

September 11, 2023

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9904-P  
P.O. Box 8010  
Baltimore, MD 21244-8010

Via Regulations.gov

To Whom it May Concern:

Thank you for the opportunity to comment on the proposed regulations 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 in the Federal Register on July 12, 2023. 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 United States territories.

As state insurance regulators, we have the primary responsibility for regulating our insurance markets, ensuring consumer protection and market competition. We appreciate the Tri-Departments' attention to the risks of consumer confusion between comprehensive health insurance coverage and more limited plans and arrangements that may not offer the same level of protection against health care expenses. Consumers should be able to understand the coverage they enroll in and should not be misled into choosing a more limited benefit product than they intend to buy. We also acknowledge that due to the underwriting frequently associated with these limited benefit products, some consumers may not have the option to purchase such coverage. At the same time, consumers should have meaningful choices in coverage that are tailored to the markets and consumers in the state. Banning certain plan features at the federal level would limit currently available options for consumers in many states and could lead them to seek coverage in unregulated markets.

Further, federal regulation should not unnecessarily limit state authority to regulate health insurance. We urge the Departments to reconsider the short-term and fixed-indemnity plan limits that would restrict valid state authority in regulating these products. We also strongly urge the Departments to enhance their efforts to cooperate with state regulators to address any allegations of misleading marketing of short-term plans, fixed indemnity products, and level-funded arrangements.

## **Short-Term, Limited Duration Insurance**

As federal regulation of short-term, limited duration insurance has tightened and loosened over the past several years, the NAIC has consistently commented in favor of states' ability to make their own choices in regulating these products. Because the maximum length of short-term plans is not specified in federal law, we believe it is more appropriate to recognize the role of states as the primary regulators of insurance products and allow states to set their own limits. The states are the more responsive regulator and know better what their individual markets can provide and what their respective consumers need.

Many states have actively considered and chosen to develop their own regulations for short-term, limited duration insurance (STLDI). Some have effectively banned the products or mandate that certain benefits are covered. Several have established time limits of approximately three months, six months, one year, or until the end of the calendar year. Other states have created new regulatory structures that extend important consumer protections and rating rules to STLDI plans. Under these state laws, short-term plans serve consumers who experience gaps in other coverage sources. There is no guarantee that such a gap will last only three or four months. With a federal four-month time limit, consumers in many states will lose plan options currently available to them. Consequently, they will go uncovered or what is worse go without treatment until they can enroll in an approved plan. Allowing for different state choices like these is precisely why the McCarran-Ferguson Act reserves the regulation of insurance for the states.

State regulators strongly request that their flexibility to determine whether, and under what conditions, STLDI is appropriate for their markets and consumers be retained. We request that the proposed rule be revised to continue state flexibility in this area. If the Departments determine that a change to current regulations is necessary, we suggest the Departments adopt either of the following alternative approaches that better protect state choices:

- A. Returning the definition of short-term, limited duration insurance to the pre-2016 language, specifically "health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract."
- B. Establishing a federal definition (that could be as limited as the proposed four months), but providing that the definition only applies in the absence of a state promulgating its own definition. This would ensure that states are able to meet the needs of their particular markets while establishing a backstop definition that applies if a state takes no action regarding the definition of STLDI.

While we believe states should retain the authority to define the length of short-term plans, state regulators recognize that some short-term plans are marketed in misleading ways. Some provide inadequate benefits and consumer protections for consumers who expect the benefits of a comprehensive health insurance policy. State regulators have worked individually and through NAIC to address misleading marketing of these plans. In addition to sharing information across states, NAIC has partnered with state attorneys general to enhance enforcement actions. NAIC is also working to

establish greater state authority over lead generators, which are often responsible for the initial contacts that may confuse consumers about the extent of coverage under short-term plans.

We seek greater collaboration with federal officials in our efforts to combat misleading marketing. We appreciate efforts to aid states in reining in improper activity by licensed or registered agents and brokers. But much of the misleading marketing comes from non-licensed entities. We urge the Tri-Departments to work with states as well as the Federal Communications Commission, the Federal Trade Commission, and the Federal Bureau of Investigation to investigate and stop lead generators and sales agents who use deceptive marketing techniques through websites, social media, phone calls, and other means.

NAIC supports strong disclosure language in marketing materials and short-term plan policies. Clear disclosures can help mitigate improper marketing practices, but they are only part of the solution. The updated notice language and additional materials where the NPRM proposes disclosures be required to appear represent improvements. We encourage the Departments to include state-specific language in the disclosures. States should have the option to substitute their own required disclosure language in place of the federally-mandated message. When the federal language is used, it should include contact information for the insurance department in the consumer's state. STLDI marketing materials should also be required to disclose the name of the insurer, the state in which the insurer is domiciled, and the name of any association involved in offering the coverage. This information would be helpful in maintaining accountability and enforcing marketing rules. The disclosure should also note the availability of special enrollment periods for consumers who qualify. Consumers with a qualifying life event should not be misled into thinking the Marketplace is closed to them until the next Open Enrollment Period.

