

August 9, 2016

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Internal Revenue Service
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To Whom It May Concern:

Thank you for the opportunity to comment on the proposed regulations on *Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance*, published in the *Federal Register* on June 10, 2016. These comments are submitted on behalf of the members of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators in the 50 states, the District of Columbia, and the 5 United States territories.

As state insurance regulators we have the primary responsibility of regulating our insurance markets and ensuring consumers are protected and the markets are competitive. Federal interference can, and often does, have unintended consequences and may not be effective in addressing the underlying issues. We believe this is the case with this proposed regulation in a couple of areas.

Definition of Short-Term, Limited Duration Insurance

State regulators share the federal agencies' concern that consumers may be misled into buying short-term, limited duration insurance that do not provide adequate protection and may result in tax penalties. We do not, however, agree with the proposal to limit such a policy to no more than a three-month period. Such a limit would reduce consumer options and could do more harm than good.

Short term, limited duration insurance has long been defined as a policy of less than 12 months both by the states and the federal government. The proposed rule provides no data to support the premise that a three-month limit would protect consumers or markets.

In fact, state regulators believe the arbitrary limit proposed in the rule could harm some consumers. For example, if an individual misses the open enrollment period and applies for short-term, limited duration coverage in February, a 3-month policy would not provide coverage until the next policy year (which will start on January 1). The only option would be to buy another short-term policy at the end of the three months, but since the short-term health plans nearly always exclude pre-existing conditions, if the person develops a new condition while covered under the first policy, the condition would be denied as a pre-existing condition under the next short-term policy. In other words, only the healthy consumers would have coverage options available to them; unhealthy consumers would not.

This is why we do not believe this proposal will actually solve the problem it is intended to address. If the concern is that healthy individuals will stay out of the general pool by buying short-term, limited duration coverage there is nothing in this proposal that would stop that. If consumers are healthy they can continue

buying a new policy every three months. Only those who become unhealthy will be unable to afford care, and that is not good for the risk pools in the long run.

We also note that many plans sold to students studying in a foreign country are regulated as short-term, limited duration plans. As a result, the proposed regulation would limit a student's coverage in a foreign country to only three months. This could create a significant burden on these students. And only healthy students could buy new policies every three months, as pointed out above.

In conclusion, there are instances when consumers simply cannot afford, even with the subsidies, an insurance plan with minimum essential coverage (MEC) or may have other reasons for choosing a shorter-term plan. Their options should not be limited to either paying for coverage they cannot afford or exposing themselves to the risk of losing their coverage after three months if they become sick. We oppose this new definition of short-term, limited-duration insurance because it could harm some consumers, limit consumer options, and have little positive impact on the risk pools in the long run.

Disclosures

Instead of redefining short-term, limited duration plans, the focus should be on educating consumers and ensuring that they are aware of the limitations of these and other excepted benefit plans. Several states have received an increasing number of consumer inquiries and complaints related to excepted benefit policies. Consumers complain that they were confused or misinformed when they purchased a policy that appeared similar to a major medical policy and thought they had purchased comprehensive medical coverage that complied with the ACA. However, when the consumer made a claim, they were dismayed to learn that the policy limited coverage and had pre-existing condition exclusions.

Because of the real risk that consumers may confuse excepted benefit policies with comprehensive health insurance, it is important that all excepted benefit plans are clearly distinguished from ACA-compliant comprehensive health insurance. It is also important to ensure that consumers are aware of the limited nature of excepted benefit policies.

The proposed rule adds important disclosure requirements. For example, the proposed policy contract notice requirement alerting consumers to the fact that a short-term plan does not satisfy the requirement to maintain MEC and that the consumer may be subject to a fine when they file taxes will help to make clear to these consumers the large downsides to purchasing this coverage in lieu of MEC. It also requires that application, enrollment, and re-enrollment materials for both individual and group fixed indemnity plans inform consumers that the coverage is a supplement to health insurance, is not a substitute for major medical coverage, and does not protect the policyholder from owing an additional payment with their federal income taxes. These disclosures may also serve as a deterrent to unscrupulous marketing behavior.

States have taken an active role in the investigation of marketing practices regarding excepted benefit plans and we urge that the final rule recognize that the disclosure language should be created by the states, should they so desire. The states issue and hold the license of each insurer and have the necessary leverage to enforce the law, including the potential revocation of an insurer's license. Therefore, the states are in the best position to determine what consumer disclosures are necessary and how to prosecute violations of those requirements.

Travel Insurance

State regulators ask for clarification of whether the Departments are including sickness, accident, and disability coverage in the category of health benefits for the purpose of defining travel insurance

August 9, 2016

Page 3

products. We see many travel insurance products where accident, sickness and disability coverage are the primary standalone benefit, and not incidental to another benefit such as loss of baggage and trip cancellation.

Fixed Indemnity

State regulators oppose the proposed fixed indemnity language that would require that these types of policies have a “per day” benefit and would prohibit a “per service” policy. Under the Public Health Service Act, the only requirements on this type of coverage to qualify as an “excepted benefit” are: 1) benefits are provided under a separate policy, certificate or contract of insurance; 2) there is no coordination of benefits; and 3) benefits are paid with “respect to an event”. Current federal law establishes what qualifies a fixed indemnity plan as an “excepted benefit” and permits the coverage to include “one or more (or any combination thereof) of” benefits. By adding the additional limitation, the proposed requirement again goes beyond the statutory language and the D.C. Circuit Court of Appeals has already ruled in *Central United Life Ins. v. Burwell*, No. 15-5310 (D.C. Cir. 2016) that such a regulatory overreach cannot stand.

We recommend that this proposal be withdrawn.

Thank you for your consideration.

Best regards,



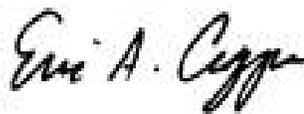
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