA tax.

Example: A policyholder has cancer and has had many cancer-related doctor visits, hospital visits, and cancer treatments. She has ACA primary medical insurance, but as with any reliable medical coverage, she will have out-of-pocket expenses in the form of deductibles and co-insurance—items not covered by her major medical plan. In a single year, these out-of-pocket expenses amounted to $6,000. She is insured by an NCB excepted benefit plan for which her employer paid the premium. This coverage provides an NCB benefit that covers the same health-related medical events covered under her major medical plan. Her maximum benefit from the NCB plan for these same health-related medical events is $5,000.

Under current law: The entire $5,000 from the NCB plan is not subject to tax, because there is no "excess benefit." The policyholder is left with only $1,000 of unreimbursed medical expenses.

Under the proposal: The policyholder would owe taxes on the $5,000 in NCB benefits (even though that is less than her unreimbursed medical expenses). Further, the NPR would appear to subject this payment to FICA and FUTA taxes on this benefit, payable by both the employer and the policyholder (in the case of FICA taxes).

As a result, if the policyholder is in the 22% tax bracket her benefit is reduced as follows:

NCB Benefit	$ 5,000.00
Income Tax (22%)	$(1,100.00)
OASDI (6.2%)	$ (310.00)
HI (1.4%)	$ (70.00)
Remaining Benefit	$ 3,520.00

The policyholder's employer also now owes $380 in FICA tax.

Moreover, depending on whether the state in which the policyholder resides conforms to the federal tax rules, her benefits could be even further reduced by state income tax.

If the NPR were finalized, employers may reconsider how and whether to offer NCB insurance to their employees. Faced with this decision, some employers will continue to offer these benefits but on an after-tax basis, which will avoid tax implications on any benefit payments. Employers and employees will have increased FICA and FUTA taxes when premiums are paid post-tax because

they will pay tax on the portion of premiums that would have been exempt if paid on a pre-tax basis. Unfortunately, with the tax increase under the NPR, some (likely smaller) employers may choose not to offer these employer-paid benefits at all. Currently, both the premium and benefits (up to the amount of unreimbursed medical expenses) are not subject to income tax and both the premium and benefits are completely exempt from FICA and FUTA tax. If changed, the harm in this situation would be felt by employees, who would lose the opportunity to have cost-effective additional financial protection.

Tax Avoidance Schemes Should Be Addressed Directly

The preamble refers to certain arrangements that purport to avoid income and employment taxes through the use of schemes that pay benefits—often on a monthly basis—based on "health-related" medical events or activities.[104] As discussed above, Treasury and the IRS have been working to address a variety of such arrangements which impermissibly use the favorable tax treatment for employer-provided health benefits as a means of avoiding taxes through sham schemes.[105] While these schemes have variations, their core element is that the employee reduces a large portion of their salary (often $1,000 or more per pay period in excess of the cost of major medical premium) through a IRC §125 cafeteria plan and receives almost the entire amount of the reduced salary (usually less the major medical coverage premium) back purportedly tax-free. The schemes' alleged "tax benefits" are triggered by completely volitional actions that apply each pay period to the entire salary reduced amount (less the major medical premium) for all participants for the entire plan year. The participant employees do not and need not suffer a medical event to receive a benefit. Activities that trigger the payment of "benefits" under these abusive schemes include activities such as watching a video regarding general health or checking in with a health coach, but do not involve a participant's medical event that gives rise to medical expenses as defined in IRC §213(d).

These tax avoidance schemes do not use defined HIPAA excepted benefits like NCB insurance. Instead, the IRC §125 cafeteria plan alone is used to perpetrate the tax avoidance scheme by pre-tax contributions to the cafeteria plan followed by return of a large portion of those contributions as cash. The contributions and benefits under these tax schemes are completely different than NCB insurance.

Contributions for NCB insurance are small relative to major medical coverage premiums and much smaller than the contributions made to the IRC §125 cafeteria plan under these tax schemes. All benefits paid under NCB insurance are based on a specific medical event such as cancer or inpatient hospital stays. Any wellness benefits paid on a fixed indemnity basis are a small part of a larger policy and pay small amounts (generally, $50-$100) for preventative health screenings. Unlike the tax schemes' large "reimbursement" paid in the same amount to each participant every pay period, NCB insurance benefits pay only at the time of specified narrowly defined medical events of the participant. Further, unlike the tax avoidance schemes – which often make payments automatically, or base payments merely on an employee certification that a health-related event occurred, traditional indemnity benefits require proof. This proof is typically in the form of a provider statement, receipt of payment, or even an EOB. And although the indemnity benefit amount is not

[104] 88 FR 44596-44658 at 44634.

[105] As part of these efforts, the IRS has released several chief counsel memoranda regarding the impermissible tax schemes which help to alter taxpayers to unscrupulous activities. The most recent is CCA 202323006, released June 9, 2023, available here https://www.irs.gov/pub/irs-wd/202323006.pdf (last visited Aug. 7, 2023).

based on the medical expenses, the specific expense delineates the medical treatment which is used to determine the specific benefits that apply under the insurance coverage. So, unlike the tax schemes, NCB benefits are tied directly to specific medical events and treatment. Additionally, unlike the tax schemes' large payments each pay period, indemnity benefits are generally much smaller than actual medical expenses incurred for treatment of a participant's injury or sickness and are triggered by an unlikely fortuitous event.

The tax avoidance schemes the agencies have attempted to squash are so different from the supplemental limited benefit coverage addressed in the regulations, that supporters of these schemes will likely argue that the proposed regulations do not apply to the large tax-free payments under the schemes. In fact, the tax avoidance schemes are similar to an impermissible flexible spending arrangement defined under IRC §125 and its regulations. Perhaps tightening those regulations would better address these tax schemes.

The potential for tax abuse is an unfortunate factor of every tax system. The IRS has considerable authority to enforce the federal tax laws and impose penalties, including criminal sanctions.[106] Further, the IRS often engages in outreach efforts to educate taxpayers about unlawful activities.[107] In the case of tax schemes involving health coverage, state insurance regulators and other federal agencies may also play a role. To date, there has been no litigation involving the tax avoidance schemes and public outreach has been limited to those within the tax community.

