September 8, 2023

The Honorable Xavier Becerra
Secretary
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

The Honorable Julie A. Su
Acting Secretary
U.S. Department of Labor
200 Constitution Ave, NW
Washington, DC 20210

The Honorable Janet Yellen
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Ave, NW
Washington, DC 20220

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

Submitted electronically via www.regulations.gov

Dear Secretary Becerra, Acting Secretary Su, and Secretary Yellen:

Aflac, Inc. appreciates the opportunity to provide comments on the above-referenced Proposed Rule published in the Federal Register on July 12, 2023[1] by the Departments of Health and Human Services, Labor and Treasury (collectively, the "Departments"). We share the Departments' concerns that consumers should understand the nature of the health coverage products they buy. As such, Aflac includes a notice on its policies, when not otherwise required to do so, to inform consumers that the policies are not comprehensive coverage or a substitute for such coverage.

As discussed further below, we have significant concerns with the portions of the Departments' Proposed Rule that would impose new interpretations of the "fixed" payment standard and the "noncoordination" requirement as applied to hospital indemnity or other fixed indemnity excepted benefits and with the tax changes Proposed by the Treasury Department. These portions of the Proposed Rule will significantly restrict cost-effective financial protection insurance options that have been available to individuals for decades and continue to be popular today. The Proposed Rule will also subject policyholders to new taxes on the benefits received under the impacted policies. We believe the Proposed Rule also goes well beyond statutory authority.

Aflac Incorporated (NYSE: AFL), a Fortune 500 company, has helped provide financial protection and peace of mind for more than 67 years to millions of policyholders and customers through its subsidiaries

[1] 88 Fed. Reg. 44596.

in the U.S. and Japan. In the U.S., Aflac is the No. 1 provider of supplemental health insurance products. In Japan, Aflac Life Insurance Japan is the leading provider of cancer and medical insurance policies in force. In 2021, Aflac company became a signatory of the Principles for Responsible Investment (PRI). In 2022, the company was included in the Dow Jones Sustainability North America Index for the ninth year, the World's Most Ethical Companies by Ethisphere for the 17th consecutive year, Fortune's World's Most Admired Companies for the 22nd time and Bloomberg's Gender-Equality Index for the fourth consecutive year.

Aflac's history began in 1955 with the idea of principal founder John Amos and his brothers, Paul and Bill Amos, who saw a need for financial protection when a medical situation occurs. The brothers pioneered the introduction of a fixed indemnity cancer policy after identifying the need to lift the financial burden of cancer patients and their families while navigating their own father's cancer diagnosis. Through that experience, they realized that there are expenses associated with a major illness or accident that comprehensive medical insurance is not designed to cover.

Today, Aflac offers a full suite of products that are commonly referred to in the marketplace as "supplemental products" or "supplemental benefits". The term supplemental is used to distinguish the products from comprehensive medical coverage. Supplemental products are not designed as comprehensive medical coverage or a substitute for such coverage. Rather, supplemental products recognize that individuals experiencing an accident, sickness, or injury face many out-of-pocket costs that comprehensive medical plans are not designed to cover. A key attraction of Aflac's supplemental products is that they pay cash directly to the policyholder, who can then use the cash as they consider best, whether to offset the impact of unreimbursed medical expenses for other related financial needs, such as for respite care giving. Aflac does not make payments directly to providers unless the policyholder assigns the benefit.

Aflac offers supplemental insurance products for individuals, families, and businesses. In the United States, Aflac is the leading provider of supplemental insurance directly to employees by enrolling them, with their employer's assistance, at their place of employment. We have not offered, and currently do not offer, comprehensive, comprehensive health insurance or short-term limited duration insurance (STLDI). We also do not market or sell our products as comprehensive medical coverage or as a substitute for such comprehensive coverage.

Under the statute, supplemental products are called "excepted" benefits because Congress has intentionally "excepted" these benefits from federal health coverage mandates that apply to comprehensive medical coverage. The federal requirements for these products to qualify as excepted benefits were first established in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Congress has kept these same requirements in place without fail every time that it has added new federal health mandates since HIPAA, including when the Affordable Care Act was adopted and, most recently, the enactment of the No Surprises Act.

Many of Aflac's supplemental products are referred to in the statute as "independent, noncoordinated" excepted benefits. This class of excepted benefits includes "hospital indemnity or other fixed indemnity" coverage, as well as specified disease or illness insurance (e.g., cancer-only coverage), which is commonly referred to as "critical illness" coverage. These "independent, noncoordinated" benefits are the subject of the Departments' Proposed Rule. Aflac also offers other excepted benefit products including accident, disability, dental and vision.

Most of our excepted benefit products are sold through the employer, rather than direct to individuals. This helps ensure that the benefits appropriately supplement the employer's other benefit offerings.

Consumers report a very high level of satisfaction with supplemental products as they exist in the market today. 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.[2]

Employment-based coverage remains the most common source of health coverage in the United States. Over 178 million people are covered under employment-based health plans. Fifty-four percent of all Americans with health coverage receive coverage through an employment-based plan.[3] Employers recognize the value of supplemental coverage and the importance of such coverage to their employees. 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.[4] 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). Aon also reported strong growth in employers offering supplemental benefits and employees selecting them in 2022 open enrollment, noting that 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).[5]

As the primary regulators of insurance, states also recognize the value these products provide to consumers, and continue to approve products in their current form, including products that vary benefits by factors such as services provided or treatments. Aflac's products are designed and offered in accordance with the applicable laws of the states and territories in which where they are issued. Aflac currently offers individual hospital indemnity or other fixed indemnity excepted benefit coverage with benefits based on treatment/service in 54 states/territories, and group hospital indemnity or other fixed indemnity excepted benefit coverage with benefits based on treatment/service in 49 states/territories.

The Proposed Rule contains two parts.

- First, the Departments propose to add two new requirements that are not in the statute for hospital indemnity or other fixed indemnity coverage to qualify as an excepted benefit in both the group and individual market by (a) changing what it means to provide a "fixed benefit" and (b) proposing a new interpretation of the "noncoordination" requirement.

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[2] Global Strategy Group, *Measuring Satisfaction with Supplemental Insurance*, conducted on behalf of AHIP, February 23, 2022, at 2. https://www.ahip.org/documents/AHIP-Supplemental-Insurance-Deck-032422.pdf ("Global Strategy Group Survey") (last visited Sept. 5, 2023).

[3] U.S. Dept. of Commerce, *Current Population Reports Health Insurance Coverage in the United States: 2021* (issued Sept. 2022), at 3,4. https://www.census.gov/library/publications/2022/demo/p60-278.html (last visited Sept. 6, 2023).

[4] 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") (last visited Sept. 5, 2023).

[5] *See* Aon Report at https://aon.mediaroom.com/2022-04-20-Voluntary-Benefit-Offerings-in-U-S-Rise-41-Percent-During-COVID-19-Pandemic,-Aon-Reports (last visited Sept. 5, 2023).

- With respect to the first proposed change, the statutory standard established by Congress requires that these products pay benefits in a fixed amount; that is, the benefit paid under the plan is triggered by the occurrence of a covered medical event but cannot be based on the amount of medical expenses incurred with respect to that event. Currently, in both the individual and group markets, the amount of the benefit may vary based on the particular medical event. Varying the fixed payment based on the particular medical event, such as the specific type of hospitalization (e.g., emergency room, hospital confinement, rehabilitation facility, or intensive care unit) or a particular treatment received is the common form for these policies. This approach provides the most value to consumers and reflects the fact that different medical events present different financial risks. The Proposed Rule would prohibit this type of benefit structure, essentially limiting these policies to one specific benefit based on a per-period basis, such as $100 per day regardless of whether the policyholder went to the hospital for a cast or was admitted to the intensive care unit (ICU).

    - With respect to the second change, excepted benefits are often referred to as "supplemental" because they are not designed or intended as comprehensive medical coverage but as a supplement to such coverage to provide an additional layer of financial protection. Employers of all sizes often offer hospital indemnity or other fixed indemnity excepted benefits along with other employee benefits, including comprehensive medical coverage. The proposed changes to the "noncoordination" rules (in the form of an illustrative example) would raise serious risks that these excepted benefits could no longer be offered by any employer that offers comprehensive medical coverage (or, in the individual market, by an insurer that also offers comprehensive medical coverage). The example of impermissible coordination in the Proposed Rule reflects an over extension and misinterpretation of current law. While the practice reflected in the example is not a very common plan design, the preamble makes it clear that the concept is broader and not limited to this particular plan design. The proposal could ultimately be read to restrict the ability of individuals to have both comprehensive medical coverage and excepted benefit coverage. While such a broad result was likely unintended, the Proposed Rule provides no further indication of the specific situations the rule was intended to cover and thus does not provide guidance for employers or issuers on what would be considered permitted plan designs.

- Second, a separate rule proposed by the Treasury Department (which is mischaracterized as a clarification) would change the long-standing tax treatment of fixed indemnity health insurance when the premium is paid on a pre-tax basis (either by direct employer contributions or by pre-tax employee salary reduction contributions through a cafeteria plan). This change in tax treatment would apply to any health plan that pays benefits based on a medical trigger, but without regard to the amount of expenses (referred to in this letter as "Indemnity-Based Health Policies"). Policies that would be subject to the Proposed Rule include hospital indemnity or other fixed indemnity excepted benefits, specified disease or illness excepted benefits, and certain accident, dental and vision benefits.

    - Current law is well settled. When Indemnity-Based Health Policies are paid for on a pre-tax basis (through direct employer contributions or employee pre-tax salary reduction), then the benefits are tax-free to the extent of the individual's unreimbursed related medical expenses. Only any "excess benefit" is taxable, that is, any benefit in excess of such unreimbursed medical

expenses.[6] (When the premium is paid by the employee on an-after tax basis, the entire benefit amount is tax free.)

- Under the proposal, however, when premiums are paid on a pre-tax basis, the entire benefit would be taxable regardless of the amount of the individual's unreimbursed medical expenses. In addition, the preamble indicates that the benefits would also be subject to employment taxes (such as FICA taxes); which means that both the employee and the employer would now be subject to a tax increase. For the employee, the increased taxes will reduce the value of the benefit payment and thereby expose the individual to increased liability for unreimbursed medical expenses.

Aflac has significant concerns with the Proposed Rule. The Departments' proposals regarding hospital indemnity or other fixed indemnity excepted benefits will be harmful to consumers by severely reducing the availability of cost-effective options that have long been available for individuals who need additional financial protection for expenses comprehensive medical insurance does not cover. According to a report by Third Way, while high medical costs and debt clearly affect low-income families, middle-income Americans, those with incomes between $50,000 to $100,000, see the highest rates of medical debt. Within these income ranges, Black and Hispanic families have the highest rates of medical debt.[7] The Departments express concern regarding the level of medical debt, yet their proposal will leave individuals and families more exposed.

What the Treasury Department describes a "clarification" would reverse what has been clear tax treatment for decades. If the Proposed Rule is finalized, individuals who purchase Indemnity-Based Health Policies on a pre-tax basis, including hospital indemnity or other fixed indemnity excepted benefits, will face increased income taxes, which will reduce the amount of benefits thereby exposing the individual to additional liability for out-of-pocket expenses. In addition, new employment tax liability would arise for employees and their employers, including small businesses.

An example illustrates the negative impact on individuals with serious illnesses.[8] Consider an individual diagnosed with cancer who has taxable income of $47,000 and is therefore in the 22% individual tax bracket. They have comprehensive medical coverage and their out-of-pocket expenses relating to the cancer are $6,000.[9] They also covered under a hospital indemnity or other fixed indemnity excepted benefit policy and receive $5,000 in benefits related to cancer treatments under that policy. Under current law, the entire $5,000 benefit would be tax-free, leaving them with $1,000 of liability for the out-of-pocket expenses. Under the proposal, the entire $5,000 benefit is taxable. The combined federal taxes (i.e., income and FICA taxes) would be $1,480, leaving only $3,520 of the fixed indemnity benefit to use for out-of-pocket medical expenses. Their exposure for out-of-pocket medical expenses is more

[6] See, for example, Internal Revenue Code (Code) § 105(b); 26 CFR § 1.105-2; Rev. Rul. 69-154, and IRS Pub. 502 (Medical and Dental Expenses) (2002) (p. 17-19).

[7] https://www.thirdway.org/report/medical-debt-hits-the-heart-of-the-middle-class (last visited Sept. 5, 2023).

[8] Further details on the example are provided in the Detailed Discussion, below.

[9] Under the ACA, for 2023, an individual may be required to pay up to $9,100 in out-of-pocket expenses for covered services under a comprehensive medical plan, even when in-network providers are used. https://www.cms.gov/files/document/2023-papi-parameters-guidance-v4-final-12-27-21-508.pdf (last visited Sept. 5, 2023).

than doubled due to the taxes, and they are now left facing $2,480 in unreimbursed medical expenses. The impact may be greater when state taxes are taken into account.

If the proposal is finalized, some employers, not wishing to expose their employees to taxation on the full indemnity benefit, may offer these benefits on an after-tax basis; this also is an increase in taxes compared to current law. Some employers, particularly smaller employers, may decide not to make the benefits available at all, thus reducing the availability of this type of additional financial protection.

The Departments do not limit the application of their proposals prospectively; rather, they would also apply to existing policies. With respect to existing policies, the Proposed Rule is retroactive, interfering with current contract rights (most of the impacted coverage is issued on a guaranteed renewal basis) and imposing new taxes on benefit arrangements that have long been in place.

In addition to causing negative impact on consumers, including increased taxes, the Proposed Rule is contrary to the relevant statutory provisions. In each of these provisions, the Departments overstep their authority.

The impact of rising health care costs is a significant problem. According to the Kaiser Family Foundation, about half of Americans say they have trouble affording medical costs and 44% worry about affording their deductible before their insurance coverage begins. [10] At the same time, the Bankrate Annual Emergency Fund Report found that 57% of Americans are uncomfortable with their level of savings[11] This aligns with Aflac's annual independent survey which found that 58% of employed Americans cannot pay over $1,000 in out-of-pocket costs for an unexpected illness or injury – 26% higher than 2021.[12]

Individuals and families are concerned not just with medical costs that might not be covered by their comprehensive insurance plan, but also with other costs associated with an accident or illness. There are "competing costs" that patients face with a medical event such as paying for the medical costs versus food, household bills, and housing. Estimating these costs of care caused by the medical event can be challenging.[13] Common costs incurred for cancer care include transportation and travel (airfare, bus, and train fares), parking, gas, ridesharing fees, childcare, household help, special clothing, wigs, and special food.[14]

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[10] Alex Montero, et al., *Americans' Challenges with Health Care Costs* (Jul. 14, 2023), https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/ (last visited Sept. 5, 2023).

[11] Gillespie, Lane. *Bankrate's 2023 annual emergency savings report*, Bankrate (June 22, 2023) https://www.bankrate.com/banking/savings/emergency-savings-report/ (last visited Sept. 5, 2023).

[12] *Health Care Costs Continue to Burden American Workers,* 2022-2023 Aflac WorkForces Report, conducted by Kandar, https://www.aflac.com/docs/awr/pdf/2022-trends-and-topics/2022-aflac-awr-financial-insecurity.pdf (last visited Sept. 5, 2023).

[13] Kim Erwin et al., *What Your Patients Aren't Telling You: How to Partner with Patients to Help Manage Hidden Costs of Healthcare* (Avalere Health, Cost-of-Care Conversations Practice Brief #2, 2018), https://essentialhospitals.org/wp-content/uploads/2018/11/CostofCarePracticeBrief2.pdf (last visited Sept. 6, 2023).

[14] Cancer.Net, *Understanding the Costs Related to Cancer Care* (08/2022), available at https://www.cancer.net/navigating-cancer-care/financial-considerations/understanding-costs-related-cancer-care (last visited Sept. 5, 2023).

This is where supplemental products fit in. They are specifically designed to provide an additional layer of financial protection. As stated earlier in this letter,[15] consumers are overwhelmingly satisfied with their supplemental coverage, and employers recognize the value of this coverage to their employees. 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%).[16] 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%).[17] 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).[18]

Yet, the Departments propose to significantly reduce the availability of these financial protection policies. Moreover, to the extent products remain available under the Proposed Rule, policyholders would receive less, because they would now be taxed on the benefits.

A key reason given in the preamble for the Proposed Rule is that some consumers may be confused as to whether hospital indemnity or other fixed indemnity excepted benefits provide comprehensive coverage. Aflac shares this concern and believes that consumers should understand the nature of the coverage they buy. This is why Aflac includes a notice on its products, even where not otherwise required to do so by law, to distinguish supplemental coverage from comprehensive coverage. Recent survey results show that by far most consumers understand the nature of their supplemental excepted benefit 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.[19]

Providing a clear notice directly addresses the Departments' concerns with respect to possible consumer confusion, without the broad negative impacts on consumers who wish to have this type of additional financial protection. While we firmly believe in the importance and effectiveness of a notice in ensuring that consumers understand the nature of supplemental coverage, we believe that this issue is best left to the states. Based on the federal court of appeals decision in *Central United*,[20] it is unclear whether a federal court would find that the Departments have the authority to require a notice as a condition of excepted benefit status. Should the final rule include a notice requirement, we have some suggestions regarding the details of the notice.

The Departments are also concerned regarding promoters and others who use deceptive marketing practices that may dupe consumers into believing that excepted benefit coverage is comprehensive coverage. These practices represent a very small portion of the market. The best way to deal with such

[15] See the text accompanying footnotes 2-5, above.

[16] Global Strategy Group Survey, at 7.

[17] *Id.* at 11.

[18] *Id*. at 6.

[19] *Id.* at 9.

[20] *Cent. United Life Ins. Co. v. Burwell*, 827 F. 3d 70, 74 (D.C. Cir. 2016).

practices is through targeted enforcement efforts, not through broad changes that impact compliant insurers and their customers. As the primary regulators of insurance, states have considerable authority to address bad actors and inappropriate marketing, including review of policy forms, market conduct reviews, and investigation of customer complaints. States often coordinate enforcement efforts, including with federal authorities. As a recent example of state-level activity, during the NAIC's 2023 Summer Meeting in Seattle, Washington, the Working Group approved its first amendments to an NAIC model law (Model #880, the Unfair Trade Practices Act). If these amendments are ultimately approved by the NAIC and adopted by the states, state laws will, for the first time, formally recognize the role that lead generators play in the sale of health insurance products, subject lead generators to the same trade requirements placed on insurers and producers, and require lead generators to maintain marketing and performance records.

In support of the tax changes in the Proposed Rule, the preamble refers to certain arrangements that purport to avoid income and employment taxes; however, the purported tax benefits of these arrangements are not real. The Treasury Department and the IRS have been working to combat these tax schemes. As part of these efforts, the IRS has issued guidance regarding the tax schemes, which serve to alert employers regarding the false claims and consequences of engaging in these transactions.[21] Aflac shares the concerns regarding tax schemes. Aflac has taken efforts to provide information to employers and others to make them aware of the schemes and how to avoid them.[22]

Legitimate plans are very different from the tax schemes. The IRS has considerable enforcement authority and should continue to use that authority to directly target promoters of such schemes, rather than engage in broad rulemaking that will impose new taxes on individuals and employers who purchase legitimate products.

Aflac recommends that both (a) the Departments' new interpretations of the "fixed payment" and "noncoordination" requirements for hospital indemnity or other fixed indemnity excepted benefits and (b) the Treasury Department's Proposed Rule increasing taxes on Indemnity-Based Health Policies be withdrawn. Further, with respect to the requirements for hospital indemnity or other fixed indemnity excepted benefits, we recommend that the Departments conform the group market rule to the current individual market rule and allow payments to vary based by service, treatment, etc. and/or by period. This would harmonize regulations in both the individual and group markets and also conform to the statute, which does not contain a per period limitation. At least, the Departments should leave the individual market rule in place and confirm that in the group market payments that vary based on the service, treatment, etc. and that also have a time period are permitted. Similarly, the Treasury Department should withdraw the proposed tax changes for Indemnity-Based Health Policies and affirm that the current-law rules continue to apply.

Finally, while not proposing a change to the requirements for specified disease or illness coverage (commonly referred to as "critical illness coverage") to qualify as an excepted benefit, the Departments request detailed information on such coverage and possible changes to the requirements for this coverage. For the reasons presented in this letter, applying the Proposed Rule (or other new

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[21] See, for example, Rev. Rul. 2002-3, 2002-2 CB 316; Chief Counsel Advice (CCA 202323006 (dated May 9, 2023, release date June 9, 2023), and CCA 201719025 (dated April 24, 2107, release date May 12, 2017).

[22] See, for example, Aflac Federal Relations Advisory, "Watch out for fraudulent health plan tax avoidance schemes", available at https://www.aflac.com/business/resources/advisories/wellness-scam-advisory.aspx (last visited Sept. 1, 2023).

restrictions) on specified disease or illness excepted benefits would unnecessarily disrupt a functioning market for these products, and prevent consumers from accessing the financial products they need to protect and provide for themselves or their families. As is the case with hospital indemnity or other fixed indemnity excepted benefits, consumers who purchase specified disease or illness coverage similarly report overwhelming satisfaction with the product and for the same reasons. In a recent survey, 97% of consumers were satisfied with their specified disease/critical illness coverage.[23]

Our Detailed Discussion the Proposed Rule follows, including in-depth analysis and further detail on our specific recommendations. For convenience, we have included a table of contents at the beginning of the Detailed Discussion.

[23] Global Strategy Group Survey at 5.

DETAILED DISCUSSION

Contents

THE ROLE OF EXCEPTED BENEFITS IN THE HEALTH COVERAGE MARKET

I. Federal and State Law Recognize a Unique Role for Excepted Benefits

As the primary regulators of insurance, before federal health coverage mandates were enacted, States recognized for decades the differences between comprehensive medical products and other types of policies. Products known as "excepted benefits," including hospital indemnity or other fixed indemnity insurance and specified disease or illness insurance, are not designed to be comprehensive medical coverage or a substitute for such medical coverage. Rather, such products recognize that when an injury or illness occurs families may face many financial needs that comprehensive medical insurance is not designed to cover. These policies provide additional funds to enable individuals to better plan for financial stability should the individual experience a medical event due to injury or illness.

