August 9, 2016

Department of the Treasury
Internal Revenue Service
Department of Health and Human Services
Department of Labor
Employee Benefits Security Administration

RE: "Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance"

Submitted Electronically via www.Regulations.gov

Dear Secretaries Burwell, Lew, and Perez,

The Council for Affordable Health Coverage (CAHC) and its campaign, the Coalition to Preserve Health Plan Choices (HPC), is pleased to comment on the Departments of Health and Human Services, Treasury, and Labor (Agencies) Proposed Rule entitled "Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance" (81 FR 38019) published in the *Federal Register* on June 10, 2016.

CAHC is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership represents a broad range of interests – organizations representing small and large employers, manufacturers, retailers, insurers, patient groups, and physician organizations. HPC is a campaign run by CAHC focused specifically on preserving employer, employee, and individual choices in health coverage options. More information and a full membership list for CAHC is available on our website at www.CAHC.net.

We appreciate the opportunity to comment on this Proposed Rule, particularly in regards to the portions related to fixed indemnity coverage and short-term medical insurance. The following comments reflect the positions of CAHC and HPC concerning the Proposed Rule, but may not necessarily reflect the individual views of our members.

I. General

The Proposed Rule would establish new benefit requirements for hospital indemnity or other fixed indemnity coverage (subsequently referred to as "fixed indemnity"), specified disease or illness insurance, and short-term, limited-duration insurance (subsequently referred to as "short-term medical insurance"), which we believe will significantly limit coverage options for consumers. In addition, CAHC and HPC believe that with regard to fixed indemnity coverage and specific disease insurance, the Proposed Rule's regulatory actions have no basis in statute and run counter to Congressional intent. A July 1, 2016, ruling by the U.S. Court of Appeals for the District of Columbia (*Central United Life, Inc. v. Burwell*) affirmed a lower court's ruling that the Department of Health and Human Services (HHS) overstepped its authority in attempting to restrict fixed indemnity plans. We believe that the Agencies are acting similarly in the Proposed Rule. The proposal seeks to impose additional requirements on fixed indemnity plans that will limit design flexibility, making them less beneficial to enrollees. There is no statutory language

supporting the limitation of excepted benefits as only benefits payable on a per-period basis or that prohibit varying amounts of benefit payments based on the type of service event. **Because of this fact, we urge you to withdraw this section of the rule. Our attached legal analysis memorandum outlines these points in depth.**

It is equally concerning that the Agencies' rule would limit coverage options for consumers. Fixed indemnity policies help to offset costs resulting from medical care by providing additional income to enrollees who may face major expenses after an illness or injury. Allowing varying benefit payment amounts based on the exposure to costs from different types of medical events provides increased financial assistance to enrollees. These plans are often purchased as supplemental coverage for Americans that have employer coverage or individual market major medical plans, for several reasons:

- **Mitigating the Impact of High Deductibles:** As of 2015, 81 percent of Americans with employer coverage have an annual deductible, averaging $1,318.[i] Fixed indemnity plans help to fill the coverage gaps caused when enrollees need health care but have not yet met their plan deductibles.

- **Accessing Providers:** Many major medical plans are increasingly turning to narrow provider networks to help manage costs, which may limit enrollees from visiting their doctor of choice. Fixed indemnity plans have no restrictions on the use of providers.

- **Providing Value for Employees:** Many employers choose to offer fixed indemnity coverage in addition to traditional coverage to provide a full range of choices for their employees based on their own budgets and family needs.
    - 74 percent of employees chose fixed indemnity coverage when offered.[ii]
    - Employers often offer fixed indemnity plans to part-time employees, providing access to benefits they might not otherwise receive.

Fixed indemnity policies are attractive to a wide variety of consumers and employers and should continue to be an option for the millions of consumers who rely on them.

The Proposed Rule's restrictions on service-based benefit payment amounts will result in reduced consumer choices for excepted benefits outside of the public Marketplace, which is counter to the intent of the Affordable Care Act (ACA) as passed by Congress. The Agencies' intent with this Proposed Rule appears to be to attempt to increase the number of consumers in the public Marketplace. However, particularly in the group market, there is no data or evidence to show that the Proposed Rule would impact the number of enrollees in Marketplace plans.