These types of improvements are just a few of the types of processes the states have been reviewing and implementing over the past few years.

### **Fixed Indemnity Insurance**

The NPRM makes a distinction between fixed indemnity benefits paid with respect to an event and those paid "per service," that is, benefits that pay fixed dollar amounts that vary based on the type or level of service a consumer receives. State regulators largely oppose the proposed language that would prohibit "per service" benefits within hospital or other fixed indemnity coverage that qualifies as an excepted benefit 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." There is nothing in federal statute prohibiting excepted benefits coverage from varying benefit amounts based on the severity of a diagnosis (for example, a heart attack versus a sprained ankle) or treatment site (for example, in an intensive care unit versus an out-patient facility). By adding the additional limitation, the proposed requirement goes beyond the statutory language.

State regulators continue to believe hospital and other fixed indemnity coverage with per service benefits provide important options to consumers to help pay for both health care costs and other expenses. Consumers often use fixed indemnity payments to replace lost earnings, to help pay for non-health related expenses triggered by the need for health services (such as transportation and

lodging), and to cover deductibles, co-pays and other out of pocket expenses. Because both non-health expenses and out of pocket costs can be proportional to the number of health services a consumer requires, “per service” payments are helpful for some consumers. It is clearly in the interest of consumers for fixed indemnity policies to pay more in benefits when, due to the severity of an accident or illness, the consumer incurs more expenses left uncovered by their major medical coverage. Consumers who purchase fixed indemnity products should be fully apprised of the limits of the plan benefits and consumer protections. Again, what fixed indemnity plans can be sold in a state market should be a decision of that state.

State regulators recognize that, like STLDI, some fixed indemnity products are marketed in a misleading manner. We believe the appropriate solution is to enhance collaboration across states and with federal partners to address improper marketing, not for federal regulations to limit plan features that some consumers value. We support the proposed disclosure requirement for marketing, application, and enrollment materials for fixed indemnity products.

State regulators further understand the proposed rules would change the long-standing tax treatment of fixed indemnity policies when premiums are funded on a pre-tax basis. Currently, taxes are imposed only on the portion of fixed indemnity benefits, if any, that exceed an individual’s medical expenses. The proposed rules would begin taxing 100% of fixed indemnity benefits as wages. The proposed change is, however, based on the false assertion that fixed indemnity benefits do not provide reimbursement for medical expenses but are rather wage replacement, like disability income coverage. As pointed out above and as the agencies are aware, the health-related events covered by fixed indemnity coverage (for instance, a cancer diagnosis and treatment) give rise to a myriad of medical expenses left uncovered by primary health coverage, including transportation to regional treatment centers, co-payments, and deductibles. It is simply not accurate to characterize benefits used to offset these medical expenses as wages.

### **Level Funded Arrangements**

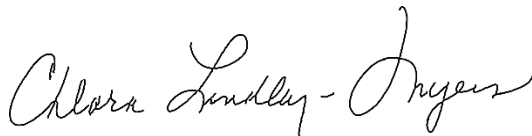
In the NPRM, the Departments seek comment on level funded arrangements. Some state regulators have concerns about these arrangements, particularly with the understanding among employers and enrollees of the risks such arrangements pose. In cases where the plan’s risk is fully transferred to an insurer, so that the insurer can guarantee that the level monthly payments will completely defray all costs of the health benefit plan, the plan is functionally a fully-insured plan and many regulators believe that it should be regulated as such.

In other cases, the “level funded” description is inaccurate and misleading. Employers and enrollees may view level funded arrangements as health insurance that is subject to the consumer protections and risk transfer that characterize insurance. There could be hidden costs that are not fully disclosed. Employers may not recognize the responsibilities they assume when offering a self-funded group health plan or the risk that premiums for the stop loss portion of the arrangement can increase, even retroactively. Level funded plans may be marketed with price comparisons to fully-insured plans that do not disclose material differences between the plans. Both employers and enrollees may be unaware that state and federal consumer protections and required benefits applicable to health insurance do not apply to the arrangements.

Some state regulators believe additional safeguards are needed to better protect against the risks of level-funded arrangements. These regulators support federal action to require disclosures to plan sponsors about federal and state consumer protections that are forfeited by the use of these arrangements in place of health insurance as well as disclosures about potential prospective and retrospective rate increases. We also encourage the Departments to work with states to develop educational and enforcement materials for agents and brokers who sell associated products to improve their disclosures to employers about the details and risks of the arrangements. Educational materials would also be useful for employers regarding their responsibilities as plan sponsors and how level-funded arrangements may trigger them.

Thank you for the opportunity to comment on these important topics. We look forward to continued collaboration with the Departments on health insurance issues.

Sincerely,



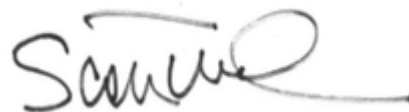
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