

INTERNAL REVENUE BULLETIN



HIGHLIGHTS OF THIS ISSUE

These synopses are intended only as aids to the reader in identifying the subject matter covered. They may not be relied upon as authoritative interpretations.

ADMINISTRATIVE

Rev. Proc. 2023-26, page 486.

This revenue procedure describes a program that provides an opportunity for fast-track processing of certain requests for letter rulings solely or primarily under the jurisdiction of the Associate Chief Counsel (Corporate). This new program replaces the pilot program established by Rev. Proc. 2022-10, 2022-6 I.R.B. 473.

EMPLOYEE PLANS, EXCISE TAX, INCOME TAX

REG-120730-21, page 491.

These proposed rules would amend the definition of short-term, limited-duration insurance for purposes of the exclusion from the definition of "individual health insurance coverage" in 26 CFR part 54, 29 CFR part 2590, and 45 CFR part 144. These proposed rules would also amend the requirements for hospital indemnity and other fixed indemnity insurance to be treated as an excepted benefit in the group and individual health insurance markets. In addition, Treasury and IRS propose rules that would clarify the tax treatment of amounts received by a taxpayer through certain employment-based accident or health insurance that generally are paid without regard to incurred medical expenses in

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26 CFR part 1. If finalized, the proposed rule would include in income and wages benefits from fixed indemnity policies purchased with employer funds, including by salary reduction through a section 125 cafeteria plan. Furthermore, these proposed rules include technical amendments to clarify that, under longstanding regulations and guidance, the substantiation requirements for reimbursement of qualified medical care expenses apply to reimbursements under section 105(b) of the Internal Revenue Code in order for those reimbursements to be excluded from an individual's gross income.

INCOME TAX

Rev. Rul. 2023-14, page 484.

This revenue ruling provides that if a taxpayer stakes cryptocurrency native to a proof-of-stake blockchain and receives additional units of cryptocurrency as rewards when validation occurs, the fair market value of the rewards received is included in the taxpayer's gross income in the taxable year in which the taxpayer gains dominion and control over the rewards. The fair market value is determined as of the date and time the taxpayer gains dominion and control over the rewards. The revenue ruling also clarifies that this also is the case if a taxpayer stakes cryptocurrency through a cryptocurrency exchange and the taxpayer receives additional units of cryptocurrency as rewards as a result of the validation.

The IRS Mission

Provide America's taxpayers top-quality service by helping them understand and meet their tax responsibilities and enforce the law with integrity and fairness to all.

Introduction

The Internal Revenue Bulletin is the authoritative instrument of the Commissioner of Internal Revenue for announcing official rulings and procedures of the Internal Revenue Service and for publishing Treasury Decisions, Executive Orders, Tax Conventions, legislation, court decisions, and other items of general interest. It is published weekly.

It is the policy of the Service to publish in the Bulletin all substantive rulings necessary to promote a uniform application of the tax laws, including all rulings that supersede, revoke, modify, or amend any of those previously published in the Bulletin. All published rulings apply retroactively unless otherwise indicated. Procedures relating solely to matters of internal management are not published; however, statements of internal practices and procedures that affect the rights and duties of taxpayers are published.

Revenue rulings represent the conclusions of the Service on the application of the law to the pivotal facts stated in the revenue ruling. In those based on positions taken in rulings to taxpayers or technical advice to Service field offices, identifying details and information of a confidential nature are deleted to prevent unwarranted invasions of privacy and to comply with statutory requirements.

Rulings and procedures reported in the Bulletin do not have the force and effect of Treasury Department Regulations, but they may be used as precedents. Unpublished rulings will not be relied on, used, or cited as precedents by Service personnel in the disposition of other cases. In applying published rulings and procedures, the effect of subsequent legislation, regulations, court decisions, rulings, and procedures must be considered, and Service personnel and others concerned are cautioned

against reaching the same conclusions in other cases unless the facts and circumstances are substantially the same.

The Bulletin is divided into four parts as follows:

Part I.—1986 Code.

This part includes rulings and decisions based on provisions of the Internal Revenue Code of 1986.

Part II.—Treaties and Tax Legislation.

This part is divided into two subparts as follows: Subpart A, Tax Conventions and Other Related Items, and Subpart B, Legislation and Related Committee Reports.

Part III.—Administrative, Procedural, and Miscellaneous.

To the extent practicable, pertinent cross references to these subjects are contained in the other Parts and Subparts. Also included in this part are Bank Secrecy Act Administrative Rulings. Bank Secrecy Act Administrative Rulings are issued by the Department of the Treasury's Office of the Assistant Secretary (Enforcement).

Part IV.—Items of General Interest.

This part includes notices of proposed rulemakings, disbarment and suspension lists, and announcements.

The last Bulletin for each month includes a cumulative index for the matters published during the preceding months. These monthly indexes are cumulated on a semiannual basis, and are published in the last Bulletin of each semiannual period.

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Part I

26 CFR 1.61-1: Gross income.
(Also § 61)

Rev. Rul. 2023-14

ISSUE

If a taxpayer that uses a cash method of accounting (cash-method taxpayer) stakes cryptocurrency native to a proof-of-stake blockchain and receives additional units of cryptocurrency as rewards when validation occurs (validation rewards or rewards), must the taxpayer include the value of the rewards in the taxpayer's gross income and, if so, in which taxable year?

BACKGROUND

Section 6045(g)(3)(D) of the Internal Revenue Code¹ generally defines a digital asset, for purposes of information reporting by brokers, as any digital representation of value which is recorded on a cryptographically secured distributed ledger or any similar technology as specified by the Secretary.

Digital assets do not exist in physical form and include, but are not limited to, property the Department of the Treasury and the Internal Revenue Service have previously referred to as convertible virtual currency and cryptocurrency. See Notice 2014-21, 2014-16 I.R.B. 938, as modified by Notice 2023-34, 2023-19 I.R.B. 837; Rev. Rul. 2019-24, 2019-44 I.R.B. 1004. Notice 2014-21 defines convertible virtual currency as virtual currency that has an equivalent value in real currency or acts as a substitute for real currency. Notice 2014-21 provides that convertible virtual currency is treated as property and that general tax principles applicable to property transactions apply to convertible virtual currency.

Cryptocurrency is a type of virtual currency that utilizes cryptography to secure transactions that are digitally recorded on a distributed ledger. See Rev. Rul. 2019-24. References to cryptocurrency in this

revenue ruling are to cryptocurrency that is convertible virtual currency. Units of cryptocurrency are generally referred to as coins or tokens.

Many cryptocurrencies utilize blockchain technology, a specific type of distributed ledger technology. Distributed ledger technology uses independent digital systems to record, share, and synchronize transactions, the details of which are recorded simultaneously on multiple nodes on a network. In this context, a node generally refers to a device that maintains a copy of the distributed ledger and runs copies of the software associated with the protocol for the distributed ledger at issue.

In general, it is these nodes that maintain the integrity of a blockchain by validating transactions and ensuring that new entries in the ledger, in the form of blocks of transactions, are legitimate and not duplicative so that a new block can be recorded on the blockchain. This can be done, for example, by rejecting transactions that attempt to move the same units to two different wallet addresses at the same time. The creation of new blocks on a blockchain generally requires the participation of multiple validators who are selected and rewarded pursuant to the blockchain protocol. These validation rewards typically consist of one or more newly created units of the cryptocurrency native to that blockchain.

A consensus mechanism is a set of protocols by which nodes reach agreement on updates to the blockchain. One consensus mechanism is commonly referred to as proof-of-stake. In a proof-of-stake consensus mechanism, persons who hold cryptocurrency may participate in the validation process by staking their holdings, if they hold the requisite number of units of a particular cryptocurrency. Persons may also participate in the validation process by staking their holdings through a cryptocurrency exchange. In a proof-of-stake consensus mechanism, validators may be selected by the protocol for the blockchain associated with the specific cryptocurrency based on a variety

of factors including the number of coins or tokens staked. These validators confirm transactions and add blocks to the blockchain in accordance with the protocol. If a validator is chosen by the protocol and validation is successful, the validator will receive a reward. If a validator is chosen by the protocol and validation is unsuccessful, the staked units may be subject to penalty in the form of “slashing,” a process by which the staked units, or a portion thereof, are forfeited.

FACTS

Transactions in *M*, a cryptocurrency, are validated by a proof-of-stake consensus mechanism. On *Date 1*, Taxpayer *A*, a cash-method taxpayer, owns 300 units of *M*. *A* stakes 200 of the units of *M* and validates a new block of transactions on the *M* blockchain, receiving 2 units of *M* as validation rewards. Pursuant to the *M* protocol, during a brief period ending on *Date 2*, *A* lacks the ability to sell, exchange, or otherwise dispose of any interest in the 2 units of *M* in any manner. The following day, on *Date 3*, *A* has the ability to sell, exchange, or otherwise dispose of the 2 units of *M*.²

LAW

Section 61(a) provides the general rule that, except as otherwise provided by subtitle A of the Code, gross income means all income from whatever source derived. Specifically, gross income includes, but is not limited to, compensation for services, gross income derived from business, and gains from dealings in property. Under section 61, “instances of undeniable accessions to wealth, clearly realized, and over which the taxpayers have complete dominion,” require inclusion in gross income. See *Commissioner v. Glenshaw Glass Co.*, 348 U.S. 426, 431 (1955). “Gross income includes income realized in any form, whether in money, property, or services. Income may be realized, therefore, in the form of services, meals,

¹ Unless otherwise specified, all “section” or “§” references are to sections of the Internal Revenue Code (Code) or the Income Tax Regulations (26 CFR part 1).

² The facts in this revenue ruling do not address any type of “gas” or transaction fees other than the validation rewards described herein.

accommodations, stock, or other property, as well as in cash.” § 1.61-1(a). Unless otherwise provided by a Code or regulatory provision, any receipt of property constitutes gross income in the amount of its fair market value at the date and time at which it is reduced to undisputed possession. *See, e.g.*, section 61(a); *Koons v. United States*, 315 F.2d 542 (9th Cir. 1963); *Rooney v. Commissioner*, 88 T.C. 523, 526-527 (1987); § 1.61-2(d)(1).

Cryptocurrency that is convertible virtual currency is treated as property for Federal income tax purposes and general tax principles applicable to property transactions apply to transactions involving cryptocurrency. *See* Notice 2014-21. For example, a taxpayer who receives cryptocurrency as a payment for goods or services or who mines cryptocurrency must include the fair market value of the cryptocurrency in the taxpayer’s gross income in the taxable year the taxpayer obtains dominion and control of the cryptocurrency. *See id.*, Q&A 3 and Q&A 8. Amounts received as gains derived from dealings in property, or as rents or

royalties, also generally must be included in a cash-method taxpayer’s gross income in the taxable year the taxpayer obtains dominion and control of those amounts through actual or constructive receipt. *See also* § 1.451-1(a).

ANALYSIS

The 2 units of *M* represent *A*’s reward for staking units and validating transactions on the *M* blockchain. On *Date 3*, *A* has an accession to wealth as *A* gains dominion and control through *A*’s ability, as of this date, to sell, exchange, or otherwise dispose of the 2 units of *M* received as validation rewards. Accordingly, the fair market value of the 2 units of *M*, as of the date and time *A* gains dominion and control over the 2 units of *M*, is included in *A*’s gross income for the taxable year that includes *Date 3*.

HOLDING

If a cash-method taxpayer stakes cryptocurrency native to a proof-of-stake

blockchain and receives additional units of cryptocurrency as rewards when validation occurs, the fair market value of the validation rewards received is included in the taxpayer’s gross income in the taxable year in which the taxpayer gains dominion and control over the validation rewards. The fair market value is determined as of the date and time the taxpayer gains dominion and control over the validation rewards.³ The same is true if a taxpayer stakes cryptocurrency native to a proof-of-stake blockchain through a cryptocurrency exchange and the taxpayer receives additional units of cryptocurrency as rewards as a result of the validation.

DRAFTING INFORMATION

The principal author of this revenue ruling is Alina Lewandowski of the Office of Associate Chief Counsel (Income Tax & Accounting). For further information regarding the revenue ruling, contact Ms. Lewandowski at (202) 317-7006 (not a toll-free number).

³This revenue ruling does not address issues that may arise under any rules not specifically cited, such as section 83.

Part III

26 CFR 601.201: Rulings and determination letters.

Rev. Proc. 2023-26

SECTION 1. PURPOSE

This revenue procedure describes a program that provides an opportunity for fast-track processing of certain requests for letter rulings solely or primarily under the jurisdiction of the Associate Chief Counsel (Corporate). This new program replaces the pilot program established by Rev. Proc. 2022-10, 2022-6 I.R.B. 473.

SECTION 2. NOTABLE CHANGES TO REV. PROC. 2022-10

The new program reflects two notable changes to the program set forth in Rev. Proc. 2022-10:

.01 Sections 4.02(2) and 5.08(2) of this revenue procedure provide that fast-track processing will not be granted if the letter ruling includes a closing agreement with respect to an issue under the jurisdiction of the Associate Chief Counsel (Corporate) or another Associate office. If the inclusion of a closing agreement arises during the fast-track processing of a letter ruling request, the fast-track processing will be terminated, and the Internal Revenue Service (IRS) will continue to process the letter ruling request under the procedures of section 7 of Rev. Proc. 2023-1. Expedited handling under section 7.02(4) of Rev. Proc. 2023-1 remains available for such requests.

.02 Section 5.03(3) of this revenue procedure clarifies that while a statement providing one or more of the taxpayer's reasons for requesting fast-track processing is required, the taxpayer is not required to demonstrate a business need unless the taxpayer is requesting a ruling in less than 12 weeks. The stated reason(s) will be used as one factor to be considered in making the determination of whether a request for fast-track processing is granted, and, if so, the length of the specified period defined in section 4.03 of this revenue procedure.

SECTION 3. BACKGROUND

.01 *Letter Rulings.*

(1) *In general.* The IRS publishes annually a revenue procedure to explain how the IRS provides advice to taxpayers on issues under the jurisdiction of each Associate office. For example, Rev. Proc. 2023-1, 2023-1 I.R.B. 1, explains the forms of advice and the manner in which advice is requested by taxpayers and provided by the IRS. References in this revenue procedure to Rev. Proc. 2023-1 include references to successor revenue procedures as appropriate.

(2) *General instructions for requesting letter rulings.* Section 7 of Rev. Proc. 2023-1 provides general instructions and procedures for requesting letter rulings and determination letters.

(a) *Expedited handling of letter ruling requests.* The IRS ordinarily processes requests for letter rulings and determination letters in order of the date received. However, section 7.02(4) of Rev. Proc. 2023-1 sets forth the procedures for requesting expedited handling of letter ruling requests (expedited handling). That section requires a request for expedited handling to be made in writing, preferably in a separate letter included with the request for the letter ruling or provided soon after its filing, and to explain in detail the need for expedited handling. That section also sets forth the circumstances in which the IRS will grant expedited handling of a letter ruling request. Specifically, that section provides that a request for expedited handling is granted only in rare and unusual cases, out of fairness to other taxpayers and because the IRS seeks to process all requests as expeditiously as possible and to give appropriate deference to normal business exigencies in all cases. Nevertheless, the IRS may grant a request for expedited handling when a factor outside a taxpayer's control creates a real business need to obtain a letter ruling or determination letter before a certain date to avoid serious business consequences.

(b) *Processing of letter ruling requests.* Section 8 of Rev. Proc. 2023-1 describes the processing of letter ruling requests by the Associate offices. Section 8.05(1) of Rev. Proc. 2023-1 provides that, if a letter ruling request lacks essential information, the branch representative will request such information, and that, unless an

extension of time is granted, the request will be closed if the Associate office does not receive the requested information within 21 calendar days from the date of the request. Section 8.05(2) of Rev. Proc. 2023-1 provides that the IRS will grant an extension of the 21-day period if the extension is justified in writing by the taxpayer and approved by the branch reviewer. Section 8.05(3) of Rev. Proc. 2023-1 provides procedures for closing a request if the taxpayer does not submit the information requested within the specified time.

(3) *Conferences for letter rulings.* Section 10 of Rev. Proc. 2023-1 provides procedures and rules regarding conferences between the taxpayer or the taxpayer's authorized representative (taxpayer) and IRS representatives to discuss a letter ruling request. A taxpayer generally is entitled, as a matter of right, to only one conference (conference of right). See Rev. Proc. 2023-1, section 10.02.

.02 *Pilot Program.* In response to comments requesting faster processing of letter rulings, the Department of the Treasury (Treasury Department) and the IRS issued Rev. Proc. 2022-10 on January 14, 2022, announcing an 18-month pilot program to provide an opportunity for fast-track processing of certain requests for letter rulings solely or primarily under the jurisdiction of the Associate Chief Counsel (Corporate). The Treasury Department and the IRS have received favorable informal comments from practitioners regarding the pilot program. After considering those comments and the results of the pilot program, the Treasury Department and the IRS have determined that it is in the best interests of sound tax administration to adopt the program set forth in this revenue procedure.

SECTION 4. SCOPE

.01 *Availability of Fast-Track Processing.* Except as provided in section 4.02 of this revenue procedure, a taxpayer requesting a letter ruling solely or primarily under the jurisdiction of the Associate Chief Counsel (Corporate) may request fast-track processing but may not request expedited handling of such request under

section 7.02(4) of Rev. Proc. 2023-1. A request for fast-track processing generally will be granted if the letter ruling request is solely under the jurisdiction of the Associate Chief Counsel (Corporate), and the requirements described in section 5 of this revenue procedure are met. However, if the letter ruling request is primarily under the jurisdiction of the Associate Chief Counsel (Corporate) but also includes a request for a ruling on an issue under the jurisdiction of another Associate office, fast-track processing will be granted only if the other Associate office with jurisdiction over the issue agrees to process the request in accordance with this revenue procedure. If the letter ruling request is primarily under the jurisdiction of the Associate Chief Counsel (Corporate) but also involves an issue under the jurisdiction of another Associate office, but no ruling with respect to such issue is requested, fast-track processing will be granted only if no other Associate office with jurisdiction over the issue objects to the request being processed in accordance with this revenue procedure.

.02 Expedited Handling Available but Not Fast-Track Processing. Expedited handling under section 7.02(4) of Rev. Proc. 2023-1, but not fast-track processing under this revenue procedure, may be available for a letter ruling request described in the following circumstances:

(1) A § 301.9100 request within the meaning of section 5.03 of Rev. Proc. 2023-1 for extension of time for making an election or for other applications for relief under §§ 301.9100-1 through 301.9100-3 of the Procedure and Administration Regulations (26 CFR part 301).

(2) Letter rulings that include a closing agreement with respect to an issue under the jurisdiction of the Associate Chief Counsel (Corporate) or another Associate office.

.03 Effect of Fast-Track Processing. If a request for fast-track processing is granted, the IRS will endeavor to complete processing of the letter ruling request and, if appropriate, to issue the letter ruling within the time period specified by the branch representative or branch reviewer (specified period). The specified period will be 12 weeks unless a shorter or longer period is designated by the branch reviewer pursuant to section 5.06 of this

revenue procedure. The specified period begins on the following dates:

(1) If the letter ruling request involves issues solely under the jurisdiction of the Associate Chief Counsel (Corporate), the specified period will begin on the date the letter ruling request is assigned to and received by the branch representative and branch reviewer processing the letter ruling request.

(2) If the letter ruling request also involves issues under the jurisdiction of an Associate office other than the Associate Chief Counsel (Corporate), the specified period will begin on the first date on which all other Associate offices having jurisdiction have informed the branch representative or branch reviewer of their agreement to fast-track processing (or, if applicable, have indicated non-objection to such processing).

SECTION 5. PROCEDURES FOR FAST-TRACK PROCESSING

.01 Qualification. The IRS will provide fast-track processing of a letter ruling request only if—

(1) the taxpayer satisfies each of the requirements described in sections 5.02 through 5.04 of this revenue procedure and agrees to satisfy the requirement described in section 5.07 of this revenue procedure; and

(2) after considering the factors listed in section 5.05(2) of this revenue procedure, the branch reviewer determines that fast-track processing is feasible.

.02 Pre-submission Conference.

(1) *Request by taxpayer.* The taxpayer must request a pre-submission conference with respect to the letter ruling request, in accordance with the procedures described in sections 10.07, 10.08, and 10.09 (as added by section 6.02(3) of this revenue procedure) of Rev. Proc. 2023-1. In the pre-submission conference, the taxpayer should address both the substantive issues and the taxpayer's request for fast-track processing.

(2) *Required information before pre-submission conference.* Before the pre-submission conference, the taxpayer must provide the information required pursuant to section 10.07(3) of Rev. Proc. 2023-1. Such information should include a clear and concise description of the

transaction and issues to be discussed during the pre-submission conference. Additionally, the taxpayer must provide a statement setting forth the reason(s) for requesting fast-track processing, the length of the specified period the taxpayer requests (if other than 12 weeks), any matters that could affect the feasibility of fast-track processing, and any issues under the jurisdiction of an Associate office other than the Associate Chief Counsel (Corporate) relevant to the transaction(s) (including whether a ruling will be requested as to each such issue).

.03 Letter Ruling Request. A letter ruling request as to which fast-track processing is requested must satisfy all applicable requirements of Rev. Proc. 2023-1 and any other applicable revenue procedures and, in addition, must include the items in sections 5.03(1) through (5) of this revenue procedure.

(1) *Required statement.* The letter ruling request must state, at the top of the first page: "Fast-Track Processing Is Requested under Revenue Procedure 2023-26."

(2) *Required information.* The letter ruling request must include information on the taxpayer's reason(s) for requesting fast-track processing, the length of the specified period the taxpayer requests (if other than 12 weeks), any information required by section 5.06 of this revenue procedure if the specified period is less than 12 weeks, any matters that could affect the feasibility of fast-track processing, and any issues under the jurisdiction of an Associate office other than the Associate Chief Counsel (Corporate) relevant to the transaction(s) (including any rulings requested on any such issues).

(3) *Rationale for fast-track processing.* The taxpayer must submit a statement providing one or more of the taxpayer's reasons for requesting fast-track processing. However, unless the taxpayer is requesting a specified period less than 12 weeks, there is no requirement that the taxpayer demonstrate a business need for requesting fast-track processing.

(4) *Agreement regarding additional information.* The letter ruling request must state that the taxpayer agrees to provide any additional information requested by the branch representative or branch reviewer within the seven business days

that begin on the next business day after the day the request for information is made (seven-day period). See section 5.07 of this revenue procedure.

(5) *Draft letter ruling.* The letter ruling request must include a draft letter ruling in a form that includes a legend of defined terms, a description of relevant facts, representations, requested rulings, and administrative matters.

.04 Submitting Request for Letter Ruling.

(1) *Suggested submission by encrypted email attachment.* To avoid delay in processing of letter ruling requests submitted by mail or delivered in physical form, it is strongly recommended that a letter ruling request for which fast-track processing is requested be submitted by encrypted email attachment, in accordance with section 7.04(3) of Rev. Proc. 2023-1.

(2) *Submission other than by encrypted email attachment.* If a letter ruling request for which fast-track processing is requested is submitted other than by encrypted email attachment, the draft letter ruling required by section 5.03(5) of this revenue procedure must be submitted separately by encrypted email attachment in accordance with section 7.04(3) of Rev. Proc. 2023-1.

.05 Notification of Receipt and Granting of Request for Fast-Track Processing.

(1) *Notification.* No later than seven business days after the day the letter ruling request is assigned to and received by the branch representative and branch reviewer, the branch representative or branch reviewer will contact the taxpayer to acknowledge receipt of the letter ruling request, to provide contact information for the branch representative and branch reviewer, and to notify the taxpayer that the request for fast-track processing is granted, denied, or still pending. If the request is granted, the branch representative or branch reviewer will inform the taxpayer of the length of the specified period and the date the specified period will end. If the request is denied, the branch representative or branch reviewer will explain the reasons for the denial. If the request is under consideration by another Associate office at that time, the branch representative or branch reviewer will so inform the taxpayer.

(2) *Factors in determining whether a request for fast-track processing will*

be granted. In making the determination whether to grant a request for fast-track processing, and, if so, the length of the specified period, the branch reviewer will consider—

(a) All the facts, representations, and circumstances, including the complexity of the proposed transactions, and the issues presented;

(b) Whether the letter ruling request fully, clearly, and concisely describes and analyzes the relevant facts and issues;

(c) Whether the draft letter ruling satisfies the requirements set forth in section 5.03 of this revenue procedure;

(d) The taxpayer's reason(s) for requesting fast-track processing as set forth in a statement provided under section 5.03(3) of this revenue procedure;

(e) Any concerns communicated by another Associate office; and

(f) Any resource constraints or other obligations of the Associate Chief Counsel (Corporate), including responsibilities with respect to examination matters, litigation matters, guidance projects, assistances provided to other Associate offices, and other letter ruling requests.

(3) *Opportunity for discussion and reconsideration; tolling.* If the branch representative or the branch reviewer informs the taxpayer that the request for fast-track processing is denied, the taxpayer may address that determination in writing, discuss that determination with the branch reviewer, or both. If the branch reviewer continues to determine that the request for fast-track processing should be denied, there is no right of appeal. See section 10.02 of Rev. Proc. 2023-1. If, after reconsideration, the branch reviewer determines that the request for fast-track processing should be granted, the specified period will be tolled for the period beginning on the date the taxpayer was informed that the request for fast-track-processing was denied and ending on the date the taxpayer is informed of the determination that such request is granted. The branch representative or the branch reviewer will inform the taxpayer that a favorable or unfavorable determination has been made as soon as possible after the determination has been made and, in the event of a favorable determination, the period of tolling of the specified period.

.06 Specified Period Shorter or Longer than 12 Weeks.

(1) *Request for specified period shorter than 12 weeks.*

(a) *In general.* Upon request, the IRS will agree to a specified period shorter than 12 weeks if the branch reviewer determines that the taxpayer has a business need to obtain a letter ruling within that specified period, and that processing is feasible.

(b) *Business need.* In a request for a specified period shorter than 12 weeks, the taxpayer must demonstrate a need for such processing by submitting information to support the following conclusions, no later than the date on which the letter ruling request is submitted:

(i) There is a business exigency outside the taxpayer's control.

(ii) There will be adverse consequences to the taxpayer or other persons if the IRS does not issue the requested letter ruling within the specified period.

(iii) The taxpayer submitted the request as promptly as possible after becoming aware of the circumstances described in paragraphs (i) and (ii) of this section 5.06(1)(b).

(c) *Insufficient reasons.* The following facts alone do not demonstrate a need for a specified period shorter than 12 weeks:

(i) The scheduling of a closing date for a transaction, a meeting of a board of directors or shareholders of a corporation, or any other corporate action within the control of the taxpayer or other parties to the transaction.

(ii) The possible effect of fluctuation in the market price of stocks on a transaction.

(2) *Specified period longer than 12 weeks.*

(a) *Taxpayer request.* Upon request by the taxpayer, the branch reviewer may agree to a specified period longer than 12 weeks.

(b) *Branch reviewer determination.* The branch reviewer may decide to designate a specified period longer than 12 weeks, if he or she determines (based on the factors described in section 5.05(2) of this revenue procedure) that fast-track processing is not feasible within 12 weeks (or other specified period requested by the taxpayer) but is feasible during the longer period. In such a case, the branch representative or branch reviewer will inform the taxpayer of the decision and the reasons therefor and will provide the taxpayer an opportunity to address the

decision. The branch representative or the branch reviewer will inform the taxpayer of any subsequent favorable or unfavorable determination.

(3) *Same procedures apply.* The procedures described in this revenue procedure apply to all requests for fast-track processing, regardless of whether the specified period is 12 weeks or is shorter or longer than 12 weeks.

.07 Requested Additional Information Not Received Within Seven-Day Period. If the branch representative or branch reviewer requests additional information, but all the requested information is not received within the seven-day period, then, unless the taxpayer requests an extension before the end of the seven-day period, and the branch reviewer grants the extension, fast-track processing will be terminated. A request for an extension of the seven-day period may be made orally, in writing, or both. However, the seven-day period will not be tolled after an extension is requested unless agreed to by the branch reviewer. The branch reviewer will grant an extension only if the taxpayer provides good cause therefor. If an extension of time to submit information is granted, and the requested information is not provided within the extended time, fast-track processing will also be terminated unless a further extension is requested and granted. If fast-track processing is terminated under this section, the request will be subject to the procedures described in section 5.08 of this revenue procedure.

.08 Termination or Delay of Fast-Track Processing.

(1) *In general.* If the branch reviewer determines that fast-track processing within the specified period is no longer feasible, the branch reviewer may terminate fast-track processing or determine that fast-track processing will be completed within a newly designated specified period.

(2) *Rationale for determination.* In determining whether fast-track processing is no longer feasible within the specified period, the branch reviewer will consider any event or situation that affects the IRS's ability to provide fast-track processing within the specified period, including—

(a) Any material change to the proposed transaction(s) since submission of the letter ruling request;

(b) Any Federal income tax issue not addressed in the original letter ruling request and subsequently identified;

(c) The accuracy or completeness of any additional information submitted;

(d) Any pending legislation, regulations, or other guidance that may affect the proposed transaction(s);

(e) Any resource constraints or other obligations of the Associate Chief Counsel (Corporate), including responsibilities with respect to examination matters, litigation matters, guidance projects, assistances provided to other Associate offices, and other letter ruling requests;

(f) The subsequent inclusion of a closing agreement in the letter ruling request; and

(g) The scheduling of a conference of right described in section 10.02 of Rev. Proc. 2023-1 or a similar conference.

(3) *Notification and opportunity for discussion and reconsideration; tolling.* If the branch representative or the branch reviewer informs the taxpayer that fast-track processing has been terminated, the specified period has been extended, or the completion of fast-track processing has otherwise been delayed, the taxpayer may address that determination in writing, discuss that determination with the branch reviewer, or both. If, upon reconsideration, the branch reviewer continues to determine that the request for fast-track processing should be terminated, the specified period should be extended, or completion of fast-track processing will otherwise be delayed, there is no right of appeal. See section 10.02 of Rev. Proc. 2023-1. If, upon reconsideration, the branch reviewer determines that fast-track processing should not be terminated, the specified period should not be extended, or completion of fast-track processing should not be otherwise delayed, the specified period will be tolled for the period beginning on the date the taxpayer was informed of the initial unfavorable determination and ending on the date the taxpayer is informed of the subsequent favorable determination. The branch representative or the branch reviewer will inform the taxpayer that a determination following reconsideration has been made as soon as possible after the determination has been made and, in the event of a favorable determination, the period of tolling of the specified period.

(4) *Continued processing of letter ruling request.* If fast-track processing is terminated, the IRS will continue to process the letter ruling request under the procedures of section 7 (exclusive of section 7.02(4)) of Rev. Proc. 2023-1. However, if fast track processing is terminated because a closing agreement that was not initially part of a letter ruling request is subsequently included with a letter ruling request, the IRS will continue to process the letter ruling request under the procedures of section 7 of Rev. Proc. 2023-1, and will consider a request for expedited handling under section 7.02(4) of that revenue procedure.

SECTION 6. MODIFICATIONS TO REV. PROC. 2023-1

Rev. Proc. 2023-1 is modified as follows:

.01 Requests for Expedited Handling. Section 7.02(4) of Rev. Proc. 2023-1 is modified by adding the following language at the end of the first paragraph:

“Expedited handling under this section 7.02(4) is not available as to a request for a letter ruling solely or primarily under the jurisdiction of the Associate Chief Counsel (Corporate) (other than a § 301.9100 request described in section 5.03 of this revenue procedure for an extension of time for making an election or other relief, or a request that includes a closing agreement with respect to an issue under the jurisdiction of the Associate Chief Counsel (Corporate) or another Associate office). For guidance on fast-track processing of such a letter ruling request, see Rev. Proc. 2023-26, 2023-33 I.R.B. 486.”

.02 Additional Information. Section 8.05(1) of Rev. Proc. 2023-1 is modified by adding the following language at the end of the first paragraph:

“Special rules and procedures apply to letter ruling requests under the jurisdiction of the Associate Chief Counsel (Corporate) for which fast-track processing is requested. Under section 5.07 of Rev. Proc. 2023-26, failure to provide, within seven business days (plus extensions, if granted), a complete response to any information request from the branch representative

or branch reviewer assigned to the letter ruling request will result in termination of fast-track processing.”

Pre-submission conferences under Rev. Proc. 2023-26.

.04 *List of Guideline Revenue Procedures*. Section .01 of Appendix F of Rev. Proc. 2023-1 is modified by

Fast-track processing of letter ruling requests solely or primarily under the jurisdiction of the Associate Chief Counsel (Corporate).

SECTION 7. EFFECT ON OTHER DOCUMENTS

.01 *Rev. Proc. 2022-10*. Rev. Proc. 2022-10 is superseded for letter ruling requests described in section 8 of this revenue procedure.

.02 *Rev. Proc. 2023-1*. Rev. Proc. 2023-1 is modified as provided in section 6 of this revenue procedure.

SECTION 8. APPLICABILITY DATE

The fast-track ruling program established by this revenue procedure applies to all letter ruling requests described in section 4.01 of this revenue procedure postmarked or, if not mailed, received by the IRS after July 26, 2023.

SECTION 9. PAPERWORK REDUCTION ACT

The collections of information in this revenue procedure have been reviewed and approved by the Office of Management and Budget (OMB) in accordance with the Paperwork Reduction Act (44 U.S.C. 3507) under control number 1545-1522.

.03 *Conferences for Letter Rulings*. Section 10 of Rev. Proc. 2023-1 is

adding the following entry to the subject matter list of guideline revenue procedures immediately before “Intercompany

solely or primarily

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number.

The collections of information in this revenue procedure are in section 5. This information is required to determine whether a taxpayer qualifies for fast-track processing. The collections of information are required to obtain a benefit. The likely respondents are corporations seeking private letter rulings.

The estimated total annual reporting and/or recordkeeping burden for Rev. Proc. 2023-1 is 316,020 hours.

The estimated annual burden per respondent/recordkeeper for Rev. Proc. 2023-1 varies from 1 to 200 hours, depending on individual circumstances, with an estimated average burden of 80 hours. The estimated number of respondents and/or recordkeepers is 3,956.

The estimated total annual reporting and/or recordkeeping burden for this revenue procedure adds 260 hours to the burden imposed by Rev. Proc. 2023-1.

The estimated annual burden per respondent/recordkeeper for this revenue

modified by adding the following new paragraph at the end:

.09 Special rules and procedures apply to letter ruling requests solely or primarily under the jurisdiction of the Associate Chief Counsel (Corporate) for which fast-track processing has been requested. For more information, see section 5.02 of Rev. Proc. 2023-26.

transactions; election not to defer gain or loss”:

Rev. Proc. 2023-26, 2023-33 I.R.B. 486.

procedure varies from 3 to 10 hours, depending on individual circumstances, with an estimate average burden of 8 hours. The estimated number of additional respondents and/or recordkeepers added to Rev. Proc. 2023-1 by this revenue procedure is 10, increasing the estimated number of respondents and/or recordkeepers to Rev. Proc. 2023-1 to 3,966.

The estimated annual frequency of response is on occasion.

Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue tax law. Generally, tax returns and tax return information are confidential, as required by section 6103 of the Internal Revenue Code.

SECTION 10. DRAFTING INFORMATION

The principal author of this revenue procedure is Kelton P. Frye of the Office of Associate Chief Counsel (Corporate). For further information, please call Mr. Frye at (202) 317-5363.

Part IV

Notice of Proposed Rulemaking

REG-120730-21

Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance

AGENCY: Internal Revenue Service, Department of the Treasury; Employee Benefits Security Administration, Department of Labor; Centers for Medicare & Medicaid Services, Department of Health and Human Services.

ACTION: Proposed rules.

SUMMARY: This document sets forth proposed rules that would amend the definition of short-term, limited-duration insurance, which is excluded from the definition of individual health insurance coverage under the Public Health Service Act. This document also sets forth proposed amendments to the requirements for hospital indemnity or other fixed indemnity insurance to be considered an excepted benefit in the group and individual health insurance markets. This document further sets forth proposed amendments to clarify the tax treatment of certain benefit payments in fixed amounts received under employer-provided accident and health plans. Finally, this document solicits comments regarding coverage only for a specified disease or illness that qualifies as excepted benefits, and comments regarding level-funded plan arrangements.

DATES: To be assured consideration, comments must be received at one of the

addresses provided below by September 11, 2023.

ADDRESSES: In commenting, please refer to file code CMS-9904-P.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to <https://www.regulations.gov>. Follow the “Submit a comment” instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY:

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

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9904-P,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the “SUPPLEMENTARY INFORMATION” section.

FOR FURTHER INFORMATION CONTACT:

Elizabeth Schumacher or Rebecca Miller, Employee Benefits Security Administration, Department of Labor at (202) 693-8335; Jason Sandoval, Internal Revenue Service, Department of the Treasury at (202) 317-5500; Cam

Clemmons, Centers for Medicare & Medicaid Services, Department of Health and Human Services at (206) 615-2338; Geraldine Doetzer, Centers for Medicare & Medicaid Services, Department of Health and Human Services at (667) 290-8855.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: Comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post comments received before the close of the comment period on the following website as soon as possible after they have been received: <https://www.regulations.gov>. Follow the search instructions on that website to view comments. We will not post on Regulations.gov comments that make threats to individuals or institutions or suggest that the individual will take actions to harm the individual. We continue to encourage individuals not to submit duplicative comments. We will post acceptable comments from multiple unique commenters even if the content is identical or nearly identical to other comments.

I. Background

These proposed rules set forth proposed revisions to the definition of “short-term, limited-duration insurance” (STLDI) for purposes of its exclusion from the definition of “individual health insurance coverage” in 26 CFR part 54, 29 CFR part 2590, and 45 CFR part 144. The definition of STLDI is also relevant for purposes of the disclosure and reporting requirements in section 2746 of the Public Health Service Act (the PHS Act), which require health insurance issuers offering individual health insurance coverage or STLDI to disclose to enrollees in such coverage, and to report annually to the Department of Health and Human Services (HHS), any direct or indirect compensation provided by the issuer to an agent or broker

associated with enrolling individuals in such coverage.

These proposed rules also set forth proposed amendments to the requirements for hospital indemnity and other fixed indemnity insurance to be treated as an excepted benefit in the group and individual health insurance markets (fixed indemnity excepted benefits coverage).¹ Further, the Department of the Treasury (Treasury Department) and the Internal Revenue Service (IRS) propose to clarify the tax treatment under 26 CFR part 1 of fixed amounts received by a taxpayer through certain employment-based accident or health insurance that are paid without regard to the amount of medical expenses incurred.

Lastly, comments are solicited regarding coverage only for a specified disease or illness that qualifies as excepted benefits (specified disease excepted benefits coverage),² and regarding level-funded plan arrangements to better understand the key features and characteristics of these arrangements and whether additional guidance or rulemaking is needed to clarify plan sponsors' obligations with respect to coverage provided through these arrangements.

The Treasury Department, the Department of Labor, and HHS (collectively, the Departments) propose these revisions to define and more clearly distinguish STLDI and fixed indemnity excepted benefits coverage from comprehensive coverage. Comprehensive coverage is subject to the federal consumer protections and requirements established under chapter 100 of the Internal Revenue Code (Code), part 7 of the Employee Retirement Income Security Act of 1974 (ERISA), and title XXVII of the PHS Act,³ such as the prohibition on exclusions for preexisting conditions, the prohibition on health status discrimination, the requirement to cover certain preventive services without cost sharing, and many others. The Departments propose these revisions to promote equitable access to high-quality,

affordable, comprehensive coverage by increasing consumers' understanding of their health coverage options and reducing misinformation about STLDI and fixed indemnity excepted benefits coverage, consistent with Executive Orders 14009 and 14070 as described in section I.B of this preamble. Similarly, clarifying the tax treatment of benefit payments in fixed amounts under hospital indemnity or other fixed indemnity coverage purchased on a pre-tax basis when those benefits are paid without regard to the medical expenses incurred is also an important means by which to distinguish that coverage from comprehensive coverage and should serve to promote the purchase of comprehensive coverage in the group market.

A. General Statutory Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Pub. L. 104-191, August 21, 1996) added chapter 100 to the Code, part 7 to ERISA, and title XXVII to the PHS Act, which set forth portability and nondiscrimination rules with respect to health coverage. These provisions of the Code, ERISA, and the PHS Act were later augmented by other laws, including the Mental Health Parity Act of 1996 (Pub. L. 104-204, September 26, 1996), the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) (Pub. L. 110-343, October 3, 2008), the Newborns' and Mothers' Health Protection Act (Pub. L. 104-204, September 26, 1996), the Women's Health and Cancer Rights Act (Pub. L. 105-277, October 21, 1998), the Genetic Information Nondiscrimination Act of 2008 (Pub. L. 110-233, May 21, 2008), the Children's Health Insurance Program Reauthorization Act of 2009 (Pub. L. 111-3, February 4, 2009), Michelle's Law (Pub. L. 110-381, October 9, 2008), the Patient Protection and Affordable Care Act (Pub. L. 111-148, March 23, 2010) (as amended by the Health Care and Education

Reconciliation Act of 2010 (Pub. L. 111-152, March 30, 2010) (collectively known as the Affordable Care Act (ACA)), and Division BB of the Consolidated Appropriations Act, 2021 (CAA, 2021) (Pub. L. 116-260, December 27, 2020), which includes the No Surprises Act.

