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

The Honorable Lisa M. Gomez
Assistant Secretary
Employee Benefits Security Administration, Department of Labor
200 Constitution Ave, NW
Washington, D.C., 20210

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8016

Submitted via www.federalregister.gov

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

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

In the proposed rule “Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance”, the Departments of the Treasury, Labor, and Health and Human Services (the Departments) propose changes to the definition of short-term, limited-duration health insurance (STLDI), propose amendments to the requirements for hospital indemnity and other fixed indemnity excepted benefit insurance, propose modifications to the tax treatment of fixed amounts paid from employment-based health insurance paid without regard to medical expenses incurred, and request comments regarding specified disease health policies and level-funded health plans.

Overall, these proposals would upend decades-old applications of federal law regarding certain types of health insurance in order to enforce the Biden administration's policy preference to severely limit access to clearly permissible insurance options which they disfavor. At nearly every step, these proposals would advance this policy preference in a manner that contravenes the statute the proposals are implementing. Moreover, in doing so, the proposals remove fields of insurance regulation from state regulators which states are better situated to regulate, and which federal law has long reserved to the states. As a state-based public policy organization, Center of the American Experiment has a particular interest in how this rule will impact insurance options and every state's flexibility to address the unique challenges facing their insurance markets. Because the proposals in this rule would largely violate federal statutes, undermine access to affordable, highly valued insurance options, and displace state regulatory authority, we strongly oppose all aspects of this proposed rule.

Proposed rule subverts longstanding regulatory framework Congress established under the McCarran-Ferguson Act

Before assessing the merits of the Departments' proposals, it's worth a brief review of the history that shaped the state and federal approach to regulating insurance. In 1869, the U.S. Supreme Court held that "insurance is not a transaction in commerce" and, therefore, not subject to federal regulation.¹ As a result, each state developed their own detailed legal framework for regulating insurance. However, the U.S. Supreme Court overturned this holding in 1944 which then threatened to undermine the regulatory framework each state spent decades honing.² Just ten months after this decision, Congress passed the McCarran-Ferguson Act that reinstated states as the primary regulators of insurance.³ The law declared Congress's sense that "the continued regulation and taxation by the several States of the business of insurance is in the public interest."⁴

Ever since McCarran-Ferguson, states have remained the primary regulators of insurance. Even when the federal government passed sweeping changes to the regulation of health insurance under the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Care Act (ACA), states retained a primary enforcement role for federally regulated insurance and retained regulatory control over health insurance not subject to federal law. While the federal government clearly has the authority to override and preempt state insurance laws under this framework, the federal government has historically only overridden state laws with clear direction from Congress. The Obama administration attempted to move away from this framework on several occasions, but was rebuffed by federal courts⁵ and later reversed by the Trump administration on many of these efforts.⁶ This proposed rule attempts to pick up where the Obama administration

¹ Paul v. Virginia, 75 U.S. 168, 183 (1869).

² United States v. South-Eastern Underwriters Assn., 322 US 533 (1944).

³ McCarran-Ferguson Act, 59 Stat. 33 (1945).

⁴ 15 U.S. Code § 1011.

⁵ See e.g., Central United Life Ins. Co. v. Burwell, 827 F.3d 70 (2016) (holding the Department of Health and Human Services cannot add criteria to the requirements to qualify as fixed indemnity except benefits coverage and require insurers to limit sales of this coverage to people who have minimum essential coverage).

⁶ See e.g., Patient Protection and Affordable Care Act; Market Stabilization final rule, 82 FR 18346, April 18, 2017 (reversing policies that had loosened enrollment requirements and remove authorities to regulate insurance from states); Short-Term, Limited-Duration Insurance final rule, 83 FR 38212, October, 2, 2018 (reversing the reduction

left off and continue efforts to subvert the regulatory framework Congress established and states have relied on since the McCarran-Ferguson Act passed in 1945.

Narrowing the definition of short-term, limited duration insurance unlawfully restricts an insurance option protected by HIPAA

The rule proposes to reinterpret the definitions of “short term” and “limited duration.” Under the proposal, the short-term definition would change from meaning a contract term of less than 12 months to a contract term of no more than 3 months. The definition of limited duration would change from restricting contract extensions beyond a total of 36 months to an extension that resulted in a contract term of no more than 4 months.