Therefore, we urge the Agencies to withdraw the regulations on fixed indemnity coverage, specified disease or illness insurance, and short-term medical insurance in this Proposed Rule and defer to state regulation with regards to disclosure and benefit requirements for these products, as the states know the circumstances and needs of their markets, consumers, and employers more closely.

II. Hospital Indemnity or Other Fixed Indemnity Coverage

The most recent "Accident and Health Policy Experience Report" published by the National Association of Insurance Commissioners (NAIC) shows that approximately 49 million Americans are enrolled in supplemental insurance coverage such as hospital indemnity or other fixed indemnity coverage

(subsequently referred to as "fixed indemnity").[1] The vast majority of these enrollees received coverage via their employer.

Fixed indemnity plans play a role in filling in the gaps in coverage for millions of people in various circumstances and provide protection against the financial impact of medical events. These plans pay fixed-dollar amounts, and benefit payment amounts are not based on actual medical expenses incurred, but rather on the type of medical event, as the financial impact varies among types of medical events. Payment is not coordinated with any other insurance the enrollee may have.

CAHC and HPC urge the Agencies to withdraw the Proposed Rule's provisions for fixed indemnity plans, and instead maintain policies that provide flexibility to ensure that varying consumer needs can be met in a changing marketplace. If the provisions of the Proposed Rule related to fixed indemnity policies are made final, we have strong reasons to believe that benefits gained from these policies will be reduced or eliminated for the millions of Americans who rely on them.

a. Requirement for Only Per-Period Basis Benefits Without Allowing Benefits to Vary by Type of Medical Service

In the Proposed Rule, the Agencies propose to establish a requirement that fixed indemnity coverage provide benefits on a per-day (or per-other-period) basis only, and not on a per-service basis, in accordance with sub-regulatory guidance issued in January 2013.[2] In addition, the Agencies also propose requiring that the amount of benefits provided per day (or per other time period) must be determined without regard to the type of items or services received (e.g., without varying benefit payment amounts based on the exposure to costs from different types of medical events).

In their reasoning for these limitations, the Agencies argue that fixed indemnity policies that provide benefits on a per-service basis are, in practice, a form of health coverage, which would not be considered an excepted benefit. The Agencies also express concerns that many current policies do not meet the condition that benefits be provided on a per-period basis when they provide benefits for physician visits or certain other services at a fixed amount per day or for prescription drugs at a fixed amount per drug.

The Agencies' proposed requirement on per-period and per service-based benefits has no basis in statute and goes against Congressional intent. Fixed indemnity plans are not comprehensive medical plans, but rather excepted health benefits. As outlined in-depth in our attached legal analysis memorandum, the statute plainly requires only that such plans:[3]

1. Are provided under a separate policy; and
2. Offer independent, non-coordinated benefits.

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[1] 2015: Accident and Health Policy Experience Report." National Association of Insurance Commissioners, 2016.

[2] "Affordable Care Act Implementation FAQs - Set 11." Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html; "FAQs about Affordable Care Act Implementation Part XI." Department of Labor, 24 Jan 2013. http://www.dol.gov/ebsa/faqs/faq-aca11.html

[3] **See the memorandum attached with this CAHC-HPC comment letter:** William G. Schiffbauer, Esq. "Legal Analysis of Tri-Agency NPRM Changing Excepted Benefits Conditions For Hospital Indemnity, Fixed Indemnity, And Specified Disease Insurance." 19 July 2016.

For group coverage, there are a set number of additional requirements. There can be no coordination between the group health plan and any exclusion of benefits under any group health plan maintained by the same employer plan sponsor, and there is a requirement that benefits are paid with respect to an "event" regardless of whether benefits are provided under the group health plan maintained by the same employer plan sponsor.

This statutory language provides support for the payment of benefits by a fixed indemnity insurance policy on both a daily (and other period) basis as well as on a per-service basis. The plain meaning of the statutory phrase "an event" would encompass anything that happens such as a surgery, emergency room visit, doctor visit, or the writing of a prescription. These are "services" that would be included in the statutory phrase "an event."

The term "event" always has been understood to include per-service and per-period triggers. In fact, states have consistently approved policies that pay event-based benefits and allow variances in the payment amounts based on the type of service in fixed indemnity policies. As the states have jurisdiction in these areas, these policies have continued.