The ACA reorganized, amended, and added to the provisions of Part A of title XXVII of the PHS Act relating to group health plans and health insurance issuers in the group and individual markets. The ACA added section 9815 of the Code and section 715 of ERISA to incorporate the provisions of Part A of title XXVII of the PHS Act, as amended or added by the ACA, into the Code and ERISA, making them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans. The provisions of the PHS Act incorporated into the Code and ERISA, as amended or added by the ACA, are sections 2701 through 2728. In addition to marketwide provisions applicable to group health plans and health insurance issuers in the group and individual markets, the ACA established Health Benefit Exchanges (Exchanges) aimed at promoting access to high-quality, affordable, comprehensive coverage. Section 1401(a) of the ACA added section 36B to the Code, providing a premium tax credit (PTC) for certain individuals with annual household income that is at least 100 percent but not more than 400 percent of the Federal poverty level (FPL) who enroll in, or who have one or more family members enrolled in, an individual market qualified health plan (QHP) through an Exchange, who are not otherwise eligible for minimum essential coverage (MEC). Section 1402 of the ACA provides for, among other things, reductions in cost sharing for essential health benefits for qualified low- and moderate-income enrollees in silver-level QHPs purchased through the individual market Exchanges. This section also provides for reductions in cost sharing for American Indians enrolled in

¹ For simplicity and readability, this preamble refers to hospital indemnity or other fixed indemnity insurance that meets all requirements to be considered an excepted benefit under the federal framework as "fixed indemnity excepted benefits coverage" in order to distinguish it from hospital indemnity or other fixed indemnity insurance that does not meet all such requirements.

² For simplicity and readability, this preamble refers to specified disease or illness insurance coverage that meets all requirements to be considered an excepted benefit under the federal framework as "specified disease excepted benefits coverage" in order to distinguish it from specified disease or illness insurance that does not meet all such requirements.

³ While STLDI is generally not subject to the federal consumer protections and requirements for comprehensive coverage that apply to individual health insurance coverage, the agent and broker compensation disclosure and reporting requirements in section 2746 of the PHS Act apply to health insurance issuers offering individual health insurance coverage or STLDI.

QHPs purchased through the individual market Exchanges at any metal level.

Section 5000A of the Code, added by section 1501(b) of the ACA, provides that individuals must maintain MEC, or make a payment known as the individual shared responsibility payment with their Federal tax return for the year in which they did not maintain MEC, if they are not otherwise exempt.⁴ On December 22, 2017, the Tax Cuts and Jobs Act (Pub. L. 115-97) was enacted, which included a provision under which the individual shared responsibility payment under section 5000A of the Code was reduced to \$0, effective for months beginning after December 31, 2018.

The American Rescue Plan Act of 2021 (ARP) (Pub. L. 117-2) was enacted on March 11, 2021. Among other policies intended to address the health care and economic needs of the country during the coronavirus disease-2019 (COVID-19) pandemic, the ARP increased the PTC amount for individuals with annual household income at or below 400 percent of the FPL and extended PTC eligibility for the first time to individuals with annual household incomes above 400 percent of the FPL. Although the expanded PTC subsidies under the ARP were applicable only for 2021 and 2022, the Inflation Reduction Act of 2022 (IRA) (Pub. L. 117-169, August 16, 2022) extended the subsidies for an additional 3 years, through December 31, 2025.

The No Surprises Act was enacted on December 27, 2020, as title I of Division BB of the CAA, 2021. The No Surprises Act added new provisions in Subchapter B of chapter 100 of the Code, Part 7 of ERISA, and Part D of title XXVII of the PHS Act, applicable to group health plans and health insurance issuers offering group or individual health insurance

coverage. These provisions provide protections against surprise medical bills for certain out-of-network services and generally require plans and issuers and providers and facilities to make certain disclosures regarding balance billing protections to the public and to individual participants, beneficiaries, and enrollees. In addition to the new provisions applicable to group health plans and issuers of group or individual health insurance coverage, the No Surprises Act added a new Part E to title XXVII of the PHS Act, establishing corresponding requirements applicable to health care providers, facilities, and providers of air ambulance services. The CAA, 2021 also amended title XXVII of the PHS Act to, among other things, add section 2746, which requires health insurance issuers offering individual health insurance coverage or STLDI to disclose the direct or indirect compensation provided by the issuer to an agent or broker associated with enrolling individuals in such coverage to the enrollees in such coverage as well as to report it annually to HHS.

The Secretaries of HHS, Labor, and the Treasury have authority to promulgate regulations as may be necessary or appropriate to carry out the parallel Federal consumer protections and requirements for comprehensive coverage established under the Code, ERISA, and the PHS Act (hereinafter referred to as the “Federal consumer protections and requirements for comprehensive coverage”).^{5,6}

B. Recent Executive Orders

On January 28, 2021, President Biden issued Executive Order 14009, “Strengthening Medicaid and the Affordable Care Act,” which directed the Departments to review policies to ensure

their consistency with the Administration’s goal of protecting and strengthening the ACA and making high-quality health care accessible and affordable for every American.⁷ Executive Order 14009 also directed Federal agencies to examine policies or practices that may undermine protections for people with preexisting conditions and that may reduce the affordability of coverage or financial assistance for coverage. Executive Order 14009 also revoked the previous Administration’s Executive Order 13813, “Promoting Healthcare Choice and Competition Across the United States,” which directed agencies to expand the availability of STLDI.⁸ On April 5, 2022, President Biden issued Executive Order 14070, “Continuing to Strengthen Americans’ Access to Affordable, Quality Health Coverage,” which directed the heads of Federal agencies with responsibilities related to Americans’ access to health coverage to examine policies or practices that make it easier for all consumers to enroll in and retain coverage, understand their coverage options, and select appropriate coverage; that strengthen benefits and improve access to health care providers; that improve the comprehensiveness of coverage and protect consumers from low-quality coverage; and that help reduce the burden of medical debt on households.⁹

In addition, on January 21, 2021, President Biden issued Executive Order 13995, “Ensuring an Equitable Pandemic Response and Recovery,” which directed the Secretaries of Labor and HHS, and the heads of all other agencies with authorities or responsibilities relating to the COVID-19 pandemic response and recovery, to consider any barriers that have restricted access to preventive measures, treatment, and other health services for populations at high risk for COVID-19 infection, and modify policies to advance equity.¹⁰

⁴ Section 5000A of the Code and Treasury regulations at 26 CFR 1.5000A-3 provide exemptions from the requirement to maintain MEC for the following individuals: (1) members of recognized religious sects; (2) members of health care sharing ministries; (3) exempt noncitizens; (4) incarcerated individuals; (5) individuals with no affordable coverage; (6) individuals with household income below the income tax filing threshold; (7) members of federally recognized Indian tribes; (8) individuals who qualify for a hardship exemption certification; and (9) individuals with a short coverage gap of a continuous period of less than 3 months in which the individual is not covered under MEC. The eligibility standards for exemptions can be found at 45 CFR 155.605.

⁵ Sections 2701 through 2728 of the PHS Act, incorporated into section 715 of ERISA and section 9815 of the Code; section 104 of HIPAA; sections 408(b)(2), 505, 734, and 716-717 of ERISA; sections 2746, 2761, 2792, 2799A-1-2, and 2799B1-B2 of the PHS Act; section 1321(a)(1) and (c) of ACA; sections 7805, 9816-9817, and 9822 of the Code; and sections 2746, 2799A-1-2, and 2799B1-B2 of the PHS Act.

⁶ See also 64 FR 70164 (December 15, 1999).

⁷ Executive Order 14009 of January 28, 2021, 86 FR 7793.

⁸ Executive Order 13813 of October 12, 2017, 82 FR 48385.

⁹ Executive Order 14070 of April 5, 2022, 87 FR 20689.

¹⁰ Executive Order 13995 of January 21, 2021, 86 FR 7193.

Consistent with these executive orders, the Departments have reviewed the regulatory provisions related to STLDI and fixed indemnity excepted benefits coverage, and propose amendments to those provisions in these proposed rules. The Departments also solicit comments on specified disease excepted benefit coverage (for example, cancer-only policies) in section III.B.2 of this preamble and on level-funded plan arrangements in section III.C of this preamble.

C. Short-Term, Limited-Duration Insurance (STLDI)

STLDI is a type of health insurance coverage sold by health insurance issuers that is primarily designed to fill temporary gaps in coverage that may occur when an individual is transitioning from one plan or coverage to another, such as transitioning between employment-based coverages. Section 2791(b)(5) of the PHS Act provides “[t]he term ‘individual health insurance coverage’ means health insurance coverage offered to individuals in the individual market, but does not include short-term, limited-duration insurance.”¹¹ The PHS Act does not, however, define the phrase “short-term, limited-duration insurance.” Sections 733(b)(4) of ERISA and 2791(b)(4) of the PHS Act provide that group health insurance coverage means “in connection with a group health plan, health insurance coverage offered in connection with such plan.” Sections 733(a)(1) of ERISA and 2791(a)(1) of the PHS Act provide that a group health plan is generally any plan, fund, or program established or maintained by an employer (or employee organization or both) for the purpose of providing medical care to employees or their dependents (as defined under the terms of the plan) directly, or through insurance, reimbursement, or otherwise. There is no corresponding

provision excluding STLDI from the definition of group health insurance coverage. Thus, any health insurance that is sold in the group market and purports to be STLDI must comply with applicable Federal group market consumer protections and requirements for comprehensive coverage, unless the coverage satisfies the requirements of one or more types of group market excepted benefits.

Because STLDI is not individual health insurance coverage, it is generally exempt from the applicable Federal individual market consumer protections and requirements for comprehensive coverage. STLDI is not subject to many PHS Act provisions that apply to individual health insurance coverage under the ACA including, for example, the prohibition of preexisting condition exclusions or other discrimination based on health status (section 2704 of the PHS Act), the prohibition on discrimination against individual participants and beneficiaries based on health status (section 2705 of the PHS Act), nondiscrimination in health care (section 2706 of the PHS Act), and the prohibition on lifetime and annual dollar limits on essential health benefits (section 2711 of the PHS Act). In addition, STLDI is not subject to the Federal consumer protections and requirements added to the PHS Act by other laws that apply to individual health insurance coverage, including MHPAEA (Pub. L. 110-343, October 3, 2008) (section 2726 of the PHS Act), and the No Surprises Act, as added by the CAA, 2021. Thus, individuals who enroll in STLDI are not guaranteed these key consumer protections under Federal law.¹² This feature of STLDI is especially problematic when it is not readily apparent to consumers deciding whether to purchase STLDI or comprehensive individual health insurance coverage.

In 1997, the Departments issued interim final rules implementing the portability

and renewability requirements of HIPAA (1997 HIPAA interim final rules).¹³ Those interim final rules included definitions of individual health insurance coverage, as well as STLDI. That definition of STLDI, which was finalized in rules issued in 2004 and applied through 2016, defined “short-term, limited-duration insurance” as “health insurance coverage provided pursuant to a contract with an issuer that has an expiration date specified in the contract (taking into account any extensions that may be elected by the policyholder without the issuer’s consent) that is less than 12 months after the original effective date of the contract.”¹⁴

To address the issue of STLDI being sold as a type of primary coverage, as well as concerns regarding possible adverse selection impacts on the individual market risk pools that were created under the ACA,¹⁵ the Departments published proposed rules on June 10, 2016 in the **Federal Register** titled “Expatriate Health Plans, Expatriate Health Plan Issuers, and Qualified Expatriates; Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance” (2016 proposed rules). Those rules proposed to revise the Federal definition of STLDI by shortening the permitted duration of such coverage, and adopting a consumer notice provision.¹⁶ On October 31, 2016, the Departments finalized the 2016 proposed rules related to STLDI without change in final rules published in the **Federal Register** titled “Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance” (2016 final rules).¹⁷ The 2016 final rules amended the definition of STLDI to specify that the maximum coverage period must be less than 3 months, taking into account any extensions that may be elected by the policyholder with or without the issuer’s consent.¹⁸ In addition, the 2016 final rules stated that the following notice must be

¹¹ The definition of individual health insurance coverage (and its exclusion of STLDI) has some limited relevance with respect to certain provisions that apply to group health plans and group health insurance issuers over which the Departments of Labor and the Treasury also have jurisdiction. For example, an individual who loses coverage due to moving out of a health maintenance organization (HMO) service area in the individual market precipitates a special enrollment right into a group health plan. See 26 CFR 54.9801-6(a)(3)(i)(B), 29 CFR 2590.701-6(a)(3)(i)(B), and 45 CFR 146.117(a)(3)(i)(B).

¹² Some state laws apply some consumer protections and requirements that parallel those in the ACA to STLDI.

¹³ 62 FR 16894 (April 8, 1997).

¹⁴ 62 FR 16894 at 16928, 16942, 16958 (April 8, 1997); see also 69 FR 78720 (December 30, 2004).

¹⁵ See Pub. L. 111-148, section 1312(c)(1) and 45 CFR 156.80.

¹⁶ 81 FR 38019 (June 10, 2016).

¹⁷ 81 FR 75316 (October 31, 2016).

¹⁸ *Id.* at 75317 – 75318.

prominently displayed in the contract and in any application materials provided in connection with enrollment in STLDI, in at least 14 point type:

“THIS IS NOT QUALIFYING HEALTH COVERAGE (“MINIMUM ESSENTIAL COVERAGE”) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON’T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.”¹⁹

On June 12, 2017, HHS published a request for information (RFI) in the **Federal Register** titled “Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients,”²⁰ which solicited comments about potential changes to existing regulations and guidance that could promote consumer choice, enhance affordability of coverage for individual consumers, and affirm the traditional regulatory authority of the States in regulating the business of health insurance, among other goals.²¹ In response to this RFI, HHS received comments that recommended maintaining the definition of STLDI adopted in the 2016 final rules, and comments that recommended expanding the definition to allow for a longer period of coverage. Commenters in support of maintaining the definition adopted in the 2016 final rules expressed concern that changing the definition could leave enrollees in STLDI at risk for significant out-of-pocket costs, and cautioned that expanding the definition of STLDI could facilitate its sale to individuals as their primary form of health coverage, even though such insurance lacks key consumer protections under Federal law that apply to individual health insurance coverage. Commenters in favor of maintaining the definition in the 2016 final rules

also suggested that amending the 2016 final rules to include coverage lasting 3 months or more could have the effect of pulling healthier people out of the individual market risk pools, thereby increasing overall premium costs for enrollees in individual health insurance coverage and destabilizing the individual market.

In contrast, several other commenters stated that changes to the 2016 final rules may provide an opportunity to achieve the goals outlined in the RFI (for example, to promote consumer choice, enhance affordability, and affirm the traditional authority of the States in regulating the business of insurance). These commenters stated that shortening the permitted length of STLDI policies in the 2016 final rules had deprived individuals of affordable coverage options. One commenter explained that due to the increased costs of comprehensive coverage, many financially stressed individuals could be faced with a choice between purchasing STLDI and going without any coverage at all. One commenter highlighted the need for STLDI for individuals who are between jobs for a relatively long period and for whom enrolling in Consolidated Omnibus Budget Reconciliation Act (COBRA)²² continuation coverage is financially infeasible. Another commenter noted that States have the primary responsibility to regulate STLDI and encouraged the Departments to defer to the States’ authority with respect to such coverage.

On February 21, 2018, the Departments published proposed rules in the **Federal Register** titled “Short-Term, Limited-Duration Insurance” (2018 proposed rules) in which the Departments proposed changing the definition of STLDI to provide that such insurance may have a maximum coverage period of less than 12 months after the original effective date of the contract, taking into account any extensions that may be elected by the policyholder without the issuer’s consent.²³

Among other things, the Departments solicited comments on whether the maximum length of STLDI should be less than 12 months or some other duration and under what conditions issuers should be able to allow such coverage to continue for 12 months or longer. In addition, the Departments proposed to revise the content of the consumer notice that must appear in the contract and any application materials provided in connection with enrollment in STLDI. The 2018 proposed rules included two variations of the consumer notice – one for policies that had a coverage start date before January 1, 2019, and the other for policies that had a coverage start date on or after January 1, 2019, which excluded language referencing the individual shared responsibility payment (which was reduced to \$0 for months beginning after December 2018).²⁴

Some commenters on the 2018 proposed rules acknowledged that STLDI fills an important role by providing temporary coverage, but that such insurance should not take the place of comprehensive coverage. These commenters expressed concern that allowing STLDI to be marketed as a viable alternative to comprehensive coverage would subject uninformed consumers to potentially severe financial risks. Commenters who opposed the proposed changes to the definition also expressed concern that such plans would siphon off healthier individuals from the market for individual health insurance coverage, thereby raising premiums for individual health insurance coverage.

Many of these commenters also expressed concerns about the lack of protections for consumers who purchase STLDI, stating that such policies are not a viable option for people with serious or chronic medical conditions due to potential coverage exclusions and benefit limitations in STLDI policies. These commenters further observed that STLDI policies can discriminate against individuals

¹⁹ *Id.*

²⁰ 82 FR 26885 (June 12, 2017).

²¹ See also Executive Order 13813 of October 12, 2017 82 FR 48385. (Directing the Secretaries of the Treasury, Labor and HHS “...to consider proposing regulations or revising guidance, consistent with law, to expand the availability of [STLDI]. To the extent permitted by law and supported by sound policy, the Secretaries should consider allowing such insurance to cover longer periods and be renewed by the consumer.”)

²² Pub. L. 99-272, April 7, 1986.

²³ 83 FR 7437 (February 21, 2018).

²⁴ Pub. L. 115-97, December 22, 2017.

with serious illnesses or preexisting conditions, including individuals with mental health and substance use disorders, older consumers, women, transgender patients, persons with gender identity-related health concerns, and victims of rape and domestic violence. Many of these commenters also expressed concern about aggressive and deceptive marketing practices utilized by marketers of STLDI.

Other commenters highlighted the important role that STLDI could play in providing temporary coverage to individuals who would otherwise be uninsured. These commenters, who supported the proposed changes to the definition, also noted that such changes would allow purchasers of STLDI to obtain the coverage they want at a more affordable price for a longer period.

With respect to the maximum length of the initial contract term for STLDI, most commenters opposed extending the maximum duration beyond 3 months. Others suggested periods such as less than 6 or 8 months. However, most commenters who supported extending the maximum initial contract term beyond 3 months suggested it should be 364 days. A few commenters suggested more than 1 year. Other commenters stated the maximum length of coverage should be left to the States. Commenters who supported the 2018 proposed rules generally favored permitting renewals of STLDI policies, while those who opposed the 2018 proposed rules generally opposed permitting such renewals.

After reviewing comments and feedback received from interested parties, on August 3, 2018, the Departments published final rules in the **Federal Register** titled “Short-Term, Limited-Duration Insurance” (2018 final rules)²⁵ with some modifications from the 2018 proposed

rules. Specifically, in the 2018 final rules, the Departments amended the definition of STLDI to provide that STLDI is coverage with an initial term specified in the contract that is less than 12 months after the original effective date of the contract, and taking into account renewals or extensions, has a duration of no longer than 36 months in total.²⁶ The 2018 final rules also finalized the provision that issuers of STLDI must display one of two versions of a notice prominently in the contract and in any application materials provided in connection with enrollment in such coverage, in at least 14-point type. Under the 2018 final rules, the notice must read as follows (with the final two sentences omitted for policies sold on or after January 1, 2019):

“This coverage is not required to comply with certain Federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not “minimum essential coverage.” If you don’t have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.”

D. Independent, Noncoordinated Excepted Benefits: Hospital Indemnity or Other Fixed Indemnity Insurance and Specified Disease or Illness Coverage

Section 9831 of the Code, section 732 of ERISA, and sections 2722(b)-(c) and 2763 of the PHS Act provide that the respective Federal consumer protections and requirements for comprehensive coverage do not apply to any individual coverage or any group health plan (or group health insurance coverage offered in connection with a group health plan) in relation to its provision of certain types of benefits, known as “excepted benefits.” These excepted benefits are described in section 9832(c) of the Code, section 733(c) of ERISA, and section 2791(c) of the PHS Act.

HIPAA defined certain types of coverage as “excepted benefits” that were exempt from its portability requirements.²⁷ The same definitions are applied to describe benefits that are not required to comply with some of the ACA requirements.²⁸ There are four statutory categories of excepted benefits: independent, noncoordinated excepted benefits, which are the subject of these proposed rules; benefits that are excepted in all circumstances;²⁹ limited excepted benefits;³⁰ and supplemental excepted benefits.³¹ The category “independent, noncoordinated excepted benefits” includes coverage for only a specified disease or illness (such as cancer-only policies) and hospital indemnity or other fixed indemnity insurance. These benefits are excepted under section 9831(c)(2) of the Code, section 732(c)(2) of ERISA, and section 2722(c)(2) of the PHS Act only if all of the following conditions are met: (1) the benefits are provided under a separate policy, certificate, or

²⁵ 83 FR 38212 (August 3, 2018).

²⁶ *Id.*

²⁷ See sections 9831(b) – (c) and 9832(c) of the Code, sections 732(b) – (c) and 733(c) of ERISA, and sections 2722(b) – (c), 2763 and 2791(c) of the PHS Act.

²⁸ Section 1551 of the ACA. See also section 1563(a) and (b)(12) of the ACA. Excepted benefits are also not subject to the consumer protections and other federal requirements that apply to comprehensive coverage, including MHPAEA, the Newborns’ and Mothers’ Health Protection Act, the Women’s Health and Cancer Rights Act, the Genetic Information Nondiscrimination Act of 2008, the Children’s Health Insurance Program Reauthorization Act of 2009, Michelle’s Law, and Division BB of the CAA, 2021

²⁹ Under section 9832(c)(1) of the Code, section 733(c)(1) of ERISA, and section 2791(c)(1) of the PHS Act, this category includes, for example, accident and disability income insurance, automobile medical payment insurance, liability insurance and workers compensation, as well as “[o]ther similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.”

³⁰ Under section 9832(c)(2) of the Code, section 733(c)(2) of ERISA, and section 2791(c)(2) of the PHS Act, this category includes limited scope vision or dental benefits, benefits for long-term care, nursing home care, home health care, or community-based care, or other, similar limited benefits specified by the Departments through regulation.

³¹ Under section 9832(c)(4) of the Code, section 733(c)(4) of ERISA, and section 2791(c)(4) of the PHS Act, this category includes Medicare supplemental health insurance (also known as Medigap), TRICARE supplemental programs, or “similar supplemental coverage provided to coverage under a group health plan.”

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 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.³² In addition, under the existing regulations, hospital indemnity and other fixed indemnity insurance in the group market must pay a fixed dollar amount per day (or other period) of hospitalization or illness, regardless of the amounts of expenses incurred, to be considered an excepted benefit.³³ In the individual market, under the existing regulations, hospital indemnity and other fixed indemnity insurance must pay benefits in a fixed dollar amount per period of hospitalization or illness and/or per-service (for example, \$100/day or \$50/visit), regardless of the amount of expense incurred, to be considered an excepted benefit.³⁴

The proposals in these rules related to independent, noncoordinated excepted benefits coverage are focused on the conditions that must be met for hospital indemnity and other fixed indemnity insurance in the group or individual markets to be considered excepted benefits under the Federal regulations. Additionally, in section III.B.2 of this preamble, the Departments solicit comments regarding specified disease excepted benefits coverage in the group and individual markets to inform potential future guidance or rulemaking related to such coverage, but are not proposing changes to the Federal

regulations governing such coverage in this rulemaking.

1. Fixed Indemnity Excepted Benefits Coverage

Like other forms of excepted benefits, fixed indemnity excepted benefits coverage does not provide comprehensive coverage. Rather, its primary purpose is to provide income replacement benefits.³⁵ Benefits under this type of coverage are paid in a flat (“fixed”) cash amount following the occurrence of a health-related event, such as a period of hospitalization or illness, subject to the terms of the contract. In addition, benefits are typically provided at a pre-determined level regardless of any actual health care costs incurred by a covered individual with respect to the qualifying event. Although a benefit payment may equal all or a portion of the cost of care related to an event, it is not necessarily designed to do so, and the benefit payment is made without regard to the amount of medical expense incurred.³⁶

Traditionally, benefits under fixed indemnity excepted benefits coverage are paid directly to a policyholder, rather than to a health care provider or facility, and the policyholder has discretion over how to use such benefits – including using the benefits to cover non-medical expenses that may or may not be related to the event that precipitated the payment of benefits.³⁷ Because fixed indemnity excepted benefits coverage is capped at a maximum benefit payment, design features aimed at reducing risk to the plan or issuer that are common in comprehensive coverage (such as medical management techniques, use of a preferred network of providers, or cost-sharing requirements)

are unnecessary and are generally absent in this coverage.³⁸

a. Group Market Regulations and Guidance

The Departments’ 1997 interim final rules implementing the portability and renewability requirements of HIPAA codified at 26 CFR 54.9831-1(c)(4), 29 CFR 2590.732(c)(4), and 45 CFR 146.145(b)(4) established requirements for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit in the group market. These requirements, which were effective until February 27, 2005, provided that coverage for hospital indemnity or other fixed dollar indemnity insurance is excepted only if it meets each of the following conditions: (1) the benefits are provided under a separate policy, certificate or contract of insurance; (2) there is no coordination between the provision of the benefits and an 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 the event under any group health plan maintained by the same plan sponsor.³⁹

The Departments’ group market regulations for fixed indemnity excepted benefits coverage were first amended in the 2004 HIPAA group market final rules. Those amendments added language to further clarify that to be hospital indemnity or other fixed indemnity insurance that is an excepted benefit, the insurance must pay a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, \$100/day) regardless of the amount of expenses

³² See also section 2763(b) of the PHS Act (providing that “[the] requirements of this part [related to the HIPAA individual market reforms] shall not apply to any health insurance coverage in relation to its provision of excepted benefits described in paragraph (2), (3), or (4) of section 2791(c) if the benefits are provided under a separate policy, certificate or contract of insurance.”).

³³ 26 CFR 54.9831-1(c)(4), 29 CFR 2590.732(c)(4), and 45 CFR 146.145(b)(4).

³⁴ 45 CFR 148.220(b)(4).

³⁵ See, e.g., 62 FR 16903 (April 8, 1997) and 79 FR 15818 (July 8, 2014).

³⁶ Jost, Timothy (2017). “ACA Round-Up: Market Stabilization, Fixed Indemnity Plans, Cost Sharing Reductions, and Penalty Updates,” *Health Affairs*, available at: <https://www.healthaffairs.org/doi/10.1377/journal.p20170208.058674.full>. (“Fixed indemnity coverage is excepted benefit coverage that pays a fixed amount per-service or per-time period of service without regard to the cost of the service or the type of items or services provided.”).

³⁷ AHIP (2019). “Supplemental Health Insurance: Hospital or Other Fixed Indemnity, Accident-Only, Critical Illness,” available at: <https://www.ahip.org/documents/Supplemental-Health-Insurance-Fast-Facts.pdf>.

³⁸ Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Coverage is a Problematic Form of ‘Junk’ Insurance,” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>. (“Consumers are often seeking a product that transfers catastrophic financial risk to the health plan, but fixed indemnity products – almost by definition – do not do this. They set a payment amount associated with a specific service or kind of service [that] is received, and consumers are responsible for any difference between this set payment amount and the actual cost of care.”).

³⁹ 62 FR 16894 at 16903, 16939 through 16940, 16954, and 16971 (April 8, 1997).

incurred.⁴⁰ An illustrative example was also codified as part of these amendments clarifying that a policy providing benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum amount per day does not qualify as an excepted benefit.⁴¹ As explained in the 2004 HIPAA group market final rules, the result is the same even if, in practice, the policy pays the maximum for every day of hospitalization.⁴²

The Departments later released an FAQ on January 24, 2013, to offer additional guidance on the types of hospital indemnity or other fixed indemnity insurance that meet the criteria for fixed indemnity excepted benefits coverage.⁴³ The Departments issued the FAQ in response to reports that policies were being advertised as fixed indemnity coverage but were paying a fixed amount on a per-service basis (for example, per doctor visit or surgical procedure) rather than a fixed amount per period (for example, per day or per week). The FAQ affirmed that, under the 2004 HIPAA group market final rules, to qualify as fixed indemnity excepted benefits coverage, the policy must pay benefits on a per-period basis as opposed to on a per-service basis.⁴⁴ It also affirmed that group health insurance coverage that provides benefits in varying amounts based on the type of procedure or item, such as the type of surgery actually performed or prescription drug provided, does not qualify as fixed indemnity excepted benefits coverage because it does not meet the condition that benefits

be provided on a per-period basis, regardless of the amount of expenses incurred.⁴⁵

The Departments proposed amendments to the group market regulations for fixed indemnity excepted benefits coverage in the 2016 proposed rules.⁴⁶ As explained in those proposed rules, the Departments were concerned that some individuals may mistake these policies for comprehensive coverage that would be considered MEC.⁴⁷ To avoid this confusion, the Departments proposed to adopt a notice requirement to inform enrollees and potential enrollees that the coverage is a supplement to, rather than a substitute for, comprehensive coverage, and also proposed to codify two illustrative examples to further clarify the condition that benefits be provided on a per-period basis.⁴⁸ The Departments also requested comments on whether the conditions for hospital indemnity or other fixed indemnity insurance to be considered excepted benefits should be more substantively aligned between the group and individual markets.⁴⁹ After consideration of comments, the Departments did not finalize the proposed changes to the group market regulation but noted their intention to address hospital indemnity and other fixed indemnity insurance in future rulemaking.⁵⁰

b. Individual Market Regulations and Guidance

HHS also issued an interim final rule in 1997 establishing the regulatory framework for the HIPAA individual market

Federal requirements and addressing the requirements for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit in the individual market.⁵¹ The initial HIPAA individual market fixed indemnity excepted benefits coverage regulation, which was effective until July 27, 2014, provided an exemption from the Federal individual market consumer protections and requirements for comprehensive coverage if the hospital indemnity or other fixed indemnity insurance provided benefits under a separate policy, certificate, or contract of insurance and met the noncoordination-of-benefits requirements outlined in the HHS group market excepted benefits regulations.⁵²

Following issuance of the Departments' January 24, 2013 FAQ,⁵³ State insurance regulators and industry groups representing health insurance issuers expressed concerns that prohibiting hospital indemnity and other fixed indemnity insurance from payment on a per-service basis in order to qualify as an excepted benefit could limit consumer access to an important supplemental coverage option.⁵⁴ Based on this feedback, HHS announced in an FAQ released in January 2014 that it intended to propose amendments to the individual market fixed indemnity excepted benefits coverage regulation to allow hospital indemnity or other fixed indemnity insurance sold in the individual market to be considered an excepted benefit if four conditions were met.⁵⁵ First, such coverage would be sold only to individuals who have other health

⁴⁰ 69 FR 78720 at 78735, 78762, 78780, and 78798 – 78799 (December 30, 2004).

⁴¹ *Id.* See also 26 CFR 54.9831-1(c)(4)(iii), 29 CFR 2590.732(c)(4)(iii), and 45 CFR 146.145(b)(4)(iii).

⁴² *Id.*

⁴³ Frequently Asked Questions about Affordable Care Act Implementation (Part XI) (Jan. 24, 2013), Q7, available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xi.pdf> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ 81 FR 38019 at 38031-38032, 38038, 38042-38043, and 38045-38046 (June 10, 2016).

⁴⁷ *Id.* at 38031- 38032.

⁴⁸ *Id.* at 38031- 38032, 38038, 38042- 38043, and 38045- 38046.

⁴⁹ As described in section I.D.1.b of this preamble, HHS amended the individual market fixed indemnity excepted benefits coverage regulation to provide additional flexibility, subject to several additional requirements that do not apply in the group market. 79 FR 30239 (May 27, 2014).

⁵⁰ 81 FR 75316 at 75317 (October 31, 2016).

⁵¹ 62 FR 16985 at 16992 and 17004 (April 8, 1997).

⁵² *Id.*; 45 CFR 146.145(b)(4)(ii)(B) and (b)(4)(ii)(C).

⁵³ Frequently Asked Questions about Affordable Care Act Implementation (Part XI) (Jan. 24, 2013), available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xi.pdf> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.

⁵⁴ While the FAQ only addressed fixed indemnity insurance sold in the group market, the same statutory framework and legal analysis also applies to hospital indemnity and fixed indemnity insurance sold in the individual market.

⁵⁵ Frequently Asked Questions about Affordable Care Act Implementation (Part XXVIII) and Mental Health Parity Implementation (Jan. 9, 2014), Q11, available at: <https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-xviii.pdf> and https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.

coverage that is MEC, within the meaning of section 5000A(f) of the Code. Second, no coordination between the provision of benefits and an exclusion of benefits under any other health coverage would be permitted. Third, benefits would be paid in a fixed dollar amount regardless of the amount of expenses incurred and without regard to whether benefits are provided with respect to an event or service under any other health insurance coverage. Finally, a notice would have to be prominently displayed to inform policyholders that the coverage is not MEC and would not satisfy the individual shared responsibility requirements of section 5000A of the Code. HHS explained that if these proposed revisions were implemented, hospital indemnity or other 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.

In the proposed rule, titled “Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond” (2014 proposed rule), HHS proposed to amend the criteria in 45 CFR 148.220 for fixed indemnity insurance to be treated as an excepted benefit in the individual market.⁵⁶ Consistent with the framework outlined in the January 2014 FAQ, the amendments proposed to eliminate the requirement that individual market fixed indemnity excepted benefits coverage must pay benefits only on a per-period basis (as opposed to a per-service basis) and instead proposed to require, among other things, that it be sold only as secondary to other health coverage that is MEC to qualify as an excepted benefit.⁵⁷

On July 28, 2014, in the rule titled “Patient Protection and Affordable Care Act; Exchange and Insurance Market

Standards for 2015 and Beyond; Final Rule” (2014 final rule), HHS finalized the proposed amendments to 45 CFR 148.220(b)(4) with some modifications. Pursuant to the finalized amendments, hospital indemnity or other fixed indemnity insurance in the individual market may qualify as fixed indemnity excepted benefits coverage if it is paid on either a per-period or per-service basis subject to several additional requirements that do not apply to fixed indemnity excepted benefits coverage in the group market.⁵⁸ Under 45 CFR 148.220(b)(4)(i), to qualify as excepted benefits coverage, benefits under an individual market hospital indemnity or other fixed indemnity insurance policy may only be provided to individuals who attest in their application that they have other health coverage that is MEC within the meaning of section 5000A(f) of the Code, or that they are treated as having MEC due to their status as a bona fide resident of any possession of the United States pursuant to section 5000A(f)(4) (B) of the Code.⁵⁹ Further, to qualify as an excepted benefit, 45 CFR 148.220(b)(4) (iv) requires specific notice language be prominently displayed in the application materials for individual market hospital indemnity or other fixed indemnity insurance. Finally, consistent with the group market fixed indemnity excepted benefits coverage regulations, 45 CFR 148.220(b) (4)(ii) implements the statutory noncoordination standard and requires that there is no coordination between the provision of benefits under the individual market fixed indemnity excepted benefits insurance policy and an exclusion of benefits under any other health coverage.

HHS made these changes in the 2014 final rule for two reasons. First, as stated previously, interested parties, including State insurance regulators and industry

groups representing health insurance issuers, communicated to HHS that fixed indemnity plans that paid benefits on a per-service basis were widely available as a complement to comprehensive coverage in the group and individual markets. The National Association of Insurance Commissioners (NAIC) also expressed that State insurance regulators believed fixed indemnity plans that paid benefits on a per-service basis provided consumers an important supplemental coverage option by helping consumers that purchase MEC pay for out-of-pocket costs.⁶⁰ Second, beginning in 2014, most consumers were required to have MEC in order to avoid being subject to an individual shared responsibility payment under section 5000A of the Code. HHS adopted the MEC attestation requirement to prevent fixed indemnity excepted benefits coverage in the individual market from being offered as a substitute for comprehensive coverage while also accommodating the concerns of interested parties who supported allowing fixed indemnity excepted benefits coverage in the individual market to pay benefits on a per-service basis, rather than only on a per-period basis.⁶¹ However, in its 2016 decision in *Central United Life Insurance Company v. Burwell*, the U.S. Court of Appeals for the District of Columbia invalidated the requirement at 45 CFR 148.220(b)(4)(i) that an individual must attest to having MEC prior to purchasing fixed indemnity excepted benefits coverage in the individual market.⁶² The Court did not engage in a severability analysis to determine whether HHS would have intended to leave the remaining provisions of the regulation in place, and left intact the language permitting fixed indemnity excepted benefits coverage in the individual market to be provided on a per-service basis.

⁵⁶ 79 FR 15807 at 15818-15820, 15869 (March 21, 2014).

⁵⁷ *Id.*

⁵⁸ 79 FR 30239 (May 27, 2014).

⁵⁹ As discussed later in this section and in section III.B.1.a of this preamble, the U.S. Court of Appeals for the District of Columbia vacated the requirement at 45 CFR 148.220(b)(4)(i) that an individual attest to having MEC prior to purchasing a fixed indemnity policy in order for the policy to qualify as an excepted benefit. *Central United Life Insurance v. Burwell*, 827 F.3d 70 (D.C. Cir. 2016).

⁶⁰ National Association of Insurance Commissioners (2013), “Letter to Secretaries of Labor, Treasury, and Health and Human Services,” available at: <https://naic.soutronglobal.net/Portal/Public/en-GB/RecordView/Index/23541>. (“State regulators believe hospital and other fixed indemnity coverage with variable fixed amounts based on service type could provide important options for consumers as supplemental coverage. Consumers who purchase comprehensive coverage that meets the definition of ‘minimum essential coverage’ may still wish to buy fixed indemnity coverage to help meet out-of-pocket medical and other costs.”)

⁶¹ 79 FR 30239 at 30255 (May 27, 2014).

⁶² 827 F.3d 70 (D.C. Cir. July 1, 2016).

2. Specified Disease Excepted Benefits Coverage

Like hospital indemnity or other fixed indemnity insurance, coverage only for a specified disease or illness that meets the requirements under section 9831(c)(2) of the Code, section 732(c)(2) of ERISA, and section 2722(c)(2) of the PHS Act qualifies as a form of independent, non-coordinated excepted benefits coverage.⁶³ Specified disease excepted benefits coverage is also not an alternative to comprehensive coverage, but rather provides a cash benefit related to the diagnosis or the receipt of items or services related to the treatment of one or more medical conditions specified in the insurance policy, certificate, or contract of insurance. The Departments are aware of various forms of coverage being marketed to consumers as specified disease or illness coverage under a number of labels, including “specified disease,” “critical illness,” and “dread disease” coverage (or insurance).⁶⁴ Some forms of specified disease excepted benefits coverage pay benefits based on diagnosis or treatment for a single condition (such as diabetes), while others pay benefits related to diagnosis or treatment for a disease category (such as cancer).

The Departments codified requirements for coverage only for a specified disease or illness to qualify as an excepted benefit in the group market in the 1997 HIPAA interim final rules.⁶⁵ To qualify as excepted benefits in the group market, specified disease or illness coverage (for example, cancer-only policies) must provide benefits under a separate policy, certificate, or contract of insurance; there must be no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and benefits must be paid with respect to an event without regard to whether benefits

are provided with respect to the event under any group health plan maintained by the same plan sponsor.^{66,67} HHS codified similar requirements for specified disease or illness coverage to qualify as an excepted benefit in the individual market in the 1997 interim final rule that established the regulatory framework for the HIPAA individual market.⁶⁸ Unlike fixed indemnity excepted benefits coverage, the Departments have not issued subsequent rulemaking or guidance regarding specified disease excepted benefits coverage.

In the preamble to the 2016 proposed rules, the Departments solicited comments on whether a policy covering multiple specified diseases or illnesses may be considered to be excepted benefits, but did not propose changes to the rules governing specified disease excepted benefits coverage. The Departments sought comments on whether such policies should be considered excepted benefits and, if so, whether protections were needed to ensure they were not mistaken for comprehensive coverage, expressing concern that individuals who purchase a specified disease policy covering multiple diseases or illnesses may incorrectly believe they are purchasing comprehensive coverage when, in fact, these policies are not subject to Federal consumer protections and requirements for comprehensive coverage.⁶⁹ The Departments declined to address specified disease excepted benefits coverage in the 2016 final rules, but noted that they might address such coverage in future regulations or guidance.⁷⁰

E. Tax Treatment and Substantiation Requirements for Amounts Received from Fixed Indemnity Insurance and Certain Other Arrangements

Hospital indemnity or other fixed indemnity insurance and coverage only for a specified disease or illness are treated

as “accident or health insurance” under sections 104, 105, and 106 of the Code whether or not they are excepted benefits. Premiums paid by an employer (including by salary reduction pursuant to section 125 of the Code) for accident or health insurance are excluded from an employee’s gross income under section 106 of the Code.

Amounts received from accident or health insurance are excluded from a taxpayer’s gross income under section 104(a)(3) of the Code if the premiums are paid for on an after-tax basis. The exclusion from gross income for these amounts under section 104(a)(3) of the Code does not apply to amounts attributable to contributions by an employer that were not includible in the gross income of the employee or amounts paid directly by the employer. This means that the exclusion under section 104(a)(3) of the Code does not apply where the premiums or contributions paid for the accident or health insurance are paid on a pre-tax basis. The taxation of amounts received by an employee from accident or health insurance where the premiums or contributions are paid on a pre-tax basis is determined under section 105 of the Code.