The Excess Benefit Rule Has Been in Effect for More than 60 Years

IRC §105(b) establishes the "excess benefit rule"

The Internal Revenue Code does not distinguish between NCB insurance and primary medical insurance; tax treatment is the same for all reimbursements for medical expenses.[108] Treasury and the IRS are proposing to change this rule, referring to it as a "clarification," and applying the rule designed for disability benefits to this sector of the health insurance market.

As is the case with accident and health coverage generally, if the premium for NCB insurance is paid on an after-tax basis, IRC §104(a)(3) establishes that the benefits are not subject to tax. This is also the case with health coverage generally. If the premium for NCB insurance is paid for on a pre-tax basis (including both employer funds and employee salary reduction, referred to in this document as "employer-paid"), IRC §105(b) provides that such benefits are not subject to tax when the benefits reimburse the employee for medical expenses (as defined in IRC §213(d)).

No direct correlation is required between the amount of benefits payable and the amount of medical expenses incurred, for the exclusion under IRC §105(b) to apply, as long as benefits are payable exclusively upon the occurrence of a triggering medical expense. This treatment differs

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[106] See https://www.irs.gov/about-irs/criminal-investigation-ci-at-a-glance.
[107] See, for example, https://www.irs.gov/businesses/small-businesses-self-employed/anti-tax-law-evasion-schemes (last visited on Aug. 16, 2023), and IRS Publication 3995 (Rev. 3-2023) "Recognizing Illegal Tax Avoidance Schemes, available at https://www.irs.gov/pub/irs-pdf/p3995.pdf (last visited on Aug. 16, 2023).
[108] The statutory provisions governing the taxation of reimbursements for medical expenses has been the same at least since the enactment of the Internal Revenue Code of 1954 they remain structurally consistent despite changes and innovations in health insurance coverage because the policy behind treatment of benefits to pay for medical expenses should not change.

from the treatment of disability benefits where pre-tax funded coverage always results in taxable benefits: disability benefits replace earned income which are subject to tax.

Treasury regulations that have been in effect since 1956 confirm the excess benefit rule

The current Treasury regulations were adopted in 1956[109] and have not been changed since then. Consistent with the statute, Treasury regulations provide:

> IRC §105(b) applies only to amounts which are paid specifically to reimburse the taxpayer for expenses incurred by him for the prescribed medical care. *Thus, IRC §105(b) does not apply to amounts which the taxpayer would be entitled to receive irrespective of whether or not he incurs expenses for medical care.*.. If the amounts are paid to the taxpayer solely to reimburse him for expenses which he incurred for the prescribed medical care*, IRC §105(b) is applicable* even though such amounts are paid without proof of the *amount of the actual expenses incurred by the taxpaye*r, but IRC §105(b) is not applicable to the extent that such amounts exceed the amount of the actual expenses for such medical care."[110] (Emphasis added).

When these regulations were promulgated, the majority of typical health plans paid a primary medical benefit (often a fixed amount of health indemnity).[111] Sometimes individuals also had optional supplemental coverage available either privately or through their employer. Thus, today's NCB coverage is exactly the type of coverage contemplated by the regulations when they state that benefits payable to reimburse a taxpayer for medical expenses incurred are excludable from income "even if such amounts are paid without proof of the amount of the actual expenses incurred."[112] The payment triggers in NCB policies, although not requiring proof of the ***amount*** of actual expenses incurred, are such that the incurring of medical expenses is required.

Revenue Ruling 69-154 illustrates the excess benefit rule

Revenue Ruling 69-154[113] specifically addresses how to apply the excess benefit rule and determine the taxable amount with respect to NCB insurance. In that ruling, an employee was covered by an employer-paid general health insurance policy and a supplemental employer-paid health policy. The benefits received under both policies were greater than the amount of the medical expenses the employee incurred. Nevertheless, the IRS determined that the supplemental

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[109] 1956-1 CB 63, 70; T.D. 6169.

[110] Treas. Reg. §1.105-2.

[111] For example, the National Academy of Medicine (formerly known as the Institute of Medicine) describes the growth of commercial insurance after World War II as including "a reliance on indemnity products that paid cash to the individual and were not linked to contracts for payment or other arrangements that involved health care practitioners and institutions directly." Further, the National Academy notes that when the Federal Employees Health Benefits Program ("FEHBP") was established in the 1950's, it included "both a service benefit plan (Blue Cross and Blue Shield) and an indemnity plan". (Emphasis added) Institute of Medicine, 1993. Employment and Health Benefits: A Connection at Risk. Washington, DC: The National Academies Press, available at https://www.NCB.nlm.nih.gov/books/NBK235989/ (last visited on Aug. 17, 2023). A history of insurance in the U.S. describes the early Blue Shield plans as having two key features. "First, they required free choice of physician, and second, they were indemnity rather than service benefit plans. This meant that the plans paid the patient a dollar amount for each covered event; the patient, in turn, was responsible for paying the physician. " Morrisey, Michael, "Health Insurance", Health Administration Press, Chicago, IL, and AUPHA Press, Washington, DC (2008), at 7.

[112] See Treas. Reg. §1.105-2.

[113] 1969-1 CB 46.

health policy was "reimbursement" for the medical care expenses and was excludable up to the amount of the otherwise unreimbursed portion of the medical expenses.

In the preamble to the NPR, Treasury and the IRS state that the application of Revenue Ruling 69-154 is limited to situations in which the policyholder receives payments from more than one insurance policy.[114] It is not clear why there is a distinction between an excess reimbursement when paid by an NCB policy or when paid by multiple policies as is the case in Revenue Ruling 69-154. In both cases, the benefit is paid without regard to the otherwise unreimbursed medical expenses of the policyholder. Otherwise, there would be no excess reimbursement.