At the federal level, the special nature of excepted benefits products and the differences between such products and comprehensive medical coverage has been recognized by Congress for 27 years. Federal excepted benefits provisions were originally enacted in 1996 as part of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA was intended to "reduce many of the current barriers to obtaining health insurance coverage by making it easier for people who change jobs or lose their jobs to maintain adequate coverage, and by providing increased purchasing power to small businesses and individuals."[24] HIPAA included limitations on pre-existing condition exclusions, guaranteed availability requirements in the small group market, and guaranteed renewability requirements in the group health insurance market.

Congress' view of excepted benefits when HIPAA was enacted is clear and unambiguous from the face of the statute: excepted benefits are not subject to the HIPAA reforms. Congress made the decision that, because of the supplemental nature of excepted benefits products, they do not present the same issues as comprehensive medical coverage and should not be regulated in the same way. Thus, Congress recognized that excepted benefits play a valuable role in the health insurance market and provide valuable options for consumers that supplement comprehensive medical coverage.

Congressional intent with respect to the treatment of excepted benefits has remained clear and unambiguous. Since HIPAA, each time Congress has added new federal coverage mandates, including the Affordable Care Act (ACA) and most recently the No Surprises Act, Congress has kept the same definition of excepted benefits and continued to except these benefits from federal health care mandates. Looking beyond the market reforms, other provisions also reflect the fact that Congress continues to recognize that excepted benefits have a role separate from comprehensive medical coverage. Thus, for example, excepted benefit products cannot be offered on the ACA exchanges.[25] Excepted benefits are not also minimum essential coverage (MEC)[26] and thus, do not satisfy the employer responsibility requirements (and did not satisfy the individual responsibility requirements when the penalty for failure to have MEC was in effect).

In short, in passing sweeping reforms for comprehensive medical coverage over almost three decades, Congress has reaffirmed the role of excepted benefits, keeping intact the definition of excepted benefits

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[24] S. Rep. 104-156, at 1 (1995).

[25] There is a very limited exception to this rule. There is a specific statutory provision that allows stand-alone excepted benefit dental covered to be offered in the exchanges to provide required pediatric dental coverage.

[26] Code § 5000A(f).

products, without any changes whatsoever. ***The message from Congress is clear -- excepted benefits, in particular hospital indemnity or other fixed indemnity excepted benefits -- play an important role in the health care marketplace and are intended to co-exist in the marketplace along with comprehensive coverage.***

II. Structure of Hospital Indemnity or other Fixed Indemnity Excepted Benefits

By law and in practice, hospital indemnity or other fixed indemnity excepted benefits are different than comprehensive medical coverage. While comprehensive medical policies are specifically designed to pay for medical expenses on an expense-incurred basis, hospital indemnity or other fixed indemnity excepted benefits provide an additional level of financial protection in the event of accident or illness. A key attractive feature of such policies is that cash benefits are paid directly to the consumer (unless assigned) to supplement comprehensive coverage. For many consumers, the benefits will be used to pay for medical expenses not covered by the individual's comprehensive medical policy, such as deductibles, co-insurance and co-payments, or other medical expenses that are not covered, such as medical travel.[27] Whether motivated by family medical history, a hazardous occupation, or general risk tolerance, hospital indemnity or other fixed indemnity excepted benefit coverage provided a layer of financial protection that comprehensive medical coverage alone does not provide.

Hospital indemnity or other fixed indemnity excepted products typically vary the benefit amount based upon a particular covered medical event. This is by far the predominant benefit structure, both historically before the enactment of HIPAA and in the current market. As the National Association of Insurance Commissioners (NAIC) noted in a 2013 comment letter to the Departments, state insurance regulators have for years under the current federal regulations consistently approved as excepted benefits hospital indemnity or other fixed indemnity products that vary benefits based on the type of service received. The NAIC has also made known the reasons for this approval -- consumers benefit from policies that provide benefits in this way.[28] Aflac currently offers individual hospital indemnity or other fixed indemnity excepted benefit coverage with benefits based on treatment/service in 54 states/territories, and group hospital indemnity or other fixed indemnity excepted benefit coverage with benefits based on treatment/service in 49 states/territories. The reason for this benefit structure is that it provides more value to consumers and recognizes that different health-related events present different risks with respect to unmet financial need. For example, a person who has an outpatient procedure faces different financial risks than someone who is admitted to the hospital for significant medical treatment. Current policies appropriately reflect these different risks.

Aflac describes its product line as "supplemental" products, and this term is used within the industry as well.[29] "Supplemental" appropriately describes Aflac's products, which are not designed as comprehensive medical coverage or a substitute for such coverage. Including a variety of medical event

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[27] In a recent survey, 90% of respondents said that their supplemental coverage helped them pay for critical medical expenses by easing the cost of copayments and deductibles. Global Strategy Group Survey, at. 12.

[28] 79 Fed. Reg. 15807, 15819 (March 21, 2014).

[29] See *Supplemental Insurance*, Aflac, https://www.aflac.com/individuals/what-we-do/default.aspx. The use of "supplemental" is descriptive in a general sense and should not be confused with the separate legal definition of the statutory category of excepted benefits that are supplemental to Medicare or similar supplemental coverage under a group health plan.

triggers does not change this concept that these products are "supplemental", but rather enables this supplemental coverage to provide better value to consumers.

The consumer need for these products could not be clearer. The impact of rising health care costs is a significant problem. According to the Kaiser Family Foundation, about half of Americans say they have trouble affording medical costs and 44% worry about affording their deductible before their insurance coverage begins. [30] At the same time, the Bankrate Annual Emergency Fund Report found that 57% of Americans are uncomfortable with their level of savings.[31] This aligns with Aflac's annual independent survey which found that 58% of employed Americans cannot pay over $1,000 in out-of-pocket costs for an unexpected illness or injury – 26% higher than 2021.[32]

III. The Role of State Regulators

States have historically been the primary regulators of insurance. HIPAA recognized and continued this role, which has remained the same as Congress has enacted an increasing number of federal health coverage mandates. The Public Health Service Act explicitly retains states' roles as the primary regulators of insurance.[33] HHS is authorized to enforce federal law only after going through a specified process to determine that the state has failed to substantially enforce federal law.[34] As stated in the regulations "each State enforces PHS Act requirements with respect to health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State."[35]

State insurance regulators take their roles very seriously, including protecting the interests of consumers. The NAIC is also very active in developing model regulations and guidance. While the details of enforcement actions and mechanisms will vary from state to state, all state regulators have a variety of enforcement tools that they use to ensure that the laws in their state are enforced.

Federal law also leaves states free to continue to enact insurance laws that are specific to that state, so long as those laws do prevent the application of a federal requirement.[36] Thus, federal law recognizes not only the enforcement power of the states with respect to insurance, but also gives the states flexibility to regulate insurance within their jurisdiction as they determine best.

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[30] Alex Montero, et al., *Americans' Challenges with Health Care Costs* (Jul. 14, 2023), https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/ (last visited Sept. 5, 2023).

[31] Gillespie, Lane. *Bankrate's 2023 annual emergency savings report*, Bankrate (June 22, 2023) https://www.bankrate.com/banking/savings/emergency-savings-report/ (last visited Sept. 5, 2023).

[32] *Health Care Costs Continue to Burden American Workers,* 2022-2023 Aflac WorkForces Report, conducted by Kandar, https://www.aflac.com/docs/awr/pdf/2022-trends-and-topics/2022-aflac-awr-financial-insecurity.pdf (last visited Sept. 5, 2023).

[33] PHS Act § 2723(a).

[34] PHS Act § 2723(b); 45 CFR Part 150.

[35] 45 CFR § 150.201.

[36] PHS Act § 2724(a).

COMMENTS ON THE DEPARMENTS' PROPOSED RULE REGARDING INDEPENDENT NONCOORDINATED EXCEPTED BENEFITS

I. Use of Statutory Terms for Excepted Benefits

Throughout the preamble, the Departments refer to "hospital indemnity or other fixed indemnity" excepted benefits as merely "fixed indemnity excepted benefits".[37] Similarly, the Departments refer to "specified disease or illness" excepted benefits as merely "specified disease" excepted benefits.[38] While the Departments state that this is being done primarily for readability and simplicity, we believe that use of this shorthand, which does not reflect the full statutory terms for these products, may inadvertently serve to create confusion as to the full nature of the products. Thus, we use the statutory terms here.

II. Proposed Changes to the Fixed Payment Standard and Noncoordination Requirements for Hospital Indemnity or Other Fixed Indemnity Coverage to Qualify as an Excepted Benefit

Summary of Proposed Rule: The Proposed Rule would add new requirements for hospital indemnity or other fixed indemnity coverage to qualify as an excepted benefit. The new restrictions would be added by making two changes: changing what it means to provide a "fixed" benefit and changing what "noncoordination" means.

New "static" payment replaces fixed payment requirement: Current regulations in the group and individual markets permit policies that vary the benefit amount based on particular medical events (e.g., services) that trigger the payment. The current group market rule permits benefits that are based on both a time period and the specific medical event, e.g., $ 200 per day per hospital confinement, $100 per day in a hospital rehabilitation facility, $300 per day when an individual is in the intensive care unit (ICU). The current individual market rules allow benefits to be paid on a per period and/or per service basis. That is, in the individual market, current regulations do not require a per period limitation. The Proposed Rule would eliminate the ability of both individual and group hospital indemnity or other fixed indemnity excepted benefit plans to vary payment of benefits based on the medical event. Specifically, both the group and individual market regulations would be revised to require that such insurance must pay benefits in "a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, $100 per day) regardless of the actual or estimated amount of expenses incurred, services or items received, severity of illness or injury experienced by a covered participant or beneficiary [covered individual in the individual market] or other characteristics particular to a course of treatment received by a participant or beneficiary [covered individual in the individual market] and not on any other basis (such as on a per-item or per-service basis)."

New restrictive interpretation of "noncoordination" requirement: One of the statutory requirements for hospital or other fixed indemnity excepted benefit coverage is that it cannot coordinate with other coverage of the same employer. The Proposed Rule would add an example to the group market regulations illustrating the Departments' new interpretation of this requirement. The specific arrangement described in the example is not a very common plan design. Thus, the example alone might lead to the mistaken conclusion that this new interpretation applies in only limited circumstances.

[37] 88 Fed. Reg. 44596, 44596 n.1 (July 12, 2023).

[38] *Id*. at 44596, n.2.

However, the preamble makes it clear that this is only one example and that the concept would be applied more broadly. Taken to one possible conclusion, this proposal could be applied broadly to impact any two plans offered by the same employer (or same insurer in the individual market). It is very common for employers to offer both a comprehensive medical plan that provides broad medical expense reimbursement coverage and a hospital indemnity or other fixed indemnity excepted benefit plan as voluntary supplemental coverage to help with additional unanticipated costs. Indeed, by definition, supplemental benefits complement comprehensive coverage; yet the comprehensive coverage is not "coordinated" with the supplemental benefit.

Summary of Comments: The proposed changes, whether taken separately or together, would completely disrupt the market for hospital indemnity or other fixed indemnity excepted benefit coverage as it exists now and has existed for decades.

The proposed static payment requirement would restrict such coverage to a single benefit only, such as $200 per day for a hospital visit. The plan could not cover any other services or vary the benefit amount based on severity, e.g., a stay in an intensive care unit vs. a trip to the emergency room for a sprained ankle.

The new restrictive noncoordination requirement would turn the market on its head by curtailing the ability of employers to offer these excepted benefits to supplement the employer's comprehensive medical coverage. Instead, this "supplemental" coverage might be limited to individuals with no other health coverage at all. While such a broad conclusion is likely unintended, the Proposed Rule provides no guidance as to what other circumstances beyond the specific example would be impacted.

Both of these changes are inconsistent with the statute and beyond the permitted scope of agency authority. The negative impact of these proposals would unfortunately fall on consumers. The Departments note their concern with rising medical costs and medical debt, yet the proposed changes would only expose consumers to more liability. These supplemental products allow consumers to voluntarily protect themselves and their families with additional financial protection in the case of accident or injury. No comprehensive medical policy, no matter how robust, covers all of the expenses associated with an accident or illness. The Proposed Rule would eliminate the availability of valuable financial protection options that have been available for over five decades through supplemental coverage.

Summary Conclusion: The Departments should withdraw these provisions of the Proposed Rule. Instead, the Departments should more closely align the group market rules with the current individual market rules (and the statutory requirements) by clarifying that per period and/or per service/treatment[39] payment events are permitted in both markets. At the least, the Departments should retain the individual market rule and affirm that in the group market, benefits that vary by service/treatment, etc. and have a period limitation are permitted.

[39] The term "per service" as used throughout this letter is meant to include variations in benefits based on factors other than "per period" i.e., it includes factors such as services or items received, severity of illness or injury experienced by a covered individual, or other characteristics particular to a course of treatment.

A. The Proposed Rule, if finalized, would be harmful to consumers by severely restricting the ability to voluntarily purchase additional financial protection in the case of accident, sickness or injury.

The Departments' proposed changes to the requirements for hospital indemnity or other fixed indemnity coverage to qualify as an excepted benefit, whether taken separately or together, would completely disrupt the market for such products and severely restrict the products that would be available to consumers compared to the type of products available today. The negative impact of these proposals would unfortunately fall on consumers who have a covered accident or sickness and who are least able to afford such costs. The Departments do not limit the application of their proposals prospectively; rather, they would also apply to existing policies. With respect to existing policies, the Proposed Rule is retroactive, interfering with current contract rights (most of the impacted coverage is issued on a guaranteed renewal basis).

The Proposed Rule misinterprets the statutory requirement to pay a fixed amount (regardless of other coverage) for specified medical events and seeks to impose an immutable "static" benefit requirement – which requires that every medical event receive the same static benefit amount. This proposed static payment requirement would restrict such coverage to a single benefit only, such as $200 per day per hospital confinement. The plan could not cover any other services or vary the benefit amount based on severity, e.g., a stay in an intensive care unit vs. hospital.

As discussed above, policies with varying benefit amounts based on factors relating to the underlying medical event provide the most benefit to consumers. State regulators' long-standing approval of these types of products reflects this value. Typical medical events that trigger payment under current hospital indemnity or other fixed indemnity excepted products range in severity, and therefore represent different financial risks to consumers. For example, an individual who is hospitalized for a day or more should be able to receive a higher benefit than an individual who has an outpatient procedure, because the risk of unmet financial need is different in these circumstances. Even different types of hospital stays may present different risks of financial exposure. For example, a person who is admitted to the intensive care unit (ICU) can be expected to have a more significant medical condition than someone who is admitted to the regular part of the hospital, and with a more significant medical condition comes a greater risk of unmet financial need.

The nature of the triggering event(s) is directly related to the potential unmet financial need to be faced by the individual. This financial exposure may come from a variety of different sources, including but not limited to medical expenses that are not covered by the individual's comprehensive medical policy. Even individuals with the most generous of health plans may face significant unexpected financial burdens due to illness, such as travel, meals and lodging, or other costs incurred to aid in their recovery. The value of hospital indemnity or other fixed indemnity policies is that they provide a cash payment for the individual to use as they determine best.

The new restrictive noncoordination requirement would turn the market on its head by potentially eliminating the ability of employers to offer these excepted benefits to supplement the employer's comprehensive medical coverage. Most of Aflac's excepted benefit products, including hospital indemnity or other fixed indemnity coverage, are sold through the workplace. This is a natural place for offering such coverage, when employees are aware of and enrolling in the comprehensive medical coverage offered by their employer. Under the Proposed Rule, unfortunately the safest approach for insurers to comply with this new interpretation might be to offer "supplemental coverage" only to individuals who do not have comprehensive medical coverage. Note, also, that some states, such as California, restrict offering such products to individuals that do not have comprehensive medical

coverage. While this interpretation of the Proposed Rule may not have been intended, the Proposed Rule does not provide any guidance as to how this new interpretation would be limited.

The Departments note their concerns regarding medical debt. According to the Kaiser Family Foundation, about half of Americans say they have trouble affording medical costs and 44% worry about affording their deductible before their insurance coverage begins. [40] At the same time, the Bankrate Annual Emergency Fund Report found that 57% of Americans are uncomfortable with the level of savings.[41] This aligns with Aflac's annual independent survey which found that 58% of employed Americans cannot pay over $1,000 in out-of-pocket costs for an unexpected illness or injury – 26% higher than 2021.[42]

Individuals and families are concerned not just with medical costs that might not be covered by their comprehensive insurance plan, but other costs associated with an accident or illness. There are other competing costs that patients face with a medical event such as paying for the medical costs versus food, household bills, and housing.[43] "There's so much more that goes into what's keeping [patients] from coming to clinic: Transportation is a huge issue. Childcare is a huge issue. Unfortunately, sometimes medical care is not, in a patient's view, a priority."[44] The American Cancer Society explains that additional costs incurred with cancer care that are not covered comprehensive coverage include transportation (including for sometimes significant distances) to medical appointments, lodging (e.g., a place to stay near a specialized treatment site); paying for help at home to care for themselves or their children; and costs of cosmetic items or special food.[45]

IRS Publication 502 ("Medical and Dental Expenses") is also instructive. The publication notes, for example, that "medical expenses" can include amounts that a taxpayer must pay for transportation to obtain medical care, certain legal fees to authorize medical services, or certain meals and lodging. The list of "medical expenses" includes (but "doesn't include all possible medical expenses") a myriad of

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[40] Alex Montero, et al., *Americans' Challenges with Health Care Costs* (Jul. 14, 2023), https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/ (last visited Sept. 5, 2023).

[41] Gillespie, Lane. *Bankrate's 2023 annual emergency savings report*, Bankrate (June 22, 2023) https://www.bankrate.com/banking/savings/emergency-savings-report/ (last visited Sept. 5, 2023).

[42] *Health Care Costs Continue to Burden American Workers,* 2022-2023 Aflac WorkForces Report, conducted by Kandar, https://www.aflac.com/docs/awr/pdf/2022-trends-and-topics/2022-aflac-awr-financial-insecurity.pdf (last visited Sept. 5, 2023).

[43] Kim Erwin et al., *What Your Patients Aren't Telling You: How to Partner With Patients to Help Manage the Hidden Costs of Healthcare*, (Avalere Health, Cost-of-Care Conversations Practice Brief #2, 2018), https://essentialhospitals.org/wp-content/uploads/2018/11/CostofCarePracticeBrief2.pdf (last visited Sept. 6, 2023).

[44] *Id. at 3.*

[45] American Cancer Society*, The Costs of Cancer* 10 (2020 ed.), https://www.fightcancer.org/sites/default/files/National%20Documents/Costs-of-Cancer-2020-10222020.pdf. See also Cancer.Net, Understanding the Costs Related to Cancer Care (08/2022) (common "non-medical" costs incurred for cancer care include transportation and travel (airfare, bus, and train fares), parking, gas, ridesharing fees, childcare, household help, legal expenses, special clothing, wigs, and special food.(both last visited Sept. 5, 2023).

other items and services directly caused by the medical care.[46] Many of these medical expenses may not be covered by a group or individual health plan.

Further, according to a report by Third Way, while high medical costs and debt clearly affect low-income families, middle-income Americans, those with incomes between $50,000 to $100,000 see the highest rates of medical debt. Within these income ranges, Black and Hispanic families have the highest rates of medical debt.[47]

This is where supplemental products, and specifically hospital indemnity or other fixed indemnity excepted benefits, fit in. They are specifically designed to provide an additional layer of financial protection. Consumers report a very high level of satisfaction with supplemental products as they exist in the market today. A recent survey 92% of consumers were satisfied with their hospital indemnity or other fixed indemnity insurance.[48]

Employers also recognize the value of supplemental coverage and the importance of such coverage to their employees. 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.[49] 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).[50] Aon also reported strong growth in employers offering supplemental benefits and employees selecting them in 2022 open enrollment, noting that one of the fastest growing voluntary benefits employees enrolled in in 2022 was hospital indemnity insurance (with participation increasing from 10% to 16% between 2021 and 2022).[51]

The Departments have acknowledged that hospital indemnity or other fixed indemnity insurance that varies the payment amount based on the services provided has been long sold in the market with the approval of state regulators because this type of benefit structure provides value to consumers.[52] Now, however, 27 years since HIPAA was enacted, the Departments seek to end this long-standing practice and restrict the types of products that consumers may buy.

The Departments indicate they are concerned that some consumers may confuse hospital indemnity or other fixed indemnity coverage with comprehensive coverage. Aflac shares this concern and carefully labels and markets its products to help ensure that consumers understand that this type of coverage is not comprehensive medical 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

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[46] See IRS Publication 502 at pp. 5-17 (2022), https://www.irs.gov/pub/irs-pdf/p502.pdf.

[47] Third Way, "Medical Debt Hits the Heart of the Middle Class" (Aug. 21, 2023), https://www.thirdway.org/report/medical-debt-hits-the-heart-of-the-middle-class (last visited Sept. 5, 2023).

[48] Global Strategies Group Study, at 5. *Measuring Satisfaction with Supplemental Insurance* (Feb. 23, 2022), https://www.ahip.org/documents/AHIP-Supplemental-Insurance-Deck-032422.pdf.

[49] Willis Towers Watson Survey, at 5.

[50] *Id*.

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

[52] See, e.g., 88 Fed. Reg. at 44603.

coverage in a way that is easy to understand.[53] The Departments' Proposed Rule goes too far and would harm consumers who want the additional financial protection afforded by this coverage.

B. The Departments cannot usurp Congressional authority; the statute prohibits the Departments from imposing new requirements on hospital indemnity or other fixed indemnity excepted benefits.

1. Congress carefully crafted a role for excepted benefits to co-exist in the health coverage marketplace along with other types of coverage, including specific requirements for hospital indemnity or other fixed indemnity benefits to be "excepted".

The definition of and requirements for excepted benefits were first established by Congress in 1996 in HIPAA. The statute is evidence that Congress considered various types of excepted benefits and carefully developed the specific requirements for each type to be "excepted". HIPAA amended the Internal Revenue Code ("Code"), ERISA and the Public Health Service (PHS) Act to similarly define "excepted benefits". There are four distinct statutory categories of excepted benefits. Each category has specific requirements that must be met for the benefits in that category to be "excepted".

The four distinct categories of excepted benefits are: [54]

> "(1) Benefits not subject to requirements. [including accident, disability, and types of insurance under which benefits for medical care are secondary or incidental to other insurance benefits] …
>
> "(2) Benefits not subject to requirements if offered separately [including e.g., dental, vision, certain long-term care benefits and such other similar benefits as specified in regulations] …
>
> "(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits.
>
> (A) Coverage only for a specified disease or illness.
>
> (B) Hospital indemnity or other fixed indemnity insurance.
>
> "(4) Benefits not subject to requirements if offered as separate insurance policy [e.g., Medicare supplemental and other similar coverage supplemental to a group health plans] … ."