The Departments justify these changes based on their determination that the current definitions are “no longer in the best interests of consumers.” This determination is based on the Departments’ newfound views on “the potential risk to individuals who enroll in STLDI, the increased availability of affordable comprehensive coverage options, the potential impact on the individual market risk pools, and consumer challenges in differentiating STLDI from individual health insurance coverage.” The most important factor driving the Departments’ reinterpretation is rooted in the belief that reducing the length of the contract term “is the most important tool for consumers to distinguish between STLDI and comprehensive coverage.” This new interpretation turns the statute on its head and, as a result, the Departments rely on impermissible factors to justify their proposed changes.

The statutory text needing definition was enacted as part of HIPAA’s new regulations on individual and group health insurance coverage. Specifically, HIPAA defined “individual health insurance coverage” to mean “health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.”⁷ The clear purpose of specifically excluding STLDI from the definition of individual health insurance coverage was to ensure that insurers could still sell this type of insurance. Without such exclusion, STLDI would have been subject to HIPAA’s new guaranteed renewability requirement which would have otherwise outlawed this type of insurance product. In fact, shortly after HIPAA passed, a few states enacted their own state versions of HIPAA without the exclusion and inadvertently banned STLDI.⁸

Instead of using the statutory exclusion to protect the availability of STLDI as HIPAA intended, the Departments now propose to use the statute to limit access to STLDI and effectively ban STLDI to a broad portion of the market.

How does the proposed rule potentially ban access to STLDI? Quite simply, regulations can become so onerous that they effectively ban the activity they regulate. The Departments must be

of the term of STLDI from less than 12 months to less 3 months); and Health Reimbursement Arrangements and Other Account-Based Group Health Plans final rule, 84 FR 28888, August 19, 2019 (reversing the ban on employers from funding individual market health insurance premiums through health reimbursement arrangements).

⁷ Health Insurance Portability and Accountability Act, Sec. 2791 (b)(5) (1996); and 42 USC 300gg-91(b)(5).

⁸ Allison Bell, “Reforms Dry Up Temporary Health Ins.,” *National Underwriter*, January 12, 1998 (reporting how Michigan, Massachusetts, Maine, Minnesota, and Washington all “accidentally shut out short-term policies by passing laws requiring all issuers of health policies, including temporary policies, to guarantee renewability.”).

aware of the experience of other states that have implemented similarly strict contract lengths and durations for short-term health plans. This Milliman actuarial report and other research the Departments cite for support relies on research from HealthInsurance.org. This same research shows that of the of the eight states that restrict the maximum duration to 4 months or less, only three states still have insurers that offer short-term plans. This research also shows that short-term plans are no longer available in several other states despite having a longer 6-month maximum duration after the state imposed additional requirements, such as requiring short-term plans to cover essential health benefits.

Considering STLDI stopped being available in over 60 percent of states with similar requirements as the rule proposes, this regulation appears to be designed by the Departments to entirely ban STLDI from around 60 percent of consumers who can currently access these plans. This is on top of eliminating consumer access to STLDI contract terms at standard terms of less than 12 months. As noted previously, this turns the statutory intent to protect STLDI on its head. By banning what the statute protects, this rule proposes an unlawful, arbitrary and capricious exercise of executive authority.

The Departments will no doubt respond that there are two sides to this coin. STLDI defined too narrowly might limit access to such plans, but STLDI defined too expansively can undermine statutory goals to enroll people in comprehensive coverage. The Departments will claim that it is within their discretion to make that balance. But that was not Congress's concern when it excluded STLDI from the definition of individual health insurance coverage.

If Congress were concerned with STLDI encroaching on the market for guaranteed renewable coverage, negatively impacting the individual market risk pool, and posing risks to consumers, then Congress would have directed the Departments to balance those goals and regulate this space. Instead, Congress directed the Departments to specifically allow SLTDI to carry on outside the federal guaranteed renewable requirements without any qualification. By applying this same standard to the ACA, Congress applied the same hands-off approach. Because the federal government did not regulate this space, Congress surely expected states to continue to be the primary regulators of STLDI. This expectation follows straight from the McCarran-Ferguson framework in place for decades. Therefore, it's likely Congress expected states to continue defining STLDI as they are the primary regulators of this insurance product and, therefore, expected nothing from the Departments. To the extent the Departments needed to define STLDI, Congress surely expected the Departments to apply a definition that was consistent with STLDI products available in the market at the time.