Publication 502 instructs taxpayers to follow the excess benefit rule

The IRS has also affirmed the excess benefit rule in its publications instructing taxpayers as to the amount of excess reimbursements for medical expenses to include on their tax returns. Since at least 1994, Publication 502 has included instructions for calculating the taxable amount of an excess medical reimbursement along with examples.[115] The examples clearly state that if a taxpayer's "reimbursements are more than [their] total medical expenses for the year, [they] have ***excess reimbursement***." (Emphasis in original.) It includes instructions for calculating the taxable amount of an excess reimbursement under several different circumstances.

The publication also contradicts the assertion in the preamble to the NPR that the excess benefit rule does not apply to excess reimbursements attributable to a single policy. One of the circumstances included is a situation in which the employee is insured by a single plan for which the premiums were paid with pre-tax employer contributions.[116]

PLR 9546016

In PLR 9546016 (Nov. 17, 1995), the IRS recognized the excess benefit rule. The letter ruling states that all or a portion of a benefit paid by an employer-paid NCB policy could be taxable, depending on the portion of the benefit that was exempt from tax under IRC §105(b).

The IRS recently confirmed the application of the excess benefit rule to NCB plans in CCA 201719025

CCA 201719025 (May 12, 2017) does not address the taxation of benefits paid by an employer-paid NCB plan as in Revenue Ruling 69-154. However, it includes a discussion of the potential legal implications for circumstances in which a self-funded NCB plan is paid for on a pre-tax basis. The IRS cited Revenue Ruling 69-154 and applied the excess benefit rule, stating that benefits paid under such a plan are taxable to the extent they exceed medical expenses.

Additionally, in a footnote in CCA 201719025, the IRS also clarified its earlier analysis in CCA 201703013 (Jan. 20, 2017) of benefits paid by an employer-paid plan. In CCA 201703013, Situations 2 and 3, employees, who may have had other comprehensive health coverage were permitted to enroll in an employer-paid NCB plan. The NCB plan paid a fixed benefit for certain health-related events without regard to the amount of medical expenses otherwise incurred by the

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[114] Supra footnote 104 at 44635, footnote 215. Additionally, Publication 502 includes a worksheet for taxpayers to determine the excess benefit attributable to reimbursements for medical expenses. At p. 18.
[115] Available at: https://www.irs.gov/pub/irs-prior/p502--1994.pdf at pp. 15-16.
[116] See the heading "Premiums paid by your employer," at p. 18.

employee. In CCA 201703013, the IRS stated that the full amount paid by the plan was taxable. However, in CCA 201719025, the IRS clarified its conclusion in the earlier CCA. It explained that the determinations in Situations 2 and 3 of CCA 201703013 were not intended to modify the analysis or result in Revenue Ruling 69-154.

The "Greenbooks"

Treasury's General Explanations of the Administration's Fiscal Year 2023 and 2024 Revenue Proposals ("Greenbooks") contain a proposed legislative clarification of the tax rules applicable to NCB policies.[117] In its explanation of current law, Treasury acknowledges the excess benefit rule:

> Under these types of policies, the amount paid is neither based upon the amount of any medical expense incurred related to the event or illness that triggered payment nor coordinated with other health coverage. Under certain circumstances, the payment may be excluded from the employee's gross income and wages to the extent that the payment does not exceed the employee's actual medical care expenses.

What Treasury and the IRS describe as a clarification is a reversal of longstanding tax treatment

While Courts have recognized agencies' right to change an interpretation or regulation, the agency must provide a reasoned analysis in doing so.[118] Treasury and the IRS have not done so here. The NPR refers to the changes to Treas. Reg. §1.105-2 as a clarification, but in fact they are drastic eliminating the excess benefit rule for NCBs. Under the NPR, employer-paid policies that are excepted benefits under IRC §9832(c)(3) and that pay benefits without regard to the amount of a policyholder's medical expenses, 100% of the benefit would be taxable income. The rule would apply regardless of the amount of the individual's related unreimbursed medical expenses (e.g., even when the total accident and health benefits received by an individual are far less than the individual's related medical expenses).

The NPR Arbitrarily Presumes that NCB Insurance Benefits Are Not Used to Pay for Medical Expenses and Does Not Qualify for the Exclusion Under IRC §105(b)

The NPR would amend Treas. Reg. §1.105-2 arbitrarily to state that no NCB benefit is paid for medical care:

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

In practice, the statement that NCB benefits are not paid for medical care is untrue. A policy may pay a lump-sum benefit upon the diagnosis of a specified disease, such as cancer, without explicitly stating that the insured must incur medical expenses. However, NCB insurance is intended to protect policyholders from potentially financially devastating costs incurred as a result of certain health events. The kinds of health-related medical events insurance companies cover are

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[117] General Explanations of the Administration's Fiscal Year 2024 Revenue Proposals, Department of the Treasury (March 9, 2023) p. 204; General Explanations of the Administration's Fiscal Year 2023 Revenue Proposals, Department of the Treasury (March 2022), p. 104.

[118] *Motor Vehicle Manufacturers Association v. State Farm Auto Mutual Insurance Co*, 463 U.S. 29 at 57 (1983).

severe enough that they will undoubtedly result in the policyholder incurring medical expenses. Additionally, while a policyholder purchases the policy as financial protection, they are undoubtedly thinking of the out-of-pocket expenses that will result from the health-related event if it occurs. Moreover, while a policyholder can use the policy proceeds for something other than medical expenses, it is unlikely that they purchase an NCB policy for that purpose or with the idea that they would not need the policy to pay for any medical expenses since they cannot access the benefits of the policy without the occurrence of a health-related event. Following settled law, and longstanding regulations and guidance, the IRS has up until now recognized these realities and excluded these benefits to the extent they are used to cover qualifying, out-of-pocket medical expenses.