For hospital indemnity or other fixed indemnity benefits to be "excepted", the following requirements must be met:

> "(A) The benefits are provided under a separate policy, certificate, or contract of insurance.
>
> "(B) 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.
>
> "(C) 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

[53] Global Strategy Group Survey, at 9.

[54] The four statutory categories of excepted benefits are in Code § 9832(c)(1)-(4), ERISA § 733(c)(1)-(4), and PHS Act §2791(c)(1)-(4).

plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer." [55]

These very specific statutory provisions provide the only requirements for excepted benefit status for hospital indemnity or other excepted benefit coverage.

The statutory provisions show that Congress carefully considered the role of excepted benefits in the health insurance market and determined that that role is very different from the role of comprehensive medical coverage, so that imposing the rules for comprehensive medical coverage on excepted benefits was not appropriate. Congress did not leave excepted benefits unregulated, however, but included specific requirements such coverage must meet based on the type of coverage. Congress also clearly decided that there is a role for both excepted benefits and comprehensive medical coverage (i.e., coverage subject to federal coverage mandates) and that these types of coverage serve vastly different roles yet should co-exist in the marketplace.

2. Since the passage of HIPAA, Congress has time and again confirmed and retained the carefully drafted statutory regime for excepted benefits, leaving the statutory requirements for excepted benefits in place without change and confirming the role of excepted benefits in the broader health coverage marketplace.

The preamble mentions in several places that the Proposed Rule is justified because of the changing legal landscape and changes in the health care marketplace.[56] It is true that there have been many changes in the health arena since HIPAA was enacted. However, rather than provide a basis for sweeping regulatory changes such as those now proposed, Congress has time and again confirmed and retained the carefully drafted statutory regime for excepted benefits, leaving the statutory requirements for excepted benefits without change through many revisions to federal requirements for health coverage.

Numerous laws enacted since HIPAA added and/or amended federal health coverage mandates and every single one of these laws retained intact the provisions relating to excepted benefits. These laws include the following:

- No Surprises Act (2020)
- Affordable Care Act (2010)
- Michelle's Law (2008)
- Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)
- Genetic Information Nondiscrimination Act of 2008 (GINA)
- Newborns' and Mothers' Health Protection Act of 1996
- Mental Health Parity Act of 1996

All of these laws made significant changes that have impacted the health insurance marketplace, with ACA making the most sweeping changes with the biggest impact. However, the changes brought about by such laws do not provide a basis for re-defining excepted benefits through regulatory or other

[55] Code § 9831(c)(2); ERISA §732(c)(2); PHS Act §2722(c)(2). The reference to individual market coverage in (C) appears in the PHS Act only.

[56] 88 Fed. Reg. at 44604, 44609, 44619, 44620.

administrative action. Indeed, the Departments, by reference to these laws, recognize the role of Congress as the sole authority for making such significant changes as those in the Proposed Rule.

The Court in *Central United* made this very clear: "The ACA, in fact, endorses the PHSA's definition [of excepted benefits]... 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."[57] The same holds true as well for every other health care reform law passed since HIPAA.

Congress has spoken numerous times and each time has reconfirmed the rules for excepted benefits. Congress clearly has continued to recognize a role for excepted benefits, and in particular hospital indemnity or other fixed indemnity excepted benefits, as co-existing in the insurance marketplace along with comprehensive insurance that is subject to the ACA and other federal health care mandates. While the Departments may have issues with some market impacts since the ACA was enacted, that does not authorize them to change rules set by and reaffirmed many times by Congress.

3. The Court of Appeals decision in Central United and The Tax Cut and Jobs Act[58] do not justify the sweeping changes proposed by the Departments.

The Departments mention two legal developments in particular as justification for the Proposed Rule: (a) the 2016 decision of the Court of Appeals in *Central United* invalidating the 2014 HHS individual market regulation requiring that hospital indemnity or other fixed indemnity excepted benefit coverage could only be sold to individuals who certified that they have minimum essential coverage (MEC); and (b) the effective elimination of the individual "mandate" by the Tax Cuts and Jobs Act, which reduced the penalty for failure to have MEC to $0 (effective starting in 2019).

In the ***Departments***' view, the combination of these two developments justifies the creation of new restrictions on hospital indemnity or other fixed indemnity excepted benefits because the changes "increased the risk that individuals would purchase fixed indemnity excepted benefits coverage as a substitute for comprehensive coverage."[59] However, the view of ***Congress*** is that these changes are ***not*** a reason for adding wholly new restrictions such as the Departments now propose. The *Central United* decision was issued in 2016, and the Tax Cuts and Jobs Act was enacted in 2017. Congress did not make any changes to the requirements for excepted benefits in the Tax Cuts and Jobs Act, nor has it made any changes since. The most recent changes to federal health care mandates were included in the No Surprises Act in 2020. Here again, Congress could have chosen this occasion to modify the requirements for excepted benefits, but clearly chose not to do so; what Congress has chosen not to do, the Departments may not do through regulatory action. Nor have the Departments provided any quantifiable data to support the assertion of increased risk of consumer confusion.

The Departments ignore the reality of the decision in *Central United*, which is that the ***Departments*** may not replace the views and decisions of ***Congress*** with their own. In reaching its decision in *Central*

[57] *Cent. United Life Ins. Co. v. Burwell*, 827 F. 3d 70, 74 (D.C. Cir. 2016).

[58] Pub. L. No. 115-97, 131 Stat. 2054 (2017) commonly referred to as the "Tax Cuts and Jobs Act".

[59] 88 Fed. Reg. at 44609.

United, the Court of Appeals made the following key points with respect to the actions of HHS that were at issue.[60]

- "Despite the ACA's sweeping reforms to the health insurance market, it left intact and incorporated the PHSA's rules regarding excepted benefits."
- "Most 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."
- "The PHSA lists only certain defined criteria for fixed indemnity plans to have 'excepted benefit status'… "[W]here Congress excepted *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".
- "Nothing in the PHSA suggests Congress left any leeway for HHS to tack on additional criteria."
- "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."
- "HHS lacked authority to demand more of fixed indemnity providers than Congress required."

Rather than give a justification for the Proposed Rule, the decision in *Central United* clearly defines the limits of regulatory authority, which the Departments clearly exceed here.

C. The Proposed Rule is arbitrary and capricious.

The Proposed Rule is arbitrary and capricious for several reasons. The Proposed Rule preamble focuses exclusively on a scenario in which consumers are misled about the scope of hospital indemnity or other fixed indemnity coverage and rely upon it to the exclusion of comprehensive coverage, thereby exposing themselves to financial risk from uncovered health care costs.[61] In so doing, the preamble ignores two critical issues: (1) the benefits to consumers from hospital indemnity or other fixed indemnity insurance and the corresponding costs (i.e., financial risk) to them from losing it; and (2) alternative approaches that would protect consumers from being misled without denying them the option of per-service hospital indemnity or other fixed indemnity coverage. It is black-letter law that an agency acts arbitrarily and capriciously where, as here, it "entirely fail[s] to consider an important aspect of the problem."[62] In addition, the Proposed Rule is arbitrary and capricious because it is not supported by substantial evidence, and because the Departments have not adequately assessed reliance interests of current policyholders.

[60] *Cent. United,* 827 F.3d at 72-75.

[61] *See, e.g.*, 88 Fed. Reg. at 44597, 44605.

[62] *Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983).

1. The Departments have ignored the benefits to consumers from hospital indemnity or other fixed indemnity coverage and the corresponding costs to them (i.e., financial risk) from losing it.

The Departments have long known that hospital indemnity or other fixed indemnity insurance provides important financial protection for consumers. Yet, they fail to consider the important consumer benefits in promulgating the Proposed Rule.

In 2014, CMS decided to amend its individual-market regulations to include, within excepted benefits, hospital indemnity or other fixed indemnity coverage that is paid in a fixed dollar amount on a per-service basis. When proposing the amendment, CMS emphasized information from the National Association of Insurance Commissioners (NAIC), and from issuer industry groups, indicating that "variable fixed amounts based on service types could provide important options for consumers as supplemental coverage," because "[c]onsumers who purchase major medical coverage that meets the definition of 'minimum essential coverage' may still want to buy fixed indemnity coverage to help meet out-of-pocket medical and other costs.''[63] CMS was so eager to address these important consumer interests that it relied on enforcement discretion to effectuate the proposal three months before the agency even published the 2014 Proposed Rule.[64] The preamble to the 2014 Final Rule reflects CMS's understanding that hospital indemnity or other fixed indemnity excepted benefit policies have significant consumer benefits.[65] The preamble to the current Proposed Rule refers to the foregoing consumer-benefit information when reciting the regulatory history.[66] And the preamble acknowledges that hospital indemnity or other fixed indemnity plans cover medical expenses not covered by comprehensive insurance.[67] But the preamble then completely ignores those benefits when explaining the rationale for the Proposed Rule.

The preamble also ignores the corresponding costs to consumers from losing the benefits of hospital indemnity or other fixed indemnity excepted benefit coverage. The Departments claim that a significant objective of the Proposed Rule is to "reduce the burden of medical debt on households" consistent with Executive Order 14070.[68] And a focus of the preamble is the Departments' stated concern that consumers who erroneously believe that hospital indemnity or other fixed indemnity excepted benefit insurance is a "substitute for" — and "lower-cost equivalent to" — comprehensive coverage will be

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[63] 79 Fed. Reg. 15808, 15819 (Mar. 21, 2014).

[64] Affordable Care Act Implementation FAQs – Set 18 (Jan. 9, 2014), https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/aca_implementation_faqs18, at Q11 ("If these proposed revisions are implemented, fixed indemnity insurance in the individual market would no longer have to pay benefits solely on a per-period basis to qualify as an excepted benefit. Until HHS finalizes this rulemaking related to these proposed amendments, HHS will treat fixed indemnity coverage in the individual market as excepted benefits for enforcement purposes if it meets the conditions above in States where HHS has direct enforcement authority. For States with primary enforcement authority, HHS encourages those States to also treat this coverage as an excepted benefit and will not consider that a State is not substantially enforcing the individual market requirements merely because it does so.").

[65] 79 Fed. Reg. 30240, 30256 (May 27, 2014) (stating concern that "limiting . . . choice of fixed indemnity issuers" might "harm consumers").

[66] 88 Fed. Reg. at 44602-03.

[67] *Id*. at 44604.

[68] *Id*. at 44598

"exposed to significant financial liability."[69] But the Departments say nothing about the significant financial liability that consumers could suffer if they have comprehensive insurance but cannot cover gaps or limits in that insurance through a supplemental hospital indemnity or other fixed indemnity excepted benefit policy.

There are at least three reasons that the Departments' approach is arbitrary and capricious. *First*, an agency acts arbitrarily and capriciously if it "'entirely fail[s] to consider an important aspect of the problem'" by "ignor[ing] evidence that undercuts its judgment" or "minimiz[ing] such evidence without adequate explanation."[70] The Departments have done exactly that in ignoring evidence (of which it has long been aware) that hospital indemnity or other fixed indemnity excepted benefit insurance provides significant consumer benefits (and significant costs if it is not available).

Second, in ignoring such evidence, the Departments conducted a skewed cost-benefit analysis, thereby rendering the Proposed Rule arbitrary and capricious.[71] In that analysis, the Departments' list of costs and benefits does not even mention the benefits of hospital indemnity or other fixed indemnity excepted benefit coverage or the costs from losing it.[72] Accordingly, the Departments do not weigh the potential costs to consumers (from substituting hospital/other fixed indemnity for comprehensive insurance) against the potential benefits to consumers (from supplementing comprehensive insurance with hospital/other fixed indemnity coverage). Instead, the Departments weigh those costs to consumers against the benefits to *issuers* from offering hospital indemnity or other fixed indemnity policies. The Departments conclude that potential risks to consumers outweigh benefits to issuers:

> HHS is no longer of the view that the value of providing issuers with the flexibility to offer fixed indemnity excepted benefits coverage in the individual market that pays benefits on a per-service basis outweighs the harm to consumers who may purchase fixed indemnity excepted benefits coverage as a substitute for, or under the misapprehension that they are purchasing, comprehensive coverage.[73]

By weighing the wrong benefits against the costs to consumers, the Departments have conducted an arbitrary and capricious cost-benefit analysis.

Finally, the Departments have arbitrarily and capriciously failed to explain why they disregarded the factual basis for the current rule (permitting per-service policies because they benefit consumers). When an agency changes position on an issue, as in this case, "'a reasoned explanation is needed for disregarding facts and circumstances that underlay . . . the prior policy.'"[74] The Departments have not given such an explanation here.

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[69] *Id*. at 44605.

[70] *Genuine Parts Co. v. EPA*, 890 F.3d 304, 307, 312 (D.C. Cir. 2018).

[71] *See, e.g., Nat'l Ass'n of Home Builders v. EPA*, 682 F.3d 1032, 1040 (D.C. Cir. 2012); *see also Motor Vehicle Mfrs.*, 463 U.S. at 54 (reasoned decision-making also requires agencies to "look at the costs as well as the benefits" of the actions they take).

[72] 88 Fed. Reg. at 44640, 44643-44.

[73] *Id*. at 44620; *see also id*. at 44641-42 (comparing consumer costs to issuer benefits).

[74] *Encino Motorcars, LLC v. Navarro*, 579 U.S. 211, 222 (2016) (citation omitted).

2. The Departments have not considered alternative approaches that would protect consumers from being misled without denying them the option of per-service hospital indemnity or other fixed indemnity coverage.

The Departments state that a major purpose of the rule is to promote equitable access to comprehensive insurance by "increasing consumers' understanding of their health coverage options and reducing misinformation about . . . fixed indemnity excepted benefits coverage."[75] An obvious way to prevent misinformation is to enhance enforcement of current prohibitions on false and misleading marketing. And an obvious way to increase consumer understanding is to provide adequate notice. Yet, the Departments did not consider either of these approaches as an alternative to banning per service hospital indemnity or other fixed indemnity coverage. Instead, the Proposed Rule couples the notice with the prohibition on per service benefits.[76] A recent survey shows that consumers understand the nature of their excepted benefit 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.[77] This evidence undermines the Departments' position that changes to the structure of the products are needed due to possible consumer confusion.

An agency is "required to consider responsible alternatives to its chosen policy and to give a reasoned explanation for its rejection of such alternatives."[78] The Proposed Rule is arbitrary and capricious, because the Departments did not consider an alternative approach that would have protected consumers from being misled without denying them the option of per-service hospital indemnity or other fixed indemnity excepted benefit coverage.

3. The Proposed Rule is not supported by substantial evidence.

An agency action is "'arbitrary and capricious if it rests upon a factual premise that is unsupported by substantial evidence.'"[79] For many of their assertions about hospital indemnity or other fixed indemnity insurance, the Departments either cite information that does not specifically address such insurance or cite no supporting facts at all.[80] When the Departments cite facts that do relate to fixed indemnity

[75] 88 Fed. Reg. at 44597.

[76] The Departments did consider providing more detailed notice, but evidently not as an alternative to banning per-service hospital indemnity or other fixed indemnity excepted benefit policies. The Departments decided to reject the more detailed notice, based in part on the conclusion that more detailed notice would suggest to consumers that such policies provide broader protection than they actually do. 88 FR at 44646.

[77] Global Strategy Group Survey, at 6.

[78] *Spirit Airlines, Inc. v. U.S. 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)).

[79] *Genuine Parts Co*., 890 F.3d at 312 (citation omitted).

[80] *See, e.g*., 88 Fed. Reg. at 44605 n.83 (citing financial risks enhanced by STLDI without referring to fixed indemnity coverage); *id*. at 44605-06 (alleging, without factual support, that people who enroll in fixed indemnity coverage may not realize that their coverage is limited); *id*. at 44606 n.90 (discussing adverse impacts to disadvantaged communities from unaffordable medical debt without referring to fixed indemnity coverage); *id*. at 44607 n.96 (citing limitations of STLDI policies without referring to fixed indemnity coverage).

coverage, many are anecdotal, vague, or speculative.[81] The Proposed Rule is arbitrary and capricious, because it is not supported by substantial evidence.

The dearth of supporting evidence is particularly notable when it comes to the Department's central claim that deceptive or misleading marketing is allegedly influencing consumers to substitute hospital indemnity or other fixed indemnity coverage for comprehensive coverage. In fact, the data cited in the preamble suggest the opposite. The preamble emphasizes that during the past three years, comprehensive coverage has greatly expanded, both in terms of the options available and the number of consumers enrolled.[82] During that same period, of course, hospital indemnity or other fixed indemnity excepted benefit policies have been sold under the current regulations that permit per-service coverage. The Departments do not cite any proof that consumers are substituting hospital indemnity or other fixed indemnity excepted benefits for comprehensive insurance (because of misleading marketing or otherwise). (In the preamble, any proof of substitution relates to STLDI and not to hospital indemnity or other fixed indemnity excepted benefit plans.)[83]

Further, the Centers for Medicare and Medicaid Services (CMS) recently announced that the national uninsured rate reached an all-time low in 2023.[84]

The Proposed Rule is not supported by substantial evidence.

4. The Departments have not adequately assessed reliance interests of current policyholders.

The Proposed Rule would effectively prohibit hospital indemnity or other fixed indemnity excepted policies that have been lawfully available for at least 27 years, since the enactment of HIPAA. Even before that, states allowed this type of coverage. This abrupt change requires a "more detailed justification than what would suffice for a new policy created on a blank slate," because longstanding prior policy has "engendered serious reliance interests that must be taken into account."[85] The Proposed Rule is arbitrary and capricious, because the Departments have not adequately assessed reliance interests.

The Departments make a general reference to existing policyholders' reliance on policies issued under existing regulations. But they do not evaluate the extent of those reliance interests or weigh them as costs in the cost-benefit analysis. Some reliance interests are weighty.

All individual hospital indemnity or other fixed indemnity policies offered by Aflac are guaranteed renewable, meaning that the insurer cannot cancel the policy as long as the applicable premium is paid, except in accordance with specified limited circumstances allowed by state law, such as fraud or misrepresentation of a material fact. This is the same throughout the industry. Guaranteed renewability

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[81] *See, e.g.*, 88 Fed. Reg. at 44607 n.100 (supporting allegations about deceptive or aggressive marketing by citing undocumented blog posts); id. at 44608 n.102 (citing news report of a consumer who believed his combined MEC and fixed indemnity coverage was broader than it was, without suggesting that the misimpression came from deceptive or aggressive marketing practices).

[82] *Id*. at 44605 (citing detailed statistics from 2021-2023 showing steadily increasing enrollment in comprehensive insurance).

[83] *Id*. at 44643.

[84] https://www.cms.gov/files/document/snapshotupdate08102023.pdf (last visited Sept. 5, 2023).

[85] *FCC v. Fox Television Stations, Inc*., 556 U.S. 502, 515 (2009).

is a valuable right because it means the policyholder can keep their policy even if their medical condition changes. The policyholder's surviving spouse (in the case of death of policyholder), ex-spouse (in the case of divorce) and dependent children, if covered under the plan, usually also have the right to continue coverage under guaranteed renewable policies. These provisions are included as contract terms and are often mandated by applicable state law.

Group policies offered by Aflac are not guaranteed renewable; however, individuals covered under group policies typically have a right to continue their coverage (called a "portability privilege"). Some group policies are issued with multi-year rate guarantee periods, for example, plans issued in the public sector in response to a request for proposal (RFP) process. In each instance, changing the nature of or requiring a termination of the coverage would create substantial practical and legal issues for Aflac and the insureds.

The Departments' only response to the reliance interests is to propose deferring the effective date of the "per service" insurance policy prohibition until January 1, 2027.[86] This only delays the impact on current policyholders but does not address the underlying problem that the proposal, if finalized, will interfere with existing contract rights.

D. The proposed changes to the standards for fixed indemnity payments are inconsistent with the statute, which specifically contemplates that benefits will be tied to medical events (such as services) and explicitly allows policies to cover more than one excepted benefit.

1. The statute contemplates that benefits will be tied to medical events, including medical services and other similar factors, such as items furnished and level of treatment.[87]

The statute provides that in order to qualify as an excepted benefit, hospital indemnity or other fixed indemnity insurance must meet the following three requirements (and only these requirements): (1) the benefits must be 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; and (3) the 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, in with respect to individual market coverage, under any health insurance coverage maintained by the same health insurance issuer.[88]

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[86] 88 Fed. Reg. at 44647.

[87] The Departments reference in several places their own FAQs, Frequently Asked Questions about Affordable Care Act Implementation (Part XI) (Jan. 24, 2013), Q7, as support for the position that hospital indemnity or other fixed indemnity excepted benefits in the group market cannot pay benefits based the level of services provided. See, for example, 88 Fed. Reg. at 44602. Reliance on this FAQ is inappropriate for a variety of reasons, including the following: the FAQ purports to be an interpretation of the current group market regulations, however, the existing regulations clearly permit these excepted benefit plans to have benefits that vary by service and are based on a period (e.g., $50 per day (or week) for doctor's visits); the Departments cannot re-write a regulation through a FAQ (which did not go through a notice and comment period); and, as discussed more fully in this letter, the statute itself clearly permits this variable type of benefit structure. Further, the per period limitation is not contained in the statute in the first instance.

[88] ERISA § 732(c)(2); Code § 9831(c)(2); PHS Act § 2722(c)(2) (emphasis added). The reference to the individual market is in the PHS Act only.

The provisions in the Proposed Rule that limit benefits to hospitalization or illness without regard to the type of items or services, severity of illness or injury experienced or other characteristics particular to a course of treatment are not consistent with the broad wording of the statutory provisions providing that any "event" is a permissible trigger.[89] The statute does not restrict the types of events that are permissible triggers for benefits. Medical events beyond and in addition to hospitalization are clearly contemplated by the statute.[90]

The statute's text compels that conclusion. It is a "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme."[91] In context, the term "event" necessarily includes the same types of medical services that might be covered by a group or individual health plan. The statute specifies that to be an excepted benefit, a fixed indemnity plan must pay benefits regardless of whether a group or individual plan pays overlapping benefits for the same "event." And group and individual plans always define covered "events" according to medical services rendered.[92] If the statutory reference to overlapping coverage is to make any sense, hospital indemnity or other fixed indemnity excepted benefit plans also must be able to cover "events" defined according to medical services rendered.