Section 105(a) of the Code provides that amounts received by an employee through accident or health insurance for personal injuries or sickness are included in gross income, except as otherwise provided in section 105. Section 105(b) of the Code excludes from gross income amounts paid by the employer to reimburse an employee’s expenses for medical care (as defined in section 213(d) of the Code). Under 26 CFR 1.105-2, the exclusion from gross income in section 105(b) of the Code “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

⁶³ See also section 2763(b) of the PHS Act.

⁶⁴ See Healthinsurance.org (2023). “Glossary: What is a Critical Illness Plan?,” available at: <https://www.healthinsurance.org/glossary/critical-illness-plan>. See also American Council of Life Insurers (2021). “Model 171 Benefits Overview: Presented to the NAIC Accident and Sickness Minimum Standards (B) Subgroup,” available at: https://content.naic.org/sites/default/files/call_materials/Supplemental%20Benefits%20Overview.pdf.

⁶⁵ 62 FR 16894 at 16903 (April 8, 1997).

⁶⁶ See 26 CFR 54.9831-1(c)(4)(i) and (ii), 29 CFR 2590.732(c)(4)(i) and (ii), and 45 CFR 146.145(b)(4)(i) and (ii).

⁶⁷ The Departments’ group market regulations for specified disease excepted benefits coverage were later affirmed, without change, in the 2004 HIPAA group market final rules. See 69 FR 78720 at 78762, 78780, and 78798—78799 (December 30, 2004). See also 45 CFR 148.220(b)(3).

⁶⁸ 62 FR 16985 at 16992, 17004 (April 8, 1997). See also section 2763(b) of the PHS Act.

⁶⁹ 81 FR 38019, 38032 (June 10, 2016).

⁷⁰ 81 FR 75316, 75317, footnote 12 (October 31, 2016).

irrespective of whether or not he incurs expenses for medical care” and “section 105(b) is not applicable to the extent that such amounts exceed the amount of the actual expenses for such medical care.” Further, under longstanding regulations and guidance issued by the Treasury Department and the IRS, amounts for medical expenses within the meaning of section 213(d) of the Code must be substantiated if reimbursed by employment-based accident or health insurance that would not be excluded from a taxpayer’s gross income but for the application of section 105(b) of the Code.⁷¹

F. Level-Funded Plan Arrangements

The Departments understand that an increasing number of group health plan sponsors are utilizing a type of self-funded arrangement in which the plan sponsor makes set monthly payments to a service provider to cover estimated claims costs, administrative costs, and premiums for stop-loss insurance for claims that surpass a maximum dollar amount beyond which the plan sponsor is no longer responsible for paying claims (attachment point). This funding mechanism or plan type, known as level-funding, is increasingly utilized by small employers in particular. Stop-loss insurance is used by employers or group health plans as part of these plan arrangements to limit their financial responsibility, and the arrangements typically involve both employer and employee contributions. When the total dollar amount of the claims paid during the year is lower than the total amount of contributions attributed to claims costs, the plan or plan sponsor generally will receive a refund or carry the surplus over to the next plan year. When annual claims exceed projected claims, the subsequent year’s monthly payments may, and oftentimes do, increase to adjust to the plan’s claims experience.

II. Promoting Access to High-Quality, Affordable, and Comprehensive Coverage

The Departments recognize that STLDI can provide temporary health insurance coverage for individuals who are experiencing brief periods without health coverage (for example, due to application of an employer waiting period), and that fixed indemnity excepted benefits coverage can provide consumers with income replacement that can be used to cover out-of-pocket expenses not covered by comprehensive coverage or to defray non-medical expenses (for example, mortgage or rent) in the event of an unexpected or serious health event. Both STLDI and fixed indemnity excepted benefits coverage generally provide limited benefits at lower premiums than comprehensive coverage,⁷² and enrollment is typically available at any time (sometimes subject to medical underwriting) rather than being restricted to open and special enrollment periods. However, given significant changes in the legal landscape and market conditions since the Departments last addressed STLDI and fixed indemnity excepted benefits coverage, and the low value that STLDI and fixed indemnity excepted benefits coverage provide to consumers when used as a substitute for comprehensive coverage, the Departments have determined that it is now necessary and appropriate to propose to amend the existing Federal regulations governing both types of coverage to more clearly distinguish them from comprehensive coverage and increase consumer awareness of coverage options that include the full range of Federal consumer protections.

A. Access to Affordable Coverage

In the preamble to the 2018 final rules, the Departments explained the decision to

amend the definition of STLDI to expand access to such policies by citing STLDI as an important means to provide more affordable coverage options and more choices for consumers.⁷³ The Departments cited a 21 percent increase in individual health insurance coverage premiums between 2016 and 2017, and a 20 percent decrease in average monthly enrollment for individuals who did not receive PTC, along with a 10 percent overall decrease in monthly enrollment during the same period.⁷⁴ Additionally, the Departments noted that in 2018 about 26 percent of enrollees (living in 52 percent of counties) had access to just one issuer on the Exchange.⁷⁵

However, since the publication of the 2018 final rules, comprehensive coverage for individuals has generally become more accessible and affordable. For example, a study examining issuer participation trends from 2014 to 2021 in every county in the United States found that the number of consumers with multiple issuer options for individual health insurance coverage on the Exchanges has grown consistently since 2018. In 2021, 78 percent of enrollees (living in 46 percent of counties) had a choice of three or more health insurance issuers, up from 67 percent of enrollees in 2020 and 58 percent of enrollees in 2019. Only 3 percent of enrollees (residing in 10 percent of counties) resided in single-issuer counties – down from 26 percent of enrollees (residing in 52 percent of counties).⁷⁶ The Centers for Medicare & Medicaid Services (CMS) reported that a record 16.4 million people enrolled in Exchange coverage during the 2023 Open Enrollment Period, including 3.7 million consumers (23 percent of total enrollments) who were new to Exchanges in 2023, and 12.7 million returning customers. Over 1.8 million more consumers signed up for coverage during the 2023 Open Enrollment Period compared

⁷¹ See, e.g., 84 FR 28888, 28917 (June 20, 2019) (describing substantiation requirements for employer-sponsored health reimbursement arrangements); see also Q44-55 of IRS Notice 2017-67, 2017-47 IRB 517; Prop. Treas. Reg. § 1.125-6; IRS Notice 2002-45, 2002-2 CB 93.

⁷² Although it is typically true that the unsubsidized premium price for comprehensive coverage is greater than STLDI or fixed indemnity excepted benefits coverage, consistent with the greater level of benefits provided under comprehensive coverage, see the additional discussion in this section of this preamble regarding the availability of financial subsidies to reduce the premium and out-of-pocket costs for comprehensive coverage purchased on an Exchange for eligible individuals.

⁷³ 83 FR 38212, at 38217 (October 2, 2018).

⁷⁴ *Id.* at 38214, citing CMS (2018). “Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment,” available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2018-07-02-Trends-Report-2.pdf>.

⁷⁵ *Id.*, citing KFF (2017). “Insurer Participation on ACA Marketplaces, 2014-2018,” now available at: <https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/>.

⁷⁶ McDermott, Daniel and Cynthia Cox (2020). “Insurer Participation on the ACA Marketplaces, 2014-2021,” KFF, available at: <https://www.kff.org/private-insurance/issue-brief/insurer-participation-on-the-aca-marketplaces-2014-2021/>.

to the same period in 2022 (a 13 percent increase), and nearly 4.4 million more consumers signed up compared to the 2021 Open Enrollment Period (a 36 percent increase).⁷⁷ As noted in section I.A of this preamble, enrollment gains during 2023 were influenced by the expansion of PTC subsidies, as first expanded under the ARP and then extended through 2025 under the IRA.⁷⁸ In an analysis prior to the passage of the IRA, the Congressional Budget Office stated that if the ARP subsidies were made permanent, they would attract 4.8 million new people to the Exchanges each year, and that 2.2 million fewer individuals would be without health insurance, on average, over the period from 2023-2032.⁷⁹

Additionally, on October 13, 2022, the IRS and the Treasury Department issued final regulations under section 36B of the Code to provide that affordability of employer-sponsored MEC for family members of an employee is determined based on the employee's share of the cost of covering the employee and those family members, not the cost of covering only the employee (2022 affordability rule).⁸⁰ It was estimated that this rule change, aimed at addressing the issue often called the "family glitch," will increase the number of individuals with PTC-subsidized Exchange coverage by approximately 1 million per year for the next 10 years.⁸¹ These anticipated enrollment trends and the availability of the enhanced subsidies allay the accessibility and affordability concerns expressed by the Departments in the preamble to the 2018 final rules

regarding the availability of affordable options for comprehensive coverage, and offer further support for the proposals in these proposed rules aimed at helping consumers differentiate between comprehensive coverage and other forms of more limited health coverage.

Although access to affordable comprehensive coverage has improved in recent years, the Departments recognize that affordability concerns continue to persist among consumers, including among consumers who are enrolled in comprehensive coverage. A 2022 national survey conducted by the Commonwealth Fund found that 29 percent of people with employer coverage and 44 percent of those with coverage purchased in the individual market were underinsured, meaning that their coverage did not provide them with affordable access to health care.⁸² The Departments believe that it is important to ensure consumers have access to a wide range of tools that can support access to affordable health care. However, neither STLDI nor fixed indemnity excepted benefits coverage represents a complete solution to larger issues of affordable access to health care and health coverage. Consumers who enroll in these plans as a substitute for comprehensive coverage or under the misapprehension that STLDI and fixed indemnity excepted benefits are a lower-cost equivalent to comprehensive coverage are at risk of being exposed to significant financial liability in the event of a costly or unexpected health event, often without knowledge of the risk associated with such coverage.

B. Risks to Consumers

As noted in the introduction to section II of this preamble, the limitations on benefits and coverage under STLDI or fixed indemnity excepted benefits coverage may allow some issuers to offer such coverage at lower monthly premiums than comprehensive coverage. The Departments are concerned about additional costs to consumers who enroll in STLDI or fixed indemnity excepted benefits coverage and incur medical expenses that are not covered by such coverage. The typical limits on coverage provided by STLDI and fixed indemnity excepted benefits coverage can lead to more and higher uncovered medical bills than consumers enrolled in comprehensive coverage would incur, exposing consumers to greater financial risk.⁸³ Healthy consumers who enroll in STLDI or fixed indemnity excepted benefits coverage as an alternative to comprehensive coverage may not realize their STLDI or fixed indemnity excepted benefits coverage excludes or limits coverage for preexisting conditions (including conditions the consumer did not know about when they enrolled), or conditions contracted after enrollment, such as COVID-19.

Additionally, a consumer enrolled in STLDI may discover that a newly-diagnosed medical condition is categorized as a preexisting condition, and related medical expenses will not be covered by, or will be only partially covered by, their STLDI policy.⁸⁴ For example, a consumer in Illinois who was diagnosed with

⁷⁷ CMS (2023). "Health Insurance Marketplaces, 2023 Open Enrollment Report," available at: <https://www.cms.gov/files/document/health-insurance-exchanges-2023-open-enrollment-report-final.pdf>.

⁷⁸ Although unsubsidized premiums for 2023 increased on average between 2.2 percent and 4.7 percent compared to the previous year, after four years of declines, PTC under the IRA largely shielded consumers from these slight increases. See Ortaliza, Jared, Justin Lo, Krutika Amin, and Cynthia Cox (2022). "How ACA Marketplace Premiums Are Changing By County in 2023," KFF, available at: <https://www.kff.org/private-insurance/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2023>.

⁷⁹ Congressional Budget Office (2022). "Letter from Phillip L. Swagel to Rep. Mike Crapo, "Re: Health Insurance Policies," available at: https://www.cbo.gov/system/files?file=2022-07/58313-Crapo_letter.pdf.

⁸⁰ 87 FR 61979 (October 13, 2022).

⁸¹ *Id.* at 61999.

⁸² Collins, Sara, Lauren Haynes, and Relebohile Masitha (2022). "The State of U.S. Health Insurance in 2022: Findings from the Commonwealth Fund Biennial Health Insurance Survey," Commonwealth Fund, available at: <https://www.commonwealthfund.org/publications/issue-briefs/2022/sep/state-us-health-insurance-2022-biennial-survey>. Specifically, this study defined a person as "underinsured" if they were insured all year but one of the following applied: 1) Out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 10 percent or more of household income; 2) Out-of-pocket costs over the prior 12 months, excluding premiums, were equal to 5 percent or more of household income for individuals living under 200 percent of the FPL (\$27,180 for an individual or \$55,500 for a family of four in 2022); or 3) The deductible constituted 5 percent or more of household income.

⁸³ Palanker, Dania, JoAnn Volk, and Kevin Lucia (2018). "Short-Term Health Plan Gaps and Limits Leave People at Risk," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2018/short-term-health-plan-gaps-and-limits-leave-people-risk>. (Describing STLDI marketing materials that list coverage limits that would fall far short of typical costs to a consumer, including \$1,000 a day for hospital room and board coverage, \$1,250 a day for the intensive care unit, \$50 a day for doctor visits while in the hospital, \$100 a day for inpatient substance abuse treatment, and \$250 for ambulance transport).

⁸⁴ See Lueck, Sarah (2018). "Key Flaws of Short-Term Health Plans Pose Risks to Consumers," Center on Budget and Policy Priorities, available at: <https://www.cbpp.org/research/health/key-flaws-of-short-term-health-plans-pose-risks-to-consumers>. See also Hall, Mark and Michael McCue (2022). "Short-Term Health Insurance and the ACA Market," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2022/short-term-health-insurance-and-aca-market>. See also Partnership to Protect Coverage (2021). "Under-Covered: How 'Insurance-Like' Products are Leaving Patients Exposed," available at: https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Undercovered_Report_03252021.pdf.

Stage IV cancer a month *after* enrolling in STLDI was denied coverage for treatment by the STLDI issuer, both for treatments that led to his successful remission and for a potentially life-saving bone marrow transplant. In his case, the STLDI issuer of his policy determined that his cancer was a preexisting condition because he had disclosed experiencing back pain of undiagnosed cause to the broker who sold him his STLDI policy – leaving him with \$800,000 of medical debt and without meaningful health coverage as he continued to fight his illness.⁸⁵

The financial risk for consumers that encounter newly diagnosed conditions or a significant medical event while enrolled in STLDI increases with the length of their policy. In fact, researchers found that because the maximum annual limitation on an individual’s cost sharing for essential health benefits under section 1302(c) (1) of the ACA does not apply to STLDI, the maximum out-of-pocket health care spending limit for STLDI was on average nearly three times that of comprehensive coverage in 2020.⁸⁶ A 2020 report found that over 60 percent of the STLDI policies surveyed had a maximum out-of-pocket limit greater than the \$7,900 limit that was permitted for self-only comprehensive coverage in 2019, and 15 percent had limits in excess of \$15,000; as is typical for STLDI, these limits apply only to the coverage period, which in some cases was only 6 months, compared to the annual limits required under the ACA.⁸⁷ Consumers enrolled in STLDI who

ultimately require medical care are more likely to incur higher out-of-pocket costs than if they had enrolled in comprehensive coverage.⁸⁸

As noted in section I.D.1 of this preamble, consumers who enroll in fixed indemnity excepted benefits coverage as an alternative to comprehensive coverage bear similar risk and exposure to significant out-of-pocket expenses due to their health care costs exceeding the fixed cash benefit to which they may be entitled, if benefits are even provided for their illness or injury. While issuers of fixed indemnity excepted benefits coverage may emphasize the potential for cash benefits that sound generous outside of the context of the true costs of a significant medical event – such as a product suggesting that a consumer could receive a flat payment in excess of \$10,000 following a five-day hospitalization – fixed indemnity excepted benefits coverage is not designed to, and typically does not, provide benefits relative to the full cost of such events. As noted by one expert, hospitalization costs can exceed \$10,000 per day, even without accounting for provider services.⁸⁹ A consumer who relied on fixed indemnity excepted benefits coverage and who required hospitalization would be left with tens of thousands of dollars in unpaid medical bills, and without comprehensive coverage designed to cover any long-term follow-up care costs.

Consumers enrolled in STLDI and fixed indemnity excepted benefits coverage may experience financial hardship

when their medical bills are unaffordable.⁹⁰ Notably, the protections against balance billing and out-of-network cost sharing for certain out-of-network services established under the No Surprises Act, which are intended to shield consumers from surprise bills that can drive medical debt,⁹¹ do not apply to STLDI or fixed indemnity excepted benefits coverage.⁹² Because STLDI is typically subject to medical underwriting and not guaranteed renewable, consumers enrolled in STLDI as an alternative to comprehensive coverage may also be unable to renew STLDI at the end of the coverage period, increasing the risk of periods during which they are uninsured. Such consumers may not be able to purchase comprehensive coverage in the individual market until an open enrollment or special enrollment period occurs. Therefore, STLDI serves better as a bridge between different sources of comprehensive coverage than as an alternative to comprehensive coverage. Similarly, as noted in section I.D.1 of this preamble, fixed indemnity excepted benefit coverage serves best as an income replacement policy⁹³ that supplements comprehensive coverage rather than as an alternative to comprehensive coverage.

In the preamble to the 2018 final rules, the Departments stated that individuals who purchased STLDI rather than being uninsured would potentially experience improved health outcomes and have greater protection from catastrophic health care expenses.⁹⁴ However, recent experience with the COVID-19 public

⁸⁵ Partnership to Protect Coverage (2021). “Under-Covered: How ‘Insurance-Like’ Products are Leaving Patients Exposed,” available at: https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Undercovered_Report_03252021.pdf.

⁸⁶ Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-term Limited-duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

⁸⁷ *Id.* See also, Palanker, Dania, Kevin Lucia, and Emily Curran (2017). “New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market,” Commonwealth Fund, available at <https://www.commonwealthfund.org/blog/2017/new-executive-order-expanding-access-short-term-health-plans-bad-consumers-and-individual>. (“When considering the deductible, the best-selling plans have out-of-pocket maximums ranging from \$7,000 to \$20,000 for just three months of coverage. In comparison, the ACA limits out-of-pocket maximums to \$7,150 for the entire [2017 calendar] year.”).

⁸⁸ *Id.*

⁸⁹ Appleby, Julie (2017). “Brokers Tout Mix-And-Match Coverage To Avoid High-Cost ACA Plans,” KFF, available at: <https://kffhealthnews.org/news/brokers-tout-mix-and-match-coverage-to-avoid-high-cost-aca-plans>.

⁹⁰ Unaffordable medical debt increasingly impacts members of disadvantaged and marginalized communities. See Lopes, Lunna, Audrey Kearney, Alex Montero, Liz Hamel, and Mollyann Brodie (2022). “Health Care Debt In The U.S.: The Broad Consequences Of Medical And Dental Bills,” KFF, available at: <https://www.kff.org/health-costs/report/kff-health-care-debt-survey>. See also Himmelstein, David, Samuel Dickman, Danny McCormick, David Bor, Adam Gaffney, and Steffie Woolhandler (2022). “Prevalence and Risk Factors for Medical Debt and Subsequent Changes in Social Determinants of Health in the US,” *JAMA Network Open*, Volume 5 Issue 9:e2231898, available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2796358>.

⁹¹ Families USA (2019). “Surprise Medical Bills, Results from a National Survey,” available at <https://familiesusa.org/wp-content/uploads/2019/11/Surprise-Billing-National-Poll-Report-FINAL.pdf>.

⁹² See 26 CFR 54.9816-2T, 29 CFR 2590.716(b), and 45 CFR 149.20(b).

⁹³ As an income replacement policy, the policyholder typically has broad discretion in how to use the fixed cash benefits provided, including but not limited to reimbursement for medical expenses not covered by comprehensive coverage (for example, deductibles, coinsurance, copays) or to defray non-medical costs (for example, mortgage or, rent).

⁹⁴ 83 FR 38212, 38229 (October 2, 2018).

health emergency (PHE)⁹⁵ has prompted the Departments to reassess the degree of protection generally afforded by coverage that is not subject to the Federal consumer protections and requirements for comprehensive coverage, such as STLDI and fixed indemnity excepted benefits coverage, and to reassess the value of a framework that instead encourages uninsured individuals to purchase comprehensive coverage. Enrollees in STLDI and fixed indemnity excepted benefits coverage with COVID-19 typically face significant limitations on coverage for COVID-19 related treatments, and high out-of-pocket expenses.⁹⁶ For example, neither STLDI nor fixed indemnity excepted benefits coverage was subject to requirements under section 6001 of the Families First Coronavirus Response Act (Pub. L. 116-127, March 18, 2020), as amended by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) (Pub. L. 116-136, March 27, 2020), to cover COVID-19 diagnostic testing, without cost sharing, furnished during the COVID-19 PHE;⁹⁷ or the requirement under section 3203 of the CARES Act to cover qualifying

coronavirus preventive services, including COVID-19 vaccines, without cost sharing. Instead, both of these important coverage expansions enacted by Congress as part of the nation's response to the COVID-19 PHE only applied to comprehensive coverage. Any coverage of COVID-19 vaccines, diagnostic testing, or treatment by STLDI or fixed indemnity excepted benefits coverage was subject to the discretion of individual plans and issuers of these policies and applicable State law. Notably, the Health Resources and Services Administration's COVID-19 Coverage Assistance Fund, which reimbursed eligible health care providers for providing COVID-19 vaccines to underinsured individuals,⁹⁸ included enrollees in STLDI and excepted benefits coverage within the definition of underinsured.⁹⁹ The CARES Act also amended the definition of "uninsured individual" in Social Security Act section 1902(ss) to include individuals enrolled only in STLDI. Even individuals enrolled in STLDI or fixed indemnity excepted benefits coverage who are generally healthy are at risk of needing health care, and thus at risk of

incurring unaffordable medical bills at any time. The COVID-19 PHE has underscored the unpredictability of when the need for medical care will arise, and the importance of encouraging individuals to enroll in comprehensive coverage.

The Departments have also become aware of potentially deceptive or aggressive marketing of STLDI and fixed indemnity excepted benefits coverage to consumers who may be unaware of the limits of these plans or the availability of Federal subsidies that could reduce the costs of premiums and out-of-pocket health care expenditures for comprehensive coverage purchased through an Exchange.¹⁰⁰ The Departments note that these concerns are not limited to individual market consumers considering STLDI or fixed indemnity excepted benefits coverage. Reports that employers are increasingly offering fixed indemnity coverage alongside a plan that offers only a very limited set of primary or preventive care benefits (or in some cases, as the only form of health coverage) have also raised similar concerns about consumers who obtain this health coverage through their

⁹⁵ On January 31, 2020, HHS Secretary Alex M. Azar II declared that as of January 27, 2020, a nationwide public health emergency (PHE) exists as a result of the 2019 novel coronavirus (COVID-19). See HHS Office of the Assistant Secretary for Preparedness and Response, Determination of the HHS Secretary that a Public Health Emergency Exists, available at: <https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx>. This declaration was last renewed by HHS Secretary Xavier Becerra on October 13, 2022, following previous renewals on April 21, 2020, July 23, 2020, October 2, 2020, January 7, 2021, April 15, 2021, July 20, 2021, and October 18, 2021, January 14, 2022, April 12, 2022, and July 15, 2022. See HHS Office of the Assistant Secretary for Preparedness and Response, Renewal of Determination That A Public Health Emergency Exists, available at: <https://aspr.hhs.gov/legal/PHE/Pages/covid19-13Oct2022.aspx>. On January 30, 2023 and February 9, 2023, the Biden-Harris Administration announced that it intended to end the PHE at the end of the day on May 11, 2023. See Executive Office of the President, Office of Management and Budget, Statement of Administration Policy: H.R. 382 and H.J. Res. 7 (Jan. 30, 2023), available at: <https://www.whitehouse.gov/wp-content/uploads/2023/01/SAP-H.R.-382-H.J.-Res.-7.pdf>; Letter to U.S. Governors from HHS Secretary Xavier Becerra on renewing COVID-19 Public Health Emergency (PHE) (Feb. 9, 2023), available at: <https://www.hhs.gov/about/news/2023/02/09/letter-us-governors-hhs-secretary-xavier-becerra-renewing-covid-19-public-health-emergency.html>. The PHE did in fact end at the end of the day on May 11, 2023.

⁹⁶ See, e.g., Curran, Emily, Kevin Lucia, JoAnn Volk, and Dania Palanker (2020). "In the Age of COVID-19, Short-Term Plans Fall Short for Consumers," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2020/age-covid-19-short-term-plans-fall-short-consumers>. This study found that STLDI policies provide less financial protection than comprehensive coverage if an enrollee needs treatment for COVID-19. The study found that, among the 12 brochures reviewed for STLDI policies being sold in Georgia, Louisiana, and Ohio, 11 excluded nearly all coverage for prescription drugs, with some providing limited coverage of inpatient drugs. The study further found that STLDI imposed high cost sharing, with deductibles ranging from \$10,000 to \$12,500 (which did not count toward the enrollees' maximum out-of-pocket costs) and that enrollees may be required to meet separate deductibles for emergency room treatment, forcing some enrollees to face out-of-pocket costs of more than \$30,000 over a 6-month period. Additionally, the study found that STLDI did not cover services related to preexisting conditions.

⁹⁷ FAQs about Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation Part 42, Q1 (April 11, 2020), available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-42.pdf> and <https://www.cms.gov/files/document/FFCRA-Part-42-FAQs.pdf>; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency, 85 FR 71142, 71173 (Nov. 6, 2020); FAQs about Affordable Care Act Implementation Part 51, Families First Coronavirus Response Act and Coronavirus Aid, Relief, and Economic Security Act Implementation (Jan. 10, 2022), available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-51.pdf> and <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-51.pdf> (FAQs Part 51); and FAQs about Families First Coronavirus Response Act, Coronavirus Aid, Relief, and Economic Security Act and Health Insurance Portability and Accountability Act Implementation (FAQs Part 58), available at: <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-58> and <https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/faqs-part-58.pdf>. Note that the COVID-19 PHE ended on May 11, 2023.

⁹⁸ Underinsured individuals are defined for this purpose as having a health plan that either does not include COVID-19 vaccine administration as a covered benefit or covers COVID-19 vaccine administration but with cost sharing. See Health Resources and Services Administration, "FAQs for The HRSA COVID-19 Coverage Assistance Fund," available at: <https://www.hrsa.gov/provider-relief/about/covid-19-coverage-assistance/faq>.

⁹⁹ Health Resources and Services Administration, "FAQs for The HRSA COVID-19 Coverage Assistance Fund," available at: <https://www.hrsa.gov/provider-relief/about/covid-19-coverage-assistance/faq>.

¹⁰⁰ Palanker, Dania and Kevin Lucia (2021). "Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk>. (Noting (noting that fixed indemnity insurance may be "bundled" with other non-comprehensive insurance products in such a way that "the plans look like comprehensive coverage" while still offering limited benefits). See also); Palanker, Dania, JoAnn Volk, and Maanasa Kona (2019). "Seeing Fraud and Misleading Marketing, States Warn Consumers About Alternative Health Insurance Products," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2019/seeing-fraud-and-misleading-marketing-states-warn-consumers-about-alternative-health>.

employers.¹⁰¹ Consumers who are unaware of the coverage limitations of these arrangements, or who are employed by employers who are similarly unaware, can be faced with overwhelming medical costs if they require items and services that are not covered by their group health plan, because the fixed indemnity excepted benefits coverage provides only fixed cash benefits that may be far lower than the costs of medical services, rather than coverage intended to cover the costs of the medical services themselves. For example, a Texas consumer who was enrolled in two forms of health insurance through his employer received a \$67,000 hospital bill after he experienced a heart attack. Although he believed his two policies would provide comprehensive coverage, he learned that his coverage was provided through a group health plan that covered only preventive services and prescription drugs and a fixed indemnity excepted benefits coverage policy that provided a cash benefit of less than \$200 per day of hospitalization.¹⁰² Additionally, employers may incur penalties if they erroneously treat fixed indemnity policies as excepted benefits when the policies do not meet the requirements for excepted benefits (for example, when they are not offered as independent, noncoordinated benefits) and fail to comply with applicable group market Federal consumer protections and requirements for comprehensive coverage, such as the requirement to provide participants, beneficiaries, and enrollees with a summary of benefits and coverage that meets applicable content requirements or the prohibition on lifetime and annual dollar limits on essential health

benefits.¹⁰³ In light of research revealing significant disparities in health insurance literacy among certain underserved racial and ethnic groups and people with incomes below the FPL,¹⁰⁴ the Departments are also concerned that underserved populations may be particularly vulnerable to misleading or aggressive sales and marketing tactics that obscure the differences between comprehensive coverage and STLDI or fixed indemnity excepted benefits coverage, exposing these populations to higher levels of health and financial risks. As noted in Executive Order 13995, the COVID-19 pandemic has “exposed and exacerbated severe and pervasive health and social inequities in America,” highlighting the urgency with which such inequities must be addressed. These concerns continue amid the Medicaid unwinding period that began on April 1, 2023 during which State Medicaid programs have 12 months to initiate, and 14 months to complete, a renewal for all individuals enrolled in Medicaid, the Children’s Health Insurance Program (CHIP), and, if applicable, the Basic Health Program (BHP).¹⁰⁵ HHS has estimated that 15 million beneficiaries will lose Medicaid, CHIP, or BHP coverage as a result of Medicaid unwinding.¹⁰⁶ The Departments are concerned that the large population of individuals at risk of losing Medicaid and those other forms of coverage, due to a loss of eligibility or as a result of administrative churn, may be susceptible to these marketing and sales tactics, and might therefore mistakenly enroll in STLDI or fixed indemnity excepted benefits coverage in lieu of comprehensive coverage.

C. Impact on Risk Pools

At the time the 2018 final rules were issued, the Departments acknowledged that expanding access to STLDI could have potential negative effects on the risk pools for individual health insurance coverage and on individuals who find themselves insufficiently protected by the typically limited benefits of an STLDI policy. The Departments were of the view that the affordability and access challenges facing consumers at that time necessitated action to increase access to STLDI to provide an alternative option for individuals who were unable or disinclined to purchase comprehensive coverage.

As discussed earlier in this section II, access to affordable comprehensive coverage has significantly improved since the 2018 final rules were published. However, research based on individual market data for plan year 2020 has substantiated concerns about the negative impact that the shift of healthier individuals from comprehensive coverage to STLDI has on individuals remaining in the individual market risk pools.¹⁰⁷ Because healthier individuals are more likely to enroll in STLDI than individuals with known medical needs, the extended contract terms and renewal periods of STLDI under the current Federal regulations result in healthier consumers leaving (or opting out of) the individual market risk pools for extended periods of time. This has resulted in increased premiums for individuals seeking to purchase

¹⁰¹ Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Coverage is a Problematic Form of “Junk” Insurance,” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>.

¹⁰² Avila, Jaie (2019). “Show Me Your Bill Helps Wipe Out \$70K in Charges After Heart Attack,” News 4 San Antonio, available at <https://news4sanantonio.com/news/trouble-shooters/show-me-your-bill-helps-wipe-out-70k-in-charges-after-heart-attack>.

¹⁰³ See 26 CFR 54.9815-2715(e); 29 CFR 2590.715-2715(e); 45 CFR 147.200(e). See also section 2711 of the PHS Act and section 4980D of the Code.

¹⁰⁴ Edward, Jean, Amanda Wiggins, Malea Hoepf Young, Mary Kay Rayens (2019). “Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform,” *Health Literacy Research and Practice*, available at: <https://pubmed.ncbi.nlm.nih.gov/31768496/>. See also Villagra, Victor and Bhumika Bhuya (2019). “Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference,” *The American Journal of Managed Care*, available at: <https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference>.

¹⁰⁵ As a condition of receiving a temporary Federal Medical Assistance Percentage (FMAP) increase under section 6008 of the Families First Coronavirus Response Act, states were required to maintain enrollment of nearly all Medicaid enrollees during the COVID-19 PHE. This “continuous enrollment condition” was decoupled from the COVID-19 PHE and ended on March 31, 2023 under the Consolidated Appropriations Act, 2023. See CMS, Center for Consumer Information and Insurance Oversight, Temporary Special Enrollment Period (SEP) for Consumers Losing Medicaid or the Children’s Health Insurance Program (CHIP) Coverage Due to Unwinding of the Medicaid Continuous Enrollment Condition—Frequently Asked Questions (FAQ) (Jan. 27, 2023), available at: <https://www.cms.gov/technical-assistance-resources/temp-sep-unwinding-faq.pdf>.

¹⁰⁶ HHS, Assistant Secretary for Planning and Evaluation, Office of Health Policy, “Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches,” August 19, 2022, available at: https://aspe.hhs.gov/sites/default/files/documents/404a7572048090ec1259d216f3fd617e/aspe-end-mcaid-continuous-coverage_IB.pdf.

¹⁰⁷ See Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-term Limited-duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

individual health insurance coverage.¹⁰⁸ For unsubsidized individuals, the costs are borne directly by the consumer, and for subsidized individuals, the costs are borne to a large extent by the Federal Government in the form of increased per capita PTC spending associated with increased individual health insurance coverage premiums. Likewise, the increased reports and anecdotes about fixed indemnity excepted benefits coverage being marketed and sold as an alternative to comprehensive coverage raise concerns about the potential for such practices having a similar impact on the small group and individual market risk pools.

Another study looking at States that have adopted policies that restrict STLDI to shorter durations than allowed under the current Federal regulations found that, from 2018 to 2020, States that restricted or prohibited the sale of STLDI saw fewer consumers enroll in such insurance, were able to keep more healthy people in the individual health insurance coverage market, and saw a greater decline in average medical costs for enrollees in individual health insurance coverage.¹⁰⁹ The study reported that, as a result, the risk score – a measurement of the relative medical costs expected for the populations covered by comprehensive coverage in each State, both on- and off-Exchange – decreased by 40 percent more in States with more regulation of STLDI than States with less regulation.¹¹⁰ As of January 20, 2020, 12 States had enacted legislation prohibiting health status underwriting for STLDI, effectively banning the sale of STLDI in those States.¹¹¹ Thirteen States and the District of Columbia prohibited the sale of STLDI policies with initial contract terms longer than 3 months.¹¹²

In addition to ensuring that consumers can clearly distinguish STLDI from

comprehensive coverage, this new evidence provides an additional basis for the Departments' conclusion that it is important to amend the Federal definition of STLDI.

D. Need for Rulemaking

For the reasons described in this section II, the Departments are of the view that it is necessary to amend the Federal definition of STLDI to ensure that consumers can clearly distinguish STLDI from comprehensive coverage, protect the risk pools and stabilize premiums in the individual market, and promote access to affordable comprehensive coverage.

With respect to individual market fixed indemnity excepted benefits coverage, the combination of the decision in the *Central United* case and the reduction of the individual shared responsibility payment to \$0 for months beginning after December 31, 2018 under the Tax Cuts and Jobs Act increased the risk that individuals would purchase fixed indemnity excepted benefits coverage as a substitute for comprehensive coverage. The Departments are of the view that these changes necessitate rulemaking with respect to fixed indemnity excepted benefits coverage. Further, while the Departments did not finalize the proposed amendments to the group market fixed indemnity excepted benefits coverage regulations outlined in the 2016 proposed rules, the Departments noted their intention to address fixed indemnity excepted benefits coverage in future rulemaking.¹¹³ The Departments have continued to monitor the impact of these coverage options and remain concerned about the negative impacts of fixed indemnity excepted benefits coverage on consumers when such products are sold as an alternative to comprehensive coverage. In light of the Departments' ongoing

concerns about the numerous negative impacts of STLDI and fixed indemnity excepted benefits coverage being offered as an alternative to comprehensive coverage, as well as the significant changes in market conditions and in the legal landscape since the Departments' last regulatory actions addressing these products, the Departments are proposing changes to the Federal individual and group market regulations governing STLDI and fixed indemnity excepted benefits coverage. For similar reasons, as discussed in more detail in section IV.A of this preamble, the Treasury Department and the IRS propose to clarify the tax treatment of fixed amounts received by a taxpayer through certain employment-based accident or health insurance that are paid without regard to the amount of medical expenses incurred. In addition, the Departments solicit comments on specified disease excepted benefits coverage, as discussed in section III.B.2 of this preamble, and on level-funded plan arrangements, as discussed in section III.C of this preamble.

III. Overview of the Proposed Rules on Short-Term, Limited-Duration Insurance and Fixed Indemnity Excepted Benefits Coverage; Comment Solicitations Regarding Specified Disease Excepted Benefits Coverage and Level-Funded Plan Arrangements – The Departments of the Treasury, Labor, and Health and Human Services

A. Short-Term, Limited-Duration Insurance

The Departments are proposing the following amendments to the Federal regulations at 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 defining “short-term, limited-duration insurance”

¹⁰⁸ *Id.* (“Carrier expectations for the impact of [regulatory actions including the expansion of short-term, limited-duration insurance policies and other loosely regulated insurance and the repeal of the federal individual shared responsibility payment being reduced to \$0] on premiums in the ACA individual market for 2020 are approximately 4 percent in states that have not restricted the sale or duration of STLD policies ... Among the states that have limited the impact of loosely regulated insurance through reinstating an individual mandate or by restricting STLD expansion, carriers have assumed an average premium impact in 2020 due to regulatory actions that is about 5 percent lower than other states.”) As noted in section VII.B.2.e of this preamble, this study also found that the few carriers that explicitly included a premium adjustment because of the adoption of the new federal definition of STLDI in the 2018 final rules increased premiums by between 0.5 percent and 2 percent in 2020.

¹⁰⁹ See Hall, Mark and Michael McCue (2022). “Short-Term Health Insurance and the ACA Market,” Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2022/short-term-health-insurance-and-aca-market>.

¹¹⁰ *Id.*

¹¹¹ National Association of Insurance Commissioners (2023). “Short-Term Limited-Duration Health Plans,” available at: <https://content.naic.org/cipr-topics/short-term-limited-duration-health-plans>.

¹¹² *Id.*

¹¹³ Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance; Final Rule, 81 FR 75316 at 75317 (October 31, 2016).

to better distinguish STLDI from individual health insurance coverage. These amendments would apply to new STLDI policies, certificates, or contracts of insurance sold or issued on or after the effective date of the final rules; that is, the date that is 75 days after publication of the final rules.¹¹⁴ STLDI policies, certificates, or contracts of insurance sold or issued before the effective date of the final rules (including any subsequent renewals or extensions consistent with applicable law) could still have an initial contract term of less than 12 months and maximum duration of up to 36 months (taking into account any renewals or extensions), subject to any limits under applicable State law, but would be required to comply with the revised notice requirement for renewals and extensions.

1. “Short-term”

Under the current Federal regulations, contracts for STLDI must specify an expiration date that is less than 12 months after the original effective date of the contract, and, taking into account renewals or extensions, must have a duration of no longer than 36 months in total.¹¹⁵ The Departments, however, are no longer of the view that permitting the longer duration for STLDI is in the best interests of consumers.

Taking into account the potential risk to individuals who enroll in STLDI, the increased availability of affordable comprehensive coverage options, the potential impact on the individual market risk pools, and consumer challenges in differentiating STLDI from individual health insurance coverage, the Departments propose to reinterpret the phrase “short-term” to refer to a contract term of no more than 3 months. More specifically, the Departments propose to amend the Federal definition for STLDI under 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 such that the coverage would have an expiration date specified in

the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date. As discussed further in section III.A.2 of this preamble, the Departments also propose to amend the Federal definition of STLDI to reinterpret the phrase “limited-duration” to mean that the maximum permitted duration for STLDI is no longer than 4 months in total, taking into account any renewals or extensions. Further, the new proposed Federal definition would provide that a renewal or extension includes the term of a new STLDI policy, certificate, or contract of insurance issued by the same issuer to the same policyholder within a 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance.

As described further in section III.A.6 of this preamble, these proposed rules would adopt a bifurcated approach to the applicability date that distinguishes between new STLDI that is sold or issued on or after the effective date of the final rules,¹¹⁶ and existing STLDI sold or issued before the effective date of the final rules. The proposed new Federal definition and maximum duration framework in these proposed rules would apply for new STLDI policies, certificates, or contracts of insurance sold or issued on or after the effective date of the final rules. Under the framework in these proposed rules, existing policies, certificates, or contracts of insurance sold or issued before the effective date (including any subsequent renewals or extensions consistent with applicable law) could still have an initial contract term of less than 12 months, and a maximum duration of up to 36 months (taking into account any renewals or extensions), subject to any limits under applicable State law. In the preamble to the 2018 final rules, the Departments discussed the importance of ensuring that consumers clearly understand the differences between these types of coverage in order to select the type of coverage that suits their needs. However, particularly in

light of recent reports regarding deceptive marketing practices (as discussed in section III.A.3 of this preamble) and the risk of consumer confusion, the Departments are now of the view that interpreting “short-term” in a manner that prevents STLDI from having terms that are similar in length to a 12-month policy year for comprehensive individual health insurance coverage is the most important tool for consumers to distinguish between STLDI and comprehensive coverage.

In addition, the Departments expressed in the preamble to the 2018 final rules an expectation that the amended definition of STLDI would result in STLDI being distinguishable from comprehensive coverage because of the differences in their initial contract terms; the maximum duration of a policy itself; the types of notice requirements applicable to each type of coverage; and the classification of comprehensive coverage, but not STLDI, as MEC.¹¹⁷ However, since the 2018 final rules became effective, and in light of the changes in the legal landscape and market conditions discussed in section II of this preamble, the Departments are now of the view that the current Federal definition of STLDI contributes to confusion between STLDI and comprehensive coverage and that confusion results in consumer harm. The Departments’ proposal to reinterpret “short-term” to refer to coverage with a term of no more than 3 months is one change that would help ensure consumers are better able to distinguish between the two types of coverage and therefore make better informed coverage purchasing decisions.