Additionally, the preamble to the NPR appears to take a more restrictive view than the language proposed in the regulation itself. The preamble states that an insurer must not only pay the benefit with regard to the amount of medical expenses the policyholder incurs, but must also determine that an insured is not reimbursed through other insurance for a benefit payment to qualify as reimbursement for medical expenses under IRC §105(b):

> The Treasury Department and the IRS interpret IRC §105(b) of the Code to not apply to benefits paid *without regard to the actual amount of incurred and otherwise* ***unreimbursed*** *IRC §213(d) medical expenses*. Because payment of these amounts is not a reimbursement of IRC §213(d) medical expenses, the amount of reimbursement is immaterial, with the result that the payment is not excluded from gross income under IRC §105(b) of the Code.[119]

Under this interpretation, the NPR would preclude any benefit paid by an employer-paid health plan that did not coordinate benefits from being considered reimbursement for medical expenses. Even policies that coordinate benefits could be considered to pay benefits "without regard to unreimbursed medical expenses" because they do not know if an individual owns another policy that does not coordinate.[120]

Moreover, the Greenbooks recognized that at least some portion of NCB benefit payments could be excluded as reimbursements for medical expenses. In fact, the Greenbooks implied that a statutory change to the law would be necessary for NCB benefits not to be reimbursements for medical expenses.

Additionally, for Treasury and the IRS to determine that all NCB insurance is not a reimbursement of IRC §213(d) medical expenses could be considered arbitrary and capricious, which would render the NPR invalid. In making such a determination, Treasury and the IRS would not be considering all of the relevant factors relating to whether NCB insurance reimburses medical expenses.[121]

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[119] Supra footnote 104 at 44635

[120] Individuals may participate in a group health plan and also own a privately purchased individual medical policy – which typically does not coordinate.

[121] *Natural Resources Defense Council, Inc. v. United States EPA*, 526 F.3d 591 (9th.Cir. 2008) (holding EPA's changed interpretation of "contamination" in storm water discharge rule was arbitrary and capricious and an impermissible construction of governing statute)*:* 5 U.S.C. §706(2)(A); Motor
Vehicle Manufacturers Association v. State Farm Auto Mutual Insurance Co, 463 U.S. 29 (1983).

The NPR is Contrary to Congressional Intent

Courts have noted that "It is well established that when Congress revisits a statute giving rise to a longstanding administrative interpretation without pertinent change, the 'congressional failure to revise or repeal the agency's interpretation is persuasive evidence that the interpretation is the one intended by Congress.'"[122]

Treasury and the IRS have repeatedly publicly affirmed the excess benefit rule, and Congress has not acted to change it.[123] Congress has had ample time and many occasions since the current IRC §105(b) regulations were adopted in 1956 to change the taxation of health benefits in the manner Treasury now proposes yet has chosen not to do.

For example, Congress has amended IRC §105 to change the tax treatment of *disability* benefits under IRC §105(d), but left the tax treatment of benefits under health plans (including NCB insurance) intact.[124] Congress could easily have considered similar changes to the taxation of health insurance (including NCB insurance) under IRC §105 at any of these times, but chose not to. Nor did Congress make changes to the taxation of health insurance when Congress revisited the entire tax code in the Tax Reform Act of 1986.

The tax treatment of benefits provided under the Code for employer-provided health care have frequently caught the attention of Congress.[125] Various proposals investigated by Congress have included elimination of the favorable tax treatment, imposing income limits on favorable tax treatment, and replacing the current treatment with an income-based deduction. Yet, none of these proposals have been adopted and the tax treatment of health benefits (including NCB benefits) remains intact.

Congress also considered changing the tax treatment of employer-provided health care as part of deliberations on the Affordable Care Act. What resulted was the excise tax on high-cost health plans, which was added to the Code as IRC §4980I (also commonly referred to as the "Cadillac Plan" tax).[126]

In the Greenbooks, Treasury and the IRS have acknowledged that congressional action is needed to make the change now proposed, having twice made budget proposals to "amend IRC §105(b)."

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[122] *Commodity Futures Trading Com v. Schor*, 478 U.S. 833, 846 (1986) *citing NLRB v. Bell Aerospace Co.,* 416 U.S. 267, 274-275 (1974) (footnotes omitted).
[123] See Rev. Rul. 69-154, Publication 502, PLR 9546016, CCA 201719205, and the 2023 and 2024 Greenbooks.
[124] See Pub. L. 88-272, the "Revenue Act of 1964" (HR 8363); Pub. L. 94-455, the "Tax Reform Act of 1976" (HR 10612); and Pub. L. 98-21, the "Social Security Amendments Act of 1983."
[125] Congressional activity regarding examination of the tax benefits for employer-provided accident and health coverage, including such things as hearings and substantial legislation, are a matter of public record. The following are a very few examples of this activity: Joint Committee on Taxation, *Present Law and Background on Federal Tax Provisions Relating to Health Care* (JCX-26-98), April 22, 1998 (prepared for a public hearing scheduled for April 23, 1998, by the Subcommittee on Oversight of the House Ways and Means Committee on federal tax-related provisions affecting heath care); Joint Committee on Taxation, *Exclusion for Employer-Provided Health Benefits and Other Health-Related Provisions of the Internal Revenue Code: Present Law and Selected Estimates,* (JCX-25-16), April 12, 2016 (prepared for a public hearing scheduled for April 14, 2016, by the House Committee on Ways and Means on the tax treatment of health care); possible revisions to the tax treatment of employer-provided health care are a perennial feature of the Congressional Budget Office (CBO) options for reducing the deficit (the most recent option may be found here https://www.cbo.gov/budget-options/58627 (last visited Aug. 6, 2023)).
[126] The Cadillac Plan tax has since been repealed. Pub. L. 116-94 (Dec. 20, 2019), Further Consolidated Appropriations Act, 2020.

For more than 60 years the public has relied on numerous public statements by Treasury and the IRS relating to the application of the excess benefit rule to NCB policies. Treasury and the IRS do not have the authority to change the law through regulations where Congress has purposefully chosen not to and any attempt to do so by Federal regulations would be a violation of the APA.[127]

NCB Benefits Are Not Disability Payments

Either one or both of the changes to Treas. Reg. §1.105-2 in the NPR (that benefits paid under NCB plans without regard to the amount of medical expenses are taxable and/or the new "substantiation" requirement) would effectively treat NCB plans as disability benefits. This result is contrary to the statute and congressional intent.