The details of the statute's text are instructive. In the statutory language quoted above, the term "event" appears twice in the same sentence — first to address the payment trigger for hospital indemnity or other fixed indemnity benefits excepted benefit plans and next to address the payment trigger for other group or individual plan benefits. Under well-established canons of statutory construction, the term "event" means the same thing both times that it appears. To begin with, there is a "presumption that 'identical words used in different parts of the same statute' carry 'the same meaning.'"[93] That presumption is heightened here, because the same term appears twice in the same sentence. When construing a statute, there is a "'*vigorous*' presumption that, 'when a term is repeated within a given sentence,' it 'is used to mean the same thing.'"[94]

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[89] ERISA § 732(c)(2)(C); Code § 9831(c)(2)(C); PHS Act § 2722(c)(2)(C) (emphasis added).

[90] If medical events were not involved, insurance could not conceivably be considered medical insurance in the first place.

[91] *Roberts v. Sea-Land Servs., Inc*., 566 U.S. 93, 102 (2012).

[92] This is inherent in how health plans pay benefits. The Departments have acknowledged this. See, for example, the template issued by the Departments under the ACA requirement to provide a summary of benefits and coverage. PHS Act § 2715, incorporated by reference into ERISA and the Code. The template includes columns for "common medical events" and the "services you [the covered individual] may need" with respect to that event. For example, for the "common medical event" the "services you may need" include a "[p]rimary care visit to treat an injury or illness," a "specialist visit," or "preventive care/screening/immunization." The template may be found here https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/sbc-template-new.pdf (last visited Sept. 1, 2023). Items and services received are typically billed using current procedural terminology (CPT) codes. See, for example CPT® overview and code approval, American Medical Ass'n (2023), https://www.ama-assn.org/practice-management/cpt/cpt-overview-and-code-approval.

[93] *Henson v. Santander Consumer USA, Inc*., 582 U.S. 79, 85 (2017) (quoting *IBP, Inc. v. Alvarez*, 546 U.S. 21, 34 (2005)).

[94] *Encino Motorcars, LLC v. Navarro*, 138 S. Ct. 1134, 1142 (2018) (emphasis added) (quoting *Brown v. Gardner*, 513 U.S. 115, 118 (1994).

Furthermore, Congress's use of the term "such" removes any doubt that "event" means the same thing both times it appears. The statute says that "benefits . . . paid with respect to an event" (under a hospital indemnity or other fixed indemnity plan) must be provided regardless of whether there are "benefits provided with respect to *such* an event" (under a group or individual plan). In a statute, "the adjective 'such' means 'of the kind or degree already described or implied.'"[95] In other words, the event covered by the hospital indemnity or other fixed indemnity excepted benefit plan is the same type of event as that covered by the other group or individual plan. It would be arbitrary and capricious to conclude otherwise. When an agency adopts "two inconsistent interpretations of the very same statutory term, [it acts] arbitrarily and capriciously."[96]

Given the foregoing analysis, it is significant that group and individual plans always define covered "events" according to medical services rendered, items received, diagnosis, severity.[97] In that context, the term "event" is a term of art with a well-established meaning in the health insurance industry. "[I]t is a 'cardinal rule of statutory construction' that, when Congress employs a term of art, 'it presumably knows and adopts the cluster of ideas that were attached to each borrowed word in the body of learning from which it was taken.'"[98] Because the term "event" means the same thing both times it appears in the statute, Congress required hospital indemnity or other fixed indemnity excepted benefit plans to base benefit payments on medical services and items received, etc.

Given the clarity of the statute's text, it is not surprising that courts have recognized that medical events are the basis for payment under current rules. Thus, for example, the Court of Appeals for the District of Columbia Circuit recently described hospital indemnity or other fixed indemnity excepted benefit insurance as follows:

> "As their label suggests, these policies pay out a fixed amount of cash upon the occurrence of a particular medical event. For instance, if a policy holder visits a hospital or *purchases prescription drugs*, the provider pays out a predetermined amount, which the policyholder is then free to use however she chooses."[99]

The current individual market rule allowing service-based payment events in the individual market demonstrates that the Departments believe that the statute does not exclude service-based triggers. We believe the statute goes further, and clearly precludes the Departments from taking the narrower position advanced in the Proposed Rule.

Furthermore, it is significant that the Departments do not have any different interpretation of the statutory term "event." The preamble concedes that hospital indemnity or other fixed indemnity excepted benefit coverage "pay[s] benefits at a fixed amount per qualifying medical event."[100] Perhaps because the term "event" so clearly covers medical events, the Departments allegedly rely on an interpretation of a different statutory term — "fixed" — as the basis for the limitations in the Proposed

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[95] *Culbertson v. Berryhill*, 139 S. Ct. 517, 522 (2019).

[96] *U.S. Dep't of the Treasury IRS Office of Chief Counsel Wash., D.C. v. Fed. Lab. Relations Auth.*, 739 F.3d 13, 21 (D.C. Cir. 2014).

[97] See footnote 91, supra.

[98] *FAA v. Cooper*, 566 U.S. 284, 291-92 (2012).

[99] *Cent. United*, 827 F.3d at 72.

[100] 88 Fed. Reg. at 44620

Rule. The Departments state that the limitations are premised upon their interpretation of the term "fixed" but do not explain how.[101] The Departments appear to be asserting that the statute calls for both a "fixed" *dollar amount* paid as a benefit and a "fixed" (i.e., single) *event* for which all benefits are paid. But the plain meaning of the statute is that the term "fixed" only applies to the amount (not to the event). As the foregoing quotation from the *Central United* explains, the meaning "suggest[ed]" by the fixed-indemnity "label" is a policy that pays a "fixed *amount*" — or "predetermined *amount*" — upon the occurrence of a triggering medical event.[102]

"Fixed" is used in the statute to connote the nature of indemnity benefits – i.e., a fixed dollar amount that does not vary based on the amount of expenses or other coverage. Traditional (i.e., non-fixed expense incurred coverage) will pay more or less based on the amount charged and/or the existence of other coverage. Thus, "fixed" is necessary as the talisman of "fixed indemnity" type coverage – i.e., a fixed amount per event regardless of provider charge amount or other coverage.

Finally, there is no basis for *Chevron* deference to the Departments' proposed limitation on hospital indemnity or other fixed indemnity excepted benefit plans. The Departments generically claim that the limitation is premised on an interpretation of the term "fixed," but they utterly fail to provide any interpretive rationale. In actuality, the Departments have justified the Proposed Rule on policy grounds and not upon a construction of the statutory language. No *Chevron* deference is appropriate when an agency has not even engaged in a statutory interpretation that could be evaluated for its reasonableness.[103] For all these reasons, we believe the Proposed Rule seeks to amend the statute in clear contravention of Congressional intent. As the Court of Appeals for the District of Columbia Circuit has recently stated: "[O]nly Congress can amend its statutes... Disagreeing with Congress's expressly codified policy choices isn't a luxury administrative agencies enjoy."[104]

2. During the consideration of HIPAA, Congress specifically considered and rejected the type of restrictions the Departments now propose.

The bill that ultimately became HIPAA was HR 3103 (104th Cong.), initially called the "Health Coverage Availability and Affordability Act." The statutory text relating to excepted benefits was revised through the legislative consideration of the bill.

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[101] *Id*. at 44621-24.

[102] *Cent. United*, 827 F.3d at 72 (emphasis added).

[103] *Pub. Citizen, Inc. v. HHS*, 332 F.3d 654, 661 (D.C. Cir. 2003). Furthermore, when "Congress has directly spoken to the precise question at issue," a court does not defer to an agency's statutory interpretation. *Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc*., 467 U.S. 837, 842-43 (1984). Deference is only due if there are statutory ambiguities, which are "delegations of authority to the agency to fill [a] statutory gap in reasonable fashion." *Nat'l Cable & Telecom's Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 980 (2007). "The fact that a statute is unambiguous means that there is no gap for the agency to fill and thus no room for agency interpretation." *United States v. Home Concrete & Supply, LLC*, 566 U.S. 478, 487 (2012) (citation omitted). This is a situation in which the "the meaning of a word may be broad in the abstract, but unambiguously narrower in context." *Truck Trailer Mfrs. Ass'n v. EPA*, 17 F.4th 1198, 1205 (D.C. Cir. 2021). The terms "fixed" and "event" are unambiguous for the reasons explained above.

[104] *Cent. United*, 827 F.3d at 73.

In the House, the legislative process involved consideration of bills by three different committees.[105] With one exception,[106] the versions in the House before House floor consideration excluded from the market reform provisions "***coverage consisting of benefit payments made on a periodic basis for a specified disease or illness or period of hospitalization, without regard to the costs incurred or services rendered during the period to which the payments relate***." (emphasis added).[107]

However, this language was rejected as the bill moved to the House floor.[108] The House-passed billed specifically created an exception from the health reform provisions for both "coverage for a specified disease or illness" and "hospital indemnity or fixed indemnity insurance" if offered under a separate contract, policy or certificate.[109]

The Senate version of the bill went through a similar process. The base bill in the Senate was S. 1028 (104th Cong.), the "Health Insurance Reform Act of 1995". The bill as introduced excluded from the health reforms: "Any plan or arrangement … that provides ***for benefit payments, on a periodic basis, for a specified disease or illness or period hospitalization without regard to the costs incurred or services rendered during the period to which the payments relate***." (emphasis added). However, as reported by the Senate Committee on Labor and Human Resources (now known as the Senate Committee on Health, Education, Labor and Employment or HELP), the bill excluded "Coverage for a specified disease or illness" and "***Hospital or fixed indemnity insurance***". This same language was included in HR 3013 as passed by the Senate on April 23, 1996.

The differences between the House and Senate were resolved through a conference. The language regarding "noncoordinated, independent" benefits first appears in the final version of the bill as passed by the House and the Senate, and remains the same in the law today. The report of the conference committee notes that there is a change in definition of excepted benefits from the House and Senate bills (indeed, the term "excepted benefits" itself does not appear in earlier versions), but there is no discussion of the reasons for any changes.[110]

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[105] The House Committees on Ways and Means, Economic and Educational Opportunities (now known as Education and Workforce), and Commerce (now known as Energy and Commerce).

[106] The one exception was the version of the bill marked up by the Committee on Economic and Educational Opportunities, H.R. 995 (104th Cong.). As introduced, that bill excluded from the market reforms "coverage for a specified disease or illness" and, separately, "***a hospital fixed indemnity policy or other fixed indemnity policy***". However, in the bill approved by the Committee, the language was changed to the same language in the other pre-floor House bills.

[107] All bills are from the 104th Congress: H.R. 995 as reported by the Economic and Educational Opportunities Committees on March 25, 1996, H.R. Rep. 104-498; H.R. 3070, as Introduced by Mr. Bilirakis (R-FL) on March 12, 1996; H.R. 3070, as Reported by the House Commerce Committee on March 25, 1996, H.R. Rep. No. 104-497; H.R. 3103 as Introduced on March 18, 1996 (by Mr. Archer (R-TX) and others); H.R. 3103 as Reported by the Ways and Means Committee on March 25, 1996, H.R. Rep. No. 104-496.

[108] Just prior to House consideration, a bill combining the work of the three House committees was introduced, H.R. 3160 (104th Cong.), by Mr. Archer (R-TX) and others on March 26, 1996. The language of H.R. 3160 was then inserted in H.R. 3103 on the House floor.

[109] H.R. 3103 (104th Cong.) as passed by the House on March 28, 1996.

[110] H.R. Rep. No. 104-736 (Conf. Rep.) at 200.

The conference report basically restates the final statutory provisions. In relevant part, the report states: "Third, if the following benefits: (a) are provided under a separate policy, certificate, or contract of insurance; (b) there is no coordination between the provision of these benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (c) such benefits are paid with respect to an event without regard to whether benefits are provided for that event under any group health plan maintained by the same plan sponsor, the [availability, portability, and renewability] requirements would not apply to: coverage only for a specified disease or illness, or hospital indemnity or other fixed indemnity insurance." [111]

The versions and changes to the statutory language made by Congress throughout the consideration of HIPAA shows that Congress considered, and then rejected the very type of restrictions on fixed indemnity payments that the Departments now proposes.

E. The Proposed reinterpretation of the "noncoordination" requirement is inconsistent with the statute.

1. The Proposed Rule could effectively preclude employees from having the additional financial protection offered by hospital indemnity or other fixed indemnity excepted benefits when their employer offers any other group health plan. This is not only bad policy, but also contravenes the statute.

In enacting the requirements for hospital indemnity or other fixed indemnity coverage in HIPAA, Congress was concerned that insurers offering such coverage would work together with the sponsors of other health plans to "coordinate" their policies so as to evade or avoid the federal protections applicable to comprehensive medical coverage policies. To prevent this, Congress included specific requirements that restrict the ability of such excepted benefits to coordinate with other medical coverage. In the intervening years, not only has Congress not changed the statutory requirements, Congress has reaffirmed these requirements in every piece of federal healthcare legislation enacted since, including the ACA and, most recently the No Surprises Act.[112] Now, after more than 25 years, the Departments proposed a new interpretation of the requirements that restrict the ability of hospital indemnity or other fixed indemnity excepted benefits to coordinate with other coverage.[113]

The Departments do not propose to amend the regulations to explain this new interpretation but instead add an example to the group market relations to "illustrate" this new interpretation. In this example, 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

[111] *Id*.

[112] See discussion in B.2, above.

[113] The same provisions regarding coordination that apply to hospital indemnity or other fixed indemnity excepted benefits also apply to specified disease or illness excepted benefits. The Departments do not at this time propose to change the rules regarding specified disease or illness excepted benefits. However, should they choose in the future to do so, the same objections and arguments that apply to hospital indemnity or other fixed indemnity excepted benefits also apply to specify disease or illness excepted benefits. Thus, for example, such a rule as applied to specify disease or illness excepted benefits would have a similar effect and would also contravene the statute.

the first benefit package. The benefit packages are not subject to a formal coordination of benefits arrangement. The Departments conclude that the second benefit package does not qualify as an excepted benefit because the benefits under that package are impermissibly coordinated with an exclusion of benefits under the other group health plan maintained by the same employer.

The Departments do not provide a general rule setting forth their new interpretation of the coordination provision, making it necessary to examine the proposed illustrative example and what further information there is in the preamble. This examination reveals a serious risk that this new interpretation could have an impermissibly broad impact. The Proposed Rule evidently does not require any concerted coordination on the part of the employer and the fixed indemnity insurer or any intent to impermissibly coordinate. Rather, it appears to be sufficient that the employer simply offers a primary medical plan along with the hospital indemnity or other fixed indemnity excepted benefit and, as is always the case, the primary medical plan has some coverage exclusions. The Departments do not articulate any limiting principle that would suggest any different result in other scenarios in which a primary medical plan is offered along with the hospital indemnity or other fixed indemnity excepted benefits. A possible end result of the example and the preamble discussion is that an employer could not offer hospital indemnity or other fixed indemnity excepted benefits if it also offered *any* primary medical plan (even if the excepted benefit plan complied with the other requirements in the Proposed Rule).

Such a result would be detrimental to consumers as the excepted benefit coverage could no longer "supplement" anything. The impact would be that workers and their families would be denied of the opportunity to purchase additional financial protection for the expenses their primary insurance is not intended to cover, whether that be deductibles and copayments or other financial needs not intended to be covered by primary insurance, such as child care for going to the doctor.

Further, that result would effectively mean that this excepted benefit coverage could only be offered to employees who are not eligible for their employer's comprehensive medical plan. That result would clearly be contrary to the Departments' intent and preference, which is that individuals should not have excepted benefits as their only health coverage.

While this result may be unintended, the Departments provide no guidance as to how this aspect of the Proposed Rule might be limited to specific scenarios.

- <u>The Departments' interpretation is not limited to the specific plan design in the example</u>.
    - In the example, the employer's Primary Medical Plan (meaning the part of the benefit package that is not a hospital indemnity or other fixed indemnity plan) is not a very common plan design (i.e., a plan that covers preventive services only). However, the Departments make it clear that this example merely "illustrates" their new interpretation and is not the only plan design that could result in violation of the applicable coordination requirements.[114] That opens up the scenario described above as a serious risk.

[114] 88 Fed. Reg. at 44629.

- As described in the preamble, the key feature the example is intended to illustrate is that the employer's Primary Medical Plan has exclusions, and the hospital or other fixed indemnity plan may provide benefits with respect to events where the Primary Medical Plan does not.[115] This is inevitably the case, and does not appear to limit the scope of the Departments' new interpretation in any way; all health plans have exclusions.
    - While the ACA imposed significant new requirements on health plans, even robust ACA plans will not cover all medical expenses incurred by employees or other individuals. For example, while the ACA limits annual out-of-pocket expenses, these limits are fairly high -- $9,100 for an individual and $18,200 for a family (for 2023).[116]
    - This means that even if a health plan otherwise covers an individual's medical expenses the individual may still be responsible for at least $9,100 in a single year ($18,200 for a family). While not all individuals or families may reach this limit, those that do will be in the hardest circumstances, e.g., have a serious chronic condition or need surgery due to an accident, heart attack or other unexpected event. Moreover, these limits only apply to in-network services, an individual can face much higher out of pocket costs if they cannot find an appropriate in-network provider or choose for personal reasons to go out-of-network.
        - More than half (58%) of Americans could not afford an out-of-pocket expense of $1,000. Almost 3 in 5 (57%) of American workers have high anxiety about health care costs beyond what their insurance coverage. Among all employees, Hispanics are most impacted at 69%. About a quarter of employees have faced a major medical event in the past year, and of these, 93% faced unexpected costs, most commonly medical-related costs such as hospital, doctor, or prescription bills.[117]
        - While high medical costs and debt clearly affect low-income families, middle-income Americans, those with incomes between $50,000 to $100,000 see the highest rates of medical debt. Within these income ranges, Black and Hispanic families have the highest rates of medical debt.[118]
    - Further, no health plan covers all medical circumstances or treatments; even the small group and individual insured plans that must cover essential health benefits have exclusions.
    - Thus, looking at Primary Medical Plans that have exclusions encompasses all health plans. In 2014, HHS adopted a rule (since held invalid) that allowed individuals to purchase

[115] *Id.*

[116] https://www.cms.gov/files/document/2023-papi-parameters-guidance-v4-final-12-27-21-508.pdf.

[117], 2022-2023 Aflac WorkForces Report, *Employee financial instability*. https://www.aflac.com/business/resources/aflac-workforces-report/fact-sheets/default.aspx (last visited Sep. 5,2023)

[118] Third Way, "Medical Debt Hits the Heart of the Middle Class" (Aug. 21, 2023), available at https://www.thirdway.org/report/medical-debt-hits-the-heart-of-the-middle-class (last visited Sept. 5, 2023).

hospital indemnity or other fixed indemnity excepted benefits only if they also had minimum essential coverage (MEC). Under the extreme scenario described above, the implications of the Proposed Rule would effectively do the opposite: only individuals ***with no other health coverage*** could have access to these excepted benefits.

- There is no practical way for insurers to comply with the Departments' new interpretation of the coordination requirements.
    - It is unclear how insurers could comply with the Proposed Rule. The insurer may not even be aware that the employer offers a Primary Medical Plan. Even if the insurer is aware, it would not necessarily know the details of the Primary Medical Plan nor would the employer be obligated to share that information. Yet, under the Proposed Rule, it is possible that if an employer merely offers both comprehensive medical coverage and hospital indemnity plan or other fixed indemnity coverage to the same employees, the indemnity coverage will not qualify as an excepted benefit.
- The Departments may have intended to limit the scope of their new interpretation to situations involving certain specific types of Primary Medical Plans. However, the Departments did not expressly do so and cannot do so without running afoul of the decision in *Central United.*
    - It is clear from the preamble that the Departments do not care for the particular Primary Medical Plan in the example.[119] While it is certainly not a very generous plan design, it does provide minimum essential coverage (MEC) as defined under the ACA.[120]
    - Perhaps the Departments meant to apply their new interpretation only where the Primary Medical Plan fails to provide some specific level of benefit. If that is the case, it's not clear where the Departments would draw the line. The Primary Medical Plan included in the example and that covers only the minimum required to be considered MEC does not appear to be enough. What higher level benefit is needed? What about plans that are not required under the ACA to cover all essential health benefits (e.g., large group plans)? More generally, what sort of benefits would the Primary Medical Plan have to include so that the employer could also offer hospital indemnity for other fixed indemnity benefits?
    - The Departments have clearly not provided any limitations on the type of Primary Medical plan that could cause a violation of the coordination requirements. Nor are any such restrictions permitted. Prohibiting the offering of excepted benefits only when an individual has some specific type of Primary Medical plan is precisely what is precluded by *Central United*.

Not only is the foregoing result of the bad policy, but it also contravenes the statute. Congress, in enacting HIPAA and in every health care law since then, clearly intended for comprehensive medical

[119] 88 Fed. Reg. at 44629 n.197.

[120] Note that, under the HHS individual market regulation adopted in 2014, which was held invalid in *Central United,* the Primary Medical Plan would have satisfied the attestation requirement, thus allow hospital indemnity or other fixed indemnity excepted benefit coverage. The Departments' Proposed Rule is a complete reversal of that position for which they provide no explanation. MEC is defined in Code § 5000A(f).

plans and excepted benefits to co-exist side by side, recognizing that comprehensive medical plans do not cover all expenses related to sickness or accident.

2. Under the express language of the statute, the question of whether a policy qualifies as "noncoordinated, excepted benefits" cannot be wholly contingent upon the scope of a group health plan maintained by the same plan sponsor or the scope of an individual market plan of the same health insurance issuer.

Under the express language of the statute in PHS Act § 2722(c)(2)(C), the question whether a policy qualifies as "noncoordinated, excepted benefits" cannot be wholly contingent upon the scope of a group health plan maintained by the same plan sponsor or, in the individual market, a plan of the same health insurance issuer. The statute specifies that a policy qualifies as noncoordinated, excepted benefits "*without regard to*" whether the policy covers the same events as a group health plan maintained by the same plan sponsor or, in the individual market, coverage of the same health insurance issuer.[121] The phrase "without regard to" means what it says. A policy can be noncoordinated, excepted benefits if it overlaps with, and covers the same events as, a group health plan maintained by the same plan sponsor or, in the individual market, coverage of the same health insurance issuer. But a policy also can be noncoordinated, excepted benefits if it does *not* cover the same events as a group health plan of the same plan sponsor (because it covers events excluded from the group health plan). Similarly, in the individual market, a policy can also be noncoordinated, excepted benefits if it does *no*t cover the same events as other coverage of the same health insurance issuer. The Proposed Rule exceeds the Departments' statutory authority by making "noncoordinated, excepted benefits" wholly contingent on the scope of a group health plan maintained by the same plan sponsor and, in the individual market, on the scope of health insurance coverage of the same health insurance issuer.