The Departments are concerned that the current interpretation and definition is too expansive and contributes to confusion regarding whether a policy is STLDI or comprehensive coverage. The combination of deceptive marketing practices (as discussed in section III.A.3 of this preamble) and the near-identical length of coverage for the initial contract term has proven to be confusing for consumers. As

¹¹⁴For purposes of this document, the term “effective date of the final rules” refers to the date that is 75 days after the date of publication of the final rules.

¹¹⁵See 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103. See also 83 FR 38212 (August 3, 2018).

¹¹⁶The Departments are of the view that an effective date that is 75 days after the date of publication of the final rule provides sufficient time for interested parties to review, understand, and meet their obligations under the final rule, without unnecessarily delaying the implementation of policies that are proposed to be finalized on the effective date. See sections III.A.6 (STLDI) and III.B.1.g (fixed indemnity excepted benefits coverage) for additional discussion of applicability proposals.

¹¹⁷83 FR at 38215 (August 3, 2018).

such, STLDI policies that include an initial term just shy of 12 months have not been easily distinguishable by consumers from comprehensive coverage available in the individual market, which generally has a 12-month policy year.¹¹⁸ In addition, the ability to renew or extend STLDI policies for up to 36 months is also somewhat similar to the structure of comprehensive coverage sold in the individual and group markets and makes STLDI harder to distinguish from comprehensive coverage options. As a result, STLDI is being sold in situations, including as a long-term replacement for comprehensive coverage, that the exception from the definition of individual health insurance coverage was not intended to address.¹¹⁹ In some instances, individuals may mistakenly purchase STLDI as long-term health insurance coverage.¹²⁰

In determining the appropriate length of STLDI for the proposed amended Federal definition, and giving meaning to “short-term,” the Departments reflected on instances when individuals may experience a temporary gap in coverage. For example, a college student enrolled in student health insurance coverage that does not provide coverage during the summer when they are not enrolled in classes, or a teacher who changes jobs and has to wait until the fall to enroll in new coverage, would experience a temporary gap in coverage of roughly 3 months and would benefit from access to STLDI during that period. Individuals transitioning between other types of jobs may also experience a temporary break in coverage, even if their break in employment is negligible. In particular, section 2708 of the PHS Act and its implementing regulations permit a group health plan or health insurance issuer offering group health insurance coverage to apply a waiting period (as

defined in section 9801(b)(4) of the Code, section 701(b)(4) of ERISA, and 2704(b)(4) of the PHS Act) of up to 90 days.¹²¹ In addition, the implementing regulations allow for a reasonable and bona fide employment-based orientation period not to exceed 1 month. These provisions can result in a delay of approximately 3 to 4 months before coverage of an individual, who is otherwise eligible to enroll under the terms of a group health plan, can become effective.

Therefore, the Departments propose to amend the Federal definition of “short-term, limited-duration insurance” in 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 to reflect a new interpretation of the phrase “short-term” to mean a policy, certificate, or contract of insurance with an issuer that has an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date of the policy, certificate, or contract of insurance. This approach is consistent with the group market rules regarding the 90-day waiting period limitation provision under the ACA and with STLDI’s role of serving as temporary coverage for individuals transitioning between other types of comprehensive coverage. It also is similar to the less-than-3-month maximum term in the Federal definition of STLDI adopted in the 2016 final rules and already enacted in a number of States,¹²² and aligns with the goal of Executive Order 14009 to support protections for people with preexisting conditions, as there are no Federal prohibitions or restrictions on preexisting condition limitations with respect to STLDI.

It is reasonable to look to the group market waiting period rules to guide the proposed amendments to the Federal definition of STLDI in giving meaning to

“short-term,” because a waiting period is the type of coverage gap that STLDI was initially intended to cover.¹²³ For longer gaps in coverage, the guaranteed availability protections established under the ACA, COBRA continuation coverage for individuals who were enrolled in employer-based coverage, and the special enrollment period requirements for group health plan and individual health insurance coverage provide individuals various opportunities to enroll in comprehensive coverage through or outside of an Exchange.

The Departments request comments on the proposed interpretation of the phrase “short-term.” The Departments also request comments on whether the interpretation of “short-term” in the proposed definition of STLDI should instead be no more than 4 months or some other length, and why.

2. “Limited-Duration”

Under the definition adopted in the 2018 final rules, the Departments interpreted the phrase “limited-duration” to preclude renewals or extensions of STLDI that extended a policy beyond a total of up to 36 months, with the total number of consecutive days of coverage under a single (that is, the same) insurance contract being the relevant metric to calculate the permissible duration of coverage. The Departments now propose an update to the Federal definition of “short-term, limited-duration insurance” under 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 that would adopt a different interpretation of the phrase “limited-duration.” The Departments propose to reinterpret “limited-duration” to refer to a maximum coverage period that is no longer than 4 months in total, taking into account any renewals or extensions.

¹¹⁸ 45 CFR 144.103 (defining policy year for non-grandfathered health plans offered in the individual health insurance market as a calendar year).

¹¹⁹ See, e.g., Palanker, Dania, and Volk JoAnn (2021). “Misleading Marketing of Non-ACA Plans Continued During COVID-19 Special Enrollment Period,” Center on Health Insurance Reforms, available at: <https://georgetown.app.box.com/s/mn7kgnhibn4kapb46tqmv6i7putry9gt>. See also Fernandez, Bernadette, Vanessa Forsberg, and Annie Mach (2018). “Background Information on Health Coverage Options Addressed in Executive Order 13813,” Congressional Research Service, available at: <https://ersreports.congress.gov/product/pdf/R/R45216>. See also Corlette, Sabrina, Kevin Lucia, Dania Palanker, and Olivia Hoppe (2019). “The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,” Urban Institute, available at: <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>.

¹²⁰ Government Accountability Office (2022). “Private Health Insurance: Limited Data Hinders Understanding Short-Term Plans Role and Value During the COVID-19 Pandemic,” available at: <https://www.gao.gov/assets/730/720774.pdf>.

¹²¹ 26 CFR 54.9815-2708, 29 CFR 2590.715-2708, and 45 CFR 147.116.

¹²² Pollitz, Karen, Michelle Long, Ashley Semanskee, and Rabah Kamal (2018). “Understanding Short-Term Limited Duration Health Insurance,” KFF, available at: <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

¹²³ 81 FR 38020 at 38032 (June 10, 2016) (the intent of the initial regulation defining STLDI was to refer to coverage that filled temporary coverage gaps when an individual was transitioning from one plan or coverage to another).

This approach would allow STLDI to be extended, when consistent with applicable State law, to avoid a temporary gap in coverage if, for example, an employer implemented a bona fide employment-based orientation period of up to 1 month under the 90-day waiting period limitation provision under the ACA. An STLDI policy would meet the Federal definition of “limited-duration” so long as the coverage was not renewed or extended beyond a total of 4 months from the original effective date of the policy, certificate, or contract of insurance, regardless of whether the coverage has an initial term of 1, 2, or 3 months. For example, an STLDI policy could have an initial term of 3 months and a renewal term of 1 month, or an initial term of 2 months and a renewal term of 2 months, consistent with the proposed amended Federal definition of STLDI.

For this purpose, the Departments propose that a renewal or extension would include the term of a new STLDI policy, certificate, or contract of insurance issued by the same issuer to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance. In this context, the phrase “same issuer” would refer to the entity licensed to sell the policy, consistent with the definition of health insurance issuer in 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103. Under this proposal, the relevant metric to calculate whether the duration of coverage satisfies the new Federal “limited-duration” standard is the total number of days of coverage (either consecutive or non-consecutive) that a

policyholder is enrolled in an STLDI policy with the same issuer. That calculation would apply regardless of whether the coverage is a renewal or extension under the same policy, certificate, or contract of insurance, or if it involves the issuance of a new STLDI policy, certificate, or contract of insurance to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance.

In the 2018 final rules, the Departments took the position that the maximum length of COBRA continuation coverage serves as an appropriate benchmark for interpreting the term “limited-duration” with respect to STLDI. The 2018 final rules likened the limited-duration maximum to the maximum duration that employers are required to provide COBRA continuation coverage to qualified beneficiaries (18, 29, or 36 months depending on the nature of the qualifying event that precipitates the temporary coverage period).¹²⁴ However, unlike STLDI, COBRA requires, and employees expect, that the elected COBRA continuation coverage provides the same benefits as the employee’s employment-based coverage, and that the qualified beneficiaries may elect either the same coverage they had the day before the qualifying event occurred or coverage options provided to similarly situated current employees/participants.¹²⁵ Additionally, Federal consumer protections and requirements for comprehensive coverage generally apply to COBRA continuation coverage. In contrast, STLDI is primarily designed to fill shorter gaps in coverage, such as when an individual is

between enrollment in employment-based coverage, and it is generally not required to comply with Federal consumer protections and requirements for comprehensive coverage,¹²⁶ or provide robust, comprehensive benefits.

In response to the 2016 and 2018 proposed rules, the Departments received comments requesting that the Departments not only limit renewals of the same policy, certificate, or contract of insurance, but also prohibit issuers from offering STLDI to consumers who have previously purchased STLDI from the same or different issuer, to prevent consumers from stringing together multiple consecutive policies, a practice commonly referred to as stacking.¹²⁷ The Departments share the commenters’ concern that stacking STLDI in effect lengthens the duration of coverage without offering the benefits and consumer protections of comprehensive coverage. As those commenters pointed out, this practice effectively circumvents the rules related to maximum duration and makes it more challenging for consumers to distinguish STLDI from comprehensive coverage, concerns that interested parties have reiterated in 2021 and 2022.¹²⁸ If an issuer strings together multiple STLDI policies (whether of a 12-month or 4-month maximum) the coverage could be stacked to look very similar to the annual renewals that are common for comprehensive coverage but without the benefits the consumer would receive from comprehensive coverage. For example, when stacking new policies, an issuer could increase premiums and cost sharing and reset the deductible every 4 months. In contrast, if

¹²⁴ For example, when a qualified employee loses coverage due to the termination of an employee’s employment for any reason other than gross misconduct, or a reduction in the number of hours of employment, the group health plan must provide the qualified employee and their covered dependents an opportunity to elect COBRA continuation coverage for up to 18 months. A spouse or dependent child of a covered employee would have the opportunity to elect COBRA continuation coverage for up to 18 months if they lost coverage due to the termination of the covered employee’s employment for any reason other than gross misconduct, a reduction in the hours worked by the covered employee, divorce or legal separation of the spouse from the covered employee, or death of the covered employee. In addition, if a child loses coverage because of a loss of dependent child status, the child would have the opportunity to elect up to 36 months of COBRA continuation coverage. The group health plan is required to provide up to 29 months of COBRA continuation coverage only if one of the qualified beneficiaries is disabled and meets certain requirements. A maximum COBRA period of 36 months is only available to a spouse and dependents in limited circumstances such as the occurrence of a second qualifying event (for instance, the death of the covered employee, the divorce or legal separation of a covered employee and spouse, or a loss of dependent child status under the plan).

¹²⁵ 26 CFR 54.4980B-5.

¹²⁶ As noted above, health insurance issuers offering STLDI are subject to the new agent and broker compensation disclosure and reporting requirements in section 2746 of the PHS Act.

¹²⁷ The Departments declined to prohibit stacking in the 2016 final rules because the requirement that individuals obtain MEC in order to avoid making an individual shared responsibility payment was an adequate deterrent to discourage consumers from purchasing multiple successive STLDI policies. See 81 FR at 75318. In the Department’s view, reconsideration of such a prohibition is now warranted because the individual shared responsibility payment was reduced to \$0 by the Tax Cuts and Jobs Act.

¹²⁸ Partnership to Protect Coverage (2021). “Under-Covered: How ‘Insurance-Like’ Products are Leaving Patients Exposed,” available at: https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Undercovered_Report_03252021.pdf. (“STLDI plans should not be renewable or allowed to continue for more than three months because of the significant financial risk posed to consumers by their combination of extraordinary deductibles and limited catastrophic financial protection.”). See also Letter from 29 organizations to Sec. Xavier Becerra (January 31, 2022), available at: <https://www.lung.org/getmedia/8a510945-cd82-41fe-968e-d83faf2292eb/013122-Letter-to-HHS-Re-Regulation-of-STLDI-policy-preferences-FINAL.pdf>. (“Allowing short-term plans to be renewed or to be sold such that nominally separate policies run consecutively... known as “stacking”—contributes to consumer confusion, increased premiums, and financial risk for consumers.”).

enrolled in comprehensive health insurance coverage, a consumer is guaranteed a stable level of coverage and cost sharing throughout the 12-month plan year, and the coverage is subject to Federal consumer protections and requirements that prohibit practices common to STLDI, including medical underwriting and coverage rescissions. Consumers that have already purchased STLDI policies from the same issuer may not be aware of, and may be less likely, to explore other coverage options that provide more comprehensive coverage at a better price. As a result, some consumers may enroll in STLDI mistaking it for comprehensive coverage or not understanding the limitations of the coverage.

In response to these concerns and continued reports about the impact of the existing Federal definition of STLDI discussed in section III.A.I of this preamble, under the Departments' authority to interpret the phrase "limited-duration," the Departments propose to add new language that provides that, for purposes of applying the new Federal definition, a renewal or extension includes the term of a new STLDI policy, certificate, or contract of insurance issued by the same issuer to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance.¹²⁹ As explained elsewhere in this preamble section, under this proposal, the relevant metric to calculate and evaluate if the duration of coverage (taking into account any renewals or extensions) satisfies the proposed permitted maximum duration of no more than 4 months is the total number of days (either consecutive or non-consecutive) of coverage that a policyholder is enrolled in an STLDI policy with the same issuer within the 12-month period

beginning on the original effective date of the initial policy, certificate, or contract of insurance, regardless of whether the coverage issued to the policyholder is under the same or a new policy, certificate, or contract of insurance. This calculation, however, would not include an STLDI policy, contract, or certificate of insurance sold to the same policyholder by a *different* issuer. This distinction would effectively limit stacking of policies sold by the same issuer, would be easier for issuers to track and comply with, and would allow consumers the flexibility to purchase subsequent STLDI policies from other issuers within a 12-month period. The Departments are of the view that subsequent sales to the same policyholder by the same issuer should be treated comparably to renewals for purposes of calculating and applying the maximum-duration standard. To do otherwise would undermine the maximum-duration requirements by allowing issuers to stack policies, and would contravene the initial purpose of STLDI policies to fill temporary gaps in comprehensive coverage.

The Departments solicit comments on the proposed revisions to the Federal definition of "short-term, limited-duration insurance," including the new proposed interpretation of the phrase "limited-duration," and whether there are circumstances under which issuers should be allowed to renew or extend STLDI for periods of time beyond what would be permitted in these proposed rules. The Departments also solicit comments on whether there are additional ways to differentiate STLDI from comprehensive coverage options, including information on State approaches or limits on the sale of STLDI by a different issuer, and how the subsequent issuer would determine whether or not an applicant had previous STLDI with another

issuer. The Departments also solicit comments on whether to broaden the limits on stacking to include issuers that are members of the same controlled group.

3. Sales and Marketing Practices

The Departments are concerned by reports of aggressive and deceptive sales and marketing practices related to STLDI. According to these reports, STLDI is often marketed as a substitute for comprehensive coverage,¹³⁰ despite being exempt from most of the Federal individual market consumer protections and requirements for comprehensive coverage. For example, some websites selling STLDI utilized logos of well-known issuers even when not affiliated with such issuers, and claimed to provide comprehensive health insurance or be providers of government-sponsored health insurance policies. Misleading marketing includes tactics such as designing websites to suggest the product for sale is comprehensive coverage and using the websites to gather personal information for call centers or brokers that later push consumers to make quick decisions about purchasing STLDI without disclosing that the insurance is not comprehensive coverage.¹³¹

As another example, consumers shopping for health insurance online are often directed to websites selling STLDI or other plans that are not comprehensive coverage, using terms like "Obamacare plans" and "ACA enroll." Websites use those terms in an effort to associate STLDI with the Federal consumer protections and requirements for comprehensive coverage.¹³² A report from the Government Accountability Office (GAO) uncovered brokers engaging in deceptive marketing practices that misrepresented or omitted information about products or claimed

¹²⁹ In response to the 2018 proposed rules, the Departments received comments regarding renewal guarantees. As explained in the preamble to the 2018 final rules, renewal guarantees generally permit a policyholder, when purchasing his or her initial insurance contract, to pay an additional amount in exchange for a guarantee that the policyholder can elect to purchase, for periods of time following expiration of the initial contract, another policy or policies at some future date, at a specific premium that would not require any additional underwriting. See 83 FR at 38219 – 38220 (Aug. 3, 2018). These proposed rules would not directly regulate renewal guarantees. However, the Departments acknowledge that the proposed revisions to the federal definition—including the proposal to count the term of a new STLDI contract issued by the same issuer to the policyholder within the same 12-month period beginning on the original effective date of the initial policy, contract, or certificate of insurance toward the total maximum duration of STLDI—would limit the guarantees that such instruments may be able to provide.

¹³⁰ Federal Trade Commission (2018). "FTC Halts Purveyors of Sham Health Insurance Plans," available at: <https://www.ftc.gov/news-events/news/press-releases/2018/11/ftc-halts-purveyors-sham-health-insurance-plans>.

¹³¹ Palanker, Dania, JoAnn Volk, and Maanasa Kona (2019). "Seeing Fraud and Misleading Marketing, States Warn Consumers About Alternative Health Insurance Products," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2019/seeing-fraud-and-misleading-marketing-states-warn-consumers-about-alternative-health>. See also, Federal Trade Commission (2022). "FTC Action Against Benefytt Results in \$100 Million in Refunds for Consumers Tricked into Sham Health Plans and Charged Exorbitant Junk Fees," available at: <https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-action-against-benefytt-results-100-million-refunds-consumers-tricked-sham-health-plans-charged>.

¹³² Corlette, Sabrina, Kevin Lucia, Dania Palanker, and Olivia Hoppe (2019). "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses," Urban Institute, available at: <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>.

that preexisting conditions were covered when plan documents reflected that they were not.¹³³ The GAO study also found that brokers have a financial incentive to enroll their clients in STLDI because brokers receive higher commissions for selling that coverage than for selling comprehensive coverage.¹³⁴ For example, the financial incentive could be up to 10 times higher commissions when compared to individual market QHPs purchased through an Exchange.¹³⁵ State regulators have also received complaints alleging that brokers engaged in deceptive practices to enroll consumers in STLDI over the phone. These practices prevent consumers from making an informed choice about their coverage.¹³⁶

In addition, the Departments have received feedback that the low levels of health insurance literacy, particularly among younger adults and underserved populations, exacerbate the harm caused by deceptive marketing practices of STLDI by issuers and agents and brokers.¹³⁷ Consumers have complained they were unaware that the issuer could decide not to renew or issue a new policy, certificate, or contract of insurance to the same consumer at the end of the contract term.¹³⁸ Some consumers unwittingly purchase STLDI with fewer protections and less robust benefits than comprehensive coverage because they do not understand the difference between these two types of coverage.¹³⁹

In the Departments' view, this risk of misleading consumers could be further minimized if STLDI was not marketed or sold to consumers during certain periods when a consumer is eligible to enroll in comprehensive coverage, such as the individual market open enrollment period. Allowing STLDI to be marketed or sold

during open enrollment can confuse consumers by causing them to perceive STLDI as a substitute for comprehensive coverage, rather than an option to fill temporary gaps in coverage. Inadvertent enrollment in STLDI may subject uninformed consumers to potentially severe financial risks, and cause them not to enroll in comprehensive coverage when eligible to do so. In addition, some healthier individuals may also inadvertently enroll in STLDI instead of comprehensive coverage, and in so doing, either leave or not enter an individual market risk pool. As discussed in section II.C of this preamble, this affects the risk pools for individual health insurance coverage, leading to increased premiums.

The Departments solicit comments on additional ways to help consumers distinguish between STLDI and comprehensive coverage. In particular, the Departments are interested in feedback on ways to prevent or otherwise mitigate the potential for direct competition between STLDI and comprehensive coverage during the open enrollment period for individual market coverage. For example, some States have prohibited the sale of STLDI during open enrollment.¹⁴⁰ The Departments are particularly interested in comments related to experience in States that have prohibited enrollment in STLDI during specific periods of time, including whether prohibiting enrollment has increased enrollment in comprehensive coverage, reduced deceptive marketing practices, or resulted in any premium changes for comprehensive coverage. In addition, the Departments request comments on what additional steps the Departments can take to help consumers better understand and distinguish between comprehensive coverage and other forms of health insurance coverage, as well as

what steps can be taken to further support State efforts to protect consumers from misleading and deceptive marketing and sales practices.

4. Notice

Under the 2018 final rules, to satisfy the definition of STLDI, issuers must display prominently in the contract and in any application materials provided in connection with enrollment in STLDI a specific notice in at least 14-point type.¹⁴¹ The 2018 final rules finalized two notices. The first notice (Notice 1) was for policies with a coverage start date before January 1, 2019, and includes language related to the individual shared responsibility payment under section 5000A of the Code. The second notice (Notice 2), which is for policies with a coverage start date on or after January 1, 2019, omits the language related to the individual shared responsibility payment because, effective for months beginning after December 31, 2018, the individual shared responsibility payment was reduced to \$0.¹⁴² The Departments propose a non-substantive technical amendment to remove Notice 1, because the period during which Notice 1 was applicable has ended; thus, that provision no longer has any effect.

The Departments continue to be of the view that the notice is important to help consumers distinguish between comprehensive coverage and STLDI. Therefore, the Departments propose to amend the notice to further clarify the differences between STLDI and comprehensive coverage, and identify options for consumers to obtain comprehensive coverage in concise, understandable language that would be meaningful to them. The proposed amendments to the notice would

¹³³ Government Accountability Office (2020). "Private Health Coverage: Results of Covert Testing for Selected Offerings," available at: <https://www.gao.gov/products/gao-20-634r>.

¹³⁴ *Ibid.*

¹³⁵ Keith, Katie (2020). "New Congressional Investigation of Short-Term Plans," *Health Affairs*, available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20200626.227261/full/>.

¹³⁶ Palanker, Dania, JoAnn Volk, and Maanasa Kona (2019). "Seeing Fraud and Misleading Marketing, States Warn Consumers About Alternative Health Insurance Products," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2019/seeing-fraud-and-misleading-marketing-states-warn-consumers-about-alternative-health>.

¹³⁷ Government Accountability Office (2020). "Private Health Coverage: Results of Covert Testing for Selected Offerings," available at: <https://www.gao.gov/products/gao-20-634r>.

¹³⁸ *Id.*

¹³⁹ *Id.*

¹⁴⁰ Washington and Maine prohibit the sale of STLDI during open enrollment. In addition, Hawaii prohibits the sale of STLDI to individuals who were eligible to purchase an Exchange plan during open enrollment in the previous calendar year. See U.S. House of Representatives Committee on Energy and Commerce (2020). "Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans Is Putting Americans at Risk," available at: <https://democrats-energycommerce.house.gov/newsroom/press-releases/ec-investigation-finds-millions-of-americans-enrolled-in-junk-health>.

¹⁴¹ 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103. See section I.C of this preamble for further discussion of this requirement.

¹⁴² See Pub. L. 115-97, December 22, 2017.

apply to all STLDI policies sold or issued on or after the effective date of the final rules. The proposed amendments to the notice would only apply to existing policies in connection with notices required to be provided upon renewal or extension of existing STLDI coverage on or after the effective date of the final rules.

After consulting with plain-language experts regarding improvements to the current required notice, the Departments propose the following revisions to both the content and formatting of the notice to inform consumers considering purchasing STLDI about the differences between STLDI and comprehensive coverage, support informed coverage purchasing decisions, and promote readability. The Departments propose that issuers must prominently display the notice (in either paper or electronic form) in at least 14-point font, on the first page of the policy, certificate, or contract of insurance, including for renewals or extensions. The Departments further propose that issuers must prominently display the notice in any marketing and application materials provided in connection with enrollment in such coverage, including on websites that advertise or enroll individuals in STLDI, and in any enrollment materials that are provided at or before the time an individual has the opportunity to enroll. In addition, if an individual is required to reenroll for purposes of renewal or extension of STLDI, the notice must be prominently displayed in the reenrollment materials (in either paper or electronic form) that are provided to the individual at or before the time the individual is given the opportunity to reenroll in coverage, as well as on any websites used to facilitate reenrollment in STLDI.

The notice would not affect any separate notice requirements under applicable State law, except to the extent that a State notice requirement would prevent

application of any Federal notice requirement. The text of the proposed STLDI notice is as follows:

“Notice to Consumers About Short-Term, Limited-Duration Insurance

IMPORTANT: This is short-term, limited-duration insurance. This is **temporary** insurance. **It isn’t comprehensive health insurance.** Review your policy carefully to make sure you understand what is covered and any limitations on coverage.

- This insurance might not cover or might limit coverage for:
 - preexisting conditions; or
 - essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, and substance use services, prescription drugs, or preventive care).
- You won’t qualify for Federal financial help to pay for premiums or out-of-pocket costs.
- You aren’t protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

Visit [HealthCare.gov](https://www.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 eligible for coverage through your employer or a family member’s employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy.”

These proposals to revise and enhance the required notice aim to increase consumer understanding of STLDI and

combat potential misinformation related to such coverage for all consumers, including historically underserved communities. As noted in section II.B of this preamble, individuals belonging to historically underserved communities often experience more health care challenges, and greater obstacles accessing and using health care services compared to the general population. Underserved communities experience worse health outcomes, higher rates of chronic conditions, lower access to health care, and have more frequent experiences of discrimination in health care settings.¹⁴³ The COVID-19 PHE amplified these longstanding inequities, resulting in disparate rates of COVID-19 infection, hospitalization, and death.¹⁴⁴ In addition, research has uncovered significant disparities in health insurance literacy rates nationwide, particularly among those who identify as female, members of underserved racial and ethnic groups, individuals with income below the FPL, and Spanish-speaking enrollees.¹⁴⁵ Because low health insurance literacy increases the likelihood of consumers not fully understanding the differences between comprehensive coverage and STLDI, as well as the potential health and financial risks of STLDI coverage,¹⁴⁶ and in light of Executive Order 13985 which requires the Administration to promote access to equity for underserved communities,¹⁴⁷ the Departments are concerned that members of underserved communities may be particularly vulnerable to misinformation or misleading or aggressive sales tactics. In light of these concerns, it is important for the notice to provide clear and easily readable information alerting consumers to the differences between STLDI coverage and comprehensive coverage. The Departments are of the view that the notice must also provide resources where consumers can access additional information about STLDI coverage and other

¹⁴³ See CMS Office of Minority Health (2022). “The Path Forward: Improving Data to Advance Health Equity Solutions,” available at: <https://www.cms.gov/files/document/path-forward-he-data-paper.pdf>.

¹⁴⁴ Moore, Jazmyn, Carolina Luna-Pinto, Heidi Cox, Sima Razi, Michael St. Louis, Jessica Ricaldi, and Leandris Liburd (2021). “Promoting Health Equity During the COVID-19 Pandemic, United States,” Bulletin of the World Health Organization, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8795842>.

¹⁴⁵ See, Edward, Jean, Amanda Wiggins, Malea Hoepf Young, Mary Kay Rayens (2019). “Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform,” *Health Literacy Research and Practice*, available at: <https://pubmed.ncbi.nlm.nih.gov/31768496/>. See also Villagra, Victor and Bhumika Bhuvu (2019). “Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference,” *The American Journal of Managed Care*, available at: <https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference>.

¹⁴⁶ Edward, Jean, Robin Thompson, and Amanda Wiggins (2022). “Health Insurance Literacy Levels of Information Intermediaries: How Prepared are They to Address the Growing Health Insurance Access Needs of Consumers?,” *Health Literacy Research and Practice*, 6(1), available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8919673/>.

¹⁴⁷ See, Executive Order 13985 of January 20, 2021, 86 FR 7009.

health coverage options so consumers can make informed choices after considering a range of available health coverage options.

The Departments propose to add language to the notice to help consumers identify where and how they might be able to enroll in comprehensive coverage. The Departments propose to add a website link and telephone number for HealthCare.gov to the notice as reliable resources for consumers to get information on the different types of available health coverage options. The Departments are also considering that the notice be tailored to specify a telephone number and a link to the State Exchange's website if the STLDI is filed in a State that does not use HealthCare.gov.¹⁴⁸ The Departments seek comments on this approach, including the proposed requirement to provide the notice in the marketing, application, and enrollment (or reenrollment) materials, including the extension of the notice requirement to websites that advertise or offer the opportunity to enroll (or reenroll) in STLDI and on the associated administrative burden for issuers, agents, brokers, or others who will be involved in providing the notice to consumers.

If, under any future final rules, the notice must be customized to specify the website and telephone number for HealthCare.gov or the State Exchange's website and telephone number, as applicable, the Departments would state that STLDI sold through associations¹⁴⁹ include a link to the website of the Exchange that operates in the State in which the individual to whom the STLDI is sold or marketed resides, regardless of the State in which the association has filed the insurance product. The Departments are considering this approach for coverage sold through associations because association coverage is sold across numerous States, and consumers interested in other coverage options would enroll through the Exchange of the State in which the consumer resides.

The proposed revised notice would also remind consumers that if they are

eligible to enroll in employment-based coverage they should contact their employer or family member's employer about the health coverage offered by the employer. In addition, the Departments propose to add language to the notice that directs consumers to contact the State department of insurance for questions and complaints about the STLDI. The Departments seek comments on whether this part of the notice should also be tailored to include the name and phone number of the State department of insurance of the State in which the product is filed. If the State-specific information must be included, for products that are filed in multiple States, the Departments propose that the notice include the name and the phone number of the State department of insurance of the State of residence of the individual to whom the STLDI is sold or marketed, unless the product is not filed in that State. If the product is not filed in the State of residence of the individual to whom the STLDI is sold or marketed, the notice would include the name and the phone number of the State department of insurance of the State in which the product is filed.

The current regulations already state that the applicable notice must be displayed prominently in the contract and in any application materials provided in connection with enrollment in such coverage in at least 14-point type. However, based on information that consumers are not receiving adequate information prior to enrollment in an STLDI policy,¹⁵⁰ the Departments are concerned that the current standard is too subjective and may be contributing to consumers not understanding the limits of STLDI and being unable to distinguish it from comprehensive coverage. Ensuring that issuers, agents, brokers or others who will be involved in providing the notice to consumers also prominently display the notice on the first page of marketing materials would increase consumer awareness, limit the impact of any deceptive marketing practices, and support informed decision making and purchasing decisions by consumers. The Departments

therefore propose that the notice be prominently displayed, in at least 14-point font, on the first page of any marketing materials used in connection with enrollment (or reenrollment) in STLDI. The Departments propose to consider the notice to be prominently displayed if it would be reasonably noticeable to a typical consumer within the context of the page on which it is displayed. For example, the notice would be prominently displayed if it uses a font color that contrasts with the background of the document, is not obscured by any other written or graphic content on the page, and when displayed on a website, is viewable without clicking on an additional link. For this purpose, the Departments would consider marketing materials to include any documents or website pages that advertise the benefits or opportunity to enroll (or reenroll) in STLDI coverage. The Departments seek comments on the benefits and burdens of applying the notice requirements to marketing materials, including websites used in connection with advertising or enrollment (or reenrollment) in STLDI coverage, and on the proposed definition of what would be considered marketing materials.

The Departments are considering adding a statement to the STLDI notice describing the maximum permitted length of STLDI under Federal rules, explaining that STLDI cannot be renewed or extended beyond the maximum allowable duration, and explaining that the length of STLDI may be shorter subject to State law. Adding this proposed additional language may reduce the impact of deceptive marketing practices on consumers that may otherwise be unaware or misinformed about the length of STLDI before renewing or extending an existing STLDI policy or enrolling in a new STLDI policy. However, including such language would also add to the length of the notice. The Departments seek comment on whether information about the maximum permitted length of new or existing STLDI and options regarding renewal and extensions would be included in enrollment materials (or reenrollment materials) provided to

¹⁴⁸ Currently, 33 states use HealthCare.gov. See, <https://www.healthcare.gov/marketplace-in-your-state/>.

¹⁴⁹ See discussion in section III.A.5 of this preamble regarding coverage sold through associations.

¹⁵⁰ See, Corlette, Sabrina, Kevin Lucia, Dania Palanker, and Olivia Hoppe (2019). "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses," Urban Institute, available at: <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>.

enrollees as part of the normal course of business. The Departments seek comment on this approach, including how best to clearly and concisely communicate such information to consumers, including on how to address the bifurcated applicability dates with respect to the proposals around maximum initial contract length and maximum duration, whether such information is already included elsewhere in the plan documents; and on the associated administrative burden for issuers, agents, brokers, or others who would be involved in providing the notice to consumers.

The Departments also solicit comments on whether it would be beneficial to consumers to require issuers to include language on the notice that clearly informs consumers that the notice is an officially required document, such as “This notice is required by Federal law”.

The Departments seek comments on all aspects of the proposed amendments to the notice and the proposed new Federal definition of STLDI, including whether the proposed language and proposed placement of the notice would achieve the stated aims of helping to inform consumers of the nature of the coverage and combat potential deceptive marketing practices as described in section III.A.3 of this preamble, and whether alternative or additional language, formatting, or mechanisms for delivery of the notice could better accomplish these goals. For example, the Departments request feedback on whether a different presentation, such as a chart comparing the protections that apply to comprehensive coverage and STLDI, would result in a more useful, consumer-friendly notice than the format proposed in these rules.

As an illustrative example of this different presentation, the Departments offer for consideration an alternative format for this notice that would aim to succinctly show important differences between STLDI and comprehensive coverage using a table. This alternative STLDI notice would include all of the information discussed earlier in this section of the preamble, but it would simplify word choice and reduce sentence length in order to further improve readability. The Departments request feedback on which version of the notice more effectively communicates information to individuals and how the notice format would impact accessibility, particularly for individuals who are vision-impaired or rely on screen readers or other technology to review written documents. The text of the alternative proposed STLDI notice is as follows:

“WARNING

This is not comprehensive insurance. This is short-term, limited-duration insurance.

This plan has fewer protections than comprehensive insurance options you can find on [HealthCare.gov](https://www.healthcare.gov).

This Insurance	Insurance on HealthCare.gov
• May deny you coverage if you have a preexisting condition	• You cannot be denied coverage because of a preexisting condition
• There may be no limit to the amount you have to pay out-of-pocket for care	• The most you have to pay out-of-pocket for essential health benefits in a year is limited
• You will not qualify for Federal financial help to pay your premiums and out-of-pocket costs	• You may qualify for Federal financial help to pay your premiums and out-of-pocket costs
• You may not have access to all essential health benefits, including: pediatric, hospital, emergency, maternity, mental health, and substance use disorder services, prescription drugs, and preventive care	• You will have access to all essential health benefits, including: pediatric, hospital, emergency, maternity, mental health, and substance use disorder services, prescription drugs, and preventive care

Questions?

- For more info about comprehensive coverage, visit [HealthCare.gov](https://www.healthcare.gov) online or call 1-800-318-2596 (TTY: 1-855-889-4325).
- For more info about your employer’s coverage, or a family member’s employer coverage, contact the employer.
- For questions or complaints about this policy, contact your State department of insurance.”

The Departments seek comments on whether additional changes to the notice language would improve readability or further help individuals distinguish STLDI from comprehensive coverage, and whether there are practical or logistical barriers that would present any challenges to compliance with the new proposed notice standards. The Departments are also interested in comments on whether the proposed placement requirements

would substantially improve the likelihood that consumers have a meaningful opportunity to review the notice and their health coverage options before applying, enrolling, or reenrolling in STLDI, as well as any practical or logistical barriers to providing this notice as proposed. The Departments particularly seek comments from members of underserved communities, and organizations that serve such communities, on whether the language

accessibility, formatting, and content of the notice sufficiently mitigate barriers that exist to ensuring all individuals can read, understand, and consider the full range of their health coverage options.

The Departments also solicit comments on the prevalence of instances where agents and brokers complete sales transactions with consumers for STLDI before distributing the applicable notice, and solicit comments on additional standards

that would encourage salespeople, agents and brokers to notify individuals of the limitations of STLDI in accordance with these proposed rules.

5. Short-Term, Limited-Duration Insurance Sold Through Associations

The Departments understand that most sales of STLDI occur through group trusts or associations that are not related to employment (sometimes referred to as individual membership associations).¹⁵¹ Under these arrangements, out-of-State issuers file insurance products for approval in one State and then sell the same policies in other States through an association, many times with few requirements for participation in the association by consumers, other than payment of association dues. Many State regulators have reported they lack the authority to track sales of policies made through out-of-State associations, and are unable to approve or regulate such policies when offered for sale by issuers that are not licensed by their State. Further, The Departments have received feedback that many issuers are taking advantage of the ambiguity about which State's jurisdiction applies, to avoid local State regulation. For example, one study found that in a review of 34 policy brochures for STLDI, 28 of the brochures included references to associations.¹⁵² Consumers may not understand that some STLDI marketed in their States is not regulated by their State and does not include State-based consumer protections.

Coverage that is provided to or through associations, but not related to employment, and is sold to individuals, either as certificate holders or policyholders, is not group coverage under section 9832 of the Code, section 733(b)(4) of ERISA, and section 2791(b)(4) of the PHS Act.¹⁵³ If the coverage is offered to an association member other than in connection with a group health plan, the coverage is considered coverage in the individual market under Federal law, regardless of whether it

is considered group coverage under State law. Thus, any health insurance sold to individuals through a group trust or association, other than in connection with a group health plan, or sold to a group trust or association to the extent the insurance is intended to cover association members who are individuals, must meet the definition of STLDI at 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103, or else be considered individual health insurance coverage that is subject to all the Federal individual market consumer protections and requirements for comprehensive coverage.

The Departments are aware that some group trusts and associations have also marketed STLDI policies to employers as a form of employer-sponsored coverage. As explained in section I.C of this preamble, there is no provision excluding STLDI from the Federal definition of group health insurance coverage.¹⁵⁴ Thus, any health insurance that is sold to or through a group trust or association in connection with a group health plan and which purports to be STLDI would in fact be group health insurance coverage that must comply with the Federal consumer protections and requirements for comprehensive coverage applicable to the group market.

The Departments are not proposing any policies or policy changes specific to STLDI sold through associations, but request comments on what steps, if any, can be taken to support State oversight of STLDI sold to or through associations.

6. Applicability Dates

In 26 CFR 54.9833-1, 29 CFR 2590.736, and 45 CFR 146.125 and 148.102, the Departments propose applicability dates for the proposed amendments to the Federal definition of STLDI that distinguishes between new and existing STLDI. The Departments also propose a technical amendment to 26 CFR 54.9833-1, 29 CFR 2590.736, and 45 CFR 146.125 to remove outdated language that

references revisions to 45 CFR parts 144 and 146 that became effective on October 1, 2004 but were superseded by subsequent revisions that became effective on July 1, 2005. The Departments propose the technical amendment would apply to all coverage (that is, both new and existing STLDI) as of the effective date of the final rules.

For new STLDI sold or issued on or after the effective date of the final rules, the amendments to the definition of STLDI would apply for coverage periods beginning on or after such date. The Departments are of the view that timely implementation of the new Federal definition of STLDI, including both the maximum duration and revised notice provisions, for new coverage sold or issued on or after the effective date of the final rules, is critical to maximize the number of individuals benefiting from the consumer protections described throughout this preamble. This proposal would prevent delays in implementation of the new Federal definition of STLDI, while providing a sufficient transition period for interested parties to implement the new definition for new coverage sold on or after the effective date of the final rules.

However, for STLDI sold or issued before the effective date of the final rules (including any subsequent renewal or extension consistent with applicable law), the current Federal definition of such coverage would continue to apply with respect to the maximum allowable duration. Therefore, existing STLDI could continue to have an initial contract term of less than 12 months and a maximum duration of up to 36 months (taking into account any renewals or extensions), subject to any limits under applicable State law. The Departments propose this applicability date with respect to the maximum allowable duration for existing STLDI (including renewals and extensions) to minimize disruption for individuals who purchased or were enrolled in STLDI prior to the effective date of the final rules.

¹⁵¹ See U.S. House of Representatives Committee on Energy and Commerce (2020). "Shortchanged: How the Trump Administration's Expansion of Junk Short-Term Health Insurance Plans Is Putting Americans at Risk," available at: <https://democrats-energycommerce.house.gov/newsroom/press-releases/ec-investigation-finds-millions-of-americans-enrolled-in-junk-health>.

¹⁵² Curran, Emily, Dania Palanker, and Sabrina Corlette (2019). "Short-term Plans Sold Through Out-of-State Associations Threaten Consumer Protections," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2019/short-term-health-plans-sold-through-out-state-associations-threaten-consumer-protections>.

¹⁵³ 45 CFR 144.102(c).

¹⁵⁴ See section 2791(b)(5) of the PHS Act, which excludes STLDI from the definition of "individual health insurance coverage."

