U.S. Chamber of Commerce

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Submitted Electronically Via Federal eRulemaking Portal: www.regulations.gov

Re: Proposed Rule, Department of Treasury's Internal Revenue Service, the Department of Labor's Employee Benefits Security Administration, and the Department of Health and Human Services; 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. 44,596-44,658, July 12, 2023)

To Whom It May Concern:

The U.S. Chamber of Commerce ("Chamber") submits these comments to the Department of Treasury's Internal Revenue Service, the Department of Labor's Employee Benefits Security Administration, and Department of the Health and Human Services' Center for Medicare and Medicaid Services ("the Departments") in response to proposed rules on Short-Term, Limited Duration Insurance; Independent-Noncoordinated Excepted Benefits Coverage; Level Funded Plan Arrangements and Tax Treatment of Certain Accident and Health Insurance published on July 12, 2023[1] ("Proposed Rules"). The Proposed Rules would significantly amend:

- The definition of short-term, limited-duration insurance, which is excluded from the definition of individual health insurance coverage under the Public Health Service Act ("PHS Act");
- The requirements for hospital indemnity or other fixed indemnity insurance to be considered an excepted benefit in the group and individual health insurance markets; and
- The tax treatment of certain health indemnity benefit payments received under the employer-provided accident and health plans.

The Proposed Rules also solicit comments regarding:

- Coverage only for a specified disease or illness that qualities as excepted benefits; and
- Level-funded plan arrangements.

[1] Proposed Rule, 88 Fed. Reg. 44,596-44,658. (July 12, 2023) (to be codified at 26 C.F.R. Parts 1. and 54; 29 C.F.R. Part 2590, 45 C.F.R. Parts 144, 146, and 148,) [hereinafter referred to as the "Proposed Rule"] https://www.govinfo.gov/content/pkg/FR-2023-07-12/pdf/2023-14238.pdf

The Chamber supports efforts to expand access to comprehensive health coverage and the ability of employers to provide tailored and valued benefits to employees and their families. To facilitate robust health coverage and benefit offerings, the Chamber urges the Departments to consider the delineated procedural concerns, the problematic declarations and the substantive problems with the Proposed Rules as outlined in this comment letter. We are concerned that if the Proposed Rules are adopted the amendments will have the detrimental effect of reducing choice, limiting access and undervaluing the benefit and coverage for consumers.

Shared Goals: Business, Employees and the Departments

The Chamber has long supported the employer-sponsored insurance market. Data shows that employees highly value the health coverage they receive from their employers, and employers have a vested interest in supporting the health and welfare of employees and their families.

A recent survey conducted by Seven Letter Insight indicates consumer perceptions and satisfaction for employer provided health coverage is exceedingly favorable[2]:

- Strong majorities believe that employer provided health care plans are extremely important and cite their health plan as the most important benefit provided by their employer.
    - 93% were satisfied with their employer sponsored coverage.
    - 94% agree that the health coverage from (their) employer gives (them) peace of mind.
- An overwhelming majority view their employer provided health care plan as "affordable," "convenient" and "worth what they pay for it."
- Respondents believe their employer provided health coverage is simpler, more affordable, and higher quality than plans they could find on the open markets or government provided coverage plans.

Not only do employees highly value employer-sponsored insurance, but businesses also see a value in providing coverage as well. By offering health coverage, businesses benefit with:

- Reductions in direct medical costs,
- Improved productivity,
- Enhanced recruitment
- Greater retention, and
- Lower costs related to short- and long-term disability.

[2] https://www.uschamber.com/assets/documents/Final-PACT-Public-Opinion-Survey.pdf

In 2023, employer-sponsored benefits were estimated to account for a return on investment of 47%; for every dollar invested in employer-sponsored coverage, business sees a benefit of $1.47 in these measures. These benefits for employers are projected to continue to steadily increase to 52% in 2026.[3]

Procedural Concerns

The Chamber has several broad procedural concerns with the Proposed Rules and questions whether the Departments have authority to finalize these amendments. First and foremost, these products are regulated at the state level with guidance from the National Association of Insurance Commissioners in establishing standards, and by certain Federal Agencies only in relation to deceptive sales issues. States are charged with regulating these products and there is not sufficient evidence to demonstrate their failure to enforce the law as required by the Public Health Service Act.

States are Primary Regulators of Health Insurance Products and Marketing

States are and have long been the primary authority for regulation of health insurance, including stop-loss coverage, hospital and other fixed indemnity insurance and specified disease or illness insurance.