3. The Departments lack statutory authority to adopt the Proposed Rule as applied in the group market.

a. The Departments do not clearly state the statutory basis of the Proposed Rule.

The preamble is very vague as to the statutory basis on which the Departments rely as the basis for the noncoordination aspect of the Proposed Rule. The preamble seems to rely considerably on the Departments' interpretation and concept of the term "noncoordination" which appears in the statute only in headings,[122] but also makes some reference to specific statutory provisions, without clearly tying the provisions of the Proposed Rule to a specific statutory provision.

The validity of a rule is wholly contingent upon the agency's rationale for the rule at the time it is issued.[123] The Departments have not given a coherent explanation of why the Proposed Rule allegedly squares with the statutory term "noncoordination." Nevertheless, the following discussion attempts to address the various bases on which the Department may have rested the Proposed Rule (without expressly saying so).

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[121] PHS Act § 2722(c)(2)(C) (emphasis added).

[122] Statutory headings are "'not commanding'" when it comes to statutory meaning and simply "'supply clues'" about Congressional intent. *Children's Hosp. Ass'n of Texas v. Azar*, 933 F.3d 764, 772 n.2 (D.C. Cir. 2019) (quoting *Yates v. United States*, 574 U.S. 528, 540 (2015)).

[123] *See, e.g., Int'l Union, United Mine Workers of Am. v. U.S. Dep't of Lab.*, 358 F.3d 40, 44 (D.C. Cir. 2004).

b. The Departments state several times that they are interpreting the term "noncoordination"; however, this term provides no statutory basis for the Proposed Rule.

The Departments refer many times in the preamble to the "noncoordination' requirements" imposed on hospital indemnity or other fixed indemnity excepted benefits and appear to rely on the term "noncoordination" as the basis for their Proposed Rule.[124] Thus, for example, the preamble states that the Proposed Rule is intended to "capture the Departments' interpretation of the requirement that hospital indemnity or other fixed indemnity insurance must offer 'noncoordinated' benefits to be considered an excepted benefit".[125] As another example, the preamble states that the proposed new example to be added to the group market regulations "illustrates the Departments' proposed interpretation of the 'noncoordination' requirements".[126] In another place, the preamble refers to the "proposal to interpret the term 'noncoordination' or ('coordination')".

The relevant statutory provisions use the term "noncoordination" just two times, both times in headings. Thus, in defining excepted benefits, the statute refers to "independent, noncoordinated benefits" in Code § 9832(c)(3), ERISA §733(c)(3) and PHS Act §2791(c)(3) as follows:

> "(3) Benefits not subject to requirements if offered as independent, *noncoordinated* benefits.
>
> (A) Coverage only for a specified disease or illness.
>
> (B) Hospital indemnity or other fixed indemnity insurance."

The only other time the term is used is in the statutory requirements for this type of excepted benefit, which are set forth in Code § 9831(c)(2), ERISA §732(c)(2) and PHS Act §2722(c)(2) as follows:

> "(c) Exception for certain benefits if certain conditions met-
>
> (1) . . .
>
> (2) *Noncoordinated*, excepted benefits.-The requirements of this [chapter of the Code, part of ERISA, referenced pasts of the PHS Act] shall not apply to any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits if all of the following conditions are met:
>
> (A) The benefits are provided under a separate policy, certificate, or contract of insurance.
>
> (B) 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.
>
> (C) 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

[124] 88 Fed. Reg. at 44628-44630.

[125] *Id*. at 44629.

[126] *Id.*

plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer." [127]

The Departments assert multiple times that the term "noncoordination" is not defined.[128] This assertion completely disregards the statute. Congress has very clearly defined what it means for coverage to be "independent, noncoordinated" by specifying the three (and only three) requirements (listed above) that must be satisfied by hospital entity or other fixed indemnity coverage to be an excepted benefit. Congress left no room for the agencies to add their own views on what "noncoordination" might mean.

Thus, in order to be valid, the Proposed Rule must be supported by one of the specific statutory provisions cited above.

c. The preamble cites two specific statutory provisions as apparent support for their new interpretation of the "noncoordinated" requirement; while it is not entirely clear whether the Departments intend to rely on either one or both of these, neither one supports the Proposed Rule.

The preamble refers to two specific statutory requirements of Code § 9831(c)(2), ERISA §732(c)(2) and PHS Act §2722(c)(2) in the discussion of this aspect of the Proposed Rule:

- The requirement in (c)(2)(B) that there can be "no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor." (referred to here as the "No Collusion Requirement").
- The requirement in (c)(2)(C) that benefits must be "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." (referred to here as the "Always Payable Requirement").

The extent to which the Departments rely on the statutory No Collusion Requirement that there must be "no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor" is not entirely clear. However, the Departments use the terms "coordination" and "coordinate" many times in the preamble, as well as in the text of the proposed new example, indicating they are relying on that term. The term "coordination" appears only in the No Collusion Requirement, it does not appear in the Always Payable Requirement.

The Department states that the term "coordination" is not defined.[129] However, the term "coordination" is used in other parts of the statute. Of particular note is the use of "coordination" in HIPAA, which enacted the statutory provisions on which the Departments now rely.

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[127] The references to individual market coverage appear only in the PHS Act; the references to group health insurance coverage offered in connection with group health plan appear only in ERISA and the PHS Act.

[128] 88 Fed. Reg. at 44629.

[129] *Id*.

Specially, § 104 of HIPAA provides as follows (emphasis added):

> SEC. 104. ASSURING *COORDINATION*.
>
> The Secretary of the Treasury, the Secretary of Health and Human Services, and the Secretary of Labor shall ensure, through the execution of an interagency memorandum of understanding among such Secretaries, that
>
> > (1) regulations, rulings, and interpretations issued by such Secretaries relating to the same matter over which two or more such Secretaries have responsibility under this subtitle (and the amendments made by this subtitle and section 401) are administered so as to have the same effect at all times; and
> >
> > (2) *coordination* of policies relating to enforcing the same requirements through such Secretaries in order to have a coordinated enforcement strategy that avoids duplication of enforcement efforts and assigns priorities in enforcement.

This provision is clear on its face as to meaning of "coordination", i.e., the Departments are to work together in a concerted, deliberate fashion. The Departments issued a memorandum of understanding (MOU) describing how they will implement the Congressional direction to "coordinate".[130] The MOU demonstrates that the Departments clearly understand this Congressional direction to work together deliberately.

The term "coordination" is used in many other places as well in the relevant health care laws, and in each place the meaning is clear -- "coordination" involves concerted, deliberate action.[131] Throughout the United States Code, the term "coordination" also has a similar meaning.[132]

The Proposed Rule, however, does not follow this clear meaning of the term "coordination". The Departments state that their proposal extends to situations that do not involve a formal coordination of

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[130] 64 Fed. Reg. 70164 (Dec. 15, 1999).

[131] See, for example: PHS Act §§ 2717(a) (the Secretary of HHS is to develop reporting requirements that "improve health outcomes through the implementation activities such as quality reporting, effective case management, care coordination"); 2793 (in order to receive a health care consumer information grant from HHS, the State must designate an office of health insurance consumer assistance that works either "directly or in coordination with" State health regulators and consumer organizations; PHS Act § 2799A-10(b), ERISA §725(b), and Code §9825(b) (providing similarly that each Secretary shall "in coordination" with the respective Inspector General make available a report regarding prescription drugs); and ERISA §523(a) (Secretary of Labor "shall coordinate with States and the Secretary of Health and Human Services" "to ensure that appropriate measures have been taken" to correct certain violations with respect to the provider requirements enacted in the No Surprises Act).

[132] See, for example, 42 USC § 254c-8(c) (recipients of grants "shall coordinate their services and activities" with agencies that administer block grant programs and the Secretary of HHS "shall ensure coordination of the program" with other programs and activities related to goals supported by the Department); 42 USC § 256a(i) (directing the Secretary of HHS to coordinate patient navigator grants with "existing authorized programs in order to facilitate access to high-quality health care services"); 7 USC § 1627c(a)(9) (defining "regional food chain coordination" as "coordination and collaboration along the supply chain to increase connections between producers and markets.").

benefits agreement. The breadth of the proposal is substantial and could impact situations in which there is no coordination at all, but rather the occurrence of two events at the same time.

The statutory Always Payable Requirement is clearly intended to ensure that if the same event is covered under both a non-excepted group health plan and under a hospital indemnity or other fixed indemnity excepted benefit policy of the same plan sponsor then the excepted benefit policy must still provide payment, that is, it can't reduce or avoid payments because there is also reimbursement under the other policy. Rather, the individual is entitled to receive payments under both policies. Typically, expense-based comprehensive medical plans have coordination of benefits (COB) provisions that apply where a person is covered under more than one plan. For example, an individual could be covered under the comprehensive plan of their own employer as well as under the plan of their spouse's employer. In such cases, the plans will typically coordinate so that the individual does not get paid twice for the same service. Unlike expense incurred benefits, the Always Payable Requirement ensures the benefit is always paid, by requiring that the excepted benefit policy must pay benefits "without regard to" benefits under another group health plan of the same plan sponsor.

The Departments appear to twist this concept of "without regard to" to mean the opposite – i.e., that benefits cannot be paid "with regard to" benefits provided under another group health plan of the same plan sponsor. This clearly contradicts the plain wording of the statute.

3. HHS lacks the authority to apply the same new interpretation in the individual market.

a. The statute prohibits HHS from adopting the new restrictive interpretation in the individual market.

The preamble states that HHS intends to apply this same new restrictive interpretation of "noncoordination" to the individual market.[133] The discussion above regarding the group market is equally applicable to the individual market; thus, for all these the same reasons HHS lacks the authority to apply the proposed new interpretation in the individual market.

The preamble to the Proposed Rule in the individual market relies on the preamble discussion for the group market and also makes similar general references to "noncoordination". Thus, there is the same problem with determining HHS' rationale for the rule. The only specific statutory provision mentioned is PHS Act § 2722(c)(2)(C) (the Always Payable Requirement). As discussed above in detail, this provision does not support either the Departments' or HHS' new restrictive interpretation of the "noncoordination" requirement.

In addition, to the extent HHS relies on PHS Act § 2722(c)(2)(B) (the No Collusion Requirement), there is an additional basis that prohibits the application of this proposal to individual market policies. This provision provides as follows:

> "There is no coordination between the provision of such benefits [under a hospital indemnity or other fixed indemnity plan] and any exclusion of benefits *under any group health plan maintained by the same plan sponsor*."[134]

[133] 88 Fed. Reg. at 44630.

[134] PHS Act § 2722 (emphasis added).

The statute does not mention individual policies in this language; it is specifically limited to *group* health plans maintained by the same plan sponsor. Thus, this provision provides no support for the Proposed Rule.

b. HHS does not have the authority to adopt the specific regulatory text in the Proposed Rule; HHS should amend the current regulation to conform to the statute.

HHS proposes to revise the individual market regulation at 45 CFR § 148.220(b)(4)(ii).[135] The preamble states that this change is being made "to specify that benefits under [hospital indemnity or other] fixed indemnity coverage must be paid without regard to whether benefits are provided with respect to such an event under any other health coverage 'maintained by the same issuer'."[136] Thus, according to the preamble, this change is made to reflect PHS Act §2722 (c)(2)(C) (i.e., the Always Payable Requirement). However, the proposed change is inconsistent with the statute.

The current regulation as it would be modified by the Proposed Rule is as follows (deletions ~~stricken,~~ additions in ***bold, italics***).

> "There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage ***maintained by the same issuer with respect to the same policyholder***."

This regulation uses completely different language than the relevant statutory provisions and thus is not supported by the statute. The proposed language reads more like PHS Act § 2722(c)(2)(B) (the No Collusion Requirement); however, as discussed above, in this section the statute mentions only group health plans and does not mention individual market coverage. Thus, that provision provides no support for the proposed language.

We note that the corresponding group market regulation correctly reflects the statutory language, and in fact just repeats that language applicable to the group market. The same approach should be taken here. Specifically, this regulation should be revised to read as follows:

> ***"The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any health insurance coverage maintained by the same health insurance issuer."***

This language will conform the regulation to the statute.

HHS requests comments on whether for this purpose the definition of same "health insurance issuer" should be "broadened" to include members of the same controlled group (rather than the licensed entity that sells the policy). There is no authority for this expansion, which would apply a different definition of "health insurance issuer" than that used generally under the statute. This change should not be made.

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[135] This section of the regulation would be redesignated as 45 CFR § 148.220(b)(4)(i) under the Proposed Rule.

[136] 88 Fed. Reg. at 44630.

F. The proposed applicability date[137] is not practical and would interfere with insurance contracts already in force.

Summary of proposed effective date

The Departments propose that, if the Proposed Rule is finalized as written, the changes to payment standards and the noncoordination requirement would be applicable starting as soon as 75 days after a final rule is published ("Effective Date"). For policies sold or issued on or after the Effective Date, the changes would apply to plan years (for group market policies) and coverage periods (for individual market policies) beginning on or after the Effective Date. For policies sold or issued before the Effective Date, the changes would apply for plan years and coverage periods beginning on or after January 1, 2027.

Comments

Policies issued before the general Effective Date

All individual hospital indemnity or other fixed indemnity policies offered by Aflac are guaranteed renewable, meaning that the insurer cannot cancel the policy as long as the applicable premium is paid, except in accordance with specified limited circumstances allowed by state law, such as fraud or misrepresentation of a material fact. This is the same throughout the industry. Guaranteed renewability is a valuable right because it means the policyholder can keep their policy even if their medical condition changes. The policyholder's surviving spouse (in the case of death of policyholder), ex-spouse (in the case of divorce) and dependent children, if covered under the plan, usually also have the right to continue coverage under guaranteed renewable policies. These provisions are included as contract terms and are often mandated by applicable state law.

Group policies offered by Aflac are not guaranteed renewable; however, individuals covered under group policies typically have a right to continue their coverage (called a "portability privilege"). Some group policies are issued with multi-year rate guarantee periods, for example, plans issued in the public sector in response to a request for proposal (RFP) process. In each instance, changing the nature of or requiring a termination of the coverage would create substantial practical and legal issues for Aflac and the insureds.

An administrative rule is retroactive if it "'takes away or impairs vested rights acquired under existing law, or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past.'"[138] The Proposed Rule's changes to requirements for hospital indemnity or other fixed indemnity policies are retroactive because they would, on the effective date, impose new restrictions on current policies and interfere with the contract rights of policyholders.

Applying the rule to contracts already in place on the Effective Date essentially puts the issuer in the position of voiding the contract or violating the law. It also presumes that all current policyholders were either misled or confused about what they purchased and no longer want the policies they purchased.

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[137] The Proposed Rule uses the term "applicability date" to refer to the date that a final rule would be applied. In this letter, the term "effective date" is also used to refer to what the Proposed Rule refers to as the "applicability date".

[138] *Nat'l Mining Ass'n v. U.S. Dep't of the Interior*, 177 F.3d 1, 8 (D.C. Cir. 1999).

Rather, because individuals do not have to keep their policies in place if they no longer want them, the presumption should be that individuals want to keep the coverage they have. There is no justification for the Departments to reach into the very personal financial decisions people make for themselves and their families and determine by fiat that they can no longer maintain the policies they knowingly and willingly purchased. The delayed effective date of Jan. 1, 2027 only delays the problem, it does not solve it. An agency has no authority to promulgate retroactive rules without express authorization from Congress.[139] The Departments have not been given that authority here.[140]

Policies issued on or after the general Effective Date

If, contrary to our recommendations, the proposed changes to the payment and noncoordination standards are finalized, more lead time than just 75 days after the Effective Date will be required for states and issuers to take the necessary steps to implement the new requirements. While the steps and process may vary to some extent, e.g., based on the particular state, in general, the following events will need to occur.

- State legislatures would need to pass laws that conform to the new requirements for both the individual and group markets. We note that not all state legislatures meet annually, meaning that it could take more than one year for some states to meet in order to consider the new requirements. Some states might have state-specific requirements, e.g., state-specific notice requirements which could take additional time.
- State Departments of Insurance (DOIs) would need to propose, finalize, and implement minimum standards regulations.
- Insurance carriers would need to work internally with benefits experts, actuaries, and accountants to develop new products that are based on sound accounting and actuarial principles and are appealing to individual consumers and employers.
- Insurers will need to update their technology platforms to accommodate new requirements.
- Insurance carriers would need to submit proposed products to state DOIs for review and approval. Some states also require that any marketing materials for a product be submitted for review and approval.
- State DOIs would need to review and approve insurance carriers' submissions. Given that every carrier will need to re-file every product in the individual and group markets, backlogs are likely to develop.

Likewise, employers will 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 in advance, and the planning process starts well in advance.

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[139] *Cox v. Kjakazi*, No. 22-5050, 2023 U.S. App. Lexis 19399, at *15 (D.C. Cir. July 29, 2023) (citing *Bowen v. Georgetown Univ. Hosp*., 488 U.S. 204, 208 (1988)).

[140] 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.

Recommendations

Should the Proposed Rule be finalized, all policies issued before the Effective Date should be exempt from the final rule.

If the Proposed Rule is finalized, we recommend a date beginning no earlier than January 1, 2027 for new policies with plan years or coverage periods beginning on or after such date, assuming the rule is finalized in 2023. If a rule is finalized later, the applicability date should be pushed back correspondingly, e.g., if the rule is finalized in 2024, we recommend a date beginning no earlier than January 1, 2028.

We want to emphasize that any changes to Effective Dates, including those we suggest here, would not serve to address the underlying issues we have raised with respect to the provisions of the Proposed Rule as relates to the noncoordination requirements and fixed payment standards. We continue to oppose these parts of the Proposed Rule for the reasons provided.

G. The Departments do not accurately assess the costs to insurers of complying with the new requirements.

The Departments state in the preamble that plans and issuers change their policy documents routinely, and for this reason the Departments make the assumption that the costs to plans and issuers to change their documents to comply with the Proposed Rule "would be part of plans' and issuers' usual business costs."[141] To the contrary, if finalized, the Proposed Rule would require significant new policy adjustments that would not otherwise be required. As discussed in the preceding section of this letter, a number of steps will generally be required for policies meeting any new requirements to be ready for market. As an initial matter, states will have to adopt new laws and regulations implementing any new requirements. Just as is the case now, each state may adopt its own specific requirements. Insurers will need consult with actuaries and other advisors to understand the specific requirements in each state, to develop new products that are actuarially sound and provide value to customers, product forms will need to be submitted and approved by states in accordance with state law, marketing materials and communications will need to be completely revised. Changes of the magnitude contemplated by the Proposed Rule will require significant actuarial and premium modifications. All of this will take considerably more time and expense than typical policy changes.

Employers also will need to make changes to their benefit plans to reflect the new products that may be offered, including determining what benefit options they wish to make available, and modifying enrollment materials and communication materials. While employers may make benefit changes from time to time, these changes will impose additional costs and burdens employers would have not voluntary undertaken absent the regulatory changes.

The Departments make no attempt to consider these additional costs.

H. Comments on the request for information on specified disease or illness excepted benefits.

While not proposing a change to the requirements for specified disease or illness coverage (commonly referred to as "critical illness coverage") to qualify as an excepted benefit, the Departments include a request for information asking for detailed information on such coverage. This indicates that the

[141] 88 Fed. Reg. at 44644.

Departments may consider changes such as those in the Proposed Rule for such coverage as well. For the reasons presented in this letter, applying the Proposed Rule (or other new restrictions) to specified disease or illness excepted benefits would unnecessarily disrupt a functioning market for these products, and prevent consumers from accessing the financial products they value to protect and provide for themselves or their families. As is the case with hospital indemnity or other fixed indemnity excepted benefits, consumers who purchase specified disease or illness coverage similarly report overwhelming satisfaction with the product and for the same reasons. In a recent survey, 97% of consumer were satisfied with their specified disease/critical illness coverage and 99% rated the service from the insurer as excellent or good.[142]

II. PROPOSED CHANGES TO THE NOTICE REQUIREMENT

Summary of Proposed Rule: The Proposed Rule would impose a new notice requirement on group market hospital indemnity or other fixed indemnity excepted benefit coverage and amend the current notice requirement for the individual market. The new notice would have to be prominently displayed on the first page of any marketing, application, and enrollment materials (in either paper or electronic form, including websites) provided at or before the time participants are given an opportunity to enroll or re-enroll. Issuers of individual policies must also provide the notice on the first page of the policy, certificate, or contract of insurance. The Notice would have to be in at least 14-point font. The Departments ask for comment on the placement of the notice (marketing/enrollment materials generally and first page of policy for individual). The proposed notice would not affect any separate notice requirements under applicable state law, excepted to the extent a state notice requirement would prevent application of any federal notice requirement. Thus, states could impose additional notice requirements.

The Proposed Rule includes the text for the proposed notice, and also asks for comments on possible alternatives, including a specific alternative notice.

This new notice requirement would apply for *all* policies, new and existing, for plan years (for group market policies) and coverage periods (for individual market policies) starting 75 days after a final rule is published ("Effective Date").

Summary of Comments: Aflac views a notice as a best practice and believes that a notice is an effective way to address concerns regarding possible confusion. Even where not required by law, Aflac includes a notice on its hospital indemnity or other fixed indemnity excepted benefit policies to the effect that the policy is not comprehensive medical coverage or a substitute for such coverage.

Summary Conclusion: Providing a clear notice directly addresses the Departments' concerns with respect to possible consumer confusion, without the broad negative impacts on consumers who wish to have this type of additional financial protection. While we firmly believe in the importance and effectiveness of a notice in ensuring that consumers understand the nature of supplemental coverage, we believe that this issue is best left to the states. Based on the federal court of appeals decision in *Central United*, it is unclear whether a federal court would find that the Departments have the authority to require a notice as a condition of excepted benefit status. Should the final rule include a notice requirement, we have some suggestions regarding the details of the notice. We oppose use of the alternative notice, which is misleading and inaccurate in many respects. Existing policies should be

[142] Global Strategy Group Survey, at 5, 6.

exempt from any notice requirement and the effective date for new products is impractical and should be modified to allow more time for compliance.