More generally, since well before HIPAA, the Internal Revenue Code has recognized the differences between health benefits and benefits that are payable on account of disability (meaning benefits triggered by an absence from work). The 1954 Internal Revenue Code provided different treatment for health benefits (including NCB benefits) and benefits payable on account of disability (absence from work), and Congress over time has changed the treatment for disability benefits only, and not the treatment of accident and health benefits.[128]

The legislative history with respect to the changes in tax treatment of disability benefits is further instructive with respect to the differences between accident and health benefits, including NCB benefits, and disability benefits and the separate role for each. Specifically, the House and Senate reports for the Tax Reform Act of 1964 contain the same explanation for the additional restrictions imposed at that time on the IRC §105(d) exclusion for disability benefits:

> [T]his sick pay exclusion in its present form is not justified. The amounts received by the employee in this case are substitutes for regular wages or salaries which, had they been received as such, would be fully taxable. ***The wage substitutes in this case are wholly unrelated to the costs involved as a result of illness or injury.*** Amounts paid by the employer for the medical expense of the employee already are excludable by the employee under other provisions of law (§105(b)) and amounts paid by the employee himself for medical expenses also are deductible elsewhere under present law (§213 of the code) to the extent that they exceed what is considered to be the normal level of medical expenses."[129] (Emphasis added).

Congress provided a different tax treatment for disability payments, which are based on an absence from work and are "unrelated to the costs involved as a result of illness or injury." On the other hand, NCB insurance, like other types of health coverage are triggered specifically by a medical event, not absence from work.

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[127] *FDA v. Brown & Williamson Tobacco Corp*., 529 U.S. 120 (2000).

[128] See discussion at page 12.

[129] 1964-1 CB (Part 2) Federal Tax Laws and Committee Reports January – June 1964, page 168 (House Report No. 749, 88th Cong., 1st Sess. (Sept. 13, 1963), Committee on Ways and Means); page 553-54 (Senate Report No. 830, 88th Cong., 2d Sess. (Jan. 28, 1964), Committee on Finance).

The key issue in distinguishing health policies from disability policies is the structure and substance of the policies.[130] Disability benefits may also be described using various terms, including "sick pay", "wage continuation", "income replacement", and the like. The key issue is how benefits are structured. Benefits under disability policies are triggered by an ***absence from and inability to work***. Such policies typically pay a set amount on a periodic basis (e.g., monthly) as long as a person is incapacitated due to an event or condition specified in the policy, i.e., the covered disabling condition that prevents the person from working. In contrast, ***NCB excepted benefits pay based on specific health-related events***, such as a hospital stay or a diagnosis of a specified disease (such as cancer). While the payment of the benefit may be linked to a period, such as $200 per day of hospitalization, the benefit is not intended to provide a periodic stream of income and is not triggered by an absence from and inability to work.

Fixed Indemnity Benefits are not Wages for Purposes of Income Tax Withholding or FICA/FUTA tax

Perhaps the most unsettling aspect of the NPR is the presumption in the preamble that employer-paid NCB insurance benefits are wages for purposes of income tax withholding and FICA/FUTA taxes. This conclusion is incorrect.

Excess benefits attributable to fixed-indemnity insurance are not wages within the plain meaning of the term

In general, "wages" for withholding purposes means "remuneration for services ... performed by an employee for his employer (including benefits paid in any medium other than cash)." IRC §3401(a). Wages for purposes of the Federal Insurance Contributions Act (FICA) and the Federal Unemployment Tax Act (FUTA) are defined in IRC §§3121(a) and 3306(b) respectively. Both Code sections define wages as "all remuneration for employment."

The definition of wages for FICA/FUTA purposes and income tax withholding purposes are similar, albeit not identical in all cases. However, the Supreme Court has held that "simplicity of administration and consistency of statutory interpretation instruct that the meaning of 'wages' should be in general the same for income-tax withholding and for FICA [and FUTA] calculations." [131] Thus, unless specifically altered by statute, wages for federal income tax, FICA, and FUTA fit within the plain meaning of "remuneration for employment."

Until the IRS issued CCA 201703013, there had been no guidance stating that NCB payments or excess reimbursements made by an insurance company are wages. In fact, PLR 9546016 and Publication 502[132] both treat excess reimbursements as nonwage income.

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[130] As justification for changes in the NPR, the Treasury and the IRS refer to fixed indemnity health coverage various times as "income replacement"." While it may be that sometimes in the marketplace this coverage is referred to as "cash replacement", "income protection", "financial protection", or even "income replacement" (because these terms may help to distinguish fixed indemnity excepted benefits from major medical or primary coverage), these descriptions are not the core issue. Expense-based major medical coverage could also be considered to be "cash replacement" or "income replacement" because the benefits replace the cash or income that the individual would have had to pay for the covered medical expense if they were not covered by insurance. Rev. Rul. 69-154 already provided a rule for determining how much of a payment made under a fixed indemnity insurance plan is used to pay medical expenses and how much is for something else (i.e., pro-ration).

[131] *U.S. v. Quality Stores, Inc.*, 134 S. Ct. 1395 1405 (2014), *citing Rowan Companies, Inc. v U.S.*, 452 U.S. 247 (1981).

[132] In pages 15-19 of Publication 502, the IRS states that excess reimbursements should be recorded on for 1040 as "other income."

NCB payments do not fit within the plain meaning of remuneration for employment. They are not based on performance of services, which are measured in increments of hours worked, tasks completed, and quality of services. Rather, NCB benefits are triggered by a health-related medical event.

Benefits paid by third-party insurers are not remuneration for employment

The benefits paid by the insurer under an NCB insurance policy are not made as a result of any employee/employer relationship or as payment for services by an employee. There is no explicit exception because none is needed. Rather, as discussed in detail below, these payments are not "wages" under the plain meaning of the statute. It is the value of the insurance coverage that is part of the policyholder's wages rather than the benefits. Accordingly, while employer-paid *premiums* for health insurance coverage would be subject to income and payroll tax withholding, absent the specific statutory exclusion, the benefits of such insurance are not.