Federal law does not "supersede" state health insurance law unless such state law "prevents the application of a requirement" of federal requirements.[4] Any federal intrusion of this "primary" state regulatory authority must be based on information that a State may not be substantially enforcing PHS Act requirements.[5]

Specific procedures must be followed to determine whether a State is substantially enforcing PHS Act requirements.[6] There are already standards and other entities charged with the oversight of these products. The PHS Act recognizes this authority, and the Affordable Care Act did not change this authority for these products.[7]

State regulation includes robust consumer protections and the active enforcement of those protections. Consumer protections include requirements for policy provisions,

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[3] https://www.uschamber.com/assets/documents/20220622_Chamber-of-Commerce_ESI-White-Paper_Final.pdf

[4] See 42 USC 300gg-23(a)(1), and 42 USC 300gg-61(a)(1); 45 CFR 150.101(a)(2)("states have primary enforcement authority with respect to the requirements of title XXVII of the PHS Act that apply to health insurance issuers offering coverage in the group or individual health insurance market"); 45 CFR 150.201 ("...each State enforces PHS Act requirements with respect to health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State").

[5] See 45 CFR 150.201, and 45 CFR 150.203.

[6] See 45 CFR 150.207-221.

[7] 42 U.S.C. § 300gg-61(a); 65 Fed. Reg. 45,786, 45,787 (1999) (“States are the primary regulators of health insurance coverage in each State.”)

filing and approval of policy forms, outlines of coverage, marketing, and advertising. State insurance departments monitor compliance with these requirements through consumer complaint investigations and market conduct examinations, impose fines and order compliance as necessary to enforce the requirements.

In addition, each state insurance department has a division for the reporting and investigation of fraud, improper marketing, and other market abuses. States remain the closest to both the consumer and the sales channels and should be entrusted with the necessary oversight of these products and their marketing.

The NAIC has established a Model Act (#170) and Model Regulations (#171) that establishes standards and required disclosure forms for these products and is currently updating these models. The NAIC has also established the Improper Marketing of Health Insurance Working Group and is working directly with the federal DOJ, DOL, HHS, and FTC to address deceptive sales issues.

Problematic Declarations

The Chamber takes issue with several messaging elements and declarations in the Proposed Rules that seem without merit: the reliance on the Departments' "view" as a reason for promulgating regulatory changes; the negative characterization of products which are in fact highly valued by consumers; and, the increased offering and election alongside major medical health coverage.

First, the Proposed Rules state on 28 separate occasions that "the Departments are of the view that…" followed by a variety of phrases and decrees. Federal agencies, however, must promulgate regulations and amend them in accordance with statutory requirements, not to placate or advance a perspective or opinion.

There is no mention of "the view" in The Guide to the Rulemaking Process prepared by the Office of the Federal Register. In answer to the question "What gives agencies the authority to issue regulations?" it states:

> Agencies get their authority to issue regulations from laws (statutes) enacted by Congress In some cases, the President may delegate existing Presidential authority to an agency. […] Congress may also pass a law that more specifically directs an agency to solve a particular problem or accomplish a certain goal.[8]

Second, fixed indemnity and supplemental excepted benefits are not "junk insurance" and are not "misleading" or confusing consumers. In fact, consumers report very high levels of satisfaction with supplemental products as they exist in the market today.

[8] https://www.federalregister.gov/uploads/2011/01/the_rulemaking_process.pdf

- A survey conducted by Global Strategy Group found that 92% of consumers were satisfied with their hospital indemnity or other fixed indemnity insurance and 97% were satisfied with the specified disease/critical illness coverage.[9]
- The reasons for the high consumer satisfaction include that the supplemental coverage helped pay for critical medical expenses by easing the cost of deductibles and copayments (90%), provides peace of mind (91%) and is there when needed (91%).
- Consumers are also satisfied with the services and benefits that are covered by the policy (93%), the value received for the monthly premium (92%), and the affordability of the coverage (89%).[10]
- Further, consumers almost universally rate the service they receive from supplemental carriers very highly, with 97% reporting excellent or good service with respect to hospital indemnity or other fixed indemnity excepted benefits, and 99% reporting excellent or good service with respect to critical illness insurance (i.e., specified disease or illness excepted benefit coverage).
- Moreover, recent survey results show that by far most consumers understand the nature of the coverage: 93% report that they understand their benefits well and 85% report that the insurer works with the customer to explain the benefits and coverage and explains the coverage in a way that is easy to understand.[11]

Third, employers are increasingly offering these products in addition to comprehensive major medical health insurance coverage to further enhance benefit packages.