A. Aflac firmly believes that consumers should understand the products they are purchasing.

Aflac shares the Departments' concern that individuals should understand the products that they buy. Aflac's products are not intended as comprehensive medical coverage or a substitute for comprehensive medical coverage and we design and market our products accordingly. In order to help consumers understand our products, Aflac voluntarily includes a notice on our products (where not otherwise required by law) explaining that hospital indemnity or other fixed indemnity excepted benefits products are not comprehensive medical coverage or a substitute for such coverage.

Recent survey data has found that by far the majority of purchasers understand their supplemental excepted benefit coverage. Ninety-three percent 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.[143]

Unlike the other changes the Departments propose, a notice requirement goes directly to the issue of potential consumer confusion, while leaving well-tested valuable consumer protection options available. A notice also helps to reduce the opportunity for explicit misrepresentations as to the nature of excepted benefit coverage. While a notice is important and effective, based on the federal court of appeals decision in *Central United*, it is unclear whether a federal court would find that the Departments have the authority to require a notice as a condition of excepted benefit status. The best way to address a notice is through state law. States also have considerable authority to police unlawful and misleading practices. In fact, we fully support industry best practice models, such as NAIC Models #40, 170, and 171, that specifically address notices and disclosures to consumers and the design and marketing of hospital indemnity and other fixed indemnity health insurance.

B. If a notice requirement is finalized, Aflac recommends that the Departments use the wording of the proposed notice with minor modifications and coordinate the notice with state law requirements.

Aflac recommends the wording of the notice as proposed be revised to read as follows (additions *in italics*, deletions ~~stricken~~):

> Notice to Consumers About Fixed Indemnity Insurance
>
> **IMPORTANT:** This is fixed indemnity insurance. **This isn't comprehensive health insurance** and ***by law does not*** ~~**doesn't *have to***~~ ***include*** most Federal consumer protections *otherwise required* for *comprehensive* health insurance.[144]
>
> *If you want to purchase comprehensive health insurance, v*~~V~~isit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325) to review your options ~~for comprehensive health insurance~~. If ~~you're~~ *you are* eligible for coverage through your employer or a family member's

[143] Global Strategy Group Survey, at 9.

[144] The phrase "**doesn**'t have to include" is included in the proposed text, we proposed bolding that entire phrase (as revised) to make it clear that this coverage, by law, is not subject to the ACA or other federal health coverage mandates.

employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy.

The proposed notice is of appropriate length, conveys that the information is important, and makes it clear the coverage is not comprehensive health insurance and by law, is not subject to the federal requirements applicable to comprehensive medical coverage.

States can impose their own notice requirements. In order to avoid duplicate notice requirements which may add confusion for consumers, any new federal notice should be coordinated with state-law requirements. Thus, for example the Departments could have a process by which a notice provided in accordance with state law satisfies any federal notice requirement.

C. The alternative notice is misleading.

The alternative notice is misleading with respect to the nature of hospital indemnity or other fixed indemnity excepted benefits. The text of the alternative notice is as follows:[145]

WARNING

This is not comprehensive health insurance. This is fixed indemnity insurance.

This may provide a cash benefit when you are sick or hospitalized. It is not intended to cover the cost of your care.

Contact your State department of insurance if you have questions or complaints about this policy.

For info on comprehensive health insurance coverage options:

- Visit HealthCare.gov online or call 1-800-318-2596 (TTY: 1-855-889-4325)
- Contact your employer or family member's employer.

There are several issues with this wording. First, the use of the term "WARNING" inappropriately implies that somehow the coverage is inherently dangerous. For the Departments to proffer this as an alternative makes clear they believe these products are essentially life threatening and consumers should be prevented from buying them. The Departments provide no empirical evidence supporting their position.

The use of the term "WARNING" inappropriately implies that somehow the coverage is inherently dangerous. In other federal labeling requirements, the use of the "WARNING" is limited to extreme situations where the product itself is inherently unsafe. Federal labeling requirements have generally used warning statements to warn of a hazard or harm associated with the use of the product.[146] Legislation, regulations, and agency guidance include extensive rules on when to use such a statement

[145] 88 Fed. Reg. at 44628.

[146] *See, e.g.,* Federal regulations for cosmetic labeling: "The label of a cosmetic product shall bear a warning statement whenever necessary or appropriate to prevent a health hazard that may be associated with the product." 21 CFR § 740.1(a).

and what signal words should precede the statement.[147] Other signal words, such as "CAUTION" or "ATTENTION", are also used even when warning of a hazard or harm. For example, the Federal warning statement for toxic shock syndrome ("TSS"), a rare disease associated with tampon use that can be fatal, requires the use of the signal word "ATTENTION."[148] Tampon usage itself is not inherently hazardous or harmful even though improper usage can, in rare cases, lead to death through TSS. The warning statement directs consumers to additional instructions and information related to proper usage and identifying symptoms of TSS.

There are numerous alternate warning statements required for cigarettes, which *are* inherently harmful to health, each statement warning of a serious health risk, and each requiring the signal word "WARNING" to precede the statement.[149] The intent of these various warning statements for cigarettes is clear: There is no safe way to use cigarettes. Cigarettes are harmful and hazardous to health.[150]

Hospital indemnity or other fixed indemnity insurance, however, is not inherently hazardous or harmful. This coverage is beneficial for individuals who purchase such coverage as a supplement for medical expenses not covered by comprehensive medical coverage. This is also consistent with how Aflac markets this coverage. The proposed notice is intended to highlight for consumers the fact that fixed indemnity coverage is not comprehensive medical coverage. The intent should not be to imply or raise concerns that the coverage is somehow inherently dangerous. Use of the signal word "WARNING" would be incorrect and misleading. The term "IMPORTANT" would be more appropriate and accurate.

The statement in the alternative notice that the insurance: "It is not intended to cover the cost of your care" is confusing. On the one hand, it could be applied to any health insurance, even comprehensive coverage, because no insurance will cover all costs of care. Further, hospital indemnity or other fixed indemnity insurance provides an alternative source of funds that may be used to cover unreimbursed medical expenses. This language in the alternative notice fails to accurately describe the function of hospital indemnity or other fixed indemnity excepted benefits.

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[147] *See, e.g.,* 15 USC § 1261(p)(1), which describes the distinctions between the signaling words "DANGER" and "WARNING" or "CAUTION" for hazardous substances; Food and Drug Administration ("FDA") Guidance for Industry for labeling of prescription drugs and biological products at https://www.fda.gov/media/71866/download (as visited September 1, 2023).

[148] See 21 CFR § 801.430(c), which mandates the following warning language: "ATTENTION: Tampons are associated with Toxic Shock Syndrome (TSS). TSS is a rare but serious disease that may cause death. Read and save the enclosed information."

[149] The Federal Cigarette Labeling and Advertising Act requires one of the following statements to be used for cigarette labeling: "WARNING: Cigarettes are addictive; WARNING: Tobacco smoke can harm your children; WARNING: Cigarettes cause fatal lung disease; WARNING: Cigarettes cause cancer; WARNING: Cigarettes cause strokes and heart disease; WARNING: Smoking during pregnancy can harm your baby; WARNING: Smoking can kill you; WARNING: Tobacco smoke causes fatal lung disease in nonsmokers; WARNING: Quitting smoking now greatly reduces serious risks to your health." 15 USC § 1333(a).

[150] Federal labeling requirements include numerous similar examples, and in all examples that we reviewed, "WARNING" was reserved for products that posed a risk to safety or bodily hazard or harm. For example, even in Federal regulations for cosmetic labeling, products with ingredients whose safety is not adequately substantiated must bear the following warning statement: "Warning — The safety of this product has not been determined." 21 CFR § 740.10(a).

Further, such notice would, in fact, mislead individuals to think that supplemental coverage is somehow avoiding requirements applicable to comprehensive coverage, when in fact the insurance is not subject to federal mandates.[151]

D. The proposed effective date should be modified.

This new notice requirement would apply for *all* policies, new and existing, for plan years (for group market policies) and coverage periods (for individual market policies) starting 75 days after a final rule is published ("Effective Date").

For the same reasons discussed above regarding the effective date of the proposed new requirements regarding the fixed payment standard and the noncoordination rule, the proposed notice requirement should not apply to existing policies. As in that situation, applying the notice to existing policies would inappropriately interfere with the individual's current contract and their choice to continue the policy. Further, imposing the notice requirement on existing policies would be confusing and impractical. For policies that are guaranteed renewable, the policy remains in force as long as premiums are paid. Thus, there is typically no renewal notice or other communication with respect to renewal of the policy. Providing a notice in such cases may unnecessarily confuse consumers regarding the renewal of their policy and their renewal rights.

Similarly, for the reasons stated above regarding the effective date of the proposed new requirements regarding the fixed payment standard and noncoordination rule, for new policies, 75 days is simply not sufficient time to implement a new notice requirement. As is the case with other changes, states may need to change their laws and regulations, policies may need to be refiled, new communications materials will need to be developed, etc. Thus, the effective date for the notice requirement for new policies should align with our proposed effective date for the other provisions, that is, if a final rule is issued in 2023, the requirement should not be effective before January 1, 2027. If the rule is finalized at a later date, then the effective date should be pushed back accordingly. For example, if the rule is finalized in 2024, requirement should not be effective before January 1, 2028.

E. The cost of implementing the proposed notice requirement is understated.

As is the case with the other elements of the Proposed Rule (see above), the Departments have underestimated the cost of implementing the notice requirements. In the preamble to the Proposed Rule, the Departments state that they expect plans and issuers to incur "minimal costs" to replace the existing notices in part because the Departments will be providing the language for these notices.[152] This statement ignores the fact that a major cost of implementing a notice requirement is not simply developing the text, but the mode of how such a notice is communicated. Significant system changes generally are needed to make changes of this sort. Further, these changes are not part of normal business costs, but would be necessary only due to the change in federal requirements. The changes may be more complicated, and costly, where states have their own notice requirements.

[151] As noted above, it is possible that a federal court might find that any notice requirement imposed as a condition of excepted benefit status is invalid; the likelihood of such a result may increase if the notice is misleading.

[152] 88 Fed. Reg. at 44644.

COMMENTS ON THE TREASURY DEPARTMENT'S PROPOSED RULE ON TAX TREATMENT AND SUBSTANTIATION REQUIREMENTS FOR FIXED INDEMNITY INSURANCE AND CERTAIN OTHER ACCIDENT AND HEALTH INSURANCE

I. Introduction

Summary of Proposed Rule: The current rules regarding taxation of benefits under policies that pay a fixed dollar amount based on the occurrence of a triggering medical event ("Indemnity-Based Health Policies")[153] are well established, having been in force for decades:

- When premiums for such policies are paid on an after-tax basis, the entire benefit is tax free.
- When premiums are paid on a pre-tax basis, i.e., through direct employer contributions or pre-tax salary reduction, the benefit is tax free, but any "excess benefit" is taxable, i.e., any benefit in excess of the individual's related unreimbursed medical expenses.[154]

Even when some portion of the benefit is includable in income, no part of the payments are wages for employment tax purposes. Further, only the individual is in a position to determine what portion (if any) of the benefits received is taxable. Neither the employer nor the insurer has all the information needed to determine the taxable amount (and cannot obtain that information due to HIPAA privacy rules and other restrictions). Thus, as historically been the case, the individual is responsible for determining any taxable excess benefit and, if some portion is taxable, including the proper amount on their income tax return.[155]

The Department proposes to change this decades-long tax treatment, imposing both income and employment taxes.

Summary of Comments: Although described as a "clarification", the proposal is a clear reversal of long-standing tax treatment and would impose new taxes on both individuals and employers (particularly small employers). Such an approach is contrary to law, would increase taxes, and could restrict the availability of valuable financial protection and health benefit options available today.

The Department is clearly concerned about specific abusive arrangements that purport to avoid income and payroll taxes and that are often marketed as health arrangements. The Department's proposal, however, goes well beyond such arrangements and would change the tax treatment for all plans, even

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[153] While the Proposed Rule generally uses the term "fixed indemnity" in the discussion of the proposed tax changes to refer to policies that pay a fixed dollar amount on the occurrence of a covered medical event without regard to the amount of expenses incurred, we use "Indemnity-Based Health Policies". A number of different types of policies may fit this description, including hospital indemnity or other fixed indemnity excepted benefits, specified disease or illness excepted benefits, and certain accident insurance as well as any other coverage that pays a fixed amount of benefits based on a medical event without regard to expenses (e.g., certain dental or vision indemnity coverage).

[154] See, for example, Code § 105(b); 26 CFR § 1.105-2; Rev. Rul. 69-154, IRS Pub. 502 (Medical and Dental Expenses) (2022)(p. 17-19).

[155] See, for example, IRS Pub. 502 (Medical and Dental Expenses), p. 17-19, which provides instructions on how to determine the excess benefit.

those operating in accordance with current law. The Department should continue to address the abusive arrangements through targeted guidance and enforcement action.

Summary Conclusion: The Proposed Rule should not be finalized; rather, the Department should affirm that current law treatment remains in place and escalate enforcement action as needed to address abusive arrangements.

II. Tax Avoidance Schemes Should be Addressed Directly

In explaining the reasons behind the Proposed Rule, the preamble refers to certain arrangements that purport to avoid income and employment taxes through the use of schemes that pay benefits based on "health-related" events or activities and often provide a monthly benefit based on these "health-related" events or activities.[156] While these schemes have variations, the core element is that the employee reduces their salary through a Code § 125 cafeteria plan and receives almost the entire amount of their salary back purportedly tax free. Recent, more sophisticated, schemes have suggested that taxes do not apply because benefits are triggered by a volitional (often illusory) medical event. However, the purported tax benefits are not realized, because the trigger for payment of benefits under these arrangements is not a medical event, but completely volitional actions. Typical activities that trigger benefit payments include activities such as watching a video regarding general health or checking in with a health coach, but do not involve a medical event that gives rise to a medical expense as defined in §213(d). In fact, the key to these schemes is that the employee purportedly simply avoids taxes without incurring medical expenses.

The IRS has been working to combat these arrangements. The IRS addressed an earlier version of these schemes, referred to as the "classic double dip" in Revenue Ruling 2002-3.[157] More recently, as part of these efforts, the IRS has released several chief counsel memoranda regarding the impermissible tax schemes, which help to alert taxpayers to unscrupulous activities.[158] Aflac shares the concerns regarding promotion of improper tax schemes and the potential harm to employers and employees who unwittingly become involved. Aflac has been proactive in making information available to employers, brokers, and others regarding such schemes and the warning signs to watch out for.[159]

Over time, while promoters of health-plan related tax avoidance schemes (like promoters in other tax areas) have modified their tactics, the core elements remain the same – employee salary reduction,

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[156] 88 Fed. Reg. at 44634.

[157] Rev. Rul. 2002-3, 202-1 C.B. 316.

[158] CCA 202323006 (dated May 9, 2023, release date June 9, 2023) available here https://www.irs.gov/pub/irs-wd/202323006.pdf ; CCA 201719025 (dated April 24, 2107, release date May 12, 2017), available here https://www.irs.gov/pub/irs-wd/201719025.pdf; CCA 201703013 (dated Dec. 12, 2016, release date Jan. 1, 2017) (clarified by footnote 1 in CCA 201719025, in footnote 1) available here https://www.irs.gov/pub/irs-wd/201703013.pdf.

[159] See, for example, Aflac Federal Relations Advisory, "Watch out for fraudulent health plan tax avoidance schemes", available at https://www.aflac.com/business/resources/advisories/wellness-scam-advisory.aspx (last visited Sept. 1, 2023)

coupled with an arrangement that purports to return almost all the employee's salary back tax free – but the tax savings are not real.

Unlike the situation with the tax avoidance schemes, which often rely on employee self-certification of volitional events, Aflac requires documented proof of loss with respect to each claim. Provider bills are often used, as they provide detailed information regarding the particular services, treatments, etc. provided.[160] Other information may also be used to document a claim depending on the particular circumstance. For example, for a claim for hospital confinement (i.e., admission), in some cases discharge papers from the facility may provide the needed information. When the benefit is based on a treatment, then proof of the particular treatment from the facility/provider will be needed. Other carriers follow similar procedures. In all cases, there must be sufficient third-party documentation of the medical event triggering the benefits to support the claim.

In legitimate arrangements, the employee is not assured of receiving their salary reduction amounts back tax-free; rather, as is the case with other insurance, the employee is purchasing protection against loss, and the loss may or may not occur. Even if the employee does not have a medical event that triggers a benefit payment, the employee recognizes that they have received value for their premium in the form of the additional protection.

The potential for tax abuse is an unfortunate aspect of every tax system. In recognition of this potential, the IRS has considerable authority to enforce the federal tax laws and impose penalties, including criminal sanctions.[161] Further, the IRS often engages in outreach efforts to educate taxpayers and practitioners about unlawful activities.[162] In the case of tax schemes involving health coverage, state insurance regulators and other federal agencies may also play a role.[163]

The existence of tax avoidance schemes, however, does not support changing long-standing tax treatment. Rather than propose a broad rule change that would negatively impact compliant taxpayers,

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[160] The universal billing form UB-40 or HCFA 1500 is commonly used by facilities for inpatient and outpatient services.

[161] Thus, for example, the IRS maintains a list of reportable transactions and can impose considerable penalties on the promoters of such transactions. See, for example, https://www.irs.gov/businesses/corporations/regulations-on-abusive-tax-shelters-and-transactions. (last visited on Sept. 1, 2023). The General Accountability Office (GAO) has recently issued a report suggesting additional steps that could be taken by the IRS, "Abusive Tax Schemes: Additional Steps Could Further IRS Efforts to Detect and Deter Promoters", GAO-23-105843 (Dec. 15, 2022), available at https://www.gao.gov/products/gao-23-105843#:~:text=GAO%2D23%2D105843%20Published%3A,of%20taxable%20income%20or%20assets.

[162] See, for example, IRS, Anti-Tax Law Evasion Schemes (last updated Apr. 7, 2023), https://www.irs.gov/businesses/small-businesses-self-employed/anti-tax-law-evasion-schemes (last visited on Sept. 1, 2023), and IRS Publication 3995 (Rev. 3-2023), Recognizing Illegal Tax Avoidance Schemes, https://www.irs.gov/pub/irs-pdf/p3995.pdf (last visited on Sept. 1, 2023).

[163] See, for example, Press Release, U.S. Dep't of Lab., *Louisiana Couple Pleads Guilty to Operating Fraudulent Multiple Employer Welfare Arrangement* (June 19, 2019), https://www.dol.gov/newsroom/releases/ebsa/ebsa20190619 (couple pleads guilty to fraudulent health plan tax scheme after investigation by multiple federal agencies).

the Department should continue to focus on improper arrangements and the promoters of such arrangements.

III. The Proposed Rule Would Increase Taxes on Consumers and Employers and May Reduce the Availability of Financial Protection Options

Under current law, benefits under Indemnity-Based Health Policies are tax free up to the amount of unreimbursed related medical expenses, and only any excess benefit is taxable. If the Proposed Rule is finalized, 100% of the benefit would be taxable income regardless of the amount of the individual's unreimbursed expenses. Further, the preamble indicates that FICA and FUTA taxes would apply, although there are no proposed changes to the employment tax regulations and there is no mechanism in place or proposed as to how imposition of employment taxes would work.

Example: Consider an individual who has been diagnoses with cancer and has had many cancer-related doctor visits, hospital visits, and cancer treatments. The individual is covered by ACA comprehensive medical coverage through their employer. The comprehensive medical plan provides coverage for these events but, as is typical with comprehensive coverage, there are out-of-pocket expenses, even when using in-network providers.[164] The individual's out-of-pocket expenses for deductibles, co-insurance, and co-payments were $6,000. The individual also has an Indemnity-Based Health Policy the premium for which was paid for by a combination of employer contributions and pre-tax salary reduction. This policy covers some of the same medical events covered as those covered under her comprehensive medical plan. Her total benefit from the Indemnity-Based Health Policy for these medical events is $5,000.

Under current law: The entire $5,000 from the Indemnity-Based Health Policy is tax free, because there is no "excess benefit". The individual is left with only $1,000 of out-of-pocket medical expenses.

Under the proposal: Taxes would be owed the $5,000 payment under the Indemnity-Based Health Policy (even though that is less than the individual's unreimbursed medical expenses). Further, the Proposed Rule would appear to subject this payment to FICA and FUTA taxes, payable by the individual (in the case of FICA taxes) and her employer (FICA and FUTA). The mechanism for paying the FICA/FUTA taxes is not clear.

[164] Under the ACA, for 2023, an individual may be required to pay up to $9,100 in out-of-pocket expenses for covered services under a comprehensive medical plan, even when in-network providers are used. https://www.cms.gov/files/document/2023-papi-parameters-guidance-v4-final-12-27-21-508.pdf

Consider the impact of the proposal in this example, assuming that the individual's total taxable income, including the $5,000 payment from the Indemnity-Based Health Policy is $47,000, placing them in the 22% bracket.[165]

Item	Current Law	Proposed Rule
Indemnity-Based Health Policy Benefit	$5,000	$5,000
Income Tax (22%)	0	($1,100)
OASDI (6.2%)	0	($310)
HI (1.4%)	0	($70)
Remaining Indemnity-Based Health Benefit	$5,000	**$3,520**
Remaining Unreimbursed Medical Expense	$1,000	**$2,480**

As a result of the tax change, this individual now has increased exposure to out-of-pocket medical expenses. In fact, the exposure has more than doubled due to the increased tax. Many states conform to federal tax rules; thus, depending on the state of residence, additional taxes might be imposed leaving more exposure to medical expenses.

The individual's employer also would now owe $380 in FICA taxes.

This represents a typical situation -- the end result is increased taxes that expose the covered individual to additional out-of-pocket expenses.

Under the Proposed Rule employers will wish to re-evaluate the cost of providing benefits under Indemnity-Based Health Policies. Employers who now pay for some or all of the premiums for such coverage (or provide for premium payment through a cafeteria plan) will need to decide whether offering the benefit on an after-tax basis (or imputing income on any employer paid premium) is preferable to subjecting the employee to tax on the payment of the benefit and also avoiding complex issues for the employer regarding potential reporting obligations and FICA and FUTA taxes.

Faced with this new decision, some employers will continue to offer these benefits but on an after-tax basis, which will avoid tax implications on any benefit payments. While the premium for the policy will be less than the potential benefits, this still results in a tax increase which will reduce the value of the benefits received. Currently, both the premium and benefits (up to the amount of unreimbursed medical expenses) are exempt from tax.