As the U.S. Supreme Court instructs: "Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider."⁹ Because Congress simply intended to exclude STLDI from the definition of individual health insurance coverage, the factors the Departments used to justify the change—increased availability of comprehensive coverage, potential impact on the individual market risk pool, and risks to consumers—are not relevant to the decision. Despite this clear congressional intent, the Departments now propose to take over the field of STLDI regulation by taking advantage of their

⁹ Motor Vehicle Manufacturers Association v. State Farm Mutual Automobile Insurance Company, 463 U.S. 29 (1983).

authority to define the term STLDI as it is used in HIPAA. The Obama administration colored outside the lines of its executive authority when it first finalized shorter contract terms for STLDI and the Departments' current proposal likewise colors outside these lines.

The factors the Departments impermissibly rely on do not support the proposed changes

Even if a court concluded the key factors the Departments rely on were relevant to the decision, the proposed rule does not provide evidence to support these factors. The Departments assert “that it is now necessary and appropriate to propose to amend the existing Federal regulations governing” both STLDI and fixed indemnity excepted benefits “given significant changes in the legal landscape and market conditions since the Departments last addressed STLDI and fixed indemnity excepted benefits coverage, and the low value that STLDI and fixed indemnity excepted benefits coverage provide to consumers when used as a substitute for comprehensive coverage.” These specific changes involved 1) increased access to affordable coverage; 2) risks to consumers from inferior insurance products and deceptive marketing; and 3) negative impacts on the individual market risk pool. The Departments offer no clear evidence to suggest anything significantly changed across the landscape since the 2018 STLDI final rules were published to justify these proposals.

Access to Affordable Coverage

The Departments assert that the decision to change the definition of STLDI in 2018 was based on the determination that STLDI provided access to more affordable coverage options. Now the Departments assert that “comprehensive coverage for individuals has generally become more accessible and affordable.” The Departments cite increased issuer participation, higher enrollment on the Exchanges, and broader access to premiums subsidies through the temporary expansion of premium subsidies under the Inflation Reduction Act and the Treasury rule which expands premiums subsidies to certain dependents. The Departments assert these new developments “allay the accessibility and affordability concerns expressed by the Departments in the preamble to the 2018 final rules.”

The Departments correctly cite certain improvements in the individual market such as substantially higher issuer participation which reflect the success of the Trump administration's work to improve the individual markets. Yet the Departments entirely ignore the key affordability issue—the lack of affordable individual market coverage for people who do not qualify for subsidies. While premiums did stabilize after 2018, the Departments fail to acknowledge how premiums remain elevated and nearly as unaffordable to the unsubsidized as they were in 2018.

In January 2021, the Centers for Medicare & Medicaid services issued a report documenting the breadth of the affordability issues that remained across the country.¹⁰ To understand regional variations in affordability, the report compared the average premium for the lowest-cost silver plan from the lowest-cost quintile of counties to the highest. It found the average premium in the

¹⁰ Centers for Medicare & Medicaid Services, *Affordability in the Marketplaces Remains an Issue for Moderate Income Americans*, CCIIO Data Brief Series (January 2021), available at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Impact-Premium-Affordability.pdf>.

highest cost quintile costs \$17,652 for an unsubsidized 60-year-old earning \$50,000—accounting for 35.3 percent of their income. The same regional variations in affordability exist today. Though the Departments cite how the expansion of premium subsidies would help this 60-year-old, this expansion is temporary and there are still people who today don't qualify for premium subsidies. The lowest cost silver plan in Hannibal, Missouri still costs \$17,668 today.

Risks to Consumer

The Departments also itemize several risks to consumers that the proposed changes would address. The Departments are concerned about additional medical expense costs consumers might incur that STLDI and fixed indemnity excepted benefit coverage do not cover. They also expressed concerns over potentially deceptive or aggressive marketing practices. To support these concerns, the Departments rely almost exclusively on articles and reports from advocacy organizations that actively oppose STLDI and fixed indemnity excepted benefit coverage. Moreover, these articles and reports do not present empirical research based on trusted data sources that can be replicated to support their positions, but rather rely on anecdotes and small consumer samples and surveys to make their case.