We are particularly concerned that the imposition of the per-period requirement for fixed indemnity plans and not allowing benefit amounts to vary by type of service received in a medical event would mean that a large share of plans would be disallowed for 2017 even after they have already been approved in various states across the country. This would cause significant disruption and harm for millions of enrollees as they would be left without the benefits that they rely on. This is particularly the case for lower wage, part-time workers who frequently receive these benefits from their employers. Significantly revised coverage plans could also lead to multiple policies to replace the existing fixed indemnity policies (a doctor visit policy, a hospital policy, an outpatient surgical policy, a prescription drug policy, etc.), draining resources from states, insurers, and employers working to ensure compliance without providing additional real benefits for enrollees and their coverage.

Because these provisions run counter to existing conditions in the statute and recent court rulings, and because these provisions would eliminate options that help protect consumers from the financial burden of the costs of medical care, we urge the Agencies to withdraw this portion of the Proposed Rule.

b. Proposed Notice Requirements

Under the Proposed Rule, the Agencies propose to require a notice that the fixed indemnity coverage is not minimum essential coverage (MEC). The proposed notice is similar to, but still differs from, the notice required for the individual fixed indemnity market. The Agencies note concerns that some fixed indemnity policies offered in the group market have "made representations" to consumers that the coverage is MEC and that some individuals may incorrectly perceive these policies to be comprehensive major medical coverage. The Agencies offer no empirical support for the alleged confusion on the part of individuals offered and enrolled in these policies. However, the majority of fixed indemnity plans purchased in the group market are through large employers. It is highly unlikely that plan enrollees would confuse the benefits available under a fixed indemnity plan with major medical plans offered through their employer.

To address this alleged practice and avoid confusion among group health plan enrollees and potential enrollees, the Proposed Rule outlines a notice requirement that would have to appear on any application or enrollment materials provided at or before the time of enrollment (and at reenrollment), which would prominently disclose that the coverage is not major medical coverage. Fixed indemnity policies are designated in statutory language as "excepted benefits" coverage because they are not major medical health insurance and should not be offered, marketed, or sold as major medical health insurance. We believe any notice outlining this fact should be explicitly displayed in the application materials for such policies as is currently required for fixed indemnity policies offered in the individual market, rather than "in any application or enrollment materials" as proposed.

The Proposed Rule also offers specific language for this proposed notice that must be prominently displayed in at least 14-point type. The proposed language is different from the text specified for the individual fixed indemnity market, but the differentiated language does not add any additional protective warning for the benefit of enrollees or potential enrollees, nor does it make the notice more comprehensible. In fact, we believe it adds potentially confusing terminology to the standard notice that most individuals are unlikely to be familiar with, such as "qualifying coverage" and "minimum essential coverage." The main purpose of any disclosure should be to educate consumers that the coverage does not provide comprehensive medical coverage. The proposed notice language will do the opposite and confuse, rather than inform, consumers.

Existing required notices in the individual market through appropriate state regulation already sufficiently inform consumers of this in a logical and easy to understand manner. States currently require effective and thorough explanations of benefits and coverage in the group market, and there is little evidence that employees confuse fixed indemnity coverage with comprehensive major medical coverage.

We encourage the Agencies to align notification requirements for fixed indemnity policies in the individual and group markets, but urge you to mirror current requirements in the individual market in the Final Rule rather than using the proposed language.

c. Treatment of Group and Individual Fixed Indemnity Plans

The Proposed Rule invites comment on but does not propose any changes to standards for fixed indemnity insurance in the individual market for purposes of making the conditions more substantively aligned with the group market. As an example, the Agencies cite that payments under fixed indemnity policies in both markets be limited to a "per-period" basis and not allow a "per-service" basis for benefit payments.

We strongly believe that it is inappropriate and unnecessary that plans in either the group fixed indemnity market or the individual fixed indemnity market should be limited in such a way.

d. Primary Role of State Insurance Regulation for Fixed Indemnity Excepted Benefits

The federal role in overseeing "fixed indemnity excepted benefits" that are the subject of this Proposed Rule and inquiry were established in the 1996 Health Insurance Portability and Accountability Act (HIPAA), but were in existence and regulated by the states prior to the enactment of HIPAA. The categories and types of insurance that were named and listed as "fixed indemnity excepted benefits" in HIPAA were borrowed from model state laws and regulations.

Federal law and regulations provide that the states have primary enforcement authority for the regulation of insurance. The HHS Secretary must initiate a process to determine whether a state has failed to substantially enforce federal insurance standards. The enactment of the ACA did not alter the treatment of "fixed indemnity excepted benefits" or the primary role of the states in establishing standards and regulating these insurance products and states continue to play an active and evolving role in regards to these benefits. In fact, the NAIC is currently reviewing its Model Law governing these fixed indemnity products.