Employers and employees would have increased FICA and FUTA taxes when premiums are paid post-tax. Unfortunately, with the tax increase under the Proposed Rule, some (likely smaller) employers may

[165] Rev. Proc. 2022-38.

choose not to make these benefits available at all. The harm in this situation would be felt by employees, who would lose the opportunity to have cost effective additional financial protection compared to what is available today.

IV. The Treasury Department Overreaches its Authority in Seeking to Change the Clear and Longstanding Tax Treatment of Indemnity-Based Health Policies as Established by Congress

A. As with health coverage generally, the rules for taxation of benefits payable under Indemnity-Based Health Policies are clear and well established: only the "excess benefit" above unreimbursed medical expenses is taxable. This tax treatment has been the same for at least 60 years and any change must come from Congress.

Code Section 105(b) establishes the "excess benefit rule"

The statutory provisions governing the taxation of health benefits has been the same at least since the enactment of the Internal Revenue Code of 1954 (the "1954 Code"). The tax treatment is the same for all health coverage, i.e., the statute does not distinguish between Indemnity-Based Health Policies and other types of health coverage. The Proposed Rule seeks to change this rule (under the auspices of a "clarification") and inappropriately conflates the rule applicable to disability benefits to apply to this sector of the health insurance market.

Taxation of employer-provided health benefits depends on two factors: (a) whether any part of the premium was paid with employer pre-tax dollars (i.e., either by the employer or through pre-tax employee salary reduction)[166] and, if so, (b) the policyholder's total medical expenses and total reimbursements for those expenses from other insurance.

As is the case with accident and health coverage generally, if the premium for an Indemnity-Based Health Policy is paid for on an after-tax basis, Code § 104(a)(3) establishes that the benefits are entirely tax free. As is also the case with health coverage generally, if the premium for an Indemnity-Based Health Policy is paid for on a pre-tax basis (including both employer funds and employee salary reduction), Code § 105(b) provides that benefits are tax free when the benefits reimburse the employee (directly or indirectly) for medical expenses (as defined in § 213(d)); however, any excess amount (beyond unreimbursed medical expenses) is taxable income. For the exclusion under § 105(b) to apply, there does not need to be a direct correlation between the amount of benefits payable and the amount of medical care expenses incurred, as long as benefits are payable only upon the incurrence of a triggering medical expense. As designed by Congress, this treatment differs from the treatment of disability benefits where pre-tax funded coverage always results in taxable benefits.

[166] Section 106(a) provides that employer contributions for coverage under an accident or health plan are excluded from gross income. This exclusion also applies to employee pre-tax salary reduction contributions made through an employer's § 125 cafeteria plan.

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

The current Treasury regulations were adopted in 1956[167] and have not been changed since then. Consistent with the statute, Treasury regulations provide as follows:

> Section 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, section 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*, section 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 section 105(b) is not applicable to the extent that such amounts exceed the amount of the actual expenses for such medical care. 26 CFR § 1.105-2 (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).[168] Sometimes individuals also had optional supplemental coverage available either privately or through their employer. Thus, today's Indemnity Based Health Policies are exactly the type of coverage contemplated by the regulations when they state that benefits payable to reimburse a taxpayer for medical care expenses incurred are excludable from income "even if such amounts are paid without proof of the amount of the actual expenses incurred." The payment triggers in Indemnity-Based Health Policies, although not requiring proof of the ***amount*** of actual expenses incurred, are such that the incurring of medical expenses is in effect required.

Revenue Ruling 69-154 illustrates the excess benefit rule, including the process for determining taxable income. The Ruling demonstrates that only the individual taxpayer has the information necessary to determine the amount of taxable benefits.

Revenue Ruling 69-154[169] specifically addresses how to apply the excess benefit rule and determine the taxable amount with respect to Indemnity-Based Health Policies. In that ruling, an employee was covered by his employer's general health insurance policy, the premium for which was paid for by the employer. The employee was also covered by another supplemental medical insurance policy that was

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[167] 1956-1 CB 63, 70; T.D. 6169.

[168] 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.ncbi.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 (emphasis added).

[169] Rev. Rul. 69-154, 1969-1 CB 46.

paid for by the employer. The amount of the indemnity received under both policies was greater than the amount of unreimbursed medical care expenses the employee incurred. Nevertheless, the Service determined that the supplemental indemnity was "reimbursement" for the medical care expenses and was excludable up to the amount of the otherwise unreimbursed portion of the medical care expenses incurred pursuant to Code § 105(b), with only the excess being taxable.

The IRS recently confirmed the continued application of Revenue Ruling 69-154 in Chief Counsel Advice (CCA) 201719025. The CCA cites Revenue Ruling 69-154 and discusses the excess benefit rule, including an example of how it applies. In addition, CCA 201719025 clarifies earlier analysis in CCA 201703013. In the context of addressing a variation of the tax schemes, CCA 201703013 includes broad statements that inadvertently indicated that the total amount of benefits under Indemnity-Based Health Policies are fully taxable. However, in CCA 201719025, the IRS clarified the earlier analysis and explained that the earlier ruling was not intended to modify the analysis or result in Revenue Ruling 69-154.[170]

Revenue Ruling 69-154 also illustrates some of the complications that may arise in determining any taxable income in certain situations. In one situation in the ruling, an employee is covered by their employer's health insurance policy for which the employer paid the annual premium. In addition, the employee is covered under a personal indemnity policy for which the employee paid the entire annual premium on an after-tax basis. The total indemnity payments from both policies exceeded the amount of the employee's medical expenses. In this circumstance, the ruling allocates the indemnification amounts between the two policies to determine which excess payments are attributable to the employer-paid policy and, thus, includible in income. This type of calculation, to the extent required, could only be done by the employee and not by either the employer or insurer, who are likely not even aware of all the policies involved, much less the amount paid under each.

IRS Publication 502 (Medical and Dental Benefits) instructs taxpayers to follow the excess benefit rule

Since at least 1994, IRS Publication 502 has directed taxpayers to apply the excess benefit rule and include any "excess reimbursement" in gross income.[171] The most recent Publication, for 2022, is similar.[172]

We note that the preamble asserts (without authority) that Revenue Ruling 69-154 is intended to apply only in situations where the individual is covered under more than one policy.[173] Publication 502 contradicts this assertion, providing instructions both where there is only one policy involved or multiple

[170] See footnote 1 in CCA 201719025.

[171] Available at: https://www.irs.gov/pub/irs-prior/p502--1994.pdf at p 15-16.

[172] Available at: https://www.irs.gov/pub/irs-pdf/p502.pdf, p. 17-19.

[173] 88 Fed. Reg. at 44635 n.215.

policies.[174] ***What the Department describes as a "clarification" is in reality a complete and total reversal of tax treatment that has been in effect for more than 60 years, even though Congress has separately addressed the tax treatment of accident and health benefits yet retained the "excess benefit" rule for health benefits.***

The Proposed Rule would completely re-write certain provisions of the § 105(b) regulations to eliminate the excess benefit rule for Indemnity-Based Health Policies. Under the Proposed Rule, when premiums under Indemnity-Based Health Policies are paid on a pre-tax basis, 100% of the benefit would be taxable income, regardless of the amount of the individual's related unreimbursed medical expenses (e.g., even when the benefits received by an individual are far less than the individual's related medical expenses).

The Proposed Rule would explicitly apply this new tax treatment to hospital indemnity or other fixed indemnity and specified disease or illness policies that are treated as excepted benefits under Code §9832(c)(3). The Proposed Rule would also apply more broadly to any Indemnity-Based Health Policy that pays amounts triggered by medical expenses regardless of the amount of § 213(d) medical expenses actually incurred. This may include some accident coverage, as well as dental and vision coverage that pays a fixed amount regardless of expenses incurred.

The statements in the preamble that the Proposed Rule is a "clarification" are without merit. It has been clear since the 1954 Code that the "excess benefit" rule applies. There has been no change in the statute to justify the changes the Department now seeks to impose. Section 105(b) remains today as it was enacted in the 1954 Code. Further, the Department itself has repeatedly confirmed the application of the excess benefit rule.[175] Yet, the Department now seeks on its own to change the law, impermissibly usurping the authority of Congress.

The Proposed Rule would also amend the current regulations to provide that the exclusion under §105(b) does not apply unless the health plan substantiates the medical expenses that are incurred by the taxpayer. At least as applied to Indemnity-Based Health Policies, this change alone would have the effect of taxing 100% of benefits received when the policy is paid for on a pre-tax basis. Thus, at least as applied to Indemnity-Based Health Policies, this proposal also contravenes the statute and Congressional intent. Revenue Ruling 69-154 and IRS Publication 502 illustrate the complications that arise in calculating the taxable amount. Insurers of Indemnity-Based Health Policies do not have access to information regarding the individual's medical expenses, because the benefit is not (and for certain excepted benefit plans) cannot be based on the amount of expenses. Nor is the employer able to obtain

[174] See, for example, IRS Pub. 502 (2022), p. 18 ("If you aren't covered by more than one policy, you can figure the amount of the excess reimbursement you must include in gross income using Worksheet B. If you are covered under more than one policy, see *More than one policy*, later."); IRS Pub. 502 (1994), p. 16 (separate instructions where there is more than one policy). Further, the assertion that the excess benefit rule only applies where there is more than one policy is not consistent with general tax principles; the tax treatment should not matter whether there is a single policy or multiple policies, the issue is whether there is any excess benefit. However, the process for determining the excess may be more complex if more than one policy is involved (as reflected in Pub. 502).

[175] See, for example, current regulations at 26 CFR § 1.105-2(a); Rev. Rul. 69-154; CCA 201719205 and IRS Pub. 502 (for multiple years). We note that should the IRS seek to revoke Revenue Ruling 69-154, change the position in Pub. 502 or take other administrative action to undermine the excess benefit rule, any such changes would also contravene Congressional authority for the reasons stated herein.

the information due to both legal impediments such as HIPAA privacy rules, and practical barriers. This does not mean that there is no substantiation; rather, it means merely that, as is the case under numerous other provisions under the Code, including the itemized deduction for medical expenses, the responsibility for determining the taxable amount is on the individual taxpayer, including retention of any required substantiating documentation.

B. The Department does not have the authority to change tax treatment when Congress has clearly chosen not to do so.

"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.' *NLRB v. Bell Aerospace Co*., 416 U.S. 267, 274-275 (1974) (footnotes omitted)." *Commodity Futures Trading Com v. Schor*, 478 U.S. 833, 846 (1986).

Congress has had ample time and many occasions since the current § 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 so.

For example, Congress has amended § 105 to change the tax treatment of *disability* benefits but left the tax treatment of benefits under health plans (including Indemnity-Based Health Policies) intact.

- In the 1954 Code, Congress provided separate treatment in § 105(b) for accident and health benefits and in § 105(d) for wage continuation plans which provide payments for periods during which an employee is absent for work on account of personal injuries or sickness, but limited the amount of excludable disability benefits to a weekly rate of $100. Yet the exclusion for health benefits (including benefits under Indemnity-Based Health Policies) remained intact. Congress revisited this disability and wage continuation provision several times.
- In 1964, additional limits on the disability exclusion were enacted based on the length of absence from work[176],yet the tax treatment of health benefits (including Indemnity-Based Health Policies) remained the same.
- In 1976 the disability exclusion was limited to individuals who retired before age 65 due to a permanent and total disability and was phased out for individuals with adjusted gross income in excess of $15,000[177], yet the tax treatment of health benefits (including Indemnity-Based Health Policies) remained the same.
- Then, in 1983, the disability exclusion was fully repealed, establishing the current tax treatment that disability benefits are fully taxable if premiums are paid on a pre-tax basis.[178] Yet, once again, the tax treatment of health benefits (including Indemnity-Based Health Policies) remained the same.

[176] Pub. L. No. 88-272, 78 Stat. 19, the "Revenue Act of 1964" (H.R. 8363).

[177] Pub. L. No. 94-455, 90 Stat. 1520, the "Tax Reform Act of 1976" (H.R. 10612).

[178] Pub. L. No. 98-21, 97 Stat. 65, the "Social Security Amendments Act of 1983."

In 2010, as part of the ACA, Congress modified § 105(b) to extend the exclusion for employer paid health benefits (including benefits paid for with pre-tax salary reduction) to any child of the taxpayer who has not yet attained age 27.[179]

Congress could easily have considered making changes such as those now proposed to the taxation of health insurance (including Indemnity-Based Health Policies) under Code § 105 at any of these times, but chose not to.

The Department itself has effectively acknowledged that Congressional action is needed to make the change now proposed, having twice made budget proposals to "amend [Code] section 105(b)" in the manner the Department now seeks through regulations.[180] The Department does not have the authority to change the law through regulations or other administrative guidance where Congress has purposefully chosen not to.

C. Indemnity-Based Health Policies are not disability benefits and should not be taxed as such

The effect of the Proposed Rule would be to tax benefits under Indemnity-Based Health Policies as if they were disability benefits rather than health benefits. Either one or both of the proposed changes (i.e., the proposal that benefits paid under Indemnity-Based Health Policies without regard to the amount of medical expenses are taxable and/or the new "substantiation" requirement) would effectively treat Indemnity-Based Health Policies as disability benefits. The end result would be that, if premiums are paid on a pre-tax basis the entire benefit is taxable income rather than only the excess benefit. This result is contrary to the statute and Congressional intent.

The changes in tax treatment under the Proposed Rule explicitly apply to hospital indemnity or other fixed indemnity and specified disease or illness policies that qualify as excepted benefits under Code section 9832(c)(3). Since this Code section was first enacted in HIPAA, these benefits have been classified as health benefits, which are "excepted" from federal health care reforms only if certain specified requirements are satisfied. On the other hand, disability benefits are always "excepted".

In the first rulemaking on excepted benefits post-HIPAA, the Department recognized that excepted benefits described in section 9832(c)(3) are health benefits. Specifically, the Department recognized in that first rule that the category of noncoordinated benefits, which includes hospital indemnity or other fixed indemnity insurance and specified disease or illness coverage, **are generally health insurance coverage** but are excepted if certain requirements are met." 62 FR 16903 (April 8, 1997). (emphasis added). The Department now wishes to change its characterization of these policies, without any corresponding change in the statutory language describing fixed indemnity excepted benefits.

The Code has long recognized the differences between health benefits and benefits that are payable on account of disability (meaning benefits triggered by an absence from work). As discussed above, the

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[179] Pub. L. No. 111-152 (111th Congress), the "Health Care and Education Reconciliation Act of 2010", title I, § 1004(d)(1).

[180] Dep't of the Treasury, General Explanations of the Administration's Fiscal Year 2024 Revenue Proposals (Mar. 9, 2023) p. 205; https://home.treasury.gov/system/files/131/General-Explanations-FY2-24.pdf; Dep't of the Treasury, General Explanations of the Administration's Fiscal Year 2023 Revenue Proposals (Mar. 2022), p. 105, https://home.treasury.gov/system/files/131/General-Explanations-FY2023.pdf.

1954 Code provided different treatment for health benefits (including Indemnity-Based Health Policies) 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 health benefits.

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 Indemnity-Based Health Policies, 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 § 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 (sec. 105(b)) and amounts paid by the employee himself for medical expenses also are deductible elsewhere under present law (sec. 213 of the code) to the extent that they exceed what is considered to be the normal level of medical expenses."[181] (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, Indemnity-Based Health Policies, like other types of health coverage, are triggered specifically by a medical event, not absence from work.

The (since repealed) Cadillac tax enacted by the ACA (in Code § 4980I) would have applied to fixed indemnity health coverage, including specifically hospital indemnity or other fixed indemnity and specified disease or illness coverage that are excepted benefits under Code § 9832(c)(3). However, the Cadillac tax would not have applied to excepted benefits described in § 9832(c)(1), including accident and disability benefits.

The key issue in distinguishing health policies from disability policies is the structure and substance of the policies.[182] As already discussed, the Code has in the past (e.g., in the various iterations of § 105(d)) and currently distinguishes health policies from disability benefits. Disability benefits may also be described using various terms, including "sick pay" "wage continuation" and the like. The key issue is how benefits are structured. Benefits under disability policies are triggered by an ***absence from or inability to work***. Such policies typically pay a set amount on a periodic basis (e.g., monthly) as along as

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[181] 1964-1 CB (Part 2) 185, 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); pp. 553-54 (Senate Report No. 830, 88th Cong., 2d Sess. (Jan. 28, 1964), Committee on Finance).

[182] As apparent justification for changes in the Proposed Rule, the Department refers to Indemnity-Based Health Policies various times as "income replacement". Sometimes in the marketplace this coverage may be referred to as "cash replacement", "income protection", "financial protection", or even "income replacement". Aflac has used such terms to describe our policies as a way to help to distinguish our policies from comprehensive medical coverage. These descriptive terms are not the issue; the real issue is the benefit trigger; Indemnity-Based Health Policies simply do not provide disability benefits.

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, Indemnity-Based Health Policies ***pay benefits based on specific medical events***, such as a hospital stay, specified treatments, or a diagnosis of a specified disease or illness (such as cancer). While the payment of the benefit may be linked to a period, such as $200 per day of hospitalization, they are not intended to provide a periodic stream of income and are not triggered by an absence from or inability to work. This is why Indemnity-Based Health Policies, like other health coverage, is subject to the current tax rules under Code § 105(b).

D. The Department is impermissibly differentiating between health policies that pay benefits based on the amount of expenses and Indemnity-Based Health Policies.

Section 105(b) does not distinguish between health expense incurred policies and Indemnity-Based Health Policies, nor since § 105(b) was adopted has Congress indicated that differentiation was appropriate. Rather, Congress has continued to endorse the current tax treatment and regulations.

Benefits under both types of policies are triggered by a medical event. Both can possibly result in excess reimbursement (e.g., group health with a privately purchased individual medical policy – which typically does not coordinate), YET only Indemnity-Based Health Policies benefits are subject to this proposed "always taxable" treatment. While Indemnity-Based Health Policies may not base benefits on the amount of expenses incurred, the medical event triggers and the claims substantiation process (as describes above) ensures that a medical expense has been incurred.

The Proposed Rule discriminates against individuals who have Indemnity-Based Health Policies. Under current law, individuals with such products are taxed in the same way as individuals in expense-based health policies, i.e., where the premiums are paid on a pre-tax basis, the benefits are excludable from income, except to the extent of any "excess benefits", i.e., benefits in excess of unreimbursed medical expenses. The Proposed Rule eliminates this parity in treatment, only for individuals who choose Indemnity-Based Health Policies, even in the usual case where these products are supplemental to comprehensive health coverage.

V. Under a Plain Reading of the Statute, Any Taxable Benefit Payments by Insurers under Indemnity-Based Health Policies Are Not Wages Subject to Income or Payroll Tax (FICA/FUTA) Reporting or Withholding.

A. Not all items of income are wages subject to withholding for income and payroll tax purposes.

The Code contains very specific and detailed provisions defining "wages" that are subject to income and payroll tax withholding and payment ("employment taxes"). These definitions are substantially narrower than the definition of "income" subject to federal income tax. In other words, while virtually all wages are income, the converse is not true – i.e., all income is not wages. Thus, to the extent that benefits under Indemnity-Based Health Policies may constitute "income" it does not necessarily follow that such benefits are subject to employment taxes. Rather, it is necessary to look to the Code's specific employment tax provisions.

Income tax reporting and withholding obligations fall on an "employer" making payments of "wages" to an employee. Code § 3402(a). An "employer" is defined for this purpose in Code § 3401(d) as a person for whom an individual performs any services as an employee. Section 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. In general, "wages" for withholding purposes means "remuneration for services ... performed by an employee for [the employee's] employer (including benefits paid in any medium other than cash)." Code § 3401(a).

Taxes under the Federal Insurance Contributions Act (FICA) consisting of social security and Medicare taxes are imposed under §§ 3101 (employee level tax) and 3111 (employer tax). FICA taxes are imposed on "wages" as that term is defined in § 3121(a), with respect to "employment," as that term is defined in § 3121(b). Section 3121(a) defines the term "wages" for FICA purposes as all remuneration for employment, with certain specific exceptions.

Section 3301 imposes taxes on employers under the Federal Unemployment Tax Act (FUTA) on "wages" paid with respect to "employment". The general definitions of the terms "wages" and "employment" for FUTA purposes are similar to the definitions for FICA purposes. *See* §§ 3306(b)(wages) and (c) (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." [183] Thus, unless specifically altered by statute, wages for federal income tax, FICA, and FUTA fit within the plain meaning of "remuneration for employment".

B. Excess benefits paid by insurers under Indemnity-Based Health Policies are not wages for payroll tax purposes under the plain meaning of the statute.

Applying the employment tax rules to health insurance coverage, if an employer pays some or all of the ***premium*** for a fixed indemnity or other health policy, the employer-paid premium clearly would fall within the definition of "remuneration for services…performed by the employee" and, thus, would be wages for income and payroll taxes, but for the fact that such employer contributions are excluded. This is why a specific exclusion is necessary.[184] Similarly, when ***premiums*** are paid on a pre-tax basis by employees by way of salary reduction under the employer's cafeteria plan, income and employment tax would apply, but for an exception. §§ 125, 3306(b)(5)(G), 3121(a)(5)(G).

The payment of ***benefits*** by the insurer under an Indemnity-Based Health Policies is a separate event from the payment of premiums by the employer and is not a payment of wages.

Code §§ 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 expense including benefits under Indemnity Based Health Policies. Benefits payable under Indemnity-Based Health Policies, which are conditioned on a medical event, such as hospitalization, or a diagnosis of a particular disease, fall within this definition. As

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

[184] Code §§ 3121(a)(2)(B) and 3306(b)(2)(B).

discussed further above, insurers require third-party substantiation to demonstrate proof of loss as part of the claims processing process.

Moreover, the ***benefits*** paid by the insurer under Indemnity-Based Health Policies are not made as a result of any employee/employer relationship or as payment for services by an employee and thus are excluded from the definition of "wages" under the plain meaning of the statute.

FICA's statutory history helps to explain the plain meaning of the term "wages" and "employer". 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 §§ 811(a) and (b), 49 Stat. 639.