The Departments recognize that consumers already enrolled in STLDI may have anticipated having the option of continuing such coverage for a given period of time, consistent with the current rules. The proposal to permit such individuals to remain covered under STLDI for the maximum initial contract term, as well as for renewals and extensions to the extent permitted under the current regulations, subject to any limits under applicable State law, would promote continuous enrollment in coverage and ensure that these consumers have adequate time to transition to comprehensive coverage.

The Departments propose that the amendments to the notice provision at paragraph (2) of the definition of “short-term, limited-duration insurance” in 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 would apply for coverage periods beginning on or after the effective date of the final rules, regardless of whether the coverage was sold or issued before, on, or after the effective date of the final rules.¹⁵⁵ The Departments are of the view that the benefit to consumers, including those currently enrolled in STLDI, of a timely notice update outweighs the burden to issuers of implementing these changes by the effective date of the final rules. Given that the updates to the notice are aimed at alerting consumers to the differences between comprehensive coverage and STLDI and providing consumers with the information necessary to make an informed decision about their coverage options, a delayed applicability date of the proposed changes to the notice could result in unnecessary harm to consumers.

The Departments seek comments on whether the proposed revised notice should apply to only new STLDI or should apply to both new STLDI and existing coverage upon renewal or extension, and whether the application of the proposed revised notice to existing STLDI should instead be delayed until January 1, 2025,

or some other date. The Departments seek comments on whether all STLDI policies and any renewals or extensions of such coverage, including existing coverage sold or issued prior to the effective date of the final rules, should instead end upon the effective date of the final rules or some other date. The Departments also seek comments on whether an applicability date that would provide a longer transition period for consumers with policies, certificates, or contracts of STLDI sold or issued before the effective date of the final rules could help alleviate any potential market disruption; for example, allowing consumers to renew existing coverage for an additional 12-month period after any renewals under their original coverage are exhausted. The Departments also seek comments on whether it would be more reasonable for all STLDI policies and any renewals or extensions of such coverage in effect before the date the final rules are published to end before January 1, 2025, or some other date.

7. Severability

In the event that any portion of the final rules implementing one or more proposals in these proposed rules is declared invalid or unenforceable, by its terms or as applied to any entity or circumstance, or stayed pending further agency action, the Departments intend that the proposed amendments to the definition of “short-term, limited-duration insurance” be severable, and that the proposed amendments to the definition of “short-term, limited-duration insurance” in 26 CFR 54.9801-2, 29 CFR 2590.701-2, and 45 CFR 144.103 would continue even if one or more aspects of the proposed changes is found invalid. To capture this intent, the Departments propose to add a severability provision to the proposed amended definition of “short-term, limited-duration insurance” at 26 CFR 54.9801-2, 29

CFR 2590.701-2, and 45 CFR 144.103. The severability of these provisions is discussed in more detail in section VI of this preamble.

B. Independent, Noncoordinated Excepted Benefits Coverage

1. Fixed Indemnity Excepted Benefits Coverage

As described in section I.D of this preamble, Congress identified various types of excepted benefits, each of which is not subject to the Federal consumer protections and requirements for comprehensive coverage.¹⁵⁶ In so doing, Congress established an exemption for those types of coverage that offer more limited and narrow benefits than comprehensive coverage.¹⁵⁷ Insurance that pays a fixed amount under specified conditions without regard to other insurance (that is, “hospital indemnity or other fixed indemnity insurance”) is considered an excepted benefit if offered on an independent, noncoordinated basis, and such insurance coverage is exempt from Federal consumer protections and requirements for comprehensive coverage.¹⁵⁸

In order to address reports of troubling marketing and sales tactics and the creation of new benefit designs that mislead consumers to believe that hospital indemnity or other fixed indemnity insurance constitutes comprehensive coverage,¹⁵⁹ as well as the changes in market conditions and in the legal landscape that have taken place since the last regulatory activity on this coverage (discussed in sections I and II of this preamble), the Departments are proposing amendments to the Federal regulations at 26 CFR 54.9831-1(c)(4), 29 CFR 2590.732(c)(4), and 45 CFR 146.145(b)(4) that outline the conditions for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit in the group

¹⁵⁵ As noted above, the proposed revised notice would also apply to new STLDI coverage for coverage periods beginning on or after the effective date of the final rules.

¹⁵⁶ See sections 9831(b) – (c) and 9832(c) of the Code, sections 732(b) – (c) and 733(c) of ERISA, and sections 2722(b) – (c), 2763 and 2791(c) of the PHS Act.

¹⁵⁷ See Interim Rules for Health Insurance Portability for Group Health Plans; Interim Rules, 62 FR 16894, 16903 (April 8, 1997).

¹⁵⁸ See sections 9831(b) – (c) and 9832(c) of the Code, sections 732(b) – (c) and 733(c) of ERISA, and sections 2722(c)(2), 2763(b) and 2791(c)(3)(B) of the PHS Act. See also 26 CFR 54.9831-1(c)(4), 29 CFR 2590.732(c)(4), 45 CFR 146.145(b)(4), and 45 CFR 148.220(b)(4).

¹⁵⁹ See, e.g., Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Coverage is a Problematic Form of “Junk” Insurance,” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>. See also Partnership to Protect Coverage (2021). “Under-Covered: How ‘Insurance-Like’ Products are Leaving Patients Exposed,” available at: https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Undercovered_Report_03252021.pdf.

market. HHS is also proposing several amendments to the regulation at 45 CFR 148.220(b)(4) that outline the conditions for such insurance to qualify as excepted benefits coverage in the individual market. These proposals would provide greater clarity regarding what it means for fixed indemnity excepted benefits coverage to be offered on an “independent, noncoordinated” basis and to provide benefits in a “fixed” amount, consistent with the statutory purpose of exempting this type of coverage from the Federal consumer protections and requirements for comprehensive coverage.

Specifically, HHS proposes to require that fixed indemnity excepted benefits coverage in the individual market must provide benefits that are paid only on a per-period basis. This change to the HHS individual market regulations for excepted benefits would align the standard for individual market fixed indemnity excepted benefits coverage with the Departments’ current group market regulations for such coverage.¹⁶⁰

Additionally, the Departments propose to amend the group market regulations for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit, including proposing new standards governing the payment of fixed benefits and examples to clarify these new proposed standards. HHS similarly proposes to amend the standards governing the payment of fixed benefits under such coverage in the individual market. The Departments further propose to add a new example to the group market regulations to address the prohibition on coordination between fixed indemnity excepted benefits coverage and any group health plan maintained by the same plan sponsor. This example illustrates the

Departments’ proposed interpretation of the “noncoordination” requirements for hospital indemnity or other fixed indemnity coverage to qualify as excepted benefits and the extension of this interpretation to situations that do not involve a formal coordination-of-benefits arrangement. HHS similarly proposes to apply this interpretation of the “noncoordination” requirement to individual market fixed indemnity excepted benefits coverage. As detailed in section III.B.1.e of this preamble, HHS further proposes to modify the requirement at current 45 CFR 148.220(b)(4)(ii) to align with the statutory requirement that “noncoordinated, excepted benefits” in the individual market be provided without regard to whether benefits are provided under any health insurance coverage maintained by the same health insurance issuer.^{161, 162}

The Departments also propose to require a consumer notice be provided when offering fixed indemnity excepted benefits coverage in the group market, in alignment with the existing requirement to provide such a notice in connection with fixed indemnity excepted benefits coverage offered in the individual market. HHS also proposes changes to the consumer notice that must be provided when offering fixed indemnity excepted benefits coverage in the individual market.¹⁶³

These proposed changes are generally intended to more clearly distinguish fixed indemnity excepted benefits coverage from comprehensive coverage in order to reduce confusion and misinformation related to fixed indemnity excepted benefits coverage, increase consumers’ understanding of their health coverage options, and provide more information to support consumers in making informed coverage purchasing decisions. In addition, as noted

in section II.B of this preamble, the recent experience with the COVID-19 PHE has highlighted the value of a framework that encourages individuals to enroll in comprehensive coverage and also prompted the Departments to examine the Federal regulations governing fixed indemnity excepted benefits coverage. The proposed amendments are also designed to align the fixed indemnity excepted benefits coverage regulations across the individual and group markets when practical and appropriate and clarify the conditions applicable to fixed indemnity excepted benefits coverage for all interested parties, including consumers, issuers, employers, agents, brokers, and State regulators.

a. Per-Period Basis Fixed Payment Standard

HHS proposes to amend 45 CFR 148.220(b)(4) to reinstate the condition that to qualify as an excepted benefit in the individual market, hospital indemnity or other fixed indemnity insurance must pay fixed benefits only on a per-period basis and to remove the current option for such coverage to pay fixed benefits on a per-service basis.¹⁶⁴ As proposed, HHS would move the fixed payment standard currently captured in 45 CFR 148.220(b)(4)(iii) to a new proposed paragraph at 45 CFR 148.220(b)(4)(ii) and revise it to require that benefits are paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, \$100/day).¹⁶⁵

Fixed indemnity excepted benefits coverage is intended to serve as a source of income replacement or financial support, paying benefits at a fixed amount per qualifying medical event. This type of coverage is not comprehensive coverage, and

¹⁶⁰ See 26 CFR 54.9831-1(c)(4)(i), 29 CFR 2590.732(c)(4)(i), and 45 CFR 146.145(b)(4)(i).

¹⁶¹ See section 2722(c)(2)(C) of the PHS Act.

¹⁶² As discussed in section III.B.1.f of this preamble, HHS is also proposing a technical amendment to redesignate 45 CFR 148.220(b)(4)(ii) as 45 CFR 148.220(b)(4)(i).

¹⁶³ The consumer notice for individual market fixed indemnity excepted benefits coverage is currently codified at 45 CFR 148.220(b)(4)(iv). If HHS finalizes the proposed amendments to the individual market fixed indemnity excepted benefit regulation as proposed, the individual market consumer notice would be revised and moved to 45 CFR 148.220(b)(4)(iii). See section III.B.1.d of this preamble for more details.

¹⁶⁴ As discussed further in section III.B.1.b of this preamble, HHS proposes other amendments to the new proposed paragraph at 45 CFR 148.220(b)(4)(ii) to capture the proposed new additional payment standards for hospital indemnity or other fixed indemnity insurance to qualify as excepted benefits. As part of other amendments to 45 CFR 148.220(b), HHS also proposes to revise and move the consumer notice requirement applicable to individual market fixed indemnity excepted benefits coverage. See section III.B.1.d of this preamble for further details. As part of other technical and conforming amendments to the individual market regulation, HHS also proposes to move and modify the existing individual market “noncoordination” standard from its current location at 45 CFR 148.220(b)(4)(ii) to 45 CFR 148.220(b)(4)(i). See section III.B.1.e and III.B.1.f of this preamble for further details.

¹⁶⁵ As discussed further in section III.B.1.b of this preamble, HHS proposes other amendments to the new proposed paragraph at 45 CFR 148.220(b)(4)(ii) to capture the proposed new additional payment standards for hospital indemnity or other fixed indemnity insurance to qualify as excepted benefits.

benefit payments under fixed indemnity excepted benefits coverage are paid without regard to the actual amount of expenses incurred by a covered individual.¹⁶⁶ HHS is of the view that hospital indemnity or other fixed indemnity insurance products made available in the individual market that closely resemble comprehensive coverage, by incorporating features typically included in comprehensive coverage, obscure the difference between fixed indemnity excepted benefits coverage and comprehensive coverage. 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 potential 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. Because fixed indemnity excepted benefits coverage typically provides benefits that are far below actual medical expenses, individuals who rely on this type of coverage as their primary form of health insurance are at risk of financial harm.¹⁶⁷

Significant legal and market developments since the 2014 final rule was published have altered the landscape in which fixed indemnity excepted benefits coverage is marketed and sold to consumers.¹⁶⁸ The Departments are of the view that these changes have increased the likelihood that individual market consumers may purchase fixed indemnity excepted benefits coverage as a substitute for comprehensive coverage, rather than as a form of income replacement or financial support that supplements comprehensive coverage. Therefore, these changes have also altered the balance that HHS intended to achieve with the amendments

to the individual market fixed indemnity excepted benefits coverage regulation in its 2014 final rule.

In addition to these changes, HHS has observed concerning trends in how fixed indemnity excepted benefits coverage in the individual market is designed and marketed. As noted in the preamble to the 2014 proposed rule, hospital indemnity or other fixed indemnity insurance policies that pay benefits on a “per-service” basis have been widely available in the individual market for many years, including prior to the 2014 final rule, in part because many State regulators determined that consumers valued the ability to purchase per-service hospital indemnity or other fixed indemnity insurance to complement MEC, emphasizing its value as a supplement to (rather than a replacement for) comprehensive coverage.¹⁶⁹ Since the 2014 final rule was finalized, however, HHS has seen products marketed and sold in the individual market as fixed indemnity excepted benefits coverage with features that make the products more closely resemble comprehensive coverage than traditional forms of fixed indemnity excepted benefits coverage, but without many of the required consumer protections of comprehensive coverage.

For example, some issuers now offer individual market fixed indemnity policies that pay benefits on the basis of extensive, variable schedules with tens or hundreds of thousands of different benefit amounts that vary by item or service.¹⁷⁰ Some benefits associated with particular items and services appear to be based on Medicare fee-for-service or Diagnosis Related Group (DRG) service descriptions.¹⁷¹ Some marketing materials claim that benefits are based on “relative value units,” an apparent reference to an element of Medicare’s physician fee schedule

formula, and that exact benefits will vary by the Current Procedural Terminology® (CPT) code submitted by the health care provider furnishing the relevant service, suggesting that benefit levels are based on either actual or estimated costs of care. Benefits under this coverage might be provided related to the receipt of items and services outside the scope of a traditional understanding of “hospitalization or illness,” such as preventive cancer screenings, pediatric vaccines, or wellness visits, which further increases the likelihood that a consumer could confuse the coverage with comprehensive coverage.

Common benefit designs for individual market fixed indemnity coverage include fixed benefit schedules (for example, \$50 per office visit, \$100 per surgical procedure, or \$20 per generic prescription), payments made on a percentage basis up to a cap that might itself vary based on benefit category (for example, 25 percent of a fixed amount for a hospitalization, capped at \$5,000), or on the basis of “tiers” of complexity (for example, \$500 for a lower-complexity “Tier 7” surgery such as a tonsillectomy or up to \$50,000 for a major organ transplant categorized as a “Tier 1” procedure). Some issuers of hospital indemnity or other fixed indemnity insurance in the individual market advertise the availability of a network of providers that accept a lower rate of reimbursement. Additionally, some hospital indemnity or other fixed indemnity insurance pay benefits directly to the health care provider or facility that furnished services to the covered individual, rather than directly to the policyholder (as would be expected if the benefits were actually functioning as income replacement or a supplement to comprehensive coverage).¹⁷² In this manner, these policies operate in a way that is similar to the way in which plans and

¹⁶⁶ 26 CFR 54.9831-1(c)(4)(i), 29 CFR 2590.732(c)(4)(i), 45 CFR 146.145(b)(4)(i), and; 45 CFR 148.220(b)(4)(iii).

¹⁶⁷ See Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Coverage is a Problematic Form of ‘Junk’ Insurance,” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>.

¹⁶⁸ See discussion elsewhere in this preamble (for example, in sections I.A, I.D.1 and II of this preamble) related to such developments, including the enactment of the Tax Cuts and Jobs Act and the decision in *Central United Life v. Burwell*.

¹⁶⁹ National Association of Insurance Commissioners (2013). “Letter to Secretaries of Labor, Treasury, and Health and Human Services,” available at: <https://naic.soutrnglobal.net/Portal/Public/en-GB/RecordView/Index/23541>.

¹⁷⁰ See Appleby, Julie (2021). “New Health Plans Offer Twists on Existing Options, With a Dose of ‘Buyer Beware,’” KFF Health News, available at: <https://khn.org/news/article/new-health-plans-offer-twists-on-existing-options-with-a-dose-of-buyer-beware>.

¹⁷¹ Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Coverage is a Problematic Form of ‘Junk’ Insurance,” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>.

¹⁷² See section III.B.1.c of this preamble for a discussion of the Departments’ concerns with respect to benefit designs for hospital indemnity or other fixed indemnity insurance that provides direct reimbursement to health care providers and facilities.

issuers frequently reimburse providers under comprehensive coverage.

Therefore, to limit the practice of designing complex, fee-for-service style fixed indemnity plans that are marketed and sold as an alternative to comprehensive coverage, HHS proposes to reinterpret what it means for hospital indemnity or other fixed indemnity insurance to provide “fixed” benefits in the individual market and remove the language that permits individual market fixed indemnity excepted benefits coverage to provide fixed benefits on a per-service basis. HHS also proposes to update the parenthetical reference that captures the allowance for issuers to provide fixed benefits per other period, to refer to per other “time” period, to further emphasize the prohibition on providing benefits on a per-service or per-item basis. To implement these changes, HHS proposes to move the current fixed payment standard from 45 CFR 148.220(b)(4)(iii) to a new proposed paragraph at 45 CFR 148.220(b)(4)(ii) and revise it to require that benefits are paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, \$100/day).¹⁷³

Under this proposal, issuers may offer coverage similar to hospital indemnity or other fixed indemnity insurance that pays benefits on a per-service basis, subject to applicable State law requirements, but under Federal law these plans would not be considered excepted benefits and would be required to comply with the Federal consumer protections and requirements for comprehensive coverage.

HHS seeks comments on these proposed changes. In particular, HHS seeks comments on how the proposed amendment to require individual market fixed indemnity excepted benefits coverage to pay fixed benefits only on a per-period

basis may affect consumers’ ability to make an informed choice regarding health insurance options and how it may impact affordability or access to health coverage or care.

b. Additional Fixed Payment Standards

The Departments propose to amend the group market fixed indemnity excepted benefits coverage provisions at 26 CFR 54.9831-1(c)(4), 29 CFR 2590.732(c)(4), and 45 CFR 146.145(b)(4) to recodify existing payment standards and to establish additional standards related to the payment of benefits under fixed indemnity excepted benefits coverage in the group market. These proposals are intended to provide greater clarity and reduce the potential for consumers to mistakenly enroll in excepted benefits coverage as a replacement for or alternative to comprehensive coverage by further interpreting what it means for hospital indemnity or other fixed indemnity insurance to provide “fixed” benefits.

Specifically, these proposed rules provide that to be hospital indemnity or other fixed indemnity insurance that qualifies as an excepted benefit in the group market, the benefits must also meet each of the additional fixed payment standards specified in new proposed 26 CFR 54.9831-1(c)(4)(ii)(D)(I), 29 CFR 2590.731-1(c)(4)(ii)(D)(I), and 45 CFR 146.145(b)(4)(ii)(D)(I).¹⁷⁴ These new proposed rules would retain and amend¹⁷⁵ the existing per-period fixed payment standard to require that benefits under hospital indemnity or other fixed indemnity insurance be paid as a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, \$100 day) regardless of the amount of expenses incurred.¹⁷⁶ In doing so, these proposed rules would require that

benefits be offered as “fixed” amounts, align with the statutory condition that the coverage be offered on a noncoordinated basis,¹⁷⁷ and distinguish fixed indemnity excepted benefits coverage from coverage for actual health care costs incurred or services received. These proposed rules thus reflect that fixed indemnity excepted benefits coverage is intended to offer income replacement or financial support for medical expenses not covered by comprehensive coverage or for non-medical related expenses in the event of an unexpected or serious health event.

Rather than transferring risk for health care costs from a participant, beneficiary, or enrollee to the issuer or plan sponsor or otherwise providing comprehensive coverage, fixed indemnity excepted benefits coverage is intended to provide a fixed, pre-determined level of cash benefits. These benefits payments are made upon the occurrence of a health-related event, such as a period of hospitalization or illness, but are otherwise unrelated to expenses incurred or health care services received. Coverage that varies benefits based on health care costs, services received, or benefits paid under other forms of coverage does not provide the kind of “fixed” benefits that are fixed indemnity excepted benefits exempt from the Federal consumer protections and requirements for comprehensive coverage.

The Departments therefore propose to expand the existing payment standards for group market fixed indemnity excepted benefits coverage to further interpret what it means to provide “fixed” benefits. The Departments also propose to require that benefits under fixed indemnity excepted benefits coverage in the group market be paid regardless of the actual or estimated amount of expenses incurred, services or items received, severity of illness or

¹⁷³ As discussed in section III.B.1.b of this preamble, HHS proposes other amendments to the new proposed paragraph at 45 CFR 148.220(b)(4)(ii) to capture the proposed new additional payment standards for hospital indemnity or other fixed indemnity insurance to qualify as excepted benefits in the individual market.

¹⁷⁴ To qualify as excepted benefits coverage in the group market, hospital indemnity or other fixed indemnity insurance would continue to be required to satisfy each of the conditions currently captured in 26 CFR 54.9831-1(c)(4)(ii)(A)-(C), 29 CFR 2590.731-1(c)(4)(ii)(A)-(C), and 45 CFR 146.145(b)(4)(ii)(A)-(C). If these proposed rules are finalized as proposed, the issuer would also be required to comply with the consumer notice requirements in new proposed 26 CFR 54.9831-1(c)(4)(ii)(D)(2)-(4), 29 CFR 2590.731-1(c)(4)(ii)(D)(2)-(4), and 45 CFR 146.145(b)(4)(ii)(D)(2)-(4).

¹⁷⁵ Similar to the individual market fixed indemnity excepted benefits coverage regulation, the Departments propose to update the parenthetical reference that captures the allowance for plans and issuers to provide fixed benefits per other period to refer to per other “time” period, to further emphasize the prohibition on providing benefits on a per-service or per-item basis.

¹⁷⁶ 26 CFR 54.9831-1(c)(4)(i), 29 CFR 2590.731-1(c)(4)(i), and 45 CFR 146.145(b)(4)(i).

¹⁷⁷ Section 9832(c)(3) of the Code, section 733(c)(3) of ERISA, and section 2791(c)(3) of the PHS Act. See also section 9831(c)(2) of the Code, section 732(c)(2) of ERISA, and sections 2722(c)(2) and 2763(b) of the PHS Act.

injury experienced by a covered participant or beneficiary, or any other characteristics particular to a course of treatment received by a covered participant or beneficiary. The Departments further propose to amend the group market fixed indemnity excepted benefit regulations to affirm that benefits cannot be paid on any other basis (such as on a per-item or per-service basis). The Departments propose to set forth these new payment standards for group market fixed indemnity excepted benefits coverage at 26 CFR 54.9831-1(c)(4)(ii)(D)(I), 29 CFR 2590.732(c)(4)(ii)(D)(I), and 45 CFR 146.145(b)(4)(ii)(D)(I). HHS proposes parallel amendments to similarly expand the payment standards for individual market fixed indemnity excepted benefits coverage in 45 CFR 148.220(b)(4)(ii). These new proposed payment standards are designed to further distinguish fixed indemnity excepted benefits coverage from comprehensive coverage, in order to reduce the potential for consumer confusion that can result in consumers mistakenly enrolling in hospital indemnity or other fixed indemnity insurance as a replacement for or alternative to comprehensive coverage. Additionally, these proposals would ensure that hospital indemnity or other fixed indemnity insurance that qualifies as excepted benefits is providing benefits in a “fixed” amount per-day or per other time period.

These proposals also would help to prevent attempts to circumvent otherwise applicable Federal consumer protections and requirements for comprehensive coverage by labeling a policy that provides extensive benefits that vary based on expenses incurred, services or items received, or other clinical or diagnostic criteria as fixed indemnity excepted benefits coverage.¹⁷⁸ The Departments are aware of some policies sold as hospital indemnity or other fixed indemnity insurance in the group market that appear to label benefits as though they are being paid on a “per-period” basis, when benefits are effectively based on the types of services or items received. For example, a policy may provide a fixed payment of

\$25 “per day” that a participant or beneficiary fills a prescription, receives a medical exam, or undergoes a wellness screening. In these cases, the benefit is effectively provided on a per-service basis because typically an individual does not fill a prescription or receive a medical exam or wellness screening more than once per day; therefore, merely affixing “per day” (or per other period) to the benefit description does not serve to limit payment to a per-period benefit in any meaningful sense.

In addition, some issuers offering these policies pay benefits according to a “tiered” payment schedule under which the benefit amount increases (or decreases) based on the severity of the participant’s, beneficiary’s, or enrollee’s condition or the complexity of a service or item received, with exact benefit amounts based on the relative value unit for the exact service code for the service or item provided. Similarly, a structure that provides higher benefit amounts as a result of a covered individual taking air versus ground transportation services represents another example of a benefit and payment structure for hospital indemnity or other fixed indemnity insurance that varies based on actual costs or estimated cost of services or severity of the illness, injury or condition of a covered participant or beneficiary.

The Departments are of the view that these benefit designs and practices circumvent the requirement that fixed indemnity excepted benefits coverage provide benefits on a fixed, per-period basis. The proposed regulatory amendments and changes to the interpretation of what it means to provide benefits in a “fixed” amount, particularly the proposal that benefits be paid without regard to items or services received, would further safeguard against practices designed to evade the existing per-period requirement in the group market and would strengthen the proposed parallel requirement in the individual market. The proposed update to the parenthetical reference in new proposed 26 CFR 54.9831-1(c)(4)(ii)(D)(1), 29 CFR 2590.732(c)(4)(ii)(D)(1), and 45

CFR 146.145(b)(4)(ii)(D)(1) that captures the allowance for plans and issuers to provide fixed benefits per other period, to refer to per other “time” period, further emphasizes the prohibition on providing benefits on a per-service or per-item basis. Additionally, the proposed new example at 26 CFR 54.9831-1(c)(4)(iv)(B), 29 CFR 2590.732(c)(4)(iv)(B), and 45 CFR 146.145(b)(4)(iii)(B), and discussed elsewhere in this preamble section, specifically provides that merely appending a “per day” (or per other time period) label to a benefit that is being paid on the basis of the provision of an item or service does not meet the requirement that fixed indemnity excepted benefits coverage provide benefits on the basis of a period of hospitalization or illness.

The Departments will closely examine as part of potential enforcement actions whether any product offered as fixed indemnity excepted benefits coverage in the group market that claims to provide benefits per day (or other period) of hospitalization or illness is in effect making payment on any other basis, such as a per-service or per-item basis, for example, by simply affixing a “per day” term to benefits offered that are related to the receipt of specific items and services. HHS will take a similar approach with respect to products offered as fixed indemnity excepted benefits in the individual market if the proposal to require that individual market fixed indemnity excepted benefits be paid only on a per-period basis is finalized.

In addition, some interested parties have suggested that a fixed indemnity plan that pays benefits on a per-service schedule is paying benefits regardless of the amount of expenses incurred if the plan does not vary benefits based on the actual amounts charged for services received. However, varying benefits based on items or services increases the risk that consumers will confuse fixed indemnity excepted benefits coverage with comprehensive coverage, undermining a central reason for exempting this type of coverage from the Federal consumer protections and requirements for comprehensive

¹⁷⁸ When analyzing whether a policy, certificate, or contract of insurance is subject to the federal consumer protections and requirements for comprehensive coverage, the Departments look past the label used, to examine whether the policy, certificate, or contract of insurance meets applicable requirements or conditions to qualify as an excepted benefit, or whether it is comprehensive coverage that is subject to the federal consumer protections and requirements applicable to such coverage.

coverage. The provisions of these proposed rules to require that fixed indemnity excepted benefits coverage pay benefits in a fixed amount regardless of the actual or estimated amount of expenses incurred, services or items received, or severity of illness or injury experienced would help further distinguish fixed indemnity excepted benefits coverage from comprehensive coverage, mitigate the potential for consumers to confuse the two types of coverage, and thereby reduce the risk that a consumer would enroll in fixed indemnity excepted benefits coverage as a replacement for or alternative to comprehensive coverage.

The Departments are also considering whether the requirement that hospital or other fixed indemnity insurance pay a fixed dollar amount “per day (or per other period) of hospitalization or illness” in the group market regulations¹⁷⁹ should be interpreted as a requirement that benefits be paid on the basis of an actual period of time during which a covered individual experiences a qualifying period of hospitalization or illness (subject to the terms of the contract) in order to qualify as an excepted benefit. Under this interpretation, hospital or fixed indemnity insurance that pays a fixed dollar benefit on a per-period basis but not specifically related to a period of “hospitalization or illness” – such as \$50 per day that an individual receives one or more specified screening tests – would not qualify as fixed indemnity excepted benefits. For example, benefit payments that are provided solely on the basis of the receipt of a surgical service or medical exam rather than a period of time during which a covered individual is hospitalized or experiences an illness would not qualify as fixed indemnity excepted benefits under the approach the Departments are considering.

The Departments seek comment on this interpretation, including how adopting this approach would affect existing products that are sold and marketed as fixed indemnity excepted benefits coverage and how such an interpretation would

enhance or detract from consumer access to high-quality, affordable health care. HHS similarly requests comment on the effects of applying this interpretation of the phrase “per day (or per other period) of hospitalization or illness” in the individual market regulation at 45 CFR 148.220(b)(ii),¹⁸⁰ if the proposal to require that individual market fixed indemnity excepted benefits be paid only on a per-period basis is finalized and the Departments finalize this additional interpretation of what it means to provide benefit payments in a “fixed” amount.

Finally, the Departments propose to amend the payment standards for fixed indemnity excepted benefits coverage to require that benefits be paid in a fixed amount regardless of any other characteristics particular to a course of treatment received by the covered participant or beneficiary. This standard is proposed as part of the proposed new payment standards in the group market regulations at 26 CFR 54.9831-1(c)(4)(ii)(D)(1), 29 CFR 2590.732(c)(4)(ii)(D)(1), and 45 CFR 146.145(b)(4)(ii)(D)(1). For purposes of this proposal, a “course of treatment” refers to a coordinated series of items or services intended to treat a particular health condition over a fixed period of time or indefinitely, pursuant to a plan of care established and managed by a health care professional or team of health care professionals. For example, an oncologist may establish a course of treatment for an individual with a cancer diagnosis that includes a sequence of surgery, chemotherapy, and radiation, scheduled to begin and end over a set period of months; or a psychiatrist and therapist may work together to establish a course of treatment for an individual with a chronic mental health condition that includes prescription medication and group and individual talk therapy on an ongoing basis without a specified end date.

Because a course of treatment is a set of coordinated services, interpreting “fixed” benefits to exclude payments based on a course of treatment is aligned

with and strengthens the proposal to require that benefits be paid regardless of items or services received. Such interpretation also prevents plans and issuers of hospital indemnity or other fixed indemnity insurance from basing payment on a set of multiple items or services, thereby circumventing the requirement that payment not be based on items or services received. It is similarly aligned with the proposals to require that benefits be paid regardless of actual or estimated cost of services and regardless of the severity of illness or injury. Additionally, consumers are more likely to have difficulty distinguishing between comprehensive coverage and fixed indemnity excepted benefits coverage that adopts such benefit designs and are therefore more likely to enroll in fixed indemnity excepted benefits coverage under the mistaken belief that it is a suitable replacement for or alternative to comprehensive coverage.

The Departments are concerned about the practice among some issuers, employers, agents, brokers, and associations of offering fixed indemnity excepted benefits coverage as a package in combination with other products (including other excepted benefits) in order to appear to provide comprehensive coverage.¹⁸¹ In addition, as discussed in section III.B.1.e of this preamble, the Departments are concerned about the practice among some employers and issuers of presenting a group health plan that includes only limited benefits coupled with an extensive fixed indemnity policy. In light of the potential harm to consumers who may enroll in fixed indemnity excepted benefits coverage under the mistaken impression that they have access to comprehensive coverage because it was paired with a limited employer-sponsored group health plan, the Departments are of the view that prohibiting fixed indemnity excepted benefits coverage from paying benefits on the basis of a course of treatment would further reduce the risk that this coverage would be packaged with other forms of coverage to circumvent Federal consumer protections and requirements

¹⁷⁹ 26 CFR 54.9831-1(c)(4)(i), 29 CFR 2590.731-1(c)(4)(i), and 45 CFR 146.145(b)(4)(i).

¹⁸⁰ As discussed in section III.B.1.f of this preamble, HHS is also proposing a technical amendment to redesignate 45 CFR 148.220(b)(4)(ii) as 45 CFR 148.220(b)(4)(i).

¹⁸¹ Palanker, Dania and Kevin Lucia (2021). “Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk,” Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk>.

for comprehensive coverage. Therefore, the Departments propose to adopt a new interpretation of what it means for fixed indemnity excepted benefits coverage to provide “fixed” benefits and require such coverage to also pay benefits in a “fixed” amount that does not vary based on the characteristics particular to a course of treatment received by a covered participant or beneficiary. The Departments seek comments on whether this proposal is a necessary complement to the other additional fixed payment standards in these proposed rules.

The Departments also propose including a new example (Example 2) in the group market regulations, at new proposed 26 CFR 54.9831-1(c)(4)(iv)(B), 29 CFR 2590.732(c)(4)(iv)(B), 45 CFR 146.145(b)(4)(iii)(B), to illustrate the requirement that fixed indemnity excepted benefits coverage in the group market must pay a fixed dollar amount per day (or per other period) of hospitalization or illness. This proposed example would also illustrate the new payment standards proposed in these rules that fixed indemnity excepted benefits coverage in the group market pay benefits without regard to services received. This new example describes a group health plan or health insurance issuer offering coverage through an insurance policy that provides benefits related to the receipt of specific items and services in a fixed amount, such as \$50 per blood test or \$100 per visit. The example concludes that the policy would not qualify as fixed indemnity excepted benefits coverage, because the benefits are not paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness. The proposed example also explains that the conclusion would be the same even if the policy added a per day (or per other time period) term to the benefit description, such as “\$50 per blood test per day,” because the benefits are not paid regardless of the services or items received. The Departments also propose to retain, while making technical and conforming amendments to, the existing example (which the Departments propose

to designate as Example 1) in the group market rules.¹⁸²

HHS also proposes parallel amendments to the individual market fixed indemnity excepted benefits coverage regulation at new proposed 45 CFR 148.220(b)(4)(ii) to require that fixed indemnity excepted benefits coverage in the individual market provide benefits in a “fixed” amount regardless of the actual or estimated amount of expenses incurred, services or items received, severity of illness or injury experienced by a covered individual, or any other characteristics particular to a course of treatment received by a covered individual.

In addition, and as discussed in greater detail in section III.B.1.e of this preamble, HHS proposes to include language in new proposed 45 CFR 148.220(b)(4)(ii) to align with section 2722(c)(2)(C) of the PHS Act, which provides that benefits under fixed indemnity excepted benefits coverage in the individual market must also be paid without regard to whether benefits are provided with respect to the event under any other health insurance coverage maintained by the same health insurance issuer. HHS further proposes in new proposed 45 CFR 148.220(b)(4)(ii) to affirm that benefits cannot be paid on any other basis (such as on a per-item or per-service basis). For the same reasons as described in this section with respect to the Departments’ parallel changes to the group market regulations, HHS is of the view that these changes to the interpretation of what it means to provide benefits in a “fixed” amount are necessary to ensure that issuers of fixed indemnity excepted benefits coverage in the individual market are not able to circumvent the fixed payment standards at new proposed 45 CFR 148.220(b)(4)(ii) that the coverage be provided on a per-period basis. These proposed changes would also align the payment standards for what it means to provide “fixed” benefits across the group and individual markets and serve to further distinguish fixed indemnity excepted benefits coverage from comprehensive coverage in both markets.

The Departments request comments on all aspects of these proposed additional standards for fixed payment as they would apply to fixed indemnity excepted benefits coverage offered in the group and individual markets, as well as the proposed new example to illustrate the proposed new “fixed” payment standards. Specifically, the Departments seek comments on the effectiveness of the proposed additional fixed payment standards in furthering the Departments’ goal of differentiating fixed indemnity excepted benefits coverage from comprehensive coverage to reduce the likelihood that consumers would enroll in fixed indemnity excepted benefits coverage as an alternative to or replacement for comprehensive coverage, including feedback on each proposed payment standard. Additionally, the Departments seek comments on how the proposed payment standards, if finalized, would interact with the existing requirement that group market fixed indemnity excepted benefits coverage provide benefits on a per-period basis only, either individually or collectively, and whether the proposed payment standards would support the effectiveness of the per-period basis requirement and prevent issuers from attempting to circumvent Federal requirements. Similarly, HHS seeks comments on how the proposed additional fixed payment standards would interact with the proposed requirement that individual market fixed indemnity excepted benefits coverage offer benefits on a per-period basis only, if the per-period-only requirement were finalized, including whether the proposed additional payment standards would support the effectiveness of the proposed per-period payment standard, either individually or collectively.

c. Payments Made Directly to Providers

The Departments are aware that some hospital indemnity and other fixed indemnity insurance in the group and individual markets labeled as excepted benefits pay benefits directly to the providers or facilities providing the services or items, rather

¹⁸² The Departments propose to retain the existing example describing a group health plan that provides benefits only for hospital stays at a fixed percentage of expenses up to a maximum of \$100 a day in new proposed 26 CFR 54.9831-1(c)(4)(iv)(A), 29 CFR 2590.732(c)(4)(iv)(A), and 45 CFR 146.145(b)(4)(iii)(A). Consistent with the conclusion reflected in the Departments’ current group market regulations, even if the benefits under such a policy satisfy the other applicable conditions, because the policy pays benefits based on a percentage of expenses incurred, the policy does not qualify as excepted benefits coverage. This is the result even if, in practice, the policy pays the maximum of \$100 for every day of hospitalization.

than to the participant, beneficiary, or enrollee. These arrangements may remove participants, beneficiaries, and enrollees from the payment transaction entirely, if the benefit amount under the hospital indemnity or other fixed indemnity insurance is less than or equal to the provider's or facility's billed charges for care. In other cases, the hospital indemnity or other fixed indemnity insurance may pay benefits directly to the provider or facility as a form of reimbursement for items and services, and issue any balance of benefits to the participant, beneficiary, or enrollee after paying the provider or facility.

For example, one fixed indemnity insurance issuer provides policyholders with a debit card that allows for payment of benefits at the point of service in the form of a temporary advance of the benefits the policyholder may ultimately be eligible to receive. In these cases, the policyholder cannot access any benefit payment under the fixed indemnity insurance until the advance payment to the provider or facility is reconciled with the actual costs and a final determination of benefits is made. Other products labeled as fixed indemnity insurance advertise plan ID cards that participants, beneficiaries, or enrollees are encouraged to use to allow providers to file claims directly with the plan or third-party administrator.¹⁸³ Another fixed indemnity plan advertises that members who go to an “in-network” retail clinic or urgent care clinic for covered services for the cost of a flat “co-pay” will avoid a “balance bill,” suggesting that the fixed indemnity coverage is providing direct payment for “in-network” services.

By providing direct reimbursement for health care items and services to a provider or facility, these arrangements further obscure the differences between fixed indemnity excepted benefits coverage and comprehensive coverage. In the Departments' view, these arrangements generally are not structured in a way that would meet the current requirement in the

group market for benefits to be paid on a per-period basis or the parallel proposed requirement for the individual market. Because the amount of any payment to a provider is often based on the amount reimbursed by another plan or coverage, these arrangements may also be structured in a way that does not meet the statutory requirement that benefits be noncoordinated and paid without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor, or with respect to individual health insurance coverage, under any health insurance coverage offered by the same health insurance issuer.¹⁸⁴ The Departments are also concerned that some of these arrangements may not meet the existing requirement for fixed indemnity excepted benefits coverage to pay a fixed amount regardless of the amount of the expenses incurred.¹⁸⁵

The Departments reiterate that it is important to look past the label used on any given product to examine whether the coverage meets applicable requirements to qualify as an excepted benefit or is instead coverage that is subject to the Federal consumer protections and requirements for comprehensive coverage. The Departments will closely examine as part of enforcement actions¹⁸⁶ whether any product labeled as fixed indemnity excepted benefits coverage actually satisfies all the applicable requirements, including products that employ a design feature (as opposed to a case-by-case assignment of benefits specifically made by a covered participant, beneficiary, or enrollee) under which benefits are paid directly to health care providers and facilities rather than to the policyholder or participant. HHS intends to follow a similar approach for examining whether any given individual market product meets applicable requirements to qualify as an excepted benefit or is instead comprehensive coverage subject to the Federal

consumer protections and requirements for comprehensive coverage.

Although these proposed rules do not include policy or regulatory changes specific to the payment of benefits to providers under fixed indemnity excepted benefits coverage, the Departments seek comments on changes that interested parties think may be useful in this context. The Departments also seek comments on whether additional guidance or rulemaking is needed with respect to such payment arrangements.

d. Notice

To further ensure that consumers purchasing fixed indemnity excepted benefits coverage are aware of the limitations of the coverage and that it is not mistakenly purchased as an alternative or replacement for comprehensive coverage, the Departments propose to require that a consumer notice be provided in relation to group market fixed indemnity excepted benefits coverage.

By requiring a notice be provided to consumers considering enrolling or re-enrolling in group market fixed indemnity excepted benefits coverage, the Departments aim to reduce the potential for consumers to mistakenly enroll in hospital indemnity or other fixed indemnity insurance as their primary source of coverage and increase consumer understanding of the differences between fixed indemnity excepted benefits coverage and comprehensive coverage. As noted in section II.B of this preamble, individuals belonging to historically marginalized populations often experience greater health challenges, as well as greater challenges accessing and using health care services, compared to the general population, including worse health outcomes, higher rates of chronic conditions, lower access to health care, and more frequent experiences of discrimination in health care settings.¹⁸⁷ The Departments are

¹⁸³ Young, Christen Linke, and Kathleen Hannick (2020). “Fixed Indemnity Coverage is a Problematic Form of “Junk” Insurance,” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>.