We urge the Agencies to withdraw the Proposed Rule's provisions on fixed indemnity excepted benefits and allow the NAIC and the states their jurisdiction authority. We strongly urge the Agencies to pay deference to the states in regards to these products as they know the circumstances and needs of their markets, consumers, and employers more closely. Federal regulators do not necessarily possess this local understanding, and there is a strong likelihood that markets, consumers, and employers could all be harmed if regulations are imposed that may be inappropriate and too inflexible to meet the needs of specific populations within a state or locality.

III. Group and Individual Market Specified Disease or Illness Insurance

The Proposed Rule includes a preamble discussion regarding the Agencies' concern with a specified disease or illness policy covering multiple diseases, which it believes could be mistaken as comprehensive health insurance. The Proposed Rule does not propose any new "excepted benefit" conditions but only invites comment on (1) limiting the number of diseases or illnesses covered in a policy, and (2) the requirement of a disclosure that such coverage is not MEC.

a. Limiting the Number of Diseases or Illnesses in Specified Disease or Illness Insurance

The current statutory language in regards to specified disease or illness excepted benefits only requires that such coverage is offered as "independent, non-coordinated" benefits provided under a separate policy, and for group arrangements that there is no coordination between the group health plan and any exclusion of benefits, and that benefits are paid with respect to an "event" under any group health plan regardless of whether benefits are provided under the group health plan. The same statutory text applies to hospital indemnity or other fixed indemnity insurance. There is absolutely no statutory basis for a limitation on the number of diseases or illnesses covered in a policy.

CAHC and HPC strongly believe that plans, employers, and individuals should be granted maximum flexibility to address diverse needs when it comes to health benefits.

b. Required Disclosure in Specified Disease or Illness Insurance

In the Proposed Rule, the Agencies express the concern that some individuals who purchase a specified disease policy covering multiple diseases or illnesses "may incorrectly believe" that they are purchasing comprehensive major medical coverage. The Agencies cite no data or hard evidence of instances or market practices that would have this perverse result. To address any alleged confusion among group health plan enrollees and potential enrollees or individuals, the Proposed Rule solicits comments on a whether a notice should be required.

We suggest that any notice should be explicitly displayed in the application materials as is currently required for fixed indemnity policies offered in the individual fixed indemnity market. Furthermore, we believe that similar language requirements for fixed indemnity plans should be mirrored in any notification requirements for disease-specific plans.

IV. Short-Term, Limited Duration Insurance

In a similar manner as how the Agencies seek to limit coverage options through restrictions on fixed indemnity plans, the Agencies propose to amend the current definition of "short-term, limited duration insurance" to restrict this form of coverage. Under current regulations, these short-term medical plans have an expiration date (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract. Like excepted benefits, these plans are exempt from many Public Health Service Act requirements and regulations, including the offering of essential health benefits. This means that such plans do not qualify as MEC for purposes of the individual mandate.

The Proposed Rule seeks to significantly reduce the permissible contract expiration date from one that is within 12 months of the date of the contract's effective date to one that is within three months of the effective date of coverage. The Agencies express concerns that, in some instances, individuals are purchasing this coverage as their primary form of health coverage and that issuers are renewing this coverage beyond 12 months. The Agencies further note that this coverage option is "adversely impacting the risk pool for ACA-compliant coverage" through the insurance exchanges, in part because healthier individuals may be more likely to be targeted and enrolled in this type of coverage.

The Agencies have not provided empirical data to show any effect on the risk pool or any estimate of how the proposed policy would affect plan choice and costs for consumers. The Agencies cite only one news report that indicated that enrollment in short-term medical plans have increased significantly since 2014, when the new marketplace rules went into effect, as a partial justification for limiting these plans.[4] According to this report, the uptick in enrollment is due, in large part, to the fact that consumers—particularly those who are not eligible for subsidies—find existing options on the individual market to be unaffordable. In fact, more than half of respondents to a recent survey cited price as the primary reason for purchasing short-term medical plans.[5] The Proposed Rule would not affect this dynamic and therefore will not significantly and positively impact the risk pool of the insurance exchanges.