Under the Social Security Act of 1936, the Treasury Department promulgated regulations defining an employer as any person, "who employs one or more individuals in an employment, that is, for the performance within the United States of services not specifically excepted."[185] The regulation further states that, "An employer may be an individual, a corporation, a partnership, a trust or estate, a joint-stock company, an association, or a syndicate, group, pool, joint venture, or other unincorporated organization, group, or entity. An employer may be a person acting in a fiduciary capacity or on behalf of another, such as a guardian, committee, trustee, executor or administrator, trustee in bankruptcy, receiver, assignee for the benefit of creditors, or conservator."[186] Additionally, beginning with the Supreme Court's decision in *Otte v. United States*, 419 U.S. 43 (1974), courts have incorporated the definition of "employer" under § 3401(d)(1) into FICA and FUTA.

Cases involving § 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 *Otte,* a bankruptcy trustee was found to be liable for employment tax withholding on back wages owed to employees by the estate. Additionally, In *In re Armadillo Corp.,* 561 F.2d 1382 (10th Cir.1977), bankruptcy trustees were found to be the employer for federal tax purposes. The court held that because even though the employees provided services to the bankrupt companies, the trustees were in control of the payment of wages. In *Winstead v. United States*, 109 F.3d 989 (4th Cir.1997), the Fourth Circuit considered who was the employer of day laborers who worked on the plaintiff's land - the sharecroppers for whom the day laborers worked, or the plaintiff, who paid the day laborers from his own accounts. 109 F.3d at 991. The court held that the plaintiff was considered the employer for purposes of determining responsibility for withholding, paying and reporting FICA and FUTA taxes.

Accordingly, the judicial interpretation of who qualifies as a § 3401(d)(1) employer is consistent with the, "person acting in a fiduciary capacity or on behalf of another, such as a guardian, committee, trustee, executor or administrator, trustee in bankruptcy, receiver, assignee for the benefit of creditors, or conservator," described in the 1936 regulation.

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[185] Bureau of Internal Revenue, Employees' Tax and the Employers' Tax Under Title VIII of the Social Security Act, 1 Fed. Reg. 1764, 1769 (Nov. 11, 1936).

[186] *Id*.

The third-party issuer of an insurance policy, subject to insurance risk, does not fit within this definition. The payment of benefits under an insurance policy is fundamentally different than payments that are "wages" for "employment". This concept is reflected in 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 "wages". Tres. Reg. § 3401(a)-1(b)(8). An insurance policy is a financial product. Benefits are paid as a result of the contractual relationship between the insurer and the policyholder and are contingent upon the occurrence of a medical event as specified in the policy. It is possible that in some circumstances some portion of the benefit payments made to a particular policyholder may be includible in income; however, this does not convert the payments into wages.

Additional 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.[187] FICA and FUTA were enacted in 1935 and 1939 respectively and the definition of wages in those Code sections was based on the existing definition used for wages for Federal income tax purposes—"all remuneration for employment." Before the enactment of the 1954 Code, the exemption that is under Code §105 today fell under Code §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. Code §105(b) extended the exclusion for reimbursements for medical expenses to uninsured accident and health plans.[188] No change was made to payroll tax provisions to include payments made by insurance companies until Code §3402(o)(1)(C) was modified to include third-party sick pay as a payment "other than wages" for which policyholders could request withholding189. After which, Code §§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.

[187] 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.

[188] 83 Conf. Rep. 2543 at 24.

[189] Pub. L. 96-601, § 4(b) and P.L. 97-123.

C. Temporary Treasury Regulation §32.1 does not apply to excess benefits or is invalid

In the preamble to the Proposed Rule, the Department refers to temporary regulations[190] issued in 1982 (at 26 CFR § 32.1(a)), as support for the idea that benefits that are taxable income under Code § 105(a) are always subject to FICA taxes. This temporary regulation provides that that "payments on account of sickness or accident ***disability***" subject to FICA tax include "any payment for personal injuries or sickness includible in gross income under section 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 section 105(b) and the regulations thereunder. The preamble goes on to say that, because of this temporary regulation "if these rules are finalized as proposed, taxpayers would need to consider the impact this proposal would have on determinations of whether amounts received under accident and health plans constitute wages for employment tax and income tax withholding purposes."[191] .

In making this statement, the Department conflates the two separate and distinct provisions under Code §§ 3121(a)(2)(A) and 3121(a)(2)(B). The provision applies to "***disability***" payments (as set forth in §3121(a)(2)(A)) but should NOT apply to amounts paid ***on account of medical or hospitalization expenses*** under § 3121(a)(2)(B).

In addition, the Department is impermissibly converting taxable income into wages. FICA/FUTA and income tax withholding apply only to "wages" for "employment". As discussed in detail above, fixed indemnity payments under an accident or health plan that are subject to insurance risk are not "wages" within the plain meaning of the statute.

The employment tax withholding rules relating to sick pay payments under accident and health plans provide an instructive contrast with the rules for withholding on payments made on account of medical or hospitalization expenses. In the case of sick pay (i.e., payments for absence from work), §§ 3121 and 3306 provide that payments made by a third party on account of accident or disability are wages unless they are paid pursuant to workers compensation laws, and that third-party insurers are required to withhold on such wages.[192] The statute does not apply this third-party withholding in the case of payments on account of medical or hospitalization expenses.[193] 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.[194]

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[190] Section 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 (T.D.) 9233, 70 Fed. Reg. 74198 (Dec. 15, 1005), 2006-1 CB 303. Note, however, that the provision of the temporary regulation relied on in the Proposed Rule was not amended by T.D. 9233. CCM 201719025 (dated April 24, 2017), https://www.irs.gov/pub/irs-wd/201719025.pdf. Whether this regulation has any effect is discussed in the text.

[191] 88 Fed. Reg. at 44636. Similar statements are made in CCA 202323006, CCA 201719025 and CCA 201703013.

[192] Code §§ 3121(a)(2)(A) and 3306(b)(2)(A), and flush sentence following §§ 3121(a) and 3306(b).

[193] Code §§ 3121(a)(2)(B) and 3306(b)(2)(B).

[194] H.R. Rep. No. 97-409 (Conf. Rep.) (relating to Pub. L. No. 97-123), 12-15, *reprinted in* 1981 U.S.C.C.A.N. 2681, 2688-2689.

Congress could have applied this sort of rule to payments subject to insurance risk that are on account of medical or hospitalization expenses but chose not to. The Department may not through administrative action 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.[195]

Further, Temp. Treas. Reg. §32.1 was not subject to notice and comment and was clearly intended to apply to disability payments.[196] 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 Indemnity-Based Health Policies 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.

VI. Reporting Should Not be Required of Payors with Respect to Any Taxable Amounts under Indemnity-Based Health Policies

A. Insurers should not be required to report the amount of benefits under Indemnity-Based Health Policies because the taxable amount, if any, of benefits under such policies is not determinable by the insurer.

As discussed above, benefits under Indemnity-Based Health Policies paid by an insurer are not subject to income tax or FICA/FUTA withholding because the payments are not "wages". Thus, the reporting rules that apply with respect to wages do not apply to amounts paid "on account of medical or hospitalization expense" by an insurer under fixed indemnity health policies.

Although the Code requires reporting of certain specific types of payments, none of these requirements apply here.[197] Because there is no specific requirement that insurers report the amount payable under fixed indemnity health policies (or any other medical policies), any reporting requirement imposed with respect to such policies would have to be imposed by a general reporting rule. Thus, any reporting requirement imposed on a carrier with respect to such policies must be imposed by the general reporting rules applicable under Code § 6041.

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[195] Available at https://www.irs.gov/pub/irs-pdf/p502.pdf at pp. 18-19.

[196] See 47 Fed. Reg. at 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 notice of proposed rulemaking but was part of the final rule. See 70 Fed. Reg. at 12164 (the NPR) and 70 Fed. Reg. at 74198 (the final rule).

[197] For example, Code § 6051(g) (previously § 6051(a)(14)) requires employers to report the premium or other cost of "applicable employer-sponsored coverage" on Forms W-2, in some cases regardless of whether or not such premium or cost is excludable from the employees' income. This requirement does not extend to the *benefits* paid under such plans.

Code § 6041(a) provides that all persons "engaged 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".[198] (emphasis added). Thus, for reporting to apply, it is not sufficient for the amount of the payment to be fixed; rather the amount includible in income must be fixed or determinable.

Treasury regulations follow the statute in this regard. Under the regulations: "*Income* is fixed when it is to be paid in amounts definitely predetermined. *Income* is determinable whenever there is a basis of calculation by which the amount to be paid may be ascertained." 26 CFR § 1.6041-1(c)(emphasis added). Further, the regulations provide that the amount required to be reported is the "amount includible in the gross income of the payee". 26 CFR § 1.6041-1(f). Thus, the statute and regulations on their face lead to the conclusion that, in order for reporting to apply under § 6041, the payor must be able to determine a fixed amount of gross income and, conversely, no reporting is required where the payor cannot determine a fixed amount of gross income.

The obvious purpose of the information reporting requirements in § 6041 (as well as other similar reporting provisions of the Code) is to promote the enforcement of the income tax laws through third-party reporting of income. The statutory and regulatory requirement that the amount of income be fixed or determinable (rather than just requiring reporting of all payments) furthers this purpose. In contrast, reporting of payments that are not income would impose significant burdens on taxpayers and the IRS, without providing either with the information needed to determine the income of the payees for federal tax purposes.

The IRS addressed the issue of what constitutes fixed or determinable income in Rev. Rul. 80-22.[199] 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. Capitalization establishes the farmer's basis in the destroyed crops. The determination of whether any insurance proceeds received for the destroyed crops are taxable and, thus, constitute "gains, profits, or income," depends upon the amount of farmer's basis in the crops. Thus, the IRS concluded 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."

A number of IRS private letter rulings (PLRs) address the question of whether income is fixed or determinable, thus triggering reporting under § 6041. PLRs cannot be relied upon as precedent by taxpayers other than the one to whom the ruling was issued or by the IRS, but the reasoning employed in the rulings is sometimes instructive. The PLRs on this issue overwhelmingly conclude that the payer is not obligated to report under § 6041 when it is not able to determine a fixed amount of gross income to the payee because it does not have the necessary information. Thus, for example, in PLR 200610003 the

[198] If reporting is required, Form 1099 generally is used.

[199] 1981-1 C.B. 286; Rev. Rul. 80-22 clarified Rev. Rul. 78-110, 1978-1 C.B. 390, and was amplified by Rev. Rul. 82-93, 1982-1 C.B. 196.

IRS ruled that a settlement fund did not have a reporting obligation where taxation depended on whether the taxpayer had derived a tax benefit from a previous medical expense deduction and the fund "is unaware of whether a class member took a deduction in a previous year and the amount by which the deduction reduced the class member's federal income tax liability. Thus, Fund is unable to determine if a cash distribution to class members is includible in the gross income of a class member and the amount of the gross income inclusion, if any").[200]

As discussed above, a significant amount of information from varying sources is needed to determine the taxable amount, if any, of benefits under fixed indemnity health policies. Revenue Ruling 69-154 illustrates the type of information that is required.[201] As with any medical based policy, the issuer of an Indemnity-Based Health Policy does not have the necessary information. For example, the insurer typically does not know whether the premiums for a particular policy are pre- or post-tax. Even if such information were known, the insurer lacks information regarding any other medical coverage the individual may have (e.g., through the employer, a spouse's employer or a former employer or individually purchased) and/or the insured's medical expenses, nor does the insurer have any reasonable means of obtaining this information. While more traditional "expense incurred" health insurers (i.e., where benefits are based on the amount of expenses) are permitted (or even required) to share payment information for benefits coordination purposes, this sharing of information generally does not occur with respect to Indemnity-Based Health Policies. This is attributable in part because such insurance is generally prohibited from coordinating payments with other employer sponsored plans.[202] In addition, HIPAA privacy rules limit the ability of the health care provider, employer or insurer to obtain and/or share information under other coverage that would be needed to determine the taxable amount. Thus, because the insurer does not know the amount of "fixed or determinable" income reporting should not be required.

We note that PLR 9546016 comes to a different conclusion than other rulings in this area. In PLR 9546016, IRS addressed two different types of policies offered by an insurance company. Under one of the policies, predetermined benefits are paid upon the occurrence of a defined accidental injury or sickness (e.g., cancer) and diagnosis or treatment by a physician. Under the other of the Policies, benefits are paid in a predetermined amount upon occurrence of a defined accidental injury or sickness

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[200] Other examples relating to § 6041 include: PLR 201444001 (July 18, 2014) (reporting not required because the "amount Includable in [the payee's] gross income on the sale of the property is [the] excess of the amount realized over [the payee's] adjusted basis. [The payor], however, represents that it does not know [the payee's] adjusted basis in the property. Therefore, [the payor] cannot know the amount, if any, of the $z payment that is included in [the payee's] gross income."); PLR 200819013 (Feb. 1, 2008) ("because the Fund lacks the information and the capacity to obtain the information [to determine the taxable amount, if any, of the distribution], any income investors would realize from the Fund distributions is not 'fixed or determinable' within the meaning of the regulations under section 6041"); ITA 200032041 (May 18, 2000) (reporting not required with respect to flood relief payments where taxation of the payments was dependent on a variety of factors unknown to the payor; "A payor is not required to make a return under section 6041 for payments that are not includable in the recipient's income, nor is a payor required to make a return if the payor does not have a basis to determine the amount of the payment that is required to be included in the recipients gross income"; citing Rev. Rul. 80-20, as amplified by Rev. Rul. 82-93)

[201] 1969-1 C.B. 46.

[202] Code § 9831(c)(2).

and use of some medical service such as use of an ambulance, emergency room treatment, hospital confinement, etc. Under both policies, benefits are paid regardless of whether medical expenses are actually incurred by an insured. The benefits under the policies are employer provided. The PLR notes that it may be that the taxpayer uses the funds to pay for medical expenses incurred by the taxpayer, but the insurer is not in a position to know whether the taxpayer has done so. The letter concludes that whether any amount paid under the policy are excluded from income "depends on facts and circumstances beyond the knowledge of [the payor]. Therefore, [the payor] is required to file an information return, pursuant to section 6041, for the entire amount of any payment of 600 or more made under the policies".

One of the facts stated in the PLR is that benefits are paid under the policy regardless of whether medical expenses are actually incurred. If the conclusion were limited to a very narrow situation, i.e., situations such as in the tax schemes where benefits are paid upon volitional health-related events that do not involve any medical events (such as checking in with a health coach), then requiring reporting of the total amount paid might be consistent with § 6041.

However, applying the conclusion in the letter more broadly to Indemnity-Based Health Policies is not consistent with § 6041. Section 6041 specifically requires that the amount reported is an amount that is included in gross income. Where the payor does not have the information and no reasonable way to obtain the information regarding the amount of the payment includible in gross income, § 6041 simply does not apply. Further, the conclusion in the PLR appears to circumvent the excess benefit rule by assuming that all benefits are necessarily taxable, which is not the law.

Like other types of health insurance, Indemnity-Based Health Policies pay benefits on the occurrence of specific medical events as specified in the policy, such as a hospitalization, emergency room treatment, diagnosis of cancer. As discussed above, as is the case with other types of health insurance, Aflac and other issuers of Indemnity-Based Health Policies. have proof of loss protocols as part of claims processing that ensure that a medical expense is incurred. Provider bills are often used, as they provide detailed information regarding the particular services, treatments, etc. provided.[203] Other information may also be used to document a claim depending on the particular circumstance. For example, for a claim for hospital confinement (i.e., admission), discharge papers from the facility may provide the needed information in some cases. When the benefit is based on a treatment, then proof of the particular treatment from the facility/provider will be needed. Some policies may provide for a medical travel benefit (such as transportation and lodging), in which case there must be substantiation not only of the travel expenses but that the travel expenses were tied to a covered medical service. In all cases, there must be sufficient third-party documentation to support the claim.

This process ensures that a medical expense was incurred. However, the insurer typically does not necessarily know the amount of the expenses and does not know whether any of the expenses might have been paid by other coverage. It is precisely this lack of knowledge and the ability to determine a "fixed or determinable" amount of income that makes § 6041 inapplicable. Further, as discussed in detail, there is currently not an appropriate mechanism by which to report the total amount of payments under Indemnity-Based Health Policies.

Congress has left for itself the ability to require reporting of the total amount of payments or information with respect to transactions that may or may not involve taxable income. Congress has

[203] The universal billing form UB-40 or HCFA 1500 is often used by facilities for inpatient and outpatient services.

required such reporting in many situations,[204] but has not done so with respect to payments under Indemnity-Based Health Policies or other health coverage. The Department does not have the authority to require such reporting when Congress has not done so. The Department should clarify that reporting is not required.

B. If insurers are required to report the full amount of fixed indemnity health payments, it needs to be clear to taxpayers and the IRS that the reported amount does not represent the taxable amount.

As discussed above, there is no statutory requirement for insurers to report the full amount of benefits under Indemnity-Based Health Policies because the extent to which benefits are taxable is not "fixed or determinable". Thus, we believe that such reporting should not be required. However, should the Department seek to impose such a reporting requirement, it must be clear that just because an amount is reported that does not mean that there is any taxable amount; rather, the individual would need to determine the taxable amount, if any.

There is no current IRS Form that is truly appropriate for this purpose. 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 under the excess benefit rule with respect to payments from Indemnity-Based Health Policies.

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". As another example, 1099-K is used to report payment card and third party network transactions. The amount reported is the "Gross amount of payment card/third-party network transactions." The instructions to the payee provide additional information as to how to deal with the amounts reported. Specifically, if the Form 1099-K is related to the payee's business, the payee is directed to IRS Publication 334; if the form 1099-K is related to the payee's work as part of the gig economy, the taxpayer is referred to the IRS Gig Economy website; in other circumstances, the payee is referred to the separate instructions for their income tax return.

To prevent taxpayer confusion, any form for reporting requirement for fixed indemnity health payments would need to be clear that the amount reported is not necessarily income as well as information as to when they payments may be income. Also, an appropriate threshold for reporting is needed, as in many or even most cases, there will not be a taxable amount.

[204] See generally Code §§ 6050A-6050Z.

VII. The Proposed Applicability Date[205] is Unworkable, Unfair to Taxpayers, and Would Impermissibly Impact the Taxation of Insurance Contracts Already in Force.

As discussed in detail above, the Proposed Rule oversteps statutory authority and should not be finalized. However, should the Department finalize a restrictive change in tax treatment, there are serious issues with the proposed applicability date that would need to be addressed. 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 must be retained for all in force policies, and that any more restrictive rule must be prospectively effective for newly issued policies with sufficient time to allow for needed planning and adjustments necessitated by the tax changes.

Taxing the benefits under existing Indemnity-Based Health Policies is a retroactive tax increase on taxpayers who relied on current law, including regulations and other guidance, when purchasing this coverage through pre-tax salary reduction elections or enrolling in employer-funded plans. A regulation is retroactive if it "'takes away or impairs vested rights acquired under existing law, or creates a new obligation, imposes a new duty, or attaches a new disability in respect to transactions or considerations already past.'"[206] The Proposed Rule's tax provisions are retroactive because they would, on the applicability date, impose new tax duties on policyholders based upon Indemnity-Based Health Policies purchased before the rule became effective.

Labeling the proposed change a tax "clarification" merely seeks to hide this impact and does not cure the problem. As explained in detail above, the new taxes imposed by the Proposed Rule are a significant *change*, not a mere clarification, in the tax treatment of benefit payments for Indemnity-Based Health Policies that are employer funded or purchased with employee pre-tax salary reduction. Consistent with limitations on the Department's regulatory authority and long-standing tax policy, such dramatic changes to the tax treatment of these policies should be applied prospectively only to new policy purchasers.[207]

The taxation of payments from Indemnity-Based Health Policies under the Proposed Rule arises when the premiums are paid for by the employer or by the employee with pre-tax salary reduction dollars. Currently, the benefits from such policies can be used on a dollar-for-dollar basis to offset unreimbursed

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[205] In this letter "effective date" may be used to refer to what the Proposed Rule refers to as the "applicability date."

[206] *Nat'l Mining Ass'n v. U.S. Dep't of the Interior*, 177 F.3d 1, 8 (D.C. Cir. 1999).

[207] Retroactive tax increases have an aura of patent unfairness. Congress has limited the ability of the Department to impose retroactive tax regulations in Code §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 §7805 that allow retroactive tax regulations apply here. The only rationale put forward by the Department for the effective date of the Proposed Rule is that the proposal is a "clarification." However, as discussed in detail in this letter, 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 Indemnity-Based Health Policies 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.

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 spring) for the following plan year. An immediate applicability date (or even 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 Proposed Rule will require prudent employers to re-evaluate the cost of providing these benefits and update enrollment materials in order to accurately communicate the benefits to employees. Employers who pay for some or all of the premiums for fixed indemnity 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.

Throughout the tri-agency proposed rule that accompanies the Department's Proposed Rule, the agencies comment that individuals need to be fully and accurately informed of the consequences of purchasing Indemnity-Based Health Policies. By imposing a January 1, 2024, or later but immediate applicability date on the tax treatment of these benefit payments, the Department does just the opposite, effectively creating the same problem that the tri-agencies claim to avoid. By calling a change in the tax treatment of Indemnity-Based Health Policies a mere "clarification" with an immediate applicability date, the Department ensures unexpected negative and costly tax consequences for taxpayers. If, contrary to our recommendations, the proposed changes to the tax treatment of Indemnity-Based Health Policies are finalized, longer time will be needed before the final rule applies.

For these reasons, we propose a bifurcated applicability date; whereby existing policyholders will continue coverage under the current tax treatment, and any new restrictive tax treatment would apply prospectively only. Thus, assuming that a final rule is adopted in 2023, we recommend an applicability date that is not earlier than taxable 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 taxable years beginning on or after January 1, 2026.

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 Proposed Rule. We continue to oppose the Proposed Rule for the reasons addressed here and recommend that it be withdrawn and that the Department clarify that current tax treatment remains in place. In particular the Department should confirm the following: the continued application of the "excess benefit" rule; the individual is responsible for determining any taxable amount; payments under Indemnity-Based Health Policies are not subject to employment taxes; and no reporting of such payments is required (because the amount includible in income is not fixed or determinable).

CLOSING

Aflac appreciates the opportunity to comment on the Proposed Rule. We would be happy to discuss any of these issues further and answer any questions you may have. Please contact Brad Knox, Senior Vice President, Federal Public Policy, Corporate & Government Affairs, at bknox2@aflac.com or Dan Trsic, Chief Tax Officer and Senior VP, Corporate Tax at dtrsic@aflac.com.

Sincerely,

Brad Knox
Senior Vice President
Federal Public Policy, Corporate & Government Affairs

Dan Trsic
Chief Tax Officer and Senior VP, Corporate Tax