¹⁸⁴ See section 9831(c)(2)(C) of the Code, section 732(c)(2)(C) of ERISA, and sections 2722(c)(2)(B)-(C) of the PHS Act.

¹⁸⁵ See 26 CFR 54.9831-1(c)(4)(i), 29 CFR 2590.732(c)(4)(i), 45 CFR 146.145(b)(4)(i), and 45 CFR 148.220(b)(4)(iii).

¹⁸⁶ For an overview of applicable enforcement mechanisms, see Staman, Jennifer (2020). “Federal Private Health Insurance Market Reforms: Legal Framework and Enforcement,” Congressional Research Service, available at <https://crsreports.congress.gov/product/pdf/R/R46637>.

¹⁸⁷ See CMS Office of Minority Health (2022). “The Path Forward: Improving Data to Advance Health Equity Solutions,” available at: <https://www.cms.gov/files/document/path-forward-he-data-paper.pdf>.

concerned that members of these populations may be particularly vulnerable to misinformation or misleading or aggressive sales tactics. The COVID-19 PHE amplified these longstanding inequities, resulting in disparate rates of COVID-19 infection, hospitalization, and death.¹⁸⁸ In light of these concerns, as well as research identifying disparities in health insurance literacy among certain racial and ethnic minorities and people with incomes below the FPL,¹⁸⁹ these proposals aim to ensure that all consumers, including those in underserved communities, have the necessary information to make an informed choice after considering and comparing the full range of health coverage options available to them.

The current notice requirement, which applies only in the individual market, requires that the following language be provided in application materials in at least 14-point type:

“THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.”¹⁹⁰

In order to align the notice with the changes made by the Tax Cuts and Jobs Act to section 5000A of the Code, and to clarify the message to consumers, the Departments propose to require the following consumer notice for group market fixed indemnity excepted benefits coverage:

“Notice to Consumers About Fixed Indemnity Insurance

IMPORTANT: This is fixed indemnity insurance. This **isn’t comprehensive health insurance coverage** and **doesn’t** have to include most Federal consumer protections for health insurance.

Visit 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 eligible for coverage through your employer or a family member’s employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy.”

This proposed notice would not affect any separate notice requirements under applicable State law, except to the extent that a State notice requirement would prevent application of any Federal notice requirement.

In developing the proposed notice language, the Departments sought to balance the goals of distinguishing fixed indemnity excepted benefits coverage from comprehensive coverage and combating potential sources of misinformation by directing consumers to appropriate resources to learn more about comprehensive coverage, with the need to provide a concise, understandable notice that would be meaningful to and actionable by consumers. After consulting with plain-language experts, the Departments propose to require the notice as proposed in this section of the preamble, including both the content and formatting of the notice, in order to promote readability, including requiring the notice be provided in sentence case rather than all-caps case (except for the lead-in word “IMPORTANT”) and requiring the limited use of **bold** formatting.¹⁹¹

The Departments propose to require that plans and issuers prominently display the notice (in either paper or electronic form, including on a website) in at least 14-point font, on the first page of any marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll in the coverage. For

this purpose, the Departments would consider marketing materials to include any documents or website pages that advertise the benefits or opportunity to enroll (or reenroll) in fixed indemnity excepted benefits coverage. The Departments are of the view that requiring plans and issuers offering fixed indemnity excepted benefits coverage in the group market to provide the proposed notice to participants (rather than to both participants and any beneficiaries) would appropriately balance the need to ensure that consumers who are considering whether to enroll themselves and their beneficiaries in such coverage are sufficiently informed of their health coverage options with the administrative burden on plans and issuers to provide the notice. The Departments propose to consider the notice to be prominently displayed if it would be easily noticeable to a typical consumer within the context of the page (either print or electronic) on which it is displayed (for example, using a font color that contrasts with the background of the document; ensuring the notice is not obscured by any other written or graphic content on the page; and, when displayed on a website, ensuring the notice is visible without requiring the viewer to click on a link to view the notice). Additionally, if participants are required to reenroll (in either paper or electronic form) for purposes of renewal or reissuance of the group market fixed indemnity excepted benefits coverage, the notice would be required to be displayed in the reenrollment materials that are provided to the participants at or before the time they are given the opportunity to reenroll in coverage. If a plan or issuer provides the required group market notice in accordance with the timeframes in these proposed rules, the obligation to provide the notice would be satisfied for both the plan and issuer.

HHS also proposes to revise the existing individual market consumer notice requirement to use the same content and formatting proposed to be required for the

¹⁸⁸ Moore, Jazmyn, Carolina Luna-Pinto, Heidi Cox, Sima Razi, Michael St. Louis, Jessica Ricaldi, and Leandris Liburd (2021). “Promoting Health Equity During the COVID-19 Pandemic, United States,” Bulletin of the World Health Organization, available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8795842>.

¹⁸⁹ Edward, Jean, Amanda Wiggins, Malea Hoepf Young, and Mary Kay Rayens (2019). “Significant Disparities Exist in Consumer Health Insurance Literacy: Implications for Health Care Reform,” *Health Literacy Research and Practice*, available at: <https://pubmed.ncbi.nlm.nih.gov/31768496/>. See also Villagra, Victor and Bhumika Bhuvu (2019). “Health Insurance Literacy: Disparities by Race, Ethnicity, and Language Preference,” *The American Journal of Managed Care*, available at: <https://www.ajmc.com/view/health-insurance-literacy-disparities-by-race-ethnicity-and-language-preference>.

¹⁹⁰ 45 CFR 148.220(b)(4)(iv). In these proposed rules, HHS proposes to revise and move the individual market consumer notice to 45 CFR 148.220(b)(4)(iii).

¹⁹¹ Arbel, Yonathan and Andrew Toler (2020). “ALL-CAPS,” *Journal of Empirical Legal Studies*, available at: https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3519630. (Finding that all-caps clauses in consumer contracts fail to appreciably improve consumer understanding or information recall, and may have a disproportionately harmful effect on older consumers).

group market fixed indemnity excepted benefits coverage notice and to move the individual market notice requirement to new proposed 45 CFR 148.220(b)(4) (iii). With respect to the individual market fixed indemnity excepted benefits coverage notice, HHS proposes to require that issuers prominently display the notice (in either print or electronic form) in at least 14-point font on the first page of any marketing, application, and enrollment materials that are provided at or before the time an individual has the opportunity to enroll or re-enroll in coverage, in alignment with the proposed group market notice requirements set out in this section of the preamble. For this purpose, HHS would also consider marketing materials to include any documents or website pages that advertise the benefits or opportunity to enroll (or reenroll) in fixed indemnity excepted benefits coverage. HHS further proposes that the individual market notice must also be provided on the first page of the policy, certificate, or contract of insurance, including any documents related to renewals or extensions of fixed indemnity excepted benefit coverage. Similar to the proposed group market notice requirement, the proposed individual market notice would not affect any separate notice requirements under applicable State law, except to the extent that a State notice requirement would prevent the application of any Federal notice requirement.

The Departments are proposing slightly different placement requirements with respect to the group market consumer notice compared to those proposed by HHS with respect to the individual market consumer notice. These different proposed placement requirements are intended to reflect the differences between the types of documents that consumers in the individual market typically receive when considering enrolling or reenrolling in fixed indemnity excepted benefits coverage compared to participants in the group market.

Because the group policy, certificate, or contract of insurance in the group market is often provided to the plan sponsor or the group health plan administrator, the Departments do not propose to require that plans and issuers include the consumer notice in these documents for group market fixed indemnity excepted benefits coverage. Rather, the Departments

propose to require that plans and issuers provide this notice on the first page of any marketing, application and enrollment materials (including on a website advertising or offering an opportunity to enroll in fixed indemnity excepted benefits coverage) provided to participants at or before the time they are given the opportunity to enroll. In addition, if participants are required to reenroll (in either paper or electronic form) for purposes of renewal or reissuance of group market fixed indemnity excepted benefits coverage, the notice must be displayed in all reenrollment materials that are provided to the participants at or before the time participants are given the opportunity to reenroll in coverage.

With respect to individual market fixed indemnity excepted benefits coverage, HHS proposes that issuers in the individual market also provide the notice on the first page of the policy, certificate, or contract of insurance, including renewals or extensions, because individual market consumers are likely to receive these documents upon enrollment. This is in addition to providing the notice in all marketing, application and enrollment (or reenrollment) materials for individual market excepted benefit coverage, and also includes prominently displaying the notice on websites that advertise or offer an opportunity to enroll (or reenroll) in fixed indemnity excepted benefits coverage. These proposed requirements related to notice placement are intended to ensure that the notice is provided on documents that consumers are most likely to have the opportunity to review before application, enrollment or reenrollment, based on the Departments' and HHS' understanding of how consumers receive information related to group market versus individual market fixed indemnity excepted benefits coverage.

The Departments also solicit comments on whether it would be beneficial to consumers to require plans and issuers to include some language on the notice that clearly informs consumers that the notice is an officially required document, such as "This notice is required by Federal law."

The Departments seek comments on all aspects of the proposed consumer notice for both individual and group market fixed indemnity excepted benefits coverage, including whether its language,

formatting, and placement would achieve the stated aims of informing consumers of the nature of the coverage and reducing misinformation, and whether alternative or additional language or mechanisms or timing for delivery could better accomplish these goals. For example, the Departments seek comments on whether providing more detailed information about the Federal consumer protections and requirements for comprehensive coverage versus fixed indemnity excepted benefits coverage, similar to the proposed amendments to the consumer notice for STLDI discussed in section III.A.4 of this preamble, would be valuable to consumers; and if so, what details would be most helpful to highlight for consumers and what format (such as a chart, list, or other presentation) would be most effective to convey this more detailed information.

In addition, the Departments seek comment on alternative language to convey the information in the proposed notice. The Departments offer for consideration an illustrative example. This alternative notice would include the information in the proposed notice, with simplified word choice and reduced sentence length in order to further improve readability. The Departments request feedback on which version of the notice more effectively communicates information to individuals. The text of the alternative proposed fixed indemnity excepted benefits coverage notice is as follows:

“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](https://www.healthcare.gov) online or call 1-800-318-2596 (TTY: 1-855-889-4325)
- Contact your employer or family member's employer"

Similar to the proposed consumer notice for STLDI, the Departments are also considering whether the fixed indemnity excepted benefits consumer notice should include State-specific contact language. The Departments therefore also seek comments on any benefits or burdens associated with requiring plans and issuers of fixed indemnity excepted benefits coverage to direct consumers to State-specific resources, including requiring that the notice identify the applicable State Exchange, if the fixed indemnity excepted benefits coverage is filed in a State that does not use HealthCare.gov. The Departments also seek comments on any burdens that would be created by a requirement to provide State-specific contact information for the State agency responsible for regulating fixed indemnity excepted benefits coverage in the State where the coverage is filed, rather than a generic reference to the consumer's State department of insurance, as is proposed. If the notice were finalized to require State-specific information, for products that are filed in multiple States, the Departments are considering and solicit comments on whether the notice should include the name of and the phone number for the State department of insurance of the State in which the individual to whom the fixed indemnity excepted benefits coverage is sold or marketed resides, unless the product is not filed in that State. If the product is not filed in the State in which the individual to whom the fixed indemnity excepted benefits coverage is sold or marketed resides, under this approach, if adopted, the Departments would require that the notice include the name and phone number for the department of insurance of the State in which the fixed indemnity excepted benefits coverage policy is filed.

The Departments particularly seek comments from members of underserved communities, and organizations that serve such communities, on whether the language accessibility, formatting, and content of the notice sufficiently mitigate barriers that exist to help all individuals read, understand, and consider the full

range of their health coverage options. The Departments also seek comments on the proposed requirement to provide the notice in the marketing, application, and enrollment (or reenrollment) materials for group market coverage, and in the policy, certificate, or contract of insurance, as well as in the marketing, application and enrollment (or reenrollment) materials, for individual market coverage, including the extension of the notice requirement to websites that advertise or offer the opportunity to enroll (or reenroll) in fixed indemnity excepted benefits coverage in the individual and group markets.

The Departments are also interested in comments on whether the proposed placement requirements would substantially improve the likelihood that consumers have a meaningful opportunity to review the notice and their health coverage options before applying, enrolling, or reenrolling in the fixed indemnity excepted benefits coverage, as well as any practical or logistical barriers to providing this notice requirement as proposed.

e. "Noncoordination" Requirements

To be considered excepted benefits coverage, hospital indemnity or other fixed indemnity insurance must provide benefits on an independent, noncoordinated basis.¹⁹² Thus, benefits under the coverage must be provided under a separate policy, certificate, or contract of insurance.¹⁹³ In addition, consistent with section 9831(c)(2)(B) of the Code, section 732(c)(2)(B) of ERISA, and section 2722(c)(2)(B) of the PHS Act, the group market regulations at 26 CFR 54.9831-1(c)(4)(ii)(B), 29 CFR 2590.732(c)(4)(ii)(B), and 45 CFR 146.145(b)(4)(ii)(B) prohibit coordination between the provision of benefits under fixed indemnity excepted benefits coverage and an exclusion of benefits under any group health plan maintained by the same plan sponsor. Consistent with section 9831(c)(2)(C) of the Code, section 732(c)(2)(C) of ERISA, and section 2722(c)(2)(C) of the PHS Act, the group market regulations at 26 CFR 54.9831-1(c)(4)(ii)

(C), 29 CFR 2590.732(c)(4)(ii)(C), and 45 CFR 146.145(b)(4)(ii)(C) further provide that benefits under fixed indemnity excepted benefits coverage 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.

Despite these statutory and regulatory requirements regarding noncoordination, the Departments are aware that some employers offer employees a "package" of coverage options that include a non-excepted benefit group health plan that provides minimal coverage (for example, coverage of preventive services only) with fixed indemnity insurance that provides benefits associated with receiving a broad category of other services, but is labeled as an excepted benefit. An employee's coverage associated with any non-preventive service provided under the fixed indemnity insurance is typically treated by the plan or issuer as exempt from the Federal consumer protections and requirements for comprehensive coverage because the insurance has been labeled an excepted benefit.¹⁹⁴ The Departments are concerned that some employers are attempting to circumvent the Federal consumer protections and requirements for comprehensive coverage that otherwise apply to group health plans by offering most benefits associated with receiving health care services as fixed indemnity insurance with an excepted benefit label, potentially leaving employees without crucial Federal consumer protections. This is particularly concerning if the employees are under the impression or are misled to believe that their employee health benefits package or plan provides comprehensive coverage and therefore forgo pursuing other available options that would provide comprehensive coverage.

To further address this concern and capture the Departments' interpretation of the requirement that hospital indemnity and other fixed indemnity insurance must offer "noncoordinated" benefits to be considered an excepted benefit, the Departments propose to include a new example (Example 3) in the group market

¹⁹² See section 9832(c) of the Code, section 733(c)(3) of ERISA, and sections 2722(c), 2763(b) and 2791(c)(3) of the PHS Act.

¹⁹³ *Id.*

¹⁹⁴ The Departments note that such an arrangement would not be treated as providing minimum value if it failed to provide substantial coverage of inpatient hospital services and physician services. 26 CFR 1.36B-6; 45 CFR 156.145.

regulations at 26 CFR 54.9831-1(c)(4)(iii)(C), 29 CFR 2590.731-1(c)(4)(iii)(C), and 45 CFR 146.145(b)(4)(iii)(C).¹⁹⁵ This new example illustrates the Departments' proposed interpretation of the "noncoordination" requirements for hospital indemnity or other fixed indemnity coverage to qualify as excepted benefits and reflects that the prohibition on coordination of benefits is not limited to only those situations involving a formal coordination of benefits arrangement, but rather also encompasses other situations that involve "coordination."

In this proposed new example, an employer sponsors a group health plan that provides two benefit packages. The first benefit package excludes benefits associated with all services other than preventive services.¹⁹⁶ The second benefit package provides coverage through an insurance policy that pays a fixed dollar amount per day of hospitalization or illness, for a wide variety of illnesses that are not preventive services covered under the first benefit package. The two benefit packages are offered to employees at the same time and can be elected together. The benefit packages are not subject to a coordination-of-benefits arrangement. However, as explained in the new example, because the benefits under the fixed indemnity insurance are designed to fill coverage gaps in, and are effectively tied to an exclusion of benefits under, the group health plan maintained by the same plan sponsor (in this case, the preventive services benefit package), the benefits offered under the fixed indemnity insurance would not satisfy the "noncoordination" requirements. Instead, under this arrangement, there is coordination between the provision of benefits under the fixed indemnity insurance with an exclusion(s) of benefits under a group health plan maintained by the same plan sponsor. This arrangement violates the "noncoordination" requirements because benefits under the fixed indemnity insurance are

provided, and therefore paid, with respect to an event *with* regard to (rather than *without* regard to) whether benefits are provided with respect to the event under a group health plan maintained by the same plan sponsor. Therefore, the insurance policy under the second benefit package is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit under the Federal framework. The proposed new example also notes that the conclusion would be the same even if the benefit packages were not offered to employees at the same time or if the second benefit option's insurance policy did not pay benefits associated with a wide variety of illnesses.

The term "noncoordination" (or "coordination") for purposes of hospital indemnity or other fixed indemnity insurance to be considered excepted benefits is not defined in the relevant statutory provisions or enacting legislation. While the current examples make clear that the existing framework prohibits coordination of benefits when there is a formal coordination of benefits arrangement, the current group market regulations do not directly address other situations that involve coordination and therefore violate the "noncoordination" requirements. The new proposed example, which would be added to the group market fixed indemnity excepted benefits coverage regulations, reflects the Departments' proposed interpretation of the undefined term "noncoordination," when applied to fixed indemnity excepted benefits coverage, as also including a scenario in which a sponsor of a group health plan offers both hospital indemnity or other fixed indemnity insurance along with a second benefit package that excludes benefits with respect to events that are covered by the hospital indemnity or other fixed indemnity insurance.

In these cases, the hospital indemnity or other fixed indemnity insurance and the other benefit package offered by the same group health plan sponsor to the same

employees (and their dependents, if applicable) are reasonably considered to be "coordinated" in terms of providing complementary benefits. It is the Departments' view that these arrangements violate the "noncoordination" requirements for hospital indemnity or other fixed indemnity insurance to be considered an excepted benefit, even though they do not involve formal coordination of benefits. As explained elsewhere in this preamble section, these arrangements violate these requirements because they involve coordination between the provision of benefits under the hospital indemnity or other fixed indemnity insurance and an exclusion of benefits under a group health plan maintained by the same plan sponsor. Under these arrangements, benefits are provided, and therefore paid, under the fixed indemnity insurance with respect to an event *with* regard (rather than *without* regard) to whether benefits are provided with respect to the event under a group health plan maintained by the same plan sponsor. Thus, as reflected in the proposed new example, the Departments would not consider the hospital indemnity or other fixed indemnity insurance offered as part of this arrangement to be an excepted benefit that is exempt from the Federal consumer protections and requirements for comprehensive coverage.

The Departments seek comments on the proposed addition of this example to the group market regulations and the proposal to interpret the term "noncoordination" (or "coordination") to also prohibit situations involving benefit coordination beyond those that involve formal coordination-of-benefits arrangements.

Although the proposed example would be added to the group market regulations, parallel statutory and regulatory requirements related to "noncoordination" apply in the individual market. Under 2722(c)(2)(C) of the PHS Act, "noncoordinated, excepted benefits" with respect to individual market hospital indemnity or other

¹⁹⁵ As detailed in section III.B.1.b of this preamble, the Departments also propose including another new example (Example 2) in the group market regulations, at new proposed 26 CFR 54.9831-1(c)(4)(iv)(B), 29 CFR 2590.732(c)(4)(iv)(B), and 45 CFR 146.145(b)(4)(iii)(B), to illustrate the new proposed payment standards for fixed indemnity excepted benefits coverage.

¹⁹⁶ The Departments are aware that some large employers offer group health plans that cover only preventive services, as reflected in this hypothetical example, and are not directly addressing such plans in these proposed rules, which are instead focused on the accompanying coverage, labeled "fixed indemnity" insurance in the example. However, the Departments discourage the provision of such limited coverage because it exposes employees to significant health and financial risk in the event that they require any health care services other than preventive services. See, e.g., Hancock, Jay (2015). "How Not to Find Out Your Health Plan Lacks Hospital Benefits," KFF, available at: <https://khn.org/news/how-not-to-find-out-your-health-plan-lacks-hospital-benefits>. Additionally, such coverage would not provide minimum value, such that the employer may be subject to an assessable payment under 4980H(b) of the Code if one or more full-time employees is certified as having enrolled in a qualified health plan for which a premium tax credit or cost-sharing reduction is allowed.

fixed indemnity excepted benefits coverage must be paid with respect to an event without regard to whether benefits are provided under any health insurance coverage maintained by the same health insurance issuer. Consistent with the interpretation and application of the statutory requirement that fixed indemnity excepted benefits coverage in the individual market must be offered on a noncoordinated basis, HHS is proposing to modify the requirement at current 45 CFR 148.220(b)(4)(ii)¹⁹⁷ to specify that benefits under fixed indemnity excepted benefits coverage must be paid with respect to an event without regard to whether benefits are provided with respect to such an event under any other health coverage “maintained by the same issuer”. For this purpose, HHS proposes that the phrase “same issuer” would refer to the entity licensed to sell the policy, consistent with the definition of health insurance issuer in 45 CFR 144.103. HHS solicits comments on whether to broaden the limits on coordination to include issuers that are members of the same controlled group.

In parallel with this proposed amendment, HHS proposes to apply the same interpretation of the term “noncoordination” to individual market fixed indemnity excepted benefits coverage as proposed in this preamble section for group market fixed indemnity excepted benefits. If this proposal is finalized, benefits that are paid under fixed indemnity insurance with respect to an event *with* regard to whether benefits are provided with respect to the event under any other health coverage maintained by the same issuer would not meet the requirement that individual market fixed indemnity excepted benefits coverage be provided on a noncoordinated basis, regardless of whether there is a formal coordination-of-benefits arrangement between the fixed indemnity insurance and any other coverage. HHS seeks comment on these proposals.

f. Technical Amendments

The Departments propose to strike the last sentence in 26 CFR 54.9831-1(c)(4)(i), 29 CFR 2590.732(c)(4)(i),

and 45 CFR 146.145(b)(4)(i), in order to consolidate the requirements that are specific to hospital indemnity or other fixed indemnity insurance to qualify as an excepted benefit in a new proposed paragraph at 26 CFR 54.9831-1(c)(4)(ii)(D), 29 CFR 2590.732(c)(4)(ii)(D), and 45 CFR 146.145(b)(4)(ii)(D). This current fixed payment standard would be retained as part of the fixed payment standards proposed to be captured in new proposed 26 CFR 54.9831-1(c)(4)(ii)(D)(I), 29 CFR 2590.732(c)(4)(ii)(D)(I), and 45 CFR 146.145(b)(4)(ii)(D)(I).

The Departments also propose technical amendments to clarify certain language in the existing example (now proposed Example 1) at new proposed 26 CFR 54.9831-1(c)(4)(iii)(A), 29 CFR 2590.732(c)(4)(iii)(A), and 45 CFR 146.146(b)(4)(iii)(A). The proposed technical amendments would clarify that the insurance policy in the example provides benefits only “related to” hospital stays (as opposed to “for” hospital stays), and emphasize the requirement that such benefits must be provided on a per-period basis. The general facts and ultimate conclusion in this example, however, remain the same.

HHS further proposes a technical amendment to the individual market excepted benefits rules to remove the existing requirement at 45 CFR 148.220(b)(4)(i) that fixed indemnity excepted benefits coverage must be provided only to individuals who attest, in their fixed indemnity insurance application, that they have other health coverage that is MEC, or that they are treated as having MEC due to their status as a bona fide resident of any possession of the United States pursuant to section 5000A(f)(4)(B) of the Code. This proposal would remove the regulatory provision that was invalidated in *Central United v. Burwell*.¹⁹⁸ As an accompanying conforming technical amendment, HHS also proposes to move the proposed revised noncoordination requirement described in section III.B.1.e of this preamble, that there is no coordination between the provision of benefits under the individual market hospital indemnity or other fixed indemnity insurance and

an exclusion of benefits under any other health coverage maintained by the same issuer, from 45 CFR 148.220(b)(4)(ii) to paragraph (b)(4)(i).

g. Applicability Dates

In 26 CFR 54.9831-1(c)(4)(iv), 29 CFR 2590.732(c)(4)(iv), and 45 CFR 146.145(b)(4)(iv), the Departments are proposing applicability dates that distinguish between new and existing fixed indemnity excepted benefits coverage in the group market. HHS proposes a similar approach to applicability with respect to new and existing fixed indemnity excepted benefits coverage in the individual market at 45 CFR 148.220(b)(iv). The applicability date proposals described in this section of the preamble are similar to the bifurcated approach for STLDI applicability dates proposed at 26 CFR 54.9833-1, 29 CFR 2590.736, and 45 CFR 146.125 and 148.102 and described in section III.A.6 of this preamble.

The Departments propose that the proposed amendments related to group market fixed indemnity excepted benefits coverage would apply to new coverage that is sold or issued on or after the effective date of the final rules with respect to plan years that begin on or after such date. HHS proposes the same applicability date for the proposed amendments related to individual market fixed indemnity excepted benefits coverage for new coverage that is sold or issued on or after the effective date of the final rules. The Departments are of the view that timely implementation of the proposed amendments to the fixed indemnity excepted benefits coverage regulations is essential for maximizing the number of individuals benefiting from the consumer protections described throughout this preamble.

The Departments propose that the proposed amendments related to group market fixed indemnity excepted benefit coverage would apply to existing coverage that is sold or issued before the effective date of the final rules with respect to plan years that begin on or after January 1,

¹⁹⁷ As discussed in section III.B.1.f of this preamble, HHS is also proposing a technical amendment to redesignate 45 CFR 148.220(b)(4)(ii) as 45 CFR 148.220(b)(4)(i).

¹⁹⁸ 827 F.3d 70 (D.C. Cir July 1, 2016).

2027, except with respect to the new group market notice requirements proposed at 26 CFR 54.9831-1(c)(4)(ii)(D)(2)-(4), 29 CFR 2590.732-1(c)(4)(ii)(D)(2)-(4), and 45 CFR 146.145(b)(4)(ii)(D)(2)-(4), the technical amendments described in section III.B.1.f of this preamble, and the proposed severability provision at 26 CFR 54.9831-1(c)(4)(v), 29 CFR 2590.732-1(c)(4)(v), and 45 CFR 146.145(b)(4)(v). The Departments propose that the provisions related to the notice would apply for plan years beginning on or after the effective date of the final rules and the technical amendments and severability provision would apply to new and existing group market fixed indemnity excepted benefits coverage beginning on the effective date of the final rules. As discussed further in this preamble section, HHS proposes to adopt a similar bifurcated approach to the applicability date for the proposed amendments related to individual market fixed indemnity excepted benefits coverage.

The Departments are aware that the proposed amendments to the group and individual market regulations for fixed indemnity excepted benefits coverage could, if finalized, affect hospital or other fixed indemnity insurance coverage that was sold or issued before the effective date of the final rules. In these cases, consumers may have chosen to purchase or enroll in fixed indemnity excepted benefits coverage in reliance on a framework that could be altered by the final rules. The Departments recognize that these proposed rules, if finalized, could also affect existing policies, including coverage or costs. Therefore, the Departments are of the view that the proposed bifurcated approach to the applicability date that provides for a more extended transition period for existing coverage to come into compliance with the applicable new payment standards and noncoordination requirements is appropriate with respect to fixed indemnity excepted benefits coverage sold or issued before the effective date of the final rules. This period is intended to provide plans, issuers, and those currently enrolled in group and individual market fixed indemnity excepted benefits with sufficient time to consider the effects and prepare for implementation of these proposed rules with respect to existing fixed indemnity excepted benefits

coverage, without unnecessarily delaying their applicability to new coverage.

However, the Departments propose that the proposed notice requirement at 26 CFR 54.9831-1(c)(4)(ii)(D)(2)-(4), 29 CFR 2590.732-1(c)(4)(ii)(D)(2)-(4), and 45 CFR 146.145(b)(4)(ii)(D)(2)-(4) would apply with respect to all group market fixed indemnity excepted benefits coverage that was sold or issued before the effective date of the final rules (including renewals) for plan years that begin on or after the effective date of the final rules. HHS proposes a similar applicability date for the revised individual market fixed indemnity excepted benefits coverage notice at 45 CFR 148.220(b)(4)(iii). As such, the proposed notice requirements would apply to both new and existing fixed indemnity excepted benefit coverage in the group or individual market for notices required to be provided for coverage periods (including renewals) beginning on or after the effective date of the final rules. In the Departments' view, the benefit to consumers, including those currently enrolled in group market fixed indemnity excepted benefits coverage, of this information outweighs the burden to plans and issuers of implementing these changes for existing fixed indemnity excepted benefits coverage by the effective date of the final rules.

The Departments also propose that the technical amendments to the group market regulations described in section III.B.1.f of this preamble would apply to group market fixed indemnity excepted benefits on the effective date of the final rules. These changes are primarily aimed at consolidating and clarifying existing requirements and aligning regulatory language with current legal standards, and would impose limited if any additional burden on interested parties, if finalized. Therefore, the Departments are of the view that a longer transition period is unnecessary, and a bifurcated approach could contribute to confusion without benefitting interested parties.

For similar reasons, the Departments propose that the severability provision proposed at 26 CFR 54.9831-1(c)(4)(v), 29 CFR 2590.731-2(c)(4)(v), and 45 CFR 146.145(b)(4)(v) would apply on the effective date of the final rules. This provision is intended to ensure that, in the event of any successful legal challenge to one or

more discrete provisions of the final rules, remaining provisions of the final rules can continue to be successfully implemented. The Departments are of the view that delaying the applicability date of this provision for fixed indemnity excepted benefits coverage sold or issued prior to the effective date of the final rules would be confusing and difficult to implement in the event of a legal challenge and would not provide any clear benefit to consumers, issuers, States, or other interested parties.

HHS similarly proposes that the proposed amendments related to individual market fixed indemnity excepted benefits coverage would generally apply to coverage that is sold or issued before the effective date of the final rule beginning on the first renewal on or after January 1, 2027. However, the changes related to the notice proposed at 45 CFR 148.220(b)(4)(iii) would apply to notices required to be provided in connection with the first renewal on or after the effective date of the final rules. The technical amendments to the individual market regulation described in section III.B.1.f of this preamble and the severability provision proposed at 45 CFR 148.220(b)(4)(v) would also become effective on the effective date of the final rules for existing individual market excepted benefits coverage. Under the proposed bifurcated applicability date, all of the proposed amendments related to individual market fixed indemnity excepted benefits coverage would apply to new coverage that is sold or issued on or after the effective date of the final rules beginning with coverage periods (including renewals) on or after the effective date of the final rules.

The Departments seek comments on their approach to applicability for fixed indemnity excepted benefits coverage, including whether applying the updated fixed indemnity excepted benefits regulations to fixed indemnity excepted benefits coverage sold or issued on or after the effective date of the final rules would provide a sufficient transition period in the group and individual markets for new coverage, or whether delaying the applicability date, such as for plan years or coverage periods beginning on or after January 1, 2025, would ensure a smoother transition to the new Federal standards for the sale of

new fixed indemnity excepted benefits coverage. Additionally, the Departments seek comments on whether delaying applicability of most of the proposed changes to the fixed indemnity excepted benefits regulations for existing fixed indemnity excepted benefits coverage until plan years beginning on or after January 1, 2027 provides a sufficient transition period or if it should be modified to provide a shorter transition. In particular, the Departments are interested in feedback on whether the proposed January 1, 2027 effective date would leave consumers with this coverage at risk of harm generally, or with respect to any specific proposal, and if so, whether a more immediate applicability date (such as the effective date of the final rules or an interim date such as January 1, 2025), would strike a better balance by applying new consumer protections sooner while still providing a smooth transition to the new requirements.

The Departments also seek comment on the proposal to apply the proposed notice requirements to existing fixed indemnity excepted benefits coverage beginning with plan years or coverage periods (including renewals) on or after the effective date of the final rules, and whether a different applicability date (such as January 1, 2027 or an interim date such as January 1, 2025) for the notice requirements would be appropriate for this cohort since they already opted to enroll in such coverage and would be permitted to continue their existing coverage or could seek to enroll in new coverage on or after the effective date of the final rules.

h. Severability

In the event that any portion of the final rules implementing one or more proposals in these proposed rules is declared invalid, the Departments intend that the proposals related to group market fixed indemnity excepted benefits coverage in these proposed rules be severable, and that the amendments the Departments propose with respect to the Federal regulations at 26 CFR 54.9831-1(c)(4), 29 CFR 2590.732(c)(4), and 45 CFR 146.145(b)(4) that outline the conditions for hospital indemnity and other fixed indemnity insurance to qualify as an

excepted benefit in the group market would continue even if one or more aspects of the proposed changes is found invalid. To capture this intent, the Departments propose to add a severability provision at 26 CFR 54.9831-1(c)(4)(v), 29 CFR 2590.731-2(c)(4)(v), and 45 CFR 146.145(b)(4)(v). Similarly, HHS intends that its proposed amendments to the regulation at 45 CFR 148.220(b)(4) that outlines the conditions for such insurance to qualify as excepted benefits coverage in the individual market continue even if one or more of the proposed changes is found invalid. To capture this intent, HHS proposes to add a severability provision at 45 CFR 148.220(b)(4)(v). The severability of these provisions is discussed in more detail in section VI of these proposed rules.

2. Specified Disease Excepted Benefits Coverage

These proposed rules do not propose amendments to the Federal regulations regarding specified disease excepted benefits coverage. However, the Departments solicit comments on whether the proposed changes to fixed indemnity excepted benefits coverage in these proposed rules could have unintended consequences that would affect the market for specified disease excepted benefits coverage, if finalized. For example, would such changes have the effect of shifting consumers from hospital indemnity or other fixed indemnity insurance to specified disease excepted benefits coverage as an alternative to or replacement for comprehensive coverage? Would the proposed changes incentivize issuers, agents, and brokers that offer specified disease excepted benefits coverage to shift the misleading or aggressive sales, advertising, and marketing tactics to encourage enrollment in specified disease excepted benefits coverage as an alternative to or replacement for comprehensive coverage? The Departments also seek comments on whether and what additional protections or clarifications are necessary or would be helpful to more clearly distinguish specified disease excepted benefits coverage from comprehensive coverage and to increase consumer understanding

of the differences between these two types of health coverage.

Additionally, the Departments seek comments on typical benefit design features of specified disease excepted benefits coverage. For example, under what circumstances would that coverage pay benefits based on a diagnosis versus on the basis of receipt of services for one or more specified medical conditions, and which design is more common? Under what circumstances and how common is it for specified disease excepted benefits coverage to pay benefits in a hybrid fashion, meaning some benefits are paid based on a diagnosis, and other benefits are paid based on receipt of services for one or more specified medical conditions? To the extent benefits under specified disease excepted benefits coverage policies are paid based on receipt of services for one or more specified medical conditions, are benefits typically paid to the policyholder or to the provider of the services? If the latter, do the issuers typically require use of a provider network for the enrollee to receive benefits (or more favorable benefits) under the specified disease excepted benefits coverage policy?

The Departments also seek comments on potential sources of information and data related to specified disease excepted benefits coverage policies offered for sale in the group and individual markets, including the number of policies sold, the types of individuals who typically purchase this coverage, the reasons for which they purchase it, and the types of common benefit exclusions or limitations.

C. Level-Funded Plan Arrangements

As stated in section I.F of this preamble, the Departments understand that an increasing number of group health plan sponsors, particularly small employers, are utilizing a funding mechanism or plan arrangement known as level-funding. According to the KFF Employer Health Benefits Survey, 42 percent of small employers (defined as having 3-199 workers) reported offering a level-funded plan in 2021, compared to just 13 percent in 2020.¹⁹⁹ This figure remained at

¹⁹⁹ KFF (2021). "2021 Employer Health Benefits," available at: <https://www.kff.org/report-section/ehbs-2021-section-10-plan-funding/>.

approximately the same level in 2022, with 38 percent of small employers reporting that they offered a level-funded plan.²⁰⁰ These arrangements are often marketed to small employers on the premise that level-funding provides predictable, and generally lower, costs and risk associated with potential high-dollar claims for plan sponsors, relative to traditional methods of self-funding.

As the uptake of level-funded plan arrangements increases, the Departments have heard concerns and received questions from interested parties related to level-funded arrangements' status as self-funded plans. Because level-funded arrangements purport to be, and are often regulated as, self-funded plans, they are typically not regulated by States.²⁰¹

In general, ERISA applies to private, employment-based group health plans.^{202,203} Therefore, in a level-funded plan arrangement sponsored by a private employer, the self-funded plan is the entity that is legally responsible for compliance with ERISA group health plan requirements. The parallel group market PHS Act requirements apply to health insurance issuers offering group health insurance coverage and also generally apply to non-Federal Governmental plans.^{204,205} In a self-insured, level-funded arrangement sponsored by a public employer, the plan sponsor or employer is the entity legally responsible for compliance with applicable group health plan requirements under the PHS Act.²⁰⁶

Interested parties have raised concerns that stop-loss coverage, a product traditionally purchased by large employers

sponsoring self-funded plans, is not required to comply with the Federal consumer protections and requirements applicable to group health plans or health insurance issuers offering group health insurance coverage, or meet requirements under State regulations that apply to health insurance coverage. Interested parties have expressed that these concerns are exacerbated when small employers utilize level-funded plan arrangements with stop-loss coverage that has low attachment points. This is because the majority of the benefits covered under such an arrangement would be provided via the stop-loss coverage, which may deny or limit the individual's claim in a way that would be prohibited under the group market Federal consumer protections and requirements. This means that if the stop-loss insurer defines the scope of coverage more narrowly than otherwise permitted by the Federal consumer protections and requirements applicable to group health plans or health insurance issuers offering group health insurance coverage (for example, by including a preexisting condition exclusion), the small employer remains liable for the claim for coverage, yet may be unprepared to absorb such costs. This is in large part due to the complexity of level-funding arrangements; because small employers typically pay a monthly amount that resembles a premium, they may not understand whether their health plan is self-funded or insured and, furthermore, that coverage of certain benefits may vary depending on where the attachment point is set. In addition, covered individuals generally do not know

whether their claim is being paid by the group health plan itself or by the stop-loss coverage. This raises additional concerns when an extensive portion of the individuals' claims are covered by the stop loss coverage that is not subject to the group market Federal consumer protections and requirements and has a low attachment point. For example, the stop loss coverage might deny a claim due to application of a lifetime or annual dollar limit in a way that would be prohibited under the group market Federal consumer protections and requirements.

Level-funded plans are most commonly adopted by small employers who are leaving the small group health insurance market, where policies must cover State- and Federally-mandated benefits and include various essential health benefits and consumer protections such as those included in MHPAEA.²⁰⁷ Interested parties have expressed that small employers that switch from fully-insured coverage to level-funded arrangements may be unaware that the self-funded plans they are offering to their employees may not include certain benefits that would have to be covered if the plan were fully-insured.

The Departments are also aware of interested parties' concerns that if level-funded plan arrangements are marketed only to small employer plan sponsors with relatively low expected claims costs, this may lead to adverse selection in the State's small group health insurance market and may destabilize the States' small group market risk pools. The potential for adverse selection caused by the increasing use of these level-funded plan

²⁰⁰ KFF (2022). "2022 Employer Health Benefits," available at: <https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/>.

²⁰¹ The Departments further recognize that increased uptake of level-funded plans among small employers with fewer than 20 employees has caused continuation-of-coverage issues. This is because (i) the federal COBRA rules do not apply to such plan sponsors, and (ii) a plan that is a level-funded plan is treated as self-insured, such that state continuation-of-coverage rules would not apply.

²⁰² Section 3(1) of Title I of ERISA defines the term "employee welfare benefit plan" to include: "[A]ny plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise..."

²⁰³ The PHS Act cross-references ERISA in its definitions. *See, e.g.*, the definitions for "group health plan", "group health insurance coverage", "employer", "employee", "church plan", "governmental plan", "participant", and "plan sponsor" in section 2791(a)(1), (b)(4), (d)(5) - (d)(8), (d)(11) and (d)(13) of the PHS Act, respectively.

²⁰⁴ The definition of "non-federal governmental plan" at section 2791(d)(8)(C) of the PHS Act incorporates the definition of "governmental plan" under ERISA section 3(32).

²⁰⁵ Sponsors of self-funded non-federal governmental group health plans are permitted to elect to exempt those plans from ("opt out of") certain provisions of title XXVII of the PHS Act. *See, e.g.*, section 2722(a)(2) of the PHS Act, as amended by the Consolidated Appropriations Act, 2023 (Pub. L. 117-328), and 45 C.F.R. § 146.180. *Also see* the Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond; Proposed Rule, 79 FR 15807 at 15814 - 15815 (March 21, 2014) and <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/nonfedgovplans>.

²⁰⁶ *See, e.g.*, 45 CFR 150.305.

²⁰⁷ MHPAEA does not apply directly to plans offered by small employers. Code section 9812(c)(1), ERISA section 712(c)(1), and PHS Act section 2716(c)(1). However, most plans offered by small employers are insured and therefore subject to MHPAEA through regulations implementing the essential health benefit coverage requirements. 45 CFR 156.115(a)(3). In the case of a level-funded plan, if the entire arrangement is treated as self-insured, the essential health benefit requirements would not apply.

arrangements is further compounded by the fact that these arrangements are not generally treated as being subject to the guaranteed renewability and single risk pool requirements that apply to fully-insured small group market coverage.