While the Agencies may believe the argument that fixed indemnity and short term liability policies are negatively impacting the risk pools, the fact remains that the statute precludes the proposed regulation because the ACA itself requires the maintenance of a private market outside of the insurance exchanges. There is no legal justification for the Agencies' actions, no matter how pure the Agencies' motives.

[4] Matthews, A. "Sales of Short-Term Health Policies Surge." *The Wall Street Journal*, 10 Apr 2016. http://www.wsj.com/articles/sales-of-short-term-health-policies-surge-1460328539
[5] *Ibid.*

If the Proposed Rule is finalized as-is, consumers who cannot find affordable options could be left without options for any type of interim health coverage lasting longer than three months. These consumers negatively harmed would likely include:[6]

- Uninsured individuals who are unable to purchase insurance exchange coverage outside of the annual Open Enrollment Period.
- The nearly 3 million Americans who fall into the "Medicaid gap," according to the Kaiser Family Foundation. Uninsured individuals who do not qualify for Medicaid in non-expansion states and that have incomes below 100 percent of the Federal Poverty Level (FPL) cannot receive subsidies for exchange plans and are generally unable to afford other forms of comprehensive health insurance.
- Undocumented immigrants who are ineligible for subsidized insurance exchange coverage and may not be able to afford other comprehensive health insurance.
- Rural residents who may not have access to needed providers in insurance exchange plans, which have increasingly narrow provider networks.
- Students who are ineligible for subsidized insurance exchange coverage and may not be able to afford other comprehensive health insurance.

We firmly believe that the answer to shoring up the risk pool and attracting new, healthy consumers is by addressing the root affordability problems in the Marketplace: primarily, overly restricting plan design flexibility, which makes it more difficult to tailor benefits or negotiate rates with providers in ways that lower costs for consumers. We further believe that many policies related to ACA implementation have further harmed the risk pool, including the overly broad granting of special enrollment periods, which is only now beginning to be addressed. These issues have contributed to less than robust exchange enrollment and rising exchange plan premiums, as highlighted in a report issued by CAHC in June 2016.[7]

We urge the Agencies to withdraw the Proposed Rule's provisions on short-term insurance, rather than restricting health plan choices that will have little to no impact on affordability and for which there is no statutory justification.

V. Expatriate Health Plans

With respect to the expatriate rules, we also highlight that employer plan sponsors play a particularly important role in the administration of expatriate plans, and there are some practical limitations on the ability of issuers to directly track individual workers. Accordingly, we urge the Departments to:

- Provide a good faith compliance safe harbor;
- Include all participants when determining whether "substantially all" of the participants are expatriates, not just primary enrollees;
- Clarify that the Proposed Rule does not require issuers and administrators to calculate minimum value;
- Permit an issuer to rely on an employer's representations regarding benefits and expectations relating to travel outside the United States for Category A expatriates; and

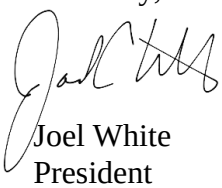
[6] "Major Consumer Harm Hidden in Proposed Short-Term Health Insurance Rule." HealthPocket, 27 Jul 2016.
[7] "Exchange Enrollment: An Opportunity for Reform." Council for Affordable Health Coverage, 7 Jun 2016. http://cahc.net/wp-content/uploads/2016/07/CAHC-IssueBrief_ExchangeEnrollment_061616.pdf

- Replace the requirement that Category C expatriates be within or outside the United States for a limited time period with a requirement that they be within or outside the United States for a "specific and temporary purpose."

Conclusion

CAHC and HPC appreciate your careful consideration of our comments. We stand ready to serve as a resource to you and your staff on issues related to affordability, access, and health plan benefit options and design.

Sincerely,



Joel White
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Enclosure: William G. Schiffbauer, Esq. "Legal Analysis of Tri-Agency NPRM Changing Excepted Benefits Conditions For Hospital Indemnity, Fixed Indemnity, And Specified Disease Insurance." 4 Aug 2016.

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[i] "2015 Employer Health Benefits Survey." Kaiser Family Foundation, 22 Sep 2015. http://kff.org/report-section/ehbs-2015-section-seven-employee-cost-sharing/

[ii] "Supplemental and Voluntary Benefits – New Attention and New Opportunities." America's Health Insurance Plans, 2016. http://trustmarkpc.com/wp-content/uploads/2016/01/CindyGoffSlides.pdf