IRC §3401(d) states that a third-party can be an employer, but insurance companies are not employers for payroll tax purposes. Income tax reporting and withholding obligations fall on an "employer" making payments of "wages" to an employee.[133] An "employer" is defined for this purpose in IRC §3401(d) as a person for whom an individual performs any services as an employee. IRC §3401(d) also provides that, if someone other than the employer controls the payment of wages, that person is considered the employer for income tax withholding purposes.

The third-party issuer of an insurance policy, subject to insurance risk, does not fit within this definition. Cases involving IRC §3401(d)(1) statutory employers generally involve persons stepping into the shoes of the employer to pay what would traditionally be considered wages. For example, in two cases involving bankruptcy trustees, courts held that because the employees provided services to bankrupt companies, the bankruptcy trustees were liable for employment taxes.[134] In *Winstead v. United States*, 109 F.3d 989 (4th Cir.1997), the Fourth Circuit decided that the plaintiff, who paid the employees from his own accounts, rather than the sharecroppers for whom the employees worked, was the employer for tax purposes.

Unlike IRC §3401(d) employers, insurance companies do not make payments in direct relationship to services performed, but for an independent fortuitous occurrence. The payment of benefits by an insurance company that has assumed an insurance risk is therefore fundamentally different than payments that are "wages" for "employment." This concept is reflected in the Code and Treasury Regulations under the income tax withholding rules, which provide that third-party payments of sick pay that are subject to insurance risk are not categorized as wages, while sick pay payments made by an employer or the employer's agent are wages.[135]

The legislative history helps explain the difference between the Code's treatment of payments made directly by an employer and payments made by a third-party insurance company.[136] When Congress established wage withholding for federal income tax purposes in 1942, the definition of

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[133] IRC §3402(a).

[134] Otte v. United States, 419 U.S. 43 (1974); In re Armadillo Corp., 561 F.2d 1382 (10th Cir.1977).

[135] IRC §3402(o)(1)(C); Treas. Reg. 1.3401(a)-1(b)(8).

[136] FICA provisions were originally enacted in 1935 in Title VIII of the Social Security Act, 49 Stat. 636. In 1939, Title VIII was transferred to the Internal Revenue Code and became FICA. 53 Stat. 1387. Title VIII contained definitions of "wages" and "employment" substantially identical to those FICA now provides. See IRC §§811(a) and (b), 49 Stat. 639. Federal Unemployment Tax Act (FUTA) was the bill passed in 1939 that established a payroll tax to fund unemployment benefits.

wages was based on the existing definition used for wages for FICA and FUTA tax purposes—"all remuneration for employment."[137] At the time, before the enactment of the 1954 Code, the exemption that is under IRC §105 today fell under IRC §22(b)(5), which exempted from income, "amounts received, through accident or health insurance or under workmen's compensation acts, as compensation for personal injuries or sickness." Additionally, amounts received by employees through an insured employer accident and health plan were not subject to income tax, but payment from an uninsured employer accident and health plan were subject to tax.[138] IRC §105(b) extended the exclusion for reimbursements for medical expenses to uninsured accident and health plans. No change was made to payroll tax provisions to include payments made by insurance companies until IRC §3402(o)(1)(C) was modified to include third-party sick pay as a payment "other than wages" for which policyholders could request withholding[139] . After which, IRC §§3121(a) and 3306(b) were modified to include third party sick pay as wages. Accordingly, while excess reimbursements paid by insurance companies may be subject to income tax, they are not wages for income tax, FICA, or FUTA tax purposes.

Additionally, IRC §§3121(a)(2)(B) and 3306(b)(2)(B) explicitly exclude from wages for FICA and FUTA, respectively, "the amount of any payment …made on account of … medical or hospitalization expenses in connection with sickness or accident disability." (Emphasis added.) This exclusion applies equally to all medical or sickness payments triggered by a medical event including NCB benefits. Benefits payable under NCB policies, which are conditioned on a medical event, such as hospitalization, or a diagnosis of a particular disease, fall within this definition.

Temporary Treasury Regulations §32.1 Does Not Apply to Excess Benefits or Is Invalid as Applied to Benefits Other than Disability Benefits

In the preamble to the NPR, Treasury and the IRS refer to Temporary Treasury Regulations ("Temp. Treas. Reg.")[140] §32.1 as support for the idea that NCB benefits that are taxable income under IRC §105(a) are always subject to FICA. Temp. Treas. Reg. §32.1(d) provides that "payments on account of sickness or accident disability" subject to FICA include "any payment for personal injuries or sickness includible in gross income under IRC §105(a) and the regulations thereunder" and do not include any payments under accident or health insurance that are expended for medical care as described in IRC §105(b) and the regulations thereunder. In recent guidance,[141] and in the preamble to the NPR, Treasury and the IRS have stated that, excess reimbursements attributable to NCB benefits are subject to FICA because they are not exempt from tax under IRC §105(b) and taxable under IRC §105(a).

In making this statement, Treasury and the IRS conflate the two separate and distinct provisions for disability and medical expenses. Provisions applicable to "amounts paid on account of sickness

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[137] S. Rep. No. 1631, 77th Cong., 2d Sess., 165 (1942) (Revenue Act of 1942).
[138] 83 Conf. Rep. 2543 at 24.
[139] Pub. L. 96-601, §4(b) and P.L. 97-123.
[140] IRC §7805(e)(2) provides that any temporary regulation shall expire within 3 years after the date of issuance. The IRS has previously stated that this provision is effective only for temporary regulations issued after Nov. 20, 1998, and thus does not apply to this temporary regulation issued in 1982. The IRS has also stated that the continuing authority of the temporary regulation was confirmed in 2005 by Treasury Decision (TD) 9233, 70 FR 74198, 2006-1 CB 303. See CCA 201719025, released May 12, 2017, available at https://www.irs.gov/pub/irs-wd/201719025.pdf (last visited Aug. 4, 2023). Note, however, that the provision of the temporary regulation relied on in the NPR was not amended by TD 9233. Whether this temporary regulation has the force of a final rule is not clear.
[141] CCA 201719025; CCA 201703013; and CCA 202323006.

or accident ***disability***" payments are set forth in IRC §§3121(a)(2)(A) and 3306(b)(2)(A). Provisions applicable to "amounts paid on account of ***medical or hospitalization expenses*** *in connection with sickness or accident disability"* are set forth in IRC §§3121(a)(2)(B) and 3306(b)(2)(B).