The Departments also acknowledge interested parties' concerns that if level-funded plan sponsors' contributions are not properly segregated from other funds held by the plans' service providers, those service providers might inadvertently be establishing multiple employer welfare arrangements, which would result in the plans being subject to a wide range of State regulation and additional requirements under ERISA.²⁰⁸ If they are unaware that their plan is a multiple employer welfare arrangement, they may not be complying with all of the applicable requirements.

Given the growing number of level-funded plans, the Departments are soliciting comments to better understand the prevalence of level-funded plans, such plans' designs and whether additional guidance or rulemaking is needed to clarify a plan sponsor's obligation with respect to coverage provided through a level-funded plan arrangement. The Departments solicit comments on the following issues:

How prevalent are level-funded group health plans among private and public employers? How many individuals are covered under level-funded plans? The Departments are also interested in information or data on whether the percentage of plan sponsors offering level-funded plans varies by State, geographic area, or other factors.

Are there data other than KFF's Employer Health Benefits Survey that the Departments should consider?

What factors are leading an increasing number of plan sponsors, particularly small employers, to utilize level-funded plans?

What are the administrative costs associated with offering level-funded plans, and how do these costs compare to the

administrative costs associated with offering fully-insured plans?

What types of benefits are commonly offered or not offered by level-funded plans?

What kinds of level-funded benefit options are generally made available to plan sponsors? How do the benefit packages differ from fully-insured plans? Do level-funded plan arrangements offer robust benefits similar to the comprehensive coverage offerings of fully-insured plans?

Are benefits provided by level-funded plans generally as comprehensive as fully-insured plans available to small employers? What benefits and consumer protections are generally no longer included when a small employer converts its plan from fully-insured coverage to a level-funded arrangement? Are changes in benefits and consumer protections communicated to plan participants and beneficiaries, and if so, how?

Are additional safeguards needed with respect to level-funded arrangements to ensure that individuals and/or small employers are not subjected to unexpected costs resulting from the stop-loss coverage failing to comply with Federal group health plan requirements? How do level-funded plans determine anticipated administrative costs and expected claims costs?

With respect to stop-loss coverage, how, and by whom, is the attachment point determined and what factors are considered in setting the attachment point?

What impact, if any, does the use of level-funding for plans offered by small employers have on the insured small group market?

How do plans' service providers manage plan sponsors' contributions for level-funded plans, including amounts that exceed actual plan costs (that is, costs for claims, administrative fees, and stop-loss premiums)? Are such arrangements consistent with section 403 of ERISA?

How are the amounts of any refunds paid to plan sponsors by stop-loss

providers determined? Are refunds remitted to participants and beneficiaries who have made contributions under the plan? If so, how are they determined and remitted?

How do plan sponsors of level-funded arrangements account for compliance with the consumer protections and mandated benefits that would apply to health benefits provided by a plan sponsor through a level-funded arrangement that is reimbursed through stop-loss insurance?

Do employers offering level-funded plans generally understand and comply with any applicable reporting requirements under sections 6055 and 6056 of the Code?

IV. Overview of the Proposed Rules on Tax Treatment and Substantiation Requirements for Fixed Indemnity Insurance and Certain Other Accident or Health Insurance – Department of the Treasury and the IRS

The Treasury Department and the IRS are proposing amendments to the rules under section 105(b) of the Code. These amendments would clarify the tax treatment of amounts received by a taxpayer through employment-based accident or health insurance that are paid without regard to the amount of incurred medical expenses under section 213(d) of the Code and where the premiums or contributions for the coverage are paid on a pre-tax basis. These amendments would also clarify that, under longstanding regulations and guidance issued by the Treasury Department and the IRS, the substantiation requirements for reimbursement of qualified medical expenses apply to reimbursements under section 105(b) of the Code in order for those reimbursements to be excluded from an individual's gross income. Additionally, the amendments would update several cross-references in the rules implementing section 105(b) of the Code to reflect statutory changes since the rules were first issued.²⁰⁹

²⁰⁸ See ERISA section 3(40); see also ERISA section 514(b)(6); see also U.S. Department of Labor, Employee Benefits Security Administration (2022). "MEWAs: Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation," available at: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf>.

²⁰⁹ The current rules reference section 105(d) of the Code, which has been repealed. The rules also reference the definition of a dependent in section 152(f) which may, in some circumstances, not include children up to the age of 26 that must be eligible to enroll in a group health plan or group or individual health insurance coverage under section 2714 of the PHS Act (which is incorporated by reference in section 9815 of the Code) if the plan or coverage makes available dependent coverage of children.

The Treasury Department and the IRS are aware of certain arrangements that purport to avoid income and employment taxes by characterizing income replacement benefits or other cash benefits as amounts paid for reimbursement of medical care, even though those amounts are paid without regard to the actual amount of any incurred, and otherwise unreimbursed, medical expenses. Frequently, these arrangements are marketed as supplemental coverage that saves employers and employees money by avoiding employment taxes when replacing income lost by an employee due to a health-related event experienced by the employee. In some arrangements, employees are paid an amount every month, purportedly for medical expenses, even if they do not incur any medical expenses, or if they simply complete certain health-related activities.

Fixed indemnity excepted benefits²¹⁰ coverage pays pre-determined benefits upon the occurrence of certain health-related events. Benefits under this type of coverage in the group market must be paid in a fixed amount on a per period basis.²¹¹ Although a benefit payment at the pre-determined level under that coverage may incidentally cover all or a portion of the cost of medical care stemming from the precipitating health-related event, it is typically not designed to do so and is paid without regard to the amount of the medical care expense incurred. Some specified disease excepted benefits coverage operates in a similar manner. For example, coverage only for a specified disease or illness might offer lump sum payments upon a specific diagnosis or on the basis of treatment received, or it might offer fixed payments per day or other time period of hospitalization or illness.²¹²

The principle that these types of accident or health insurance are not generally intended to provide reimbursement for incurred medical expenses is further illustrated by the fact that taxpayers covered by these arrangements will, in many cases, receive benefits upon the

occurrence of a health-related event under these arrangements even if any incurred expenses associated with that event are already reimbursed through other coverage. This is because these types of group market excepted benefits must be “non-coordinated” such that benefits are paid with respect to an event without regard to whether benefits are provided for that same event under any group health plan maintained by the same plan sponsor.²¹³ Thus, for example, if a particular medical expense incurred during hospitalization is reimbursed by a taxpayer’s primary, comprehensive coverage and the taxpayer also receives a benefit in a fixed amount for the hospitalization from fixed indemnity or specified disease excepted benefits coverage, the taxpayer would receive the fixed benefit without having any need to use the fixed amount received to pay for that medical expense.

These amendments are being proposed in response to ongoing questions about the proper tax treatment of payments pursuant to these arrangements. While these arrangements are sold under a variety of names, they are commonly sold as fixed indemnity excepted benefits coverage or specified disease excepted benefits coverage. However, the changes in these proposed amendments would not be limited to these types of coverage. The Treasury Department and the IRS note that it is important to look past the label on any given accident or health insurance product to determine whether amounts received by an employee are, in fact, for reimbursement of medical expenses or whether the amounts could be used for any purpose. For example, even if a benefit payment under the arrangement is *used* to reimburse an employee’s medical expenses, if the amount of the payment is not tied to the amount of the expense incurred and the employee is entitled to keep any amounts by which the benefit payment exceeds the incurred expenses, that would indicate that the benefit is not actually a reimbursement for medical expenses. The Treasury Department and the IRS request

comments on whether additional clarification is needed regarding how these rules would apply to types of benefits provided through employment-based accident or health insurance other than fixed indemnity excepted benefits coverage or specified disease excepted benefits coverage, including incentives offered through wellness programs, where the insurance, those programs, or both provide benefits without regard to the amount of medical expenses incurred and where the premiums are paid on a pre-tax basis.

A. Tax Treatment of Benefits

As described in section I.E of this preamble, hospital indemnity and other fixed indemnity insurance and coverage only for a specified disease or illness are treated as accident or health insurance under sections 104, 105, and 106 of the Code whether or not they are excepted benefits. Amounts received from accident or health insurance are excluded from a taxpayer’s gross income under section 104(a)(3) of the Code if the premiums are paid for on an after-tax basis. The taxation of amounts received by an employee from accident or health insurance where the premiums or contributions are paid on a pre-tax basis by the employer or through salary reduction under a cafeteria plan is determined under section 105 of the Code.

Under section 105(a) of the Code, amounts received by an employee through accident or health insurance for personal injuries or sickness are included in gross income; however, section 105(b) of the Code excludes from gross income amounts received by an employee to reimburse the employee’s medical expenses under section 213(d) of the Code. As is noted in section I.E of this preamble, 26 CFR 1.105-2 provides that the exclusion from gross income in section 105(b) of the Code “applies only to amounts that are paid specifically to reimburse the taxpayer for expenses incurred by him for the prescribed medical care. Thus, section 105(b) does

²¹⁰ Excepted benefits are described in section 9832 of the Code. Excepted benefits are generally not subject to the consumer protections under Chapter 100 of the Code, part 7 of ERISA, and title XXVII of the PHS Act.

²¹¹ 26 CFR 54.9831-1(c)(4).

²¹² *Id.*

²¹³ *Id.*

not apply to amounts that the taxpayer would be entitled to receive irrespective of whether or not he incurs expenses for medical care.” Further, 26 CFR 1.105-2 also provides that “section 105(b) is not applicable to the extent that such amounts exceed the actual expenses for such medical care.”

The Treasury Department and the IRS are cognizant that the language in the current rule has led to confusion among taxpayers about the circumstances under which benefits from accident or health insurance may be excluded from an individual’s gross income when the premiums for the coverage were paid on a pre-tax basis and the benefits are not directly related to a medical expense incurred by an employee. In particular, some have interpreted the current rule to mean that benefits provided to a taxpayer through an accident or health insurance policy that provides benefits without regard to the amount of medical expenses incurred, such as fixed indemnity excepted benefits coverage or specified disease excepted benefits coverage, are nonetheless excluded from the taxpayer’s gross income because they are paid upon the occurrence of a health-related event. Others have interpreted the current rule to mean that benefits can be excluded from gross income so long as the amount received does not exceed the amount of the medical expense arising from the occurrence of a health-related event.²¹⁴

The Treasury Department and the IRS interpret section 105(b) of the Code to not apply to benefits paid without regard to the actual amount of incurred and otherwise unreimbursed section 213(d) medical expenses. Because payment of these amounts is not a reimbursement of section 213(d) medical expenses, the amount of reimbursement is immaterial, with the result that the payment is not excluded from gross income under section 105(b) of the Code. The benefits would, therefore, be included in the taxpayer’s gross income.

Thus, the Treasury Department and the IRS propose to amend 26 CFR 1.105-2 to clarify that the exclusion from gross income under section 105(b) of the Code does not apply to amounts received from accident or health insurance that pays an amount or distributes a benefit if the benefit is paid without regard to the actual amount of section 213(d) medical expenses incurred by the employee. This interpretation would apply, for example, to benefit payments under fixed indemnity excepted benefits coverage and to benefit payments under specified disease excepted benefits coverage that pays benefits without regard to the amount of medical expenses incurred.

Payments that are excludible from gross income under sections 104 or 105(b) of the Code and under section 3121(a) of the Code are excluded from wages subject to Federal Insurance Contributions Act (FICA) taxes under sections 3101 and 3111. Similarly, under section 3306(b) of the Code, these payments are not wages subject to Federal Unemployment Tax Act (FUTA) taxes under section 3301 of the Code. Also, under section 3401(a) of the Code, they are not wages subject to income tax withholding under section 3402 of the Code. Temporary 26 CFR 32.1 provides rules governing the application of FICA taxes to payments on account of sickness or accident disability. Section 32.1(a) provides, in effect, that payments to or on behalf of an employee on account of sickness or accident disability are not excluded from wages unless the payments are received under a workers’ compensation law or qualify for an exception under section 3121(a)(4) of the Code (payments on account of sickness or accident disability made after the expiration of 6 calendar months). Section 32.1(d) provides that for purposes of 26 CFR 32.1(a) “payments on account of sickness or accident disability” subject to FICA tax include payments includible in gross income under section 105(a) of the Code and, thus, does not include any

amount that is not expended for medical care as described in section 105(b) of the Code and 26 CFR 1.105-2. Under the proposed amendment to 26 CFR 1.105-2, accident and health insurance payments that would not be excluded from employees’ gross income under section 105(b) because the amounts were paid without regard to the actual amount of incurred or otherwise unreimbursed section 213(d) medical care expenses would be wages subject to FICA, FUTA, and income tax withholding. Thus, 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.

B. Substantiation Requirement

26 CFR 1.105-2 currently states, in part, that “[i]f 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 taxpayer...” This language has been interpreted by certain interested parties to suggest that substantiation of a taxpayer’s incurred medical expenses is not required for the exclusion under section 105(b) of the Code to apply.

In this rulemaking, the Treasury Department and the IRS propose to amend 26 CFR 1.105-2 to clarify that, for amounts to be excluded from income under section 105(b) of the Code, the payment or reimbursement must be substantiated. Longstanding regulations and guidance issued by the Treasury Department and the IRS have confirmed that amounts paid to reimburse medical expenses under section 213(d) of the Code by employment-based accident or health insurance must be substantiated to be excluded under section

²¹⁴ Revenue Ruling 69-154, 1969-1 CB 46, provides that section 105(b) of the Code is not applicable to the extent that amounts received from accident or health insurance exceed the amount of the actual expenses for the medical care. The facts of the revenue ruling concerned a medical expense reimbursed by multiple coverages, with neither coverage paying the entire expense but the combination of coverages paying more than the amount of the medical expense. Nevertheless, the Treasury Department and the IRS are aware that some individuals have relied on the ruling to support their claims that section 105(b) allows for an exclusion from gross income for all benefits provided by accident or health insurance up to the amount of medical expenses with only the excess “indemnification” being included in gross income, even when the taxpayer is enrolled in only one coverage.

105(b) of the Code.²¹⁵ Further, if there were not a substantiation requirement under section 105(b) of the Code, the other proposed clarification that would be made to 26 CFR 1.105-2—that amounts received from accident or health insurance must be for reimbursement of incurred medical expenses for section 105(b) of the Code to apply—could be manipulated. The Treasury Department and the IRS understand that, in most circumstances, substantiation of medical expenses typically occurs prior to reimbursement but are of the view that substantiation must occur at least within a reasonable period thereafter. The Treasury Department and the IRS request comments on whether any final rules should specifically address timing requirements for substantiation.

C. Applicability Date

Generally, the proposed modifications to the tax treatment of employer reimbursements of employee medical expenses under certain accident and health plans are a clarification of long-standing Treasury Department and IRS rules and guidance limiting the exclusion from gross income to amounts that are fully substantiated and paid only with respect to the actual amount of section 213(d) medical care expenses incurred by the employee. However, in recognition that some plan sponsors and issuers may not have understood the requirements and may require time to come into compliance with the proposed amendments to 26 CFR 1.105-2, assuming that they are finalized as proposed, it is proposed that these amendments would apply as of the later of the date of publication of the final regulations or January 1, 2024.

V. Response to Comments

Because of the large number of comments the Departments normally receive on **Federal Register** documents, the Departments are not able to acknowledge or respond to them individually. The Departments will consider all comments received by the date and time specified

in the “DATES” section of the preamble, and, when the Departments proceed with a subsequent document, the Departments will respond to the comments in the preamble to that document.

VI. Severability

As previously described, the Departments are proposing to amend the Federal definition of “short-term, limited-duration insurance” and the conditions for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit in the group market, for the purpose of distinguishing STLDI and fixed indemnity excepted benefits coverage from comprehensive coverage. Similarly, HHS is proposing to amend the conditions for hospital indemnity and other fixed indemnity insurance to qualify as an excepted benefit in the individual market for the same purpose. The Departments and HHS are also proposing certain technical amendments to the regulations governing fixed indemnity excepted benefits in the group and individual markets, respectively, in order to consolidate and clarify existing requirements and align the individual market regulations with the decision of the U.S. Court of Appeals for the District of Columbia in *Central United Life Insurance Company v. Burwell*. The Departments’ and HHS’ authority to propose these amendments is well-established in law and practice, and should be upheld in any legal challenge. However, in the event that any portion of the final rules related to any of the proposals in this notice of proposed rulemaking is declared invalid, the Departments intend that the other provisions would be severable.

For example, if any proposed provision in this rulemaking related to STLDI is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, it shall be considered severable from its section and other sections of these rules; and it shall not affect the remainder thereof or the application of the provision to other entities not similarly

situated or to dissimilar conditions. Thus, if the Departments were to finalize the portion of the STLDI definition that limits the sale of multiple consecutive policies exceeding a total duration of 4 months by the same issuer to the same policyholder within a 12-month period, and a court were to find that portion or any other aspect of the new Federal STLDI definition to be unlawful, the Departments intend the remaining aspects of these proposed rules related to STLDI would stand, if finalized.

Similarly, the Departments propose that if any proposed provision in this rulemaking related to group market fixed indemnity excepted benefits coverage is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, it shall be considered severable from its section and it shall not affect the remainder thereof or the application of the provision to other entities not similarly situated or to dissimilar conditions. For example, if the Departments were to finalize all proposals related to additional fixed payment standards for group market fixed indemnity excepted benefits coverage and a court were to find one or more of those payment standards to be unlawful, the Departments intend that the other payment standards, along with the other proposals related to fixed indemnity excepted benefits coverage in the group market set forth in these proposed rules would stand, if finalized.

Similarly, HHS proposes that if any proposed provision in this rulemaking related to individual market fixed indemnity excepted benefits is held to be invalid or unenforceable by its terms, or as applied to any person or circumstance, or stayed pending further agency action, it shall be considered severable from its section and it shall not affect the remainder thereof or the application of the provision to other entities not similarly situated or to dissimilar conditions. For example, if HHS were to finalize all proposals related to the additional fixed payment standards for individual market fixed indemnity excepted benefits coverage and a court were to find one or more of the payment standards to be unlawful, HHS intends that the other

²¹⁵ See, e.g., 84 FR 28888, 28917 (June 20, 2019) (describing substantiation requirements for employer-sponsored health reimbursement arrangements); see also Q44-55 of IRS Notice 2017-67, 2017-47 IRB 517; Prop. Treas. Reg. § 1.125-6; IRS Notice 2002-45, 2002-2 CB 93.

payment standards for individual market fixed indemnity excepted benefits coverage, along with the other proposals related to fixed indemnity excepted benefits coverage in the individual market set forth in these proposed rules would stand, if finalized.

The Departments also intend for the STLDI proposals in this rulemaking to be severable from the fixed indemnity excepted benefits coverage proposals, and vice versa.

VII. Regulatory Impact Analysis

A. Summary – Departments of Health and Human Services and Labor

These proposed rules would revise the Federal definition of STLDI for new policies, certificates, or contracts of insurance to require the coverage to have an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date. These proposed rules would also revise the Federal definition of STLDI so that the maximum total coverage duration, taking into account any renewals or extensions, is no longer than 4 months. For purposes of this definition, a renewal or extension would include the term of a new STLDI policy, certificate, or contract of insurance issued by the same issuer to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance.

For new STLDI, meaning policies, certificates, or contracts of STLDI sold or issued on or after the effective date of the final rules, the maximum duration amendments to the definition of STLDI in these proposed rules would apply for coverage periods beginning on or after the effective date of the final rules. Under these proposed rules, existing STLDI, meaning policies, certificates, or contracts of STLDI sold or issued before the effective date of the final rules (including any subsequent renewals or extensions consistent with applicable law) could still have an initial contract term of less than 12 months and a maximum duration of up to 36

months (taking into account any renewals or extensions), subject to any limits under applicable State law.

These proposed rules would also revise the notice that must be prominently displayed (in either paper or electronic form) in at least 14-point font on the first page of the policy, certificate, or contract of insurance and in any marketing, application, and enrollment materials including for renewals or extensions (including on websites that advertise or enroll individuals in STLDI) for both new and existing STLDI for coverage periods beginning on or after the effective date of the final rules.

These proposed rules also would require that to be fixed indemnity excepted benefits coverage, the insurance must pay only a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, \$100/day), and not on a per-service or per-item basis, as is possible under the current HHS excepted benefit regulation applicable to the individual market. Further, for hospital indemnity or other fixed indemnity insurance to be considered an excepted benefit in the group or individual market under these proposed rules, payment must be made regardless of the actual or estimated amount of expenses incurred, services or items received, severity of illness or injury experienced by a covered participant, beneficiary, or enrollee, or other characteristics particular to a course of treatment, or on any other basis (such as per-item or per-service). All of these proposed provisions and amendments, if finalized, would apply to new group and individual market fixed indemnity excepted benefits coverage sold or issued on or after the effective date of the final rules. For existing group market fixed indemnity excepted benefits coverage sold or issued before the effective date of the final rules, the proposed provisions generally would apply with respect to plan years beginning on or after January 1, 2027. The technical amendments to the group market regulations described in section III.B.1.f of this preamble and the severability provision at 26 CFR 54.9831-1(c)(4)(v), 29 CFR 2590.732-1(c)(4)(v), and 45 CFR 146.145(b)(4)(v)

would apply beginning on the effective date of the final rules. HHS similarly proposes that these requirements generally would apply to individual market fixed indemnity excepted benefits coverage sold before the effective date of the final rule upon the first renewal on or after January 1, 2027, except the technical amendments to the individual market regulation described in section III.B.1.f of this preamble and the severability provision at 45 CFR 148.220(b)(4)(v) would apply beginning on the effective date of the final rule.

Additionally, these proposed rules would revise the notices that must be prominently displayed (in either paper or electronic form) on the first page of the policy, certificate, or contract of insurance, and any marketing and application materials provided in connection with enrollment (or re-enrollment) in fixed indemnity excepted benefits coverage in the individual market and would require a similar notice be provided for fixed indemnity excepted benefits coverage in the group market. The Departments propose that the new notice requirements for group market fixed indemnity coverage be applicable to both new and existing coverage for notices required to be provided with respect to plan years (including renewals) beginning on or after the effective date of the final rules. Similarly, HHS proposes that the changes to the notice requirements for individual market fixed indemnity coverage be applicable to existing individual market fixed indemnity coverage for notices required to be provided beginning upon the first renewal on or after the effective date of the final rule. For new individual market fixed indemnity coverage sold or issued on or after the effective date of the final rules, HHS proposes to apply the updated notice requirements with respect to coverage periods (including renewals) beginning on or after the effective date of the final rules.

The Departments have examined the effects of these proposed rules as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993),²¹⁶ Executive Order 13563 on Improving Regulation and

²¹⁶ Executive Order 12866 of September 30, 1993, 58 FR 51735.

Regulatory Review (January 18, 2011),²¹⁷ Executive Order 14094 (April 6, 2023),²¹⁸ the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995, Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999).²¹⁹

B. Executive Orders 12866, 13563, and 14094 – Departments of Health and Human Services and Labor

Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 14094 on Modernizing Regulatory Review amends section 3(f) of Executive Order 12866 (Regulatory Planning and Review). The amended section 3(f) of Executive Order 12866 defines a “significant regulatory action” as an action that is likely to result in a rule: (1) having an annual effect on the economy of \$200 million or more in any 1 year (adjusted every 3 years by the Administrator of the Office of Information and Regulatory Affairs (OIRA) of the Office of Management and Budget (OMB) for changes in gross domestic product), or adversely affecting in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, Territorial, or Tribal governments or communities; (2) creating

a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising legal or policy issues for which centralized review would meaningfully further the President’s priorities or the principles set forth in this Executive Order, as specifically authorized in a timely manner by the Administrator of OIRA in each case.

A regulatory impact analysis (RIA) must be prepared for rules with significant regulatory action or with significant effects as per section 3(f)(1) (\$200 million or more in any 1 year). Based on the Departments’ estimates, OMB’s OIRA has determined this rulemaking is significant under section 3(f)(1) as measured by the \$200 million threshold in any 1 year. With respect to Subtitle E of the Small Business Regulatory Enforcement Fairness Act of 1996, also known as the Congressional Review Act, OMB’s OIRA has also determined that these rules fall within the definition provided by 5 U.S.C. 804(2). Therefore, OMB has reviewed these proposed rules, and the Departments have provided the following assessment of their impact.

1. Need for Regulatory Action

The 2018 final rules permit enrollment in an STLDI policy with a total duration that could extend up to 36 months (including renewals or extensions). This insurance might therefore be viewed as a substitute for (and, in some cases, has been deceptively marketed as) comprehensive

coverage, rather than as a way to bridge a temporary gap in comprehensive coverage.²²⁰ Evidence shows the number of consumers buying STLDI increased following the effective date of the 2018 final rules. Data from the NAIC indicate that the number of individuals covered by STLDI sold to individuals more than doubled between 2018 and 2019, from approximately 87,000 to 188,000, and further increased to approximately 238,000 in 2020 before declining to approximately 173,000 in 2021 following the expansion of PTC subsidies provided through the ARP.²²¹ While these figures do not capture the total number of individuals covered by STLDI throughout each year (rather, only at the end of the calendar year), and do not include individuals covered by STLDI sold to or through associations, they do show the trend of increased enrollment in STLDI following the implementation of the 2018 final rules. Projections by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) suggest that 1.5 million people could currently be enrolled in STLDI,²²² and CMS previously estimated that 1.9 million individuals would enroll in STLDI by 2023.²²³ However, as noted in section VII.B.2.b, these projections were developed prior to the expansion of PTC subsidies provided through the ARP and the IRA.

Given that STLDI generally is not subject to the Federal consumer protections and requirements for comprehensive coverage sold in the individual market, STLDI policies tend to offer limited benefit coverage and have relatively low actuarial values.²²⁴ These plans therefore expose enrollees to the risk of high out-of-pocket health expenses and medical debt.²²⁵

²¹⁷ Executive Order 13563 of January 18, 2011, 76 FR 3821.

²¹⁸ Executive Order 14094 of April 6, 2023, 88 FR 21879.

²¹⁹ Executive Order 13132 of August 4, 1999, 64 FR 43255.

²²⁰ For one example of deceptive marketing practices, see Federal Trade Commission (2022). “FTC Action Against Benefytt Results in \$100 Million in Refunds for Consumers Tricked into Sham Health Plans and Charged Exorbitant Junk Fees,” available at: <https://www.ftc.gov/news-events/news/press-releases/2022/08/ftc-action-against-benefytt-results-100-million-refunds-consumers-tricked-sham-health-plans-charged>.

²²¹ National Association of Insurance Commissioners (2021). “Accident and Health Policy Experience Reports for 2018–2021,” available at: <https://naic.soutrounglobal.net/portal/Public/en-US/Search/SimpleSearch>.

²²² Congressional Budget Office (2020). “CBO’s Estimates of Enrollment in Short-Term, Limited-Duration Insurance,” available at: <https://www.cbo.gov/publication/56622>. CBO and JCT projected that enrollment in STLDI would reach 1.6 million by 2028. See Congressional Budget Office (2019). “How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans,” available at: <https://www.cbo.gov/publication/54915>.

²²³ CMS Office of the Actuary (2018). “Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule,” available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf>.

²²⁴ See, e.g., Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

²²⁵ See, e.g., Deam, Jenny (2021). “He Bought Health Insurance for Emergencies. Then He Fell Into a \$33,601 Trap,” ProPublica, available at: <https://www.propublica.org/article/junk-insurance>.

In recent years, fixed indemnity excepted benefits coverage is increasingly being designed to resemble comprehensive coverage and might therefore also be mistakenly viewed as a substitute for comprehensive coverage, rather than as independent, noncoordinated benefits that are supplemental to comprehensive coverage.²²⁶

Because both types of coverage are sold outside of the Exchanges and are not generally subject to the Federal consumer protections and requirements for comprehensive coverage, consumers may have limited information about the limitations, value, and quality of the coverage being sold.²²⁷ The recent reports of consumer confusion regarding STLDI and fixed indemnity excepted benefits coverage²²⁸ support the need to improve consumer understanding of these types of coverage (and their coverage limitations) compared to comprehensive coverage. These proposed rules would revise the notice that must be prominently displayed (in either paper

or electronic form) in at least 14-point font, on the first page of the policy, certificate, or contract of insurance and in any marketing, application, and enrollment materials provided at or before the time an individual has the opportunity to enroll (or reenroll) in STLDI, including on any websites used to advertise or enroll (or reenroll) individuals in STLDI. These proposed rules would also revise the notice that must be prominently displayed (in either paper or electronic form) in at least 14-point font on the first page of any marketing, application, and enrollment materials provided in connection with fixed indemnity excepted benefits coverage in the individual market, and on the first page of the policy, certificate, or contract of insurance of such coverage.

These proposed rules would also require the same notice be provided in the same manner in connection with fixed indemnity excepted benefits coverage in the group market in any marketing, application, or enrollment materials provided

to participants at or before the time participants are given an opportunity to enroll in the coverage. The fixed indemnity excepted benefits coverage required notices would also be required to be prominently displayed on websites used in connection with advertising or enrolling (or re-enrolling) individuals in such coverage. This would help ensure that consumers can better understand and properly distinguish fixed indemnity excepted benefits coverage from comprehensive coverage.

These proposed rules would encourage enrollment in comprehensive coverage and lower the risk that STLDI and fixed indemnity excepted benefits coverage are viewed or marketed as a substitute for comprehensive coverage.²²⁹

2. Summary of Impacts

The expected benefits, costs, and transfers associated with these proposed rules are summarized in Table 1 and discussed in detail later in this section of this preamble.

²²⁶ See, e.g., Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Health Coverage Is a Problematic Form of “Junk Insurance” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance/>.

²²⁷ See Williams, Jackson (2022). “Addressing Low-Value Insurance Products With Improved Consumer Information: The Case of Ancillary Health Products,” National Association of Insurance Commissioners, *Journal of Insurance Regulation*, available at: <https://content.naic.org/sites/default/files/cipr-jir-2022-9.pdf>.

²²⁸ Regarding consumer confusion related to short-term, limited-duration insurance, see, e.g., Deam, Jenny (2021). “He Bought Health Insurance for Emergencies. Then He Fell Into a \$33,601 Trap,” ProPublica, available at: <https://www.propublica.org/article/junk-insurance>. See also Palanker, Dania and Kevin Lucia (2021). “Limited Plans with Minimal Coverage Are Being Sold as Primary Coverage, Leaving Consumers at Risk,” Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2021/limited-plans-minimal-coverage-are-being-sold-primary-coverage-leaving-consumers-risk>. See also Schwab, Rachel and Maanasa Kona (2018). “State Insurance Department Consumer Alerts on Short-Term Plans Come Up Short,” Center on Health Insurance Reforms, available at: <https://chirblog.org/state-insurance-department-consumer-alerts-short-term-plans-come-short/>. See also Corlette, Sabrina, Kevin Lucia, Dania Palanker, and Olivia Hoppe (2019). “The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,” Urban Institute, available at: <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>. For a discussion of consumer confusion related to fixed indemnity excepted benefits coverage, see, e.g., Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Health Coverage Is a Problematic Form of “Junk Insurance,” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance/>.

²²⁹ As discussed in section I.B of this preamble, these proposed rules would build on Executive Order 14009, “Strengthening Medicaid and the Affordable Care Act” and Executive Order 14070, “Continuing to Strengthen Americans’ Access to Affordable, Quality Health Coverage” by encouraging enrollment in high-quality, comprehensive coverage. The Departments also note that the affordability of comprehensive coverage offered in the individual market has increased for many consumers in recent years, due in part to the expanded PTC subsidies provided through the ARP and the IRA, as discussed in section II of this preamble. Further, as discussed in section II of this preamble, the COVID-19 PHE has highlighted the importance of encouraging enrollment in comprehensive coverage.

TABLE 1: Accounting Table

Benefits:				
Non-Quantified:				
<ul style="list-style-type: none"> • Reductions in information asymmetries in health insurance markets through increased consumer understanding of STLDI and fixed indemnity excepted benefits coverage in relation to comprehensive coverage. • Increased enrollment in comprehensive coverage, with an estimated increase in enrollment in individual health insurance coverage purchased on an Exchange by approximately 60,000 people in 2026, 2027, and 2028 associated with the proposed provisions regarding STLDI. • Improvement in market stability and market risk pools for comprehensive coverage. • Reduction in the risk of high out-of-pocket health expenses, lower incidence of medical debt, improved health outcomes, and increased health equity, for individuals who switch to comprehensive coverage. • Potential reduction in the overall number of STLDI coverage rescissions or claims denials, if enrollment in STLDI declines. • Potential reduction in deceptive or aggressive marketing practices regarding the sale of STLDI and fixed indemnity excepted benefits coverage. 				
Costs:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	\$17,369	2023	7 percent	2024-2028
	\$16,154	2023	3 percent	2024-2028
Quantified:				
<ul style="list-style-type: none"> • One-time regulatory review cost of approximately \$76,200 for issuers of STLDI, issuers of fixed indemnity excepted benefits coverage, and other interested parties. 				
Non-Quantified:				
<ul style="list-style-type: none"> • Potential increase in premium costs for individuals who switch from STLDI to comprehensive coverage and are not eligible for the PTC. • Potential increase in the number of uninsured individuals, if some individuals with STLDI who would no longer be permitted to renew or extend their coverage with the same issuer are unable to purchase STLDI from another issuer during a 12-month period, and must wait until open enrollment to obtain comprehensive coverage, or choose not to purchase comprehensive coverage. • Potential increase in health care spending, if individuals switch to comprehensive coverage and increase their use of health care as a result. • Potential costs to States associated with enacting new legislation and implementing new laws regarding STLDI and fixed indemnity excepted benefits coverage in response to the provisions included in these proposed rules. 				
Transfers:	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized (\$/year)	-\$67.1 million	2023	7 percent	2024-2028
	-\$69.9 million	2023	3 percent	2024-2028
Quantified:				
<ul style="list-style-type: none"> • Decrease in Federal spending on PTC of approximately \$120 million in 2026, 2027, and 2028 associated with the proposed provisions regarding STLDI. • Reduction in gross premiums for individuals enrolled in individual health insurance coverage purchased on an Exchange by approximately 0.5 percent in 2026, 2027, and 2028 associated with the proposed provisions regarding STLDI. 				
Non-Quantified:				
<ul style="list-style-type: none"> • Potential transfer from issuers to consumers if consumers switch from STLDI and fixed indemnity excepted benefits coverage to comprehensive coverage and experience a reduction in out-of-pocket costs. 				

Table 2 presents the estimated effects of the provisions regarding STLDI on enrollment in and gross premiums for

individual health insurance coverage purchased on an Exchange and on Federal spending on the PTC (by calendar year),

as discussed further in sections VII.B.2.c and VII.B.2.e of this preamble.

TABLE 2: Estimated Effects of the Provisions Regarding STLDI on Enrollment in and Gross Premiums for Individual Health Insurance Coverage Purchased on an Exchange and on Federal Spending on the PTC

Calendar Year	2024	2025	2026	2027	2028
Change in Enrollment in Individual Health Insurance Coverage Purchased on an Exchange	0	0	60,000	60,000	60,000
Percentage Change in Gross Premiums for Individual Health Insurance Coverage Purchased on an Exchange	0	0	-0.5	-0.5	-0.5
Change in Federal Spending on the PTC (in millions)	\$0	\$0	-\$120	-\$120	-\$120

a. Background

STLDI and fixed indemnity excepted benefits coverage generally are not subject to the Federal consumer protections and requirements for comprehensive coverage as discussed in more detail in section I.A of this preamble. STLDI and fixed indemnity excepted benefits coverage therefore expose enrollees to financial and health risks, as discussed in this section and section II.B of this preamble.

STLDI and fixed indemnity excepted benefits coverage typically do not cover all essential health benefits (including, for example, prescription drugs, maternity services, and mental health and substance use disorder services), and typically do not cover preexisting conditions.²³⁰ STLDI can offer fewer benefits overall.²³¹ While fixed indemnity excepted benefits coverage is designed to provide a source of

income replacement or financial support following a covered illness or injury, fixed indemnity benefits are often far below a covered individual’s incurred costs.²³² Both STLDI and fixed indemnity excepted benefits coverage typically have lower medical loss ratios (MLRs) or lower actuarial values than coverage subject to the Federal consumer protections and requirements for comprehensive coverage. In one study of the medical claims of approximately 47 million enrollees in commercial plans in 2016, for example, the implied actuarial value of the STLDI coverage in the study was 49 percent, compared to an implied actuarial value of approximately 74 percent for off-Exchange comprehensive coverage plans and an implied actuarial value of 87 percent for on-Exchange plans.²³³ Additionally, according to an NAIC report, across 28 issuers of STLDI for individuals in 2021, the nationwide

loss ratio was approximately 70 percent.²³⁴ Across 95 issuers of other non-comprehensive coverage for individuals, which includes fixed indemnity excepted benefits coverage, the nationwide loss ratio was approximately 40 percent in 2021.²³⁵ By contrast, according to data from MLR annual reports for the 2021 MLR reporting year, the average MLR in the individual market for comprehensive coverage was approximately 87 percent in 2021.²³⁶

These statistics suggest that relative to issuers of comprehensive coverage, issuers of STLDI and fixed indemnity excepted benefits coverage tend to spend a lower percentage of premium dollars on health care items and services or, in the case of fixed indemnity excepted benefits coverage, payment of benefits. Such insurance might therefore be highly profitable for issuers,²³⁷ depending on the extent to which issuers incur costs related to

²³⁰ See, e.g., Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>. See also Pollitz, Karen, Michelle Long, Ashley Semanskee, and Rabah Kamal (2018). “Understanding Short-Term Limited Duration Health Insurance,” KFF, available at: <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>. See also Sanger-Katz, Margot (2018). “What to Know Before You Buy Short-Term Health Insurance,” *The New York Times*, available at: <https://www.nytimes.com/2018/08/01/upshot/buying-short-term-health-insurance-what-to-know.html>. See also Young, Christen Linke and Kathleen Hannick (2020). “Fixed Indemnity Health Coverage Is a Problematic Form of ‘Junk Insurance,’” USC-Brookings Schaeffer Initiative for Health Policy, available at: <https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2020/08/04/fixed-indemnity-health-coverage-is-a-problematic-form-of-junk-insurance>. See also Partnership to Protect Coverage (2021). “Under-Covered: How ‘Insurance-Like’ Products are Leaving Patients Exposed,” available at: https://www.nami.org/NAMI/media/NAMI-Media/Public%20Policy/Undercovered_Report_03252021.pdf.

²³¹ See, e.g., Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

²³² See Williams, Jackson (2022). “Addressing Low-Value Insurance Products With Improved Consumer Information: The Case of Ancillary Health Products,” National Association of Insurance Commissioners, *Journal of Insurance Regulation*, available at: <https://content.naic.org/sites/default/files/cipr-jir-2022-9.pdf>.

²³³ Pelech, Daria and Karen Stockley (2022). “How Price and Quantity Factors Drive Spending in Nongroup and Employer Health Plans,” Health Services Research, available at: <https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.13962>.

²³⁴ National Association of Insurance Commissioners (2022). “2021 Accident and Health Policy Experience Report,” available at: <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>. Data regarding issuers of STLDI and non-comprehensive coverage are only available for the individual market.

²³⁵ *Id.*
²³⁶ Based on internal calculations. Source: CMS, Medical Loss Ratio Data and System Resources, available at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr>.

²³⁷ See Appleby, Julie (2018). “Short-Term Health Plans Boost Profits For Brokers And Insurers,” NPR, available at: <https://www.npr.org/sections/health-shots/2018/12/21/678605152/short-term-health-plans-boost-profits-for-brokers-and-insurers>. See also Pear, Robert (2018). “‘Short Term’ Health Insurance? Up to 3 Years Under New Trump Policy,” *The New York Times*, available at: <https://www.nytimes.com/2018/08/01/us/politics/trump-short-term-health-insurance.html>.

marketing (including agent/broker compensation²³⁸), policy underwriting, and overhead. At the same time, the limited coverage provided through most STLDI and fixed indemnity excepted benefits coverage exposes individuals enrolled in such plans to health and financial risks, including the risk of high medical bills and high out-of-pocket expenses. These high out-of-pocket expenses, in turn, could contribute to an increased risk of medical debt and bankruptcy, which is particularly problematic given the extent of medical debt already present in the United States.²³⁹

Compensation for agents and brokers from sales of STLDI can also be significant, incentivizing aggressive and/or deceptive marketing tactics that may mislead customers into enrolling in STLDI instead of comprehensive coverage.^{240,241,242} One study suggests that commissions for STLDI are up to 10 times higher than those obtained for enrollment in individual health insurance coverage (averaging approximately 23 percent for STLDI, compared to 2 percent for individual health insurance coverage).²⁴³ Data that specify compensation levels for agents and brokers selling fixed indemnity excepted benefits coverage are not

available. However, one survey suggests that lead-generating websites direct consumers to insurance brokers selling both STLDI and other types of non-comprehensive coverage, including fixed indemnity excepted benefits coverage, and that both types of coverage are often marketed to resemble comprehensive coverage.²⁴⁴

Misleading marketing of STLDI and fixed indemnity excepted benefits coverage is reported to have taken place during individual health insurance coverage open enrollment periods or special enrollment periods (including during the COVID-19 special enrollment period, under which the Exchanges that used the Federal eligibility and enrollment platform operationalized functionality during a 6-month period in 2021 to make a special enrollment period available on HealthCare.gov to allow qualified individuals to enroll in 2021 individual health insurance coverage through those Exchanges amid the COVID-19 PHE).²⁴⁵ For example, one study showed that enrollment in STLDI policies by brokers increased by approximately 60 percent in December 2018 and by more than 120 percent in January 2019, suggesting that overall enrollment in STLDI spiked during the ACA open enrollment season.²⁴⁶

In order to protect consumers, a number of States and the District of Columbia enacted legislation or issued regulations regarding STLDI after the 2018 final rules were published.²⁴⁷ State regulatory actions regarding such coverage have been wide-ranging. For example, according to one report, as of January 2020, 5 States prohibited underwritten STLDI, 9 States limited the total duration of enrollment in underwritten STLDI (including renewals or extensions) to less than 364 days, and 11 States limited the initial contract term for enrollment in STLDI to less than 364 days.²⁴⁸ Other State regulatory actions on STLDI have included banning coverage rescissions (except in cases such as fraud on the part of the enrollee), adding preexisting condition protections, and requiring a certain MLR, among other restrictions.²⁴⁹ Lastly, some States have largely aligned their regulations regarding STLDI with the 2018 final rules.²⁵⁰ In some States that allow sales of STLDI, but otherwise regulate STLDI, issuers do not offer STLDI.²⁵¹

Recent analysis has found that States that allow the initial contract term of STLDI to last up to 364 days have seen a 27 percent reduction in enrollment, on average, in non-Exchange plans that are

²³⁸ Compensation includes commissions, fees, or other incentives (for example, rewards or bonuses) as established in the relevant contract between an issuer and the agent or broker.