- A recent study by Willis Towers Watson found that 85% of employers recognize the value of supplemental benefits to a total rewards strategy and see value for employees.
- This study also found that offerings by employers of group hospital indemnity insurance rose from 24% in 2018 (or prior) to 65% in 2021 (currently in place or considering for 2022).
- There has been strong growth in employers offering supplemental benefits and employees selecting them in 2022 open enrollment, with one of the fastest growing voluntary benefits employees enrolled in was hospital indemnity insurance (with participation increasing from 10% to 16% between 2021 and 2022).[12]

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[9] Global Strategy Group, *Measuring Satisfaction with Supplemental Insurance*, conducted on behalf of AHIP, February 23, 2022, https://www.ahip.org/documents/AHIP-Supplemental-Insurance-Deck-032422.pdf ("Global Strategy Group Survey")

[10] Id. At 11

[11] Id. At 9

[12] See *Willis Towers Watson 2021 Emergency Trends in Health Care Survey* at https://www.wtwco.com/en-us/insights/2021/05/2021-emerging-trends-in-health-care-survey ("Willis Towers Watson Survey")

- Employers during the last two open enrollment cycles were focused on using voluntary benefits to improve total rewards strategies and bolstering workforce resilience in order to retain talent.[13]

Substantive Concerns: Proposed Rules' Harmful Results

The Chamber has many substantive concerns with the Proposed Rules, but we have focused our comments on three harmful outcomes that would occur if the amendments are finalized. In addition to the negative impact of these policies and the misalignment with the stated goals of the Departments, the Chamber also questions the legality and veracity of the interpretations and approaches.

1. **Prohibiting Per-Service Benefits: Reduces Choice and Limits Flexibility**
   Prohibiting the ability to structure and offer a fixed indemnity plan on a per-service basis will eliminate a highly valued longstanding insurance design option (benefits per service) for the group market.

   Not only would this reduce choice and flexibility, but there is also no statutory basis for such a limitation or prohibition. Any Federal regulatory prohibitions on a "per service" basis of payment would be challengeable as being in excess of statutory authority. See *Central United Life Insurance Co. v. Burwell*.

2. **Noncoordination Interpretation: Eviscerates Access to Additional Coverage**
   The noncoordination provision will have the ironic outcome of eviscerating access to fixed indemnity plans for millions of Americans by prohibiting employers from offering fixed indemnity coverage to anyone who has comprehensive coverage.

   It is ironic given the Proposed Rule's extensive concerns that consumers are not able to "understand" and "select appropriate coverage" … "that strengthen benefits" and "improve the comprehensiveness of coverage" that the Departments would propose to cut off access to this additional form of coverage.[14]

3. **Taxation Changes: Less Value for Consumers**
   The declaration that these forms of coverage "serve as a source of income replacement," the significant changes to the taxation of these benefits, and the mischaracterization of the purpose of these products, would all serve to reduce value to consumers.

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[13] https://aon.mediaroom.com/2022-04-20-Voluntary-Benefit-Offerings-in-U-S-Rise-41-Percent-During-COVID-19-Pandemic,-Aon-Reports

[14] Proposed Rules at page 44, 598.

The Proposed Rules would treat benefit payments made for expenses caused by a medical event but that are not covered by the group health plan as income to the employee, and subject them to federal income taxes. This changes the tax treatment of these benefits in two ways:

1. 100% of the benefit would be taxable – not just the amount of the benefit received in excess of the cost of the medical event. This change will devalue the benefit and the underlying plan for consumers.

2. These benefit payments would also now be considered wages and subject to FICA which will also devalue the benefit for consumers and create new administrative challenges for employers.

Not only will the impact of this change in taxation be problematic but its authority is questionable. Benefit payments by these supplementary insurance products are only triggered by a health-care event and are not a substitute for wages. Disability benefits are triggered by an absence from work, not medical events like those that trigger the fixed indemnity coverage. The Internal Revenue Code clearly distinguishes the taxation of disability benefits from health benefits: §105(b) provides that health benefits are excluded from income regardless of whether the cost of coverage was also excluded from income.

Logistical Concerns: Practical Implementation Challenges

There are two primary logistical concerns that the Departments should correct: the effective date and the challenge in complying with any amendments versus fulfilling the guaranteed renewal obligation.

1. The Proposed Rule offers an effective date 75 days after the publication of a final rule which is not feasible given the breadth of the amendments and changes being considered. The Chamber strongly recommends that the Departments permit the necessary time to design and price new products that adhere to the final amendments and finalize an effective date for plan years beginning 12 months after the publication of a final rule.

2. These products are subject to guaranteed renewal protections meaning that the plans offered and enjoyed by consumers must be renewed consistently with the current design for subsequent coverage periods. However, given the significant changes proposed, it would be impossible to satisfy both the guaranteed renewal obligation and compliance with the new regulations. We urge the Department to permit plans to offer guaranteed renewal of the existing products to those consumers who elect to re-enroll under a grandfathered status.

IV. Conclusion

The Chamber remains committed to strengthening the employer-sponsored system on which the majority of Americans depend and rely on for coverage. We urge you to collect additional research, perform important and requisite analysis and consider the concerns outlined in our comments as you evaluate next steps.

Sincerely,

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