The employment tax withholding rules relating to sick pay payments, which are a form of disability, provide an instructive contrast with the rules for withholding for payments made on account of medical or hospitalization expenses. In the case of sick pay (i.e., payments for absence from work), the flush language of IRC §§3121(a) and 3306(b) provides that disability payments described in IRC §§3121(a)(2)(A) and 3306(b)(2)(A) made by a third-party insurance company are wages unless they are paid pursuant to workers compensation laws and that third-party insurers are required to withhold on such wages.[142] The statute does not apply this third-party withholding in the case of payments on account of medical or hospitalization expenses.[143] The legislative history further confirms that Congress intended to limit such withholding to "sick pay" (i.e., payments for absence from work) and makes no mention of applying this rule on account of medical or hospitalization expenses.[144] Congress could have applied this sort of rule to medical expenses subject to insurance risk but chose not to. Treasury and the IRS may not through regulation come to a different result than the one prescribed by Congress.

Treasury and the IRS did not characterize excess reimbursements as wages until the IRS issued CCA 201719025. Even in the current version of Publication 502, taxpayers are instructed to record excess reimbursements attributable to employer-paid insurance as "other income" on their tax returns.[145] PLR 9546016 also states that NCB benefits attributable to an employer-paid policy should be reported under IRC §6041, which does not apply to wages.

Further, Temp. Treas. Reg. §32.1 was not subject to notice and comment and was clearly intended to apply to disability payments.[146] The temporary regulation was promulgated in response to the change to the employment tax rules that made payments of third-party sick pay subject to wage treatment. For example, the preamble to the temporary regulation states that it was not intended to apply to amounts attributable to a temporary absence from work. The preamble to the temporary regulation contains no discussion about the applicability of Temp. Treas. Reg. §32.1 to NCB insurance benefits or any excess reimbursement. Additionally, considering that the rule's broad application goes far beyond the statutory language, its validity as applicable to anything other than disability payments is questionable.

Information Reporting Guidance on NCB Benefits would be Helpful

If at least some portion of NCB benefits attributable to employer-paid policies remains exempt from tax, there is no current IRS form or means that is truly appropriate for reporting NCB benefits. Issuers of NCB insurance are generally not in a position to calculate the taxable amount, if any, of benefits under NCB policies. As with any medical based policy, the issuer of a supplemental NCB policy does not have the necessary information. For example, the insurer lacks information regarding any other medical coverage the individual may have (e.g., through a spouse's employer

[142] IRC §§3121(a)(2)(A) and 3306(b)(2)(A), and flush sentence following IRC §§3121(a) and 3306(b).
[143] IRC §§3121(a)(2)(B) and 3306(b)(2)(B).
[144] H.R. Conf. Rep. 97-409 (relating to P.L. 97-123), 12-15, 1981 USCCAN 2681, 2688-2687.
[145] Available at https://www.irs.gov/pub/irs-pdf/p502.pdf at pp. 18-19.
[146] See 47 FR 29225. Additionally, the portion of the 2005 amendment relating to Temp. Treas. Reg. §32.1 Treasury and the IRS cite as ratifying . Temp. Treas. Reg. §32.1 was not subject to notice and comment. It was not included in the NPR, but was part of the final rule. See 70 FR 12164 (the NPR) and 70 FR 74198 (the final rule).

or a former employer or individually purchased) and/or the insured's total medical expenses, nor does the insurer have any reasonable means of obtaining this information. While more traditional "expense incurred" health insurers are permitted (or even required) to share payment information for benefits coordination purposes, this sharing of information generally does not occur with respect to individual market coverage and supplemental, NCB coverage. This is in part because such insurance is prohibited from coordinating payments with other employer sponsored plans. In addition, privacy rules may limit the ability of the health care provider, employer, or insurer to obtain or share information under other coverage that would be needed to determine the taxable amount. Thus, because the insurer does not know the amount that is "fixed or determinable," the entire amount of the benefit is the only information the insurer is able to report for tax purposes.

Currently, Form 1099-MISC is used to report certain miscellaneous items of income. Box 3 of Form 1099-MISC is used to report "other income." The instructions to the recipient direct the taxpayer, in general, "to report this amount [in Box 3] on the 'Other income' line of Schedule 1 (Form 1040)." Thus, based on Form 1099-MISC, the total amount in Box 3 would seem to be taxable income; yet that would not be the case with respect to NCB payments under the "excess benefit" rule.

This outcome is unfair to policyholders. While they can contest the taxable amount of the NCB benefit they receive on their return, most individuals receiving NCB benefits are unwell and the process would be overwhelming. As a result, they end up being taxed on the entire amount of the benefit.

The simplest way to avoid this outcome is to not require reporting by the insurer and instead have the insured include the taxable portion of the NCB benefit in "Other Income" as Publication 502 currently directs them. Reporting on Form 1099-MISC is not always required. IRC §6041(a) provides that all persons:

> [E]ngaged in a trade or business and making payment in the course of such trade or business to another person, of rent, salaries, wages, premiums, annuities, compensations, remunerations, emoluments, or other fixed or determinable gains, profits, and income … of $600 or more in any taxable year, … shall render a true and accurate return to the Secretary … setting forth the amount of such gains, profits, and income." (Emphasis added.)

The IRS addressed the issue of what constitutes fixed or determinable income in Rev. Rul. 80-22. The IRS ruled that payors of hail crop insurance did not have to report insurance proceeds to beneficiary farmers where they were informed by the individual farmers that pre-production expenses had been capitalized. The IRS explained that,"[b]ecause the insurance company cannot require a farmer to disclose the basis in the destroyed crops, the amount of 'gains, profits, or income,' if any, resulting from the payment of the hail crop insurance proceeds is not fixed or determinable by the company."