The truth is, nearly every insurance product, including ACA-compliant Exchange coverage, will have a disgruntled consumer willing to complain about how the insurer failed to deliver the coverage they promised. That's the nature of insurance. The proposed rule provides no data showing that consumers of STLDI or fixed indemnity excepted benefit coverage are at more risk for surprise coverage limitations or deceptive marketing than any other type of insurance.

Consumers are at far more risk if they go without insurance than if they freely choose to buy STLDI. When the Departments chose to adopt the more expansive definition in 2018, they did so with evidence which strongly suggested that a portion of the unsubsidized who were fleeing the individual market were opting to go uninsured. The Departments now dismiss this reality by oddly claiming the recent experience with COVID-19 demonstrates the value of a framework that encourages the uninsured to purchase comprehensive coverage. This is a non sequitur. No one ever argued against encouraging people to purchase comprehensive coverage. Instead, the 2018 final rule addressed the reality that a 60-year-old cannot afford comprehensive coverage when it costs 35 percent of their income. In this reality, they either buy a more affordable SLTDI plan or go uninsured.

To “encourage” people to purchase comprehensive coverage, the Departments cruelly propose to take all other options away and effectively force some people to go uninsured if they have no access to affordable comprehensive coverage. The Departments proposed rule will force these people to suffer the risk of an uninsured health event to support the greater good of broader participation in comprehensive coverage. At least the Departments do acknowledge this tradeoff and admit their proposal “could also lead to an increase in the number of individuals without some form of health insurance coverage.”

Impact on Risk Pools

There is no doubt that expanded access to STLDI may attract some healthier people to avoid the individual market risk pool and, as a result, negatively impact the risk pool. But will this impact on the risk pool be measurable and if it is, will it be a meaningful impact? The 2018 final rule

acknowledged the expansion of STLDI could raise premiums by as much as 5 percent, but it also noted the Congressional Budget Office projected premium impacts of just 2 to 3 percent. So far, there's been no reliable evidence to suggest that the expansion of SLTDI in 2018 led to any meaningful premium increase.

To the contrary, the Departments claim that “research based on individual market data for plan year 2020 has substantiated concerns about the negative impact” on the individual market risk pool. However, the research they rely on suffers from a fundamental flaw which should be obvious to the Departments.

The research they reference was authored by Mark Hall and Michael McCue and published in a blog post on the Commonwealth Fund website—one of the main advocacy think tanks which opposes STLDI.¹¹ This blog post does not actually provide the reader with a clear methodology or specific citation or link to the data sources it used. The blog only explains it used the “the ‘risk score’ that the federal government calculates to measure the relative medical costs expected for the populations covered by ACA plans in each state.”¹² This is undoubtedly referencing the “State Average Plan Liability Risk Score” that CMS calculates under the risk adjustment program for the individual market risk pool. Hall and McCue used this data to compare changes in risk score from 2018 to 2020 in states with more restrictive STLDI requirements versus less restrictive states. But there is a fundamental flaw with this comparison: The risk score calculation changes from year to year with refinements to the risk adjustment model and because the calculation changes and these changes may not impact states uniformly, the calculation cannot reliably be used to compare trends across states.

As a Senior Advisor to the Administrator at CMS from 2017 to 2021, I helped oversee the risk adjustment program and specifically recall some major changes to the risk adjustment model which impacted these risk scores. Upon further review of the annual risk adjustment reports, the report on the 2020 benefit year that Hall and McCue rely on notes “that the risk adjustment model updates between 2019 and 2020 resulted in a decrease in calculated risk scores by approximately 9.7 percent.”¹³ To the main issue concerning their methodology, this report explains:

Risk score changes year over year are affected by changes in the applicable risk adjustment modeling methodology, plan enrollment (metal or cost-sharing reduction variations), population health, and coding practices. Therefore, risk score changes do not necessarily reflect changes in population health risk over time, independent of other factors.¹⁴

¹¹ Mark Hall and Michael McCue, “Short-Term Health Insurance and the ACA Market,” *The Commonwealth Fund Blog*, March 16, 2022, at <https://www.commonwealthfund.org/blog/2022/short-term-health-insurance-and-aca-market>.