Alternatively, if insurers must report NCB payments, any form for reporting NCB payments would need to be clear that the amount reported is not necessarily income as well as information as to when the payments may be income.

The idea that a reported amount does not represent the full taxable amount is recognized in other situations. For example, Form 1099-R is used to report pension and retirement distributions. There

is a box on the form to indicate that the taxable amount is not determined. As another example, Form 1099-G is used by state and local governments to report refunds of state and local taxes. The instructions for the recipient indicate that the amount reported "may be taxable to you if you deducted the state or local income tax."

We note that, if NCB benefits were wages, the difficulty in reporting payments would drastically increase. The same issue with accurately reporting the taxable amount arises when benefits are reported on a Form 1099. However, wages also require withholding of FICA and FUTA tax. There are procedures currently in place that allow insurance companies to shift the liability for the employer's share of FICA or FUTA owed and information reporting obligation for third-party sick pay to the employer, rather than the insurance company.[147] It is not clear how insurance companies would be required to report NCB benefits as wages or whether the insurance company would have a means of transferring the FICA/FUTA tax liability to the employer.

The Proposed Applicability Date Is Unworkable and Would Impermissibly Impact the Taxation of Insurance Contracts Already in Force

If, contrary to our recommendations, Treasury and the IRS decide to finalize the NPR, then the effective date should be pushed back to prevent currently existing policy holders from experiencing a large tax increase. Additionally, insurance companies will need more than the time allotted to make any changes to administrative systems.

The proposed applicability date is the later of the date of publication of a final rule or January 1, 2024. For the reasons set forth below, we believe that the current tax treatment should be retained for all in force policies, and that any more restrictive rule should be prospectively effective for newly issued policies with sufficient time to allow for needed planning and adjustments necessitated by the tax changes.

Taxing NCB benefit payments on existing policies is a retroactive tax increase on taxpayers who relied on current law, regulations, and other guidance[148] when purchasing this coverage through pre-tax salary elections or enrolling in employer-funded plans. As explained in detail above, the new taxes imposed by the NPR are a *change*, rather than a clarification, in the tax treatment of benefit payments for employer-funded NCB insurance or for insurance purchased through pre-tax salary reduction. Consistent with longstanding tax policy, such dramatic changes to the tax treatment of these policies should be applied prospectively only to new policy purchasers.[149]

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[147] See IRC §§3121(a), 3306(b) and Temp. Treas. Reg. §31.2(e) (FICA/FUTA). See IRC §6051(f) (reporting).

[148] Other guidance includes, e.g., Rev. Rul. 69-154 and CCA 201719025.

[149] Retroactive tax increases have an aura of patent unfairness. Congress has limited the ability of the Department to impose retroactive tax regulations in IRC §7805 because it was Congress's view that "it is generally inappropriate for Treasury to issue retroactive regulations." H.R. Rep. No. 104-506, at 44 (1996). None of the specific circumstances in IRC §7805 that allow retroactive tax regulations apply here. The only rationale put forward by the Department for the effective date of the NPR is that the proposal is a "clarification." However, as discussed in detail in this memorandum, that is simply not the case, this is a clear change in the law. Thus, there is no basis for any retroactivity and the effective date should recognize the interests of taxpayers who have taken actions (i.e., purchased fixed indemnity insurance on a pre-tax through salary reduction) before this proposal (even though benefits may be payable after issuance of the regulations). Further, employees should not be impacted by actions previously taken by a completely different taxpayer, i.e., the employer. Some pre-tax contributions are made directly by the employers; employees do not control employer actions.

The taxation of NCB insurance benefit payments under the NPR arises when such premiums are paid for by the employer or by the employee with pre-tax dollars. Currently, the benefits from such policies can be used on a dollar-for-dollar basis to offset unreimbursed medical expenses. Making such benefits taxable in all cases will cause many employers to revisit whether to offer such coverage in the first instance, causing a potential ripple effect in overall benefits provided and a likely overall reduction in coverage for employees.

In most cases, benefit decisions are made well in advance (typically in the spring) for the following plan year. An immediate applicability date (or even a plan year 2024 applicability date) gives no time for employers to plan for open enrollment. Preparing for annual open enrollment requires months of lead time for employers to design their benefit offerings and effectively communicate these offerings to their employees. The NPR will require prudent employers to re-evaluate the cost of providing these benefits and update enrollment materials to accurately communicate the benefits to employees. Employers who pay for some or all of the premiums for NCB insurance will need to decide whether imputing income on the value of the employer-paid portion is preferable to subjecting the employee to tax on the payment of the benefit. Employers also need to consider the administrative burden and practicality of the withholding issues associated with a taxable benefit. Weighing these factors takes time and consideration that a January 1, 2024, or later but immediate applicability date would not allow.

Additionally, insurance companies will need time to implement systems changes. Systems that have existed for many years will need to be redesigned to account for the new wages and reporting components and tested prior to implementation. The administrative systems on which policy information is stored are complex and companies may administer different blocks of NCB policies on different administrative systems after acquiring new business or upgrading to a newer administrative system for a new product. If systems changes cannot be implemented in time before the rule takes effect, companies will be forced to comply with the rule through manual procedures, increasing the potential for human error.

Accordingly, if, contrary to our recommendations, the proposed changes to the tax treatment of NCB insurance benefits are finalized, more time will be needed before the final rule applies. For this reason, we propose a bifurcated applicability date, whereby existing policyholders will continue coverage under the current tax treatment, and only new policies will be subject to the new restrictive tax treatment. For new policies, assuming that a final rule is adopted in 2023, we recommend an applicability date that is not earlier than plan years beginning on or after January 1, 2025. If the rule were to be finalized in 2024, then it should be applied no earlier than plan years beginning on or after January 1, 2026.

Further, at the very least, a transition period affording penalty relief for failures to correctly apply reporting requirements under IRC §6724(a) and late payments of withholding under IRC §6656(a) should be provided.

We want to emphasize that any changes to the applicability date, including those we suggest here, would not serve to address the underlying issues we have raised with respect to the provisions of the NPR. We continue to oppose the NPR for the reasons addressed here and recommend that it be withdrawn.