¹² *Id.*

¹³ Centers for Medicare a& Medicaid Services, *Summary Report on Permanent Risk Adjustment Transfers for the 2020 Benefit Year*, at 5, available at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2020.pdf>.

¹⁴ *Id.* at 4.

On top of the flawed comparison of risk score trends, my own preliminary efforts failed to replicate the enrollment trends that Hall and McCue report. Based on my calculations, off-Exchange enrollment declined by 9.7 percent in more restrictive states and declined by 5.9 percent in less restrictive states. Thus, the STLDI-friendly states appear to have better maintained unsubsidized enrollment in comprehensive coverage despite the availability of STLDI. These enrollment trends are generally consistent with trends from a new report published by the Paragon Health Institute which finds the “ACA individual market, regardless of metric, has performed better in states that fully permit STLDI.”¹⁵

Aligning STLDI directly with the maximum waiting period to enroll in group coverage demonstrates the need for a longer coverage period

The Departments largely justify shrinking the definition of “short-term” to 3 months by explaining how this “approach is consistent with the group market rules regarding the 90-day waiting period limitation” for new employees. They then justify redefining “limited-duration” to a maximum period of no more than 4 months to account for the additional 1 month federal law allows for a reasonable and bona fide employment-based orientation period. The proposal claims this combination “would allow STLDI to be extended ... to avoid a temporary gap in coverage” if an employer opted for a 1-month orientation period.

While the Departments likely cite these waiting periods to establish some rationale basis for choosing such a short time period, aligning with these waiting periods likely undermines the reasonableness of their approach. The fact is, aligning with these waiting periods actually highlights a circumstance where the new definition can create a coverage gap. Because the proposed 4-month maximum duration aligns with the maximum employer coverage waiting period, this alignment will create a coverage gap for anyone who does not have coverage in the days, weeks, and months leading up to that first day on the job. This will be the case for most people that lose a job before arranging their next job. Therefore, the Departments rationale for 4 months demonstrates the clear need for a maximum duration greater and much greater than 4 months.

Federal law provides no legal authority to require STLDI or fixed indemnity excepted benefits to display a notice

The Departments propose to require STLDI and fixed indemnity excepted benefits to provide a consumer notice which clearly describes the limitations of the coverage. Each of the proposed notices would also require the plans to provide advertisements encouraging consumers to visit HealthCare.gov—the federal Exchange. While there may be issues with the content of these notices, the main problem is that the Departments do not have the statutory authority to require the notices.

In *Central United Life Ins. Co. v. Burwell*, the District of Columbia Circuit held the federal government could not add new criteria to the definition of excepted benefit that require excepted

¹⁵ Brian Blase, *Short-Term Health Plans, Long-Term Benefits: States that Allow Short-Term Coverage Have Stronger Health Insurance Markets*, Paragon Health Institute (September 2023), available at <https://paragoninstitute.org/research-paper-page-brian-blase-short-term-health-insurance-20230906/>.

benefits to only be provided to individuals who had minimum essential coverage.¹⁶ The court reasoned that the statute exempts all plans that conform to the criteria enumerated in the definition of excepted benefit and the “additional criterion, exempts *less than all*.” Notably, to support the conclusion that “HHS has no colorable claim to Chevron deference,”¹⁷ the court referenced another D.C. Circuit case which concluded “an agency’s decision to ‘add an obligation that is not in the statute ... changed the nature of the statute’ and that the ‘Secretary may not rewrite the statute’.”¹⁸ The court expanded on this reference by adding a footnote which observed that “HHS’s rule also requires fixed indemnity application materials to include a notice,” but the court then noted: “No one has challenged this part of the rule, and we express no opinion as to its validity.”¹⁹

While the D.C. Circuit expressed no opinion on the validity of the notice, the court clearly suggested that this notice may impermissibly add an obligation not included in the statute by attaching the note to a case concluding the same. The fact is, the Departments are build a body of regulations that add obligations to STLDI and fixed indemnity excepted benefits that are not included in the statute. While this should be problematic for any area of law, it is especially troublesome under insurance law when Congress has expressly made states the primary regulators of insurance where Congress remains silent. In this case, Congress has been silent and the Departments therefore do not have the legal authority to add obligations, such as the obligation to display a notice, on STLDI and fixed indemnity excepted benefits.

Federal law does not provide the authority to prohibit enrollment in STLDI during specific periods of time

The Departments request comment on state experiences in prohibiting enrollment during specific periods of time such as during the annual open enrollment period for the individual market. The Departments suggest this could be another way to help consumers distinguish between STLDI and comprehensive coverage. Considering recent data discussed previously suggests off-Exchange enrollment in STLDI-friendly states outperforms more restrictive states, it’s unlikely further restrictions on STLDI would do anything but penalize people who want to purchase STLDI. More importantly, the Departments, as just discussed, do not hve the authority to add obligations to STLDI plans and, therefore, could not limit STLDI enrollment in this way. Thus, the request for comment is moot for the purposes of guiding federal action.

Federal law does not provide the authority to require fixed indemnity excepted benefit coverage to provide benefits that are paid only on a per-period basis

The Departments propose to restrict fixed indemnity excepted benefits coverage to pay benefits only on a per-period basis. This restriction would ban these plans from paying benefits on a per service basis as they have done for decades.

¹⁶ 827 F.3d 70 (D.C. Cir. 2016).

¹⁷ Id. at 74.

¹⁸ Id. at 74-75.

¹⁹ Id. at 75.

Here again, the McCarran-Ferguson framework instructs that states should act as the primary regulators over insurance. The Departments do not provide any substantive evidence to show that state regulators are not fulfilling their duties. Rather, the justification for this restriction relies on anecdotal reports of troubling marketing practices, worries about misleading plan designs, and changes in market conditions that are not relevant to this question. To the extent action should be taken, states have more resources to effectively and efficiently implement efforts to educate consumers and oversee insurer practices. Therefore, in this case the Departments should defer to states and allow them to weigh the costs and benefits of imposing such a requirement.

Moreover, the Departments *must* defer to states on whether to require excepted benefits to be paid on a per-period basis because federal law does not grant the Departments the authority to impose this requirement. While the court in *Central United Life* did not directly rule on whether the Departments may restrict fixed indemnity excepted benefit to paying benefits only on a per service basis, the court did opine on the Departments' authority "to tack on additional criteria" to the excepted benefit requirements enumerated in the statute. In this case, the Departments propose an additional criterion beyond the criteria established in the statute.

To be exempt from certain Public Health Services Act (PHSA) requirements governing comprehensive major medical health coverage, excepted benefits must meet three requirements under the statute. First benefits must be provided under a separate policy, certificate, or contract of insurance. Second, there must be no coordination between the provision of the benefits and any exclusion of benefits under the group health plan. Third, the benefits must be paid with respect to an event without regard to whether benefits are paid for the same event by the same health plan. Nothing on this list suggests a requirement that a benefit must be paid on a per-period basis versus a per-service basis. Therefore, the Departments proposal appears to impermissibly add a new criterion.

While the lower court ruling in this case also does not decide this question, it spent time discussing the line between interpretation and invention after quoting the Ninth Circuit's view that "an interpreting body may not invent a completely new meaning for a statutory term. Any other rule of construction would rob statutes of binding force and allow free rein to those who implement federal statutes to do what they wish rather than what Congress directed."²⁰ Here, the Departments invent a new criterion and if allowed to do so, there would appear to be no limit to Departments ability to regulate as they wish regardless of what is in the statute.

The lower court in *Central United Life* also addressed the argument that rejecting the new interpretation of fixed indemnity insurance would require ignoring the provision that authorizes HHS to make regulations to accomplish the goals of the PHSA. That argument pervades the proposals found in this rule. Instead of adding meaning to the statutory text, the proposals in this rule rely on supporting goals to help consumers distinguish fixed indemnity excepted benefits coverage from comprehensive coverage and to encourage individuals to enroll in comprehensive coverage. While the lower court agreed HHS has authority to issue regulations to further the goals of the PHSA, the court admonished: "It is equally undeniable that HHS may not use such authority to contravene the very statute they are implementing."

²⁰ 128 F.Supp.3d 321.

On this proposal to limit excepted benefits to pay only on a per-period basis and several other proposals in this rulemaking, the Departments do appear focused on proposing requirements to achieve the goals of statute but in contravention of the statute itself.

Tax Treatment for Fixed Indemnity and Other Insurance

The Treasury Department proposes to “clarify” that benefits paid without regard to the actual amount incurred for medical expenses do not qualify for the exclusion from income under section 105(b) of the IRC. This appears to take the position that all benefits paid through fixed indemnity excepted benefit coverage do not qualify for the exclusion from income even if the benefits are less than the medical expenses incurred. Treasury reasons that the benefit paid is not a reimbursement for a 213(d) medical expense under section 105(b) because it is paid without regard to the amount of the medical expense.

Rather than being a clarification, this appears to be a significant change in how Treasury interprets and applies the IRC. Revenue Ruling 69-154 provides several examples on how benefits paid from two plans of coverage can be excluded from income up to the amount of the medical expense incurred, demonstrating how benefits paid are excluded from income up to the amount of medical costs incurred. In a footnote, the proposed rule aims to distinguish this and claims the example only applies in situations where a medical expense is reimbursed by multiple coverages. However, according to Groom Law, this is the first time that Treasury specifically limited this ruling in this way and they note how it is at odds with previous IRS statements.²¹ Moreover, Groom Law also cites to IRS conclusions issued previously this year which also appear to be at odds with Treasury’s argument. This conclusion found that the 105(b) exclusion did not apply to benefits paid under a fixed indemnity wellness plan “when the employee has no unreimbursed medical expense either because the activity that triggers the payment does not cost the employee anything or because the cost of the activity is reimbursed by other coverage.”²² Based on this conclusion, the 105(b) exclusion would otherwise apply if the employee did have an unreimbursed medical expense due to the activity or event that triggered the benefit payment. Thus, this conclusion suggests that the 105(b) exclusion applies to a fixed indemnity excepted benefit payment when the payment is triggered by a medical event that incurs costs that are reimbursable under 213(d) up to the amount of the incurred cost.

Treasury also included this change in their Greenbook which outlines President Bidens tax proposals to Congress.²³ If Treasury is suggesting that Congress should pass a law to address this issue, then it must go beyond a simple clarification. Indeed, the description of the need for this change in the Greenbook shows the issue is not over how to best interpret the statute but rather over Treasury’s difficulty in enforcing the statute. Treasury’s rationale notes employers who fail to track expenses generally fail to include the amount of any fixed payment in excess of actual

²¹ Groom Law Group, “Proposed Rule Has Serious Implications on the Taxation of Fixed Indemnity and Other Similar Coverages,” July 10, 2023, at <https://www.groom.com/resources/proposed-rule-has-serious-implications-on-the-taxation-of-fixed-indemnity-and-other-similar-coverages/>.

²² Office of Chief Counsel Internal Revenue Service memorandum, No. 202323006, May 9, 2023, available at <https://www.irs.gov/pub/irs-wd/202323006.pdf>.

²³ Department of the Treasury, *General Explanations of the Administration’s Fiscal Year 2024 Revenue Proposals* (March 9, 2023), at 204-05, available at <https://home.treasury.gov/policy-issues/tax-policy/revenue-proposals>.

medical expenses. Treasury cannot remove a tax exclusion included in the IRC just because it's difficult to enforce.

Unfortunately, this proposal appears to be directly aimed at making fixed indemnity excepted benefit coverage less attractive in order to encourage people to purchase comprehensive coverage. Treasury does not have the authority to decide what coverage is best for taxpayers by removing a long-held income tax exclusion for coverage they disfavor. Therefore, Treasury should not finalize this proposal.

Level-Funded Plan Arrangements Request for Information

The Departments also request comments to better understand level-funded plan arrangements. These arrangements are a variation on a self-insured plan which relies on stop-loss insurance coverage. States regulate these stop-loss insurance plans and remain the best positioned to address any issues that may arise from these types of health plans. Therefore, while the responses to this request will no doubt be educational, the Departments do not need to expend their limited resources on addressing an issue that states already cover.

These comments outline several areas where this proposed rule would color outside the lines of federal law to achieve policy goals that the Biden administration cannot get passed through Congress. The Departments should therefore withdraw this rule and look for other legal avenues to achieve the Administration's goals.

Sincerely,

/ Peter Nelson /

Peter Nelson
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