²³⁹ See, e.g., Consumer Financial Protection Bureau (2022). “Medical Debt Burden in the United States,” available at: https://files.consumerfinance.gov/f/documents/cfpb_medical-debt-burden-in-the-united-states_report_2022-03.pdf.

²⁴⁰ See, e.g., Appleby, Julie (2018). “Short-Term Health Plans Boost Profits For Brokers And Insurers,” NPR, available at: <https://www.npr.org/sections/health-shots/2018/12/21/678605152/short-term-health-plans-boost-profits-for-brokers-and-insurers>.

²⁴¹ Government Accountability Office (2020). “Private Health Coverage: Results of Covert Testing for Selected Offerings,” available at: <https://www.gao.gov/products/gao-20-634/>.

²⁴² However, even as some issuers offer higher compensation for STLDI, many brokers continue to refuse to sell products they view as overly risky for consumers, like STLDI. See, e.g., Corlette, Sabrina, Erik Wengle, Ian Hill, and Olivia Hoppe (2020). “Perspective from Brokers: The Individual Market Stabilizes While Short-Term and Other Alternative Products Pose Risks,” Urban Institute, available at: <https://www.urban.org/research/publication/perspective-brokers-individual-market-stabilizes-while-short-term-and-other-alternative-products-pose-risks>.

²⁴³ U.S. House of Representatives Committee on Energy and Commerce (2020). “Shortchanged: How the Trump Administration’s Expansion of Junk Short-Term Health Insurance Plans is Putting Americans at Risk,” available at: <https://democrats-energycommerce.house.gov/newsroom/press-releases/ec-investigation-finds-millions-of-americans-enrolled-in-junk-health>.

²⁴⁴ Corlette, Sabrina, Kevin Lucia, Dania Palanker, and Olivia Hoppe (2019). “The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,” Urban Institute, available at: <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>.²⁴⁵ See Palanker, Dania and JoAnn Volk. (2021). “Misleading Marketing of Non-ACA Health Plans Continued During COVID-19 Special Enrollment Period,” Center on Health Insurance Reforms, available at: <https://georgetown.app.box.com/s/inn7kgnhbn4kapb46tqmv6i7putry9gt>. See also Corlette, Sabrina, Kevin Lucia, Dania Palanker, and Olivia Hoppe (2019). “The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and State Regulatory Responses,” Urban Institute, available at: <https://www.urban.org/research/publication/marketing-short-term-health-plans-assessment-industry-practices-and-state-regulatory-responses>. Regarding the COVID-19 special enrollment period, see E.O. 14009; see also CMS (2021). “2021 Special Enrollment Period in Response to the COVID-19 Emergency,” available at: <https://www.cms.gov/newsroom/fact-sheets/2021-special-enrollment-period-response-covid-19-emergency>. Regarding the extension of the COVID-19 special enrollment period (to the 6-month period between February 15, 2021 and August 15, 2021), see CMS (2021). “Extended Access Opportunity to Enroll in More Affordable Coverage Through HealthCare.gov,” available at: <https://www.cms.gov/newsroom/fact-sheets/extended-access-opportunity-enroll-more-affordable-coverage-through-healthcaregov>.

²⁴⁶ U.S. House of Representatives Committee on Energy and Commerce (2020). “Shortchanged: How the Trump Administration’s Expansion of Junk Short-Term Health Insurance Plans Is Putting Americans at Risk,” available at: <https://democrats-energycommerce.house.gov/newsroom/press-releases/ec-investigation-finds-millions-of-americans-enrolled-in-junk-health>.

²⁴⁷ Norris, Louise (2020). “‘So Long’ to Limits on Short-Term Plans,” Healthinsurance.org, available at: <https://www.healthinsurance.org/so-long-to-limits-on-short-term-plans/>. See also Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

²⁴⁸ As of January 2020. Giovannelli, Justin, JoAnn Volk, and Kevin Lucia (2020). “States Work to Make Individual Market Health Coverage More Affordable, But Long-Term Solutions Call for Federal Leadership,” Commonwealth Fund, available at: <https://www.commonwealthfund.org/publications/issue-briefs/2020/jan/states-make-individual-coverage-more-affordable-federal-needed>.

²⁴⁹ Palanker, Dania, Maanasa Kona, and Emily Curran (2019). “States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans,” Commonwealth Fund, available at: <https://www.commonwealthfund.org/publications/issue-briefs/2019/may/states-step-up-protect-markets-consumers-short-term-plans>.

²⁵⁰ Norris, Louise (2020). “‘So Long’ to Limits on Short-Term Plans,” Healthinsurance.org, available at: <https://www.healthinsurance.org/so-long-to-limits-on-short-term-plans/>.

²⁵¹ See Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

subject to the ACA Federal consumer protections and requirements for comprehensive coverage from 2018 to 2020, compared with a 4 percent reduction in enrollment, on average, in those plans in States that banned STLDI or limited its duration to 6 months or less.²⁵² This analysis also found that market-wide risk scores (a measure of relative expected health care costs for a population) declined more in States that banned or limited STLDI coverage (-11.8 percent) than in States with less restrictions on STLDI (-8.3 percent), suggesting that the less restrictive States saw more healthier individuals enroll in STLDI policies in lieu of comprehensive coverage, which put upward pressure on the average expected health care costs among those with comprehensive coverage.

b. Number of Affected Entities

These proposed rules would directly impact individuals who are currently enrolled in STLDI or fixed indemnity excepted benefits coverage or who may choose to purchase or consider purchasing such coverage in the future. The Departments have limited information about the number of individuals currently enrolled in STLDI. Data from the NAIC indicate that approximately 173,000 individuals were covered by STLDI sold to individuals at the end of 2021.²⁵³ However, as noted in section VII.B.1, this figure does not capture the total number of individuals covered by STLDI throughout the year, and does not include individuals covered by STLDI sold to or through associations. As noted in section VII.B.1, projections by CBO and JCT suggest that 1.5 million people could currently be enrolled in STLDI,²⁵⁴ and CMS previously estimated that 1.9 million individuals would

enroll in STLDI by 2023.²⁵⁵ However, the CBO and JCT and CMS estimates were developed prior to the expansion of PTC subsidies provided through the ARP and the IRA, which likely supported increased enrollment in individual health insurance coverage purchased on an Exchange in lieu of STLDI and other forms of health insurance not subject to the Federal consumer protections and requirements for comprehensive coverage.²⁵⁶ The number of enrollees in STLDI might have also been affected by any changes in State law or regulation that occurred since the 2018 final rules were issued. The Departments are unaware of any estimates or sources of information for the number of individuals enrolled in fixed indemnity excepted benefits coverage.

These proposed rules would also directly impact issuers of STLDI and fixed indemnity excepted benefits coverage, and agents and brokers who enroll consumers in that coverage. The NAIC reported that there were at least 28 issuers of STLDI for individuals across the U.S. in 2021.²⁵⁷ Due to a lack of data, the Departments are unable to estimate the number of issuers of individual market fixed indemnity excepted benefits coverage that would be affected by these proposed rules, though as noted earlier in this section of this preamble, the NAIC reported that there were at least 95 issuers of “other non-comprehensive coverage” (including fixed indemnity excepted benefits coverage) for individuals across the U.S. in 2021.²⁵⁸ The Departments also lack data about the number of agents and brokers that currently enroll individuals in STLDI or fixed indemnity excepted benefits coverage.

Lastly, these proposed rules could also indirectly impact consumers enrolled in comprehensive coverage due to the

effects of increased enrollment in comprehensive coverage on risk pools, premiums, plan offerings, or issuer participation in the markets for that coverage. While the Departments are unable to estimate whether or how these proposed rules would impact plan offerings or issuer participation in the markets for comprehensive coverage, in sections VII.B.2.c and VII.B.2.e of this preamble, the Departments discuss the estimated effects of the provisions regarding STLDI included in these proposed rules on enrollment in and premiums for individual health insurance coverage purchased on an Exchange.

The Departments seek comments on the number of entities that would be affected by these proposed rules. In particular, the Departments seek comments on the number of issuers and the number of associations offering STLDI, the number of issuers offering individual market fixed indemnity excepted benefits coverage, the number of issuers offering group market fixed indemnity excepted benefits coverage, the number of enrollees in each type of coverage, and the number of agents and brokers that enroll individuals in these types of non-comprehensive coverage options.

c. Benefits

These proposed rules are expected to reduce the harm caused to consumers who are misled into enrolling in STLDI or fixed indemnity excepted benefits coverage as an alternative to or replacement for comprehensive coverage. The proposed notices would improve consumer understanding of STLDI and fixed indemnity excepted benefits coverage in relation to comprehensive coverage. The Departments are of the view that the proposed notices would

²⁵² Hall, Mark and Michael McCue (2022). “Short-Term Health Insurance and the ACA Market,” Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2022/short-term-health-insurance-and-aca-market>.

²⁵³ National Association of Insurance Commissioners (2022). “2021 Accident and Health Policy Experience Report,” available at: <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>.

²⁵⁴ Congressional Budget Office (2020). “CBO’s Estimates of Enrollment in Short-Term, Limited-Duration Insurance,” available at: <https://www.cbo.gov/publication/56622>. CBO and JCT projected that enrollment in STLDI would reach 1.6 million by 2028. See Congressional Budget Office (2019). “How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans,” available at: <https://www.cbo.gov/publication/54915>.

²⁵⁵ CMS Office of the Actuary (2018). “Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule,” available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf>.

²⁵⁶ See, e.g., Ortaliza, Jared, Krutika Amin, and Cynthia Cox (2022). “As ACA Marketplace Enrollment Reaches Record High, Fewer Are Buying Individual Market Coverage Elsewhere,” KFF, available at: <https://www.kff.org/policy-watch/as-aca-marketplace-enrollment-reaches-record-high-fewer-are-buying-individual-market-coverage-elsewhere/>.

²⁵⁷ National Association of Insurance Commissioners (2022). “2021 Accident and Health Policy Experience Report,” available at: <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>.

²⁵⁸ *Id.*

help ensure individuals are made aware that these plans are not comprehensive coverage. This is also expected to reduce the level of deceptive marketing of STLDI and fixed indemnity excepted benefits coverage. Consumers who switch from STLDI or fixed indemnity excepted benefits coverage to comprehensive coverage would have better access to health care, better consumer protections, more robust benefits, and therefore would be expected to experience better health outcomes.

The Departments anticipate these proposed rules would lead to an increase in enrollment in high-quality, affordable, comprehensive coverage that is subject to the Federal consumer protections and requirements for comprehensive coverage. Individuals would be less likely to wait until after they incur major medical expenses or develop a medical condition to switch from STLDI or fixed indemnity excepted benefits coverage to comprehensive coverage. This could lead to more stable markets for comprehensive coverage and improved market risk pools for such coverage. However, as noted earlier in this section of this preamble, the expanded PTC subsidies provided through the ARP and the IRA have likely already resulted in increased enrollment in individual health insurance coverage purchased on an Exchange in lieu of STLDI or fixed indemnity excepted benefits coverage, so the immediate overall effects of these proposed rules on enrollment, market stability, and risk pools are expected to be limited in 2024 and 2025.²⁵⁹ The CMS Office of the Actuary (OACT) estimates that, relative to current law, the proposed provisions regarding STLDI would not affect enrollment in individual health insurance coverage purchased on

an Exchange in 2024 and 2025, but would increase enrollment by approximately 60,000 people in 2026, 2027, and 2028.²⁶⁰

To the extent that these proposed rules would lead to an increase in enrollment in comprehensive coverage that is subject to the Federal consumer protections and requirements for comprehensive coverage, these rules would likely result in a reduction in out-of-pocket expenses, medical debt, and risk of medical bankruptcy for consumers switching to comprehensive coverage. These proposed rules could also lead to a reduction in surprise bills from out-of-network providers in certain circumstances, to the extent the proposed rules lead to an increase in enrollment in coverage that is subject to the surprise billing protections for consumers under the No Surprises Act.

By encouraging enrollment in comprehensive coverage, these proposed rules could also reduce the number of coverage rescissions, claims denials, premium increases, or coverage exclusions that are common for STLDI.

d. Costs

Individuals with STLDI or fixed indemnity excepted benefits coverage who switch to individual health insurance coverage—particularly those individuals who are not eligible for the PTC—might incur higher premium costs depending on their choice of available Exchange and off-Exchange comprehensive coverage plans, their PTC eligibility (if applicable), and the amount of advance payment of the PTC they receive (if any).²⁶¹

These proposed rules could also lead to an increase in the number of individuals without some form of health insurance

coverage, if some individuals with STLDI or fixed indemnity excepted benefits coverage lose coverage and have to wait until the next open enrollment period to purchase comprehensive coverage (for example, if an individual with existing coverage exhausts their renewal options outside of an open enrollment period), or choose to become uninsured. Those individuals who become uninsured could face an increased risk of higher out-of-pocket expenses and medical debt, reduced access to health care, and potentially worse health outcomes.

To the extent that these proposed rules would lead to an increase in enrollment in comprehensive coverage, they could result in an increase in overall health care utilization and spending, given that this coverage tends to have higher MLRs and actuarial values and might offer lower cost-sharing requirements and more generous benefits.²⁶²

Additionally, these proposed rules could impose costs on States that change their laws regarding STLDI or fixed indemnity excepted benefits coverage in response to the proposed provisions included in these proposed rules. The Departments seek comments on the magnitude of the costs that States might incur associated with enacting new legislation, implementing new laws, and updating existing regulations regarding STLDI and fixed indemnity excepted benefits coverage.

The Departments expect that plans and issuers would incur minimal costs to replace the existing notices with the revised ones (which would be provided by the Departments, as discussed in section VII.D of this preamble). The Departments also expect that since plans and issuers

²⁵⁹ See, e.g., Ortaliza, Jared, Krutika Amin, and Cynthia Cox (2022). “As ACA Marketplace Enrollment Reaches Record High, Fewer Are Buying Individual Market Coverage Elsewhere,” KFF, available at: <https://www.kff.org/policy-watch/as-aca-marketplace-enrollment-reaches-record-high-fewer-are-buying-individual-market-coverage-elsewhere/>.

²⁶⁰ In developing these estimates, OACT assumed that STLDI coverage would be significantly less expensive than individual health insurance coverage purchased on an Exchange (where available) and would be an attractive option for individuals and families with relatively low health care costs and little to no subsidies. Using their health reform model, OACT estimated that, under current law, about 60,000 people would move from individual health insurance coverage purchased on an Exchange to STLDI in 2026, when the additional PTC subsidies available through 2025 through the IRA expire. In addition, since those switching to STLDI are assumed to be healthier than average, the average premium for individual health insurance coverage purchased on an Exchange would increase by roughly 0.5 percent. Changing the maximum duration of an STLDI policy, certificate, or contract of insurance to no more than 3 months, as proposed in these proposed rules, would negate these effects.

²⁶¹ This might occur if premiums for STLDI are lower than premiums for individual health insurance coverage. One study, for example, showed that by screening out individuals with pre-existing conditions and providing fewer comprehensive benefits, issuers may be able to offer STLDI at rates 54 percent below those for (unsubsidized) comprehensive coverage. See Levitt, Larry, Rachel Fehr, Gary Claxton, Cynthia Cox, and Karen Pollitz (2018). “Why do Short-Term Health Insurance Plans Have Lower Premiums than Plans that Comply with the ACA?,” KFF, available at: <https://files.kff.org/attachment/Issue-Brief-Why-Do-Short-Term-Health-Insurance-Plans-Have-Lower-Premiums-Than-Plans-That-Comply-with-the-ACA>.

²⁶² As noted earlier in this RIA, many STLDI policies offer limited benefits coverage and have relatively low actuarial values. Many STLDI issuers spend a relatively high percentage of premium dollars on administration and overhead. See National Association of Insurance Commissioners (2022). “Accident and Health Policy Experience Report for 2021,” available at: <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>. Regarding the differences in cost-sharing requirements and out-of-pocket expenses between STLDI and individual health insurance coverage, see, e.g., Dieguez, Gabriela and Dane Hansen (2020). “The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market,” Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

change their policy documents routinely, the costs to plans and issuers to change their policy documents in response to these proposed rules would be part of plans' and issuers' usual business costs.

e. Transfers

Individuals currently enrolled in STLDI may be healthier on average than individuals enrolled in comprehensive coverage, as STLDI policies are not subject to Federal requirements that would prohibit them from excluding individuals or charging individuals higher premiums on the basis of health status, gender, and other factors. These proposed rules might cause some of these individuals to switch to comprehensive coverage. If such a switch occurs, it would improve the individual market (or merged market) risk pools and lead to lower overall premiums for individual health insurance coverage. CMS previously estimated that gross premiums for individual health insurance coverage purchased on an Exchange in 2022 would be 6 percent higher under the 2018 proposed rules than they would have been in the absence of those rules.²⁶³ CBO and JCT previously estimated that the 2018 final rules for STLDI, in conjunction with changes made through the 2018 Department of Labor rule entitled "Definition of 'Employer' Under Section 3(5) of ERISA—Association Health Plans",²⁶⁴ would increase premiums in the individual and small group health insurance coverage markets by around 3 percent.²⁶⁵ An analysis of individual health insurance coverage rate filing materials for 2020 also found that the few carriers that explicitly included a premium adjustment because of the 2018 final rules increased premiums by between 0.5

percent and 2 percent in 2020.²⁶⁶ These analyses suggest that these proposed rules could have an effect in the opposite direction, potentially reducing gross premiums for individual health insurance coverage. However, since the expanded PTC subsidies provided through the ARP and the IRA have likely already led to a reduction in enrollment in STLDI and fixed indemnity excepted benefits coverage and an increase in enrollment in individual health insurance coverage purchased on an Exchange, the Departments anticipate that the premium impact of these proposed rules would be relatively small. OACT estimates that the proposed provisions regarding STLDI would not affect gross premiums for individuals with individual health insurance coverage purchased on an Exchange in 2024 and 2025, but would reduce gross premiums by approximately 0.5 percent in 2026, 2027, and 2028.²⁶⁷

The proposed provisions regarding STLDI are expected to reduce Federal spending on PTC after the end of the expanded PTC subsidies provided through the IRA. These proposed provisions are expected to reduce gross premiums for individual health insurance coverage purchased on an Exchange and therefore lower per capita PTC spending. This effect would be partly offset by an increase in the number of individuals enrolling in Exchange coverage that would be eligible to receive the PTC (by approximately 20,000 in 2026, 2027, and 2028). On net, OACT estimates that these proposed provisions would have no impact on Federal spending on PTC in 2024 and 2025 given the expanded PTC subsidies provided through the IRA, but would reduce Federal spending on the PTC by approximately \$120 million in 2026, 2027, and 2028.²⁶⁸ This reduction

in Federal spending on the PTC would be viewed as a reduction in the amount of the transfer from the Federal government to individuals.

These proposed rules could also lead to a transfer in the form of reduced out-of-pocket expenses from issuers to consumers who switch from STLDI or fixed indemnity excepted benefits coverage to comprehensive coverage, since more health care services would be covered under comprehensive coverage and the cost-sharing requirements for comprehensive coverage might be lower than those for STLDI or fixed indemnity excepted benefits coverage.²⁶⁹

f. Uncertainty

As noted throughout this preamble, due to a lack of data and information, there are several areas of uncertainty regarding the potential impacts of these proposed rules. The Departments are unable to forecast how all of the provisions of these proposed rules would affect enrollment in STLDI and fixed indemnity excepted benefits coverage, as the Departments are uncertain how many individuals are currently enrolled in these types of coverage and would switch to comprehensive coverage, how many individuals would try to find another issuer of STLDI once their current policy ends, how many individuals would choose to remain enrolled in fixed indemnity excepted benefits coverage (particularly if their employers restructure their plan offerings in response to these proposed rules), or how many individuals would choose not to purchase any form of coverage as a result of these proposed rules.²⁷⁰ As a result, there is also some uncertainty about the potential impact on risk pools, premiums, Federal

²⁶³ CMS Office of the Actuary (2018). "Estimated Financial Effects of the Short-Term, Limited-Duration Policy Proposed Rule," available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/STLD20180406.pdf>.

²⁶⁴ 83 FR 28912 (June 21, 2018). The District Court of D.C. vacated this rule. See *State of New York, et al. v. United States Department of Labor, et al.*, 363 F.Supp.3d 109 (D.D.C. 2019).

²⁶⁵ Congressional Budget Office (2019). "How CBO and JCT Analyzed Coverage Effects of New Rules for Association Health Plans and Short-Term Plans," available at: <https://www.cbo.gov/publication/54915>.

²⁶⁶ Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

²⁶⁷ This estimate accounts for the end of the expanded PTC subsidies provided through the IRA.

²⁶⁸ In fiscal year terms, this would be a reduction in federal spending of \$90 million in 2026, \$120 million in 2027, and \$120 million in 2028.

²⁶⁹ As noted in the Costs subsection of this RIA, regarding the differences in cost-sharing requirements and out-of-pocket expenses between STLDI and individual health insurance coverage, see, e.g., Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

²⁷⁰ Previous studies have estimated the impact of the STLDI definition adopted in the 2018 final rules on enrollment in individual health insurance coverage, but in conjunction with the impact of elimination of the individual shared responsibility payment. See Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

expenditures on PTC, and compensation for agents and brokers selling STLDI, fixed indemnity excepted benefits coverage, and individual health insurance coverage. The Departments seek comments on all of these areas of uncertainty regarding the impacts of these proposed rules.

g. Health Equity Impact

Due to the typical underwriting practices and plan eligibility requirements in the market for STLDI, individuals might face higher premiums or might not be able to purchase STLDI because of preexisting health conditions, gender, or other factors.²⁷¹ STLDI and fixed indemnity excepted benefits coverage typically do not cover certain essential health benefits including prescription drugs, mental health and substance use disorder services, or maternity services,²⁷² which could contribute to disparities in access to health care and health outcomes (regarding mental health, maternal health, or infant health, for instance).²⁷³

Consumers with low health literacy, which disproportionately includes consumers with low incomes, may also be misled into purchasing STLDI or fixed indemnity excepted benefits coverage under the mistaken impression that it would lower their out-of-pocket costs while providing comprehensive coverage with lower premiums. Consumers with low income or who are members of underserved racial and ethnic groups are more likely to be uninsured and face barriers in accessing care.²⁷⁴ Individuals in these populations arguably face the greatest health and financial consequences in the event that STLDI or fixed indemnity excepted

benefits coverage proves inadequate. These individuals are also potentially most vulnerable to practices like post-claims underwriting and rescission that are common in the STLDI market, which could leave them without any coverage in a health crisis.

These proposed rules would partly address these health inequities by increasing regulation of issuers offering STLDI and fixed indemnity excepted benefits coverage and encouraging enrollment in comprehensive coverage.

The Departments seek comments on the potential health equity implications of these proposed rules.

h. Regulatory Review Cost Estimation

If regulations impose administrative costs on entities, such as the time needed to read and interpret rules, regulatory agencies should estimate the total cost associated with regulatory review. The Departments assume that approximately 250 entities will review these proposed rules, including 28 issuers of STLDI,²⁷⁵ 95 issuers of other non-comprehensive coverage,²⁷⁶ and other interested parties (for example, State insurance departments, State legislatures, industry associations, and advocacy organizations). The Departments acknowledge that this assumption may understate or overstate the number of entities that will review these proposed rules.

Using wage information from the Bureau of Labor Statistics, for Business Operations Specialists, All Other (Code 13-1199), to account for average labor costs (including a 100 percent increase for the cost of fringe benefits and other

indirect costs), the Departments estimate that the cost of reviewing these proposed rules will be \$76.20 per hour.²⁷⁷ The Departments estimate that it will take each reviewing individual approximately 4 hours to review these proposed rules, with an associated cost of approximately \$305 (4 hours x \$76.20). Therefore, the Departments estimate that the (one-time) total cost of reviewing these proposed rules will be approximately \$76,200 (250 x \$305).

The Departments welcome comments on this approach to estimating the total burden and cost for interested parties to read and interpret these proposed rules.

C. Regulatory Alternatives – Departments of Health and Human Services and Labor

In developing the proposed rules, the Departments considered various alternative approaches.

With respect to the proposed amendments to the definition of STLDI, the Departments considered leaving in place the duration standards established in the 2018 final rules, but concluded that the 2018 final rules' duration standards were too lengthy for the reasons described in section III.A.2 of this preamble. The Departments also considered proposing to limit the maximum duration of STLDI policies to a less-than-6-month period to minimize disruption for consumers in some (but not all) States that have implemented a less-than-6-month period, a less-than-3-month period as implemented in the 2016 final rules, or otherwise shortening the maximum duration to a time period shorter than allowed under current regulations. However, the Departments

²⁷¹ See, e.g., Barnes, Justin and Fumiko Chino (2022). "Short-term Health Insurance Plans Come Up Short for Patients with Cancer," *JAMA Oncology*, Vol 8 Issue 8: 1101-1103, available at: <https://jamanetwork.com/journals/jamaoncology/article-abstract/2793127>.

²⁷² Dieguez, Gabriela and Dane Hansen (2020). "The Impact of Short-Term Limited-Duration Policy Expansion on Patients and the ACA Individual Market," Milliman, available at: <https://www.milliman.com/en/insight/the-impact-of-short-term-limited-duration-policy-expansion-on-patients-and-the-aca-individual-market>.

²⁷³ See, e.g., Hill, Latoya, Samantha Artiga, and Usha Ranji (2022). "Racial Disparities in Maternal and Infant Health: Current Status and Efforts to Address Them," KFF, available at: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-maternal-and-infant-health-current-status-and-efforts-to-address-them/>.

²⁷⁴ See Tolbert, Jennifer, Kendal Orgera, and Anthony Damico (2020). "Key Facts about the Uninsured Population," KFF, available at: <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>. See also Artiga, Samantha, Latoya Hill, Kendal Orgera, and Anthony Damico (2021). "Health Coverage by Race and Ethnicity, 2010-2019," KFF, available at: <https://www.kff.org/racial-equity-and-health-policy/issue-brief/health-coverage-by-race-and-ethnicity/>. See also KFF (2021). "Adults Who Report Not Having a Personal Doctor/Health Care Provider by Race/Ethnicity," available at: <https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-having-a-personal-doctor-by-raceethnicity/>. See also KFF (2021). "Adults Who Report Not Seeing a Doctor in the Past 12 Months Because of Cost by Race/Ethnicity," available at: <https://www.kff.org/other/state-indicator/percent-of-adults-reporting-not-seeing-a-doctor-in-the-past-12-months-because-of-cost-by-raceethnicity/>.

²⁷⁵ National Association of Insurance Commissioners (2022). "2021 Accident and Health Policy Experience Report," available at: <https://content.naic.org/sites/default/files/publication-ahp-lr-accident-health-report.pdf>.

²⁷⁶ *Id.* The Departments assume that all issuers of other non-comprehensive coverage will review these proposed rules.

²⁷⁷ See Bureau of Labor Statistics (2022). "National Occupational Employment and Wage Estimates," available at: https://www.bls.gov/oes/current/oes_nat.htm.

ultimately decided to propose a maximum duration of no more than 4 months to align with the rules regarding the 90-day waiting period limitation and the optional reasonable and bona fide employment-based orientation period that is permitted under the ACA.²⁷⁸

The Departments considered proposing to limit stacking of STLDI coverage, whether sold by the same or different issuer. However, after considering the potential challenges issuers and State regulators would face in attempting to determine whether an individual had previously enrolled in an STLDI policy with a different issuer, the Departments decided to propose to limit stacking only where STLDI is sold to an individual by the same issuer, while seeking comments on whether the Departments should extend the limit on stacking to STLDI sold to an individual by issuers that are members of the same controlled group.

The Departments considered proposing a limit on the marketing and/or sale of STLDI during the individual health insurance coverage open enrollment period. The Departments are concerned that aggressive and deceptive marketing practices by some issuers have lured consumers, looking for comprehensive coverage, into enrolling in STLDI, exposing them to financial risk. The Departments solicit comments on how the Departments can support State efforts to limit the marketing and/or sale of STLDI during the open enrollment period.

With respect to the proposed amendments to the notices provided to consumers considering enrolling in STLDI, the Departments considered including a complete list of Federal protections that apply to consumers enrolled in comprehensive coverage versus STLDI. This approach would more fully distinguish STLDI from comprehensive coverage and highlight in greater detail the risks to consumers of enrolling in STLDI instead of comprehensive coverage. However, after consulting with plain language experts, the Departments are of the view that providing a complete comparison of protections that a consumer would forego by enrolling in STLDI rather than comprehensive

coverage would result in a lengthy, complex notice that could be difficult for the typical consumer to understand. Increasing the length and complexity of the notice would also increase burden for issuers to provide the notice on policy documents and marketing and application materials as proposed in these rules. However, the Departments are soliciting comments on all aspects of the revised notice, including whether a different format or presentation would result in a more useful, consumer-friendly notice.

The Departments considered proposing a more detailed notice be provided to consumers who are considering enrolling in fixed indemnity excepted benefits coverage, including language that would highlight in greater detail the differences between fixed indemnity excepted benefits coverage and comprehensive coverage and include a reference to potential financial support available for Exchange coverage, similar to the proposed consumer notice for STLDI. However, the Departments ultimately determined that the value of providing a more concise, readable notice for fixed indemnity excepted benefits coverage outweighed the benefits of providing that more detailed information. Because fixed indemnity excepted benefits coverage differs so significantly in purpose and scope from comprehensive coverage, the Departments were also concerned that providing the additional details could suggest to consumers that fixed indemnity excepted benefits coverage is something more than a form of income replacement or financial support.

The Departments also considered proposing alternative applicability dates for the proposed changes to the fixed indemnity excepted benefits regulations, including a uniform applicability date for new and existing coverage, either aligned with the effective date of the final rules or with a longer transition. The Departments acknowledge that consumers may have purchased fixed indemnity excepted benefits coverage in reliance on requirements in place prior to the publication of the final rules, and that changes to the regulations may affect the availability of such coverage, benefit design, and costs. Plans and

issuers, similarly, have designed and sold fixed indemnity excepted benefits coverage on the basis of the current regulatory framework, on which State regulators have also developed enforcement policies. In light of these reliance interests, the Departments are of the view that it is appropriate to adopt the special rule for existing coverage to delay applicability for certain changes to January 1, 2027, in order to provide a transition period with respect to fixed indemnity excepted benefits coverage sold or issued before the effective date of the final rules. However, such reliance interests would not be present with respect to new fixed indemnity excepted benefits coverage sold or issued on or after the effective date of the final rules. Further, delaying application of the final rules prolongs the risk of harm to new consumers and would frustrate the purpose of these proposed rules to distinguish between comprehensive coverage and fixed indemnity excepted benefits coverage and promote consumer access to high-quality, affordable, comprehensive coverage. In addition, as discussed in section III.B.1.g of this preamble, there are certain proposed changes (such as the applicable notice requirements, technical amendments, and the severability provisions) that do not raise concerns about reliance interests and therefore the Departments propose an earlier applicability date for those proposals for fixed indemnity excepted benefits coverage sold or issued before the effective date of the final rules.

The Departments considered proposing to apply the fixed indemnity excepted benefits coverage proposals in these proposed rules to specified disease excepted benefits coverage, to apply uniform standards to both statutorily-defined forms of independent, noncoordinated excepted benefits. However, the Departments determined that additional information about specified disease excepted benefits coverage would be useful prior to engaging in rulemaking. Therefore, the Departments have included a comment solicitation aimed at gathering information about specified disease excepted benefits coverage, including whether additional guidance or

²⁷⁸ 26 CFR 54.9815-2708, 29 CFR 2590.715-2708, and 45 CFR 147.116.

rulemaking on this type of coverage may be necessary.

D. Paperwork Reduction Act

These proposed rules provide that to be considered STLDI for coverage periods beginning on or after the effective date of the final rules, a revised consumer notice must be prominently displayed (in either paper or electronic form) on the first page of the policy, certificate, or contract of insurance and in any marketing, application, and enrollment materials (including reenrollment materials) provided to individuals at or before the time an individual has the opportunity to enroll (or reenroll) in the coverage.

These proposed rules also provide that to be considered fixed indemnity excepted benefits coverage in the group market for plan years beginning on or after the effective date of the final rules, a notice must be included in any marketing, application, or enrollment materials provided to participants at or before the time participants are given an opportunity to enroll in the coverage. The notice would indicate that the hospital indemnity or other fixed indemnity insurance is not comprehensive coverage and does not have to include most Federal consumer protections for health insurance, outline the availability of other health coverage options, and explain that individuals may contact the State department of insurance for questions or complaints. These proposed rules would propose revisions, comparable to the group market standards, for the notice that must be provided for hospital indemnity and other fixed indemnity insurance to be considered an excepted benefit in the individual market for notices required with respect to coverage periods beginning on or after the effective date of the final rules. The proposed rules provide that the individual market fixed indemnity excepted benefits notice must be included on the first page of any marketing, application, and enrollment or reenrollment materials that are provided at or before the time an individual has the opportunity to enroll or reenroll in the coverage, and on the first

page of the policy, certificate, or contract of insurance.

The Departments propose to provide the exact text for these notices, and the language would not need to be customized. The burden associated with these notices would therefore not be subject to the Paperwork Reduction Act of 1995 in accordance with 5 CFR 1320.3(c)(2) because they do not contain a “collection of information” as defined in 44 U.S.C. 3502(3). Consequently, this document need not be reviewed by OMB under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

These proposed rules also amend 26 CFR 1.105-2 to clarify that, for amounts to be excluded from income under section 105(b) of the Code, the payment or reimbursement must be substantiated by the health plan. Any information required to substantiate the expenses under this regulation is considered a usual and customary business practice and a record provided during the normal course of business in administering health plans. These customary business records impose no additional burden on respondents and are not required to be reviewed by OMB in accordance with 5 CFR 1320.3(b)(2).

The Departments seek comments on potential burden on issuers if the final rules were to include required notices with language that would need to be customized.

E. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA), (5 U.S.C. 601, *et seq.*), requires agencies to analyze options for regulatory relief of small entities to prepare an initial regulatory flexibility analysis to describe the impact of a proposed rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The RFA generally defines a “small entity” as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of

less than 50,000. States and individuals are not included in the definition of “small entity.” HHS uses a change in revenues of more than 3 to 5 percent as its measure of significant economic impact on a substantial number of small entities.

The provisions in these proposed rules would affect issuers of STLDI and issuers of fixed indemnity excepted benefits coverage. Health insurance issuers are generally classified under the North American Industry Classification System (NAICS) code 524114 (Direct Health and Medical Insurance Carriers). According to SBA size standards,²⁷⁹ entities with average annual receipts of \$47 million or less are considered small entities for this NAICS code. The Departments expect that few, if any, insurance companies underwriting health insurance policies fall below these size thresholds. Based on data from MLR annual report submissions for the 2021 MLR reporting year, approximately 87 out of 483 issuers of health insurance coverage nationwide had total premium revenue of \$47 million or less.²⁸⁰ However, it should be noted that over 77 percent of these small companies belong to larger holding groups, and many, if not all, of these small companies are likely to have non-health lines of business that will result in their revenues exceeding \$47 million. The Departments expect this to be the case for issuers of STLDI and issuers of fixed indemnity excepted benefits coverage. However, as noted earlier in this RIA, due to a lack of data, the Departments are unable to estimate how many small issuers of STLDI and small issuers of fixed indemnity excepted benefits coverage would be affected by these proposed rules. The Departments seek comments on this analysis, and seek information on the number of small issuers of STLDI and the number of small issuers of fixed indemnity excepted benefits coverage.

Agents and brokers would be classified under NAICS code 524210 (Insurance Agencies and Brokerages), with a size standard of \$15 million or less. There is the potential for the compensation²⁸¹ of small agents and brokers associated with the sale of STLDI and fixed indemnity

²⁷⁹ Small Business Administration (2023). “Table of Size Standards (last updated March 2023),” available at: <https://www.sba.gov/document/support-table-size-standards>.

²⁸⁰ Based on internal calculations. Source: CMS, Medical Loss Ratio Data and System Resources, available at: <https://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html>.

²⁸¹ Compensation includes commissions, fees, or other incentives (for example, rewards or bonuses) as established in the relevant contract between an issuer and the agent or broker.

excepted benefits coverage to be negatively affected by these proposed rules, if there is a reduction in sales of that coverage. There is also the potential for the compensation of small agents and brokers associated with the sale of individual health insurance coverage to be positively affected by these proposed rules, if there is an increase in sales of that coverage. However, due to a lack of data, the Departments are unable to precisely estimate how many agents and brokers might be affected by these proposed rules and the magnitudes of the potential changes in compensation.²⁸² The Departments seek information on the number of agents and brokers who sell STLDI, fixed indemnity excepted benefits coverage, and individual health insurance coverage, respectively, and how their compensation might be affected by these proposed rules, if finalized.

In addition, section 1102(b) of the Social Security Act requires agencies to prepare a regulatory impact analysis if a rule may have a significant economic impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. While these rules are not subject to section 1102 of the Social Security Act, the Departments are of the view that these proposed rules would not have a significant impact on the operations of a substantial number of small rural hospitals. The Departments seek comments on this

F. Special Analyses – Department of the Treasury

Pursuant to the Memorandum of Agreement, Review of Treasury Regulations under Executive Order 12866 (June 9, 2023), tax regulatory actions issued by the IRS are not subject to the requirements of section 6 of Executive Order 12866, as amended. Therefore, a regulatory impact assessment is not required. Pursuant to section 7805(f) of

the Code, these regulations have been submitted to the Chief Counsel for Advocacy of the Small Business Administration for comment on their impact on small business.

G. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a proposed rule that includes any Federal mandate that may result in expenditures in any 1 year by State, local, or Tribal governments, in the aggregate, or by the private sector, of \$100 million in 1995 dollars, updated annually for inflation. That threshold is approximately \$177 million in 2023. The Departments anticipate the combined impact on State, local, or Tribal governments and the private sector would not be above the threshold.

H. Federalism

Executive Order 13132 establishes certain requirements that Federal agencies must meet when they issue proposed rules that impose substantial direct costs on State and local governments, preempt State law, or otherwise have Federalism implications.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy-making discretion of the States, the Departments have engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the NAIC.

In the Departments' view, these proposed rules have Federalism implications because they would have direct effects on the States, the relationship between the national government and the States, or on the distribution of power and

responsibilities among various levels of government. Under these proposed rules, health insurance issuers offering STLDI or fixed indemnity excepted benefits coverage would be required to follow the minimum Federal standards for such coverage to not be subject to the Federal consumer protections and requirements for comprehensive coverage.

In general, through section 514, ERISA supersedes State laws to the extent that they relate to any covered employee benefit plan, and preserves State laws that regulate insurance, banking, or securities. While ERISA prohibits States from regulating an employee benefit plan as an insurance or investment company or bank, the preemption provisions of section 731 of ERISA and sections 2724 and 2762 of the PHS Act (implemented in 29 CFR 2590.731(a) and 45 CFR 146.143(a) and 148.210(b)) apply so that the Federal consumer protections and requirements for comprehensive coverage are not to be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a Federal requirement.²⁸³ The conference report accompanying HIPAA, when this Federal preemption standard was first established for the requirements in title XXVII of the PHS Act, indicates that this is intended to be the “narrowest” preemption of State laws.²⁸⁴

States may continue to apply State law requirements except to the extent that such requirements prevent the application of the Federal requirements that are the subject of this rulemaking. In general, State insurance requirements that are more stringent or more consumer protective than the Federal requirements are unlikely to “prevent the application of” the Federal provisions, and therefore are unlikely to

²⁸² Previously, in 86 FR 51730, 51756, the Departments noted that a total of 55,541 agents and brokers work with issuers. Many of these agents and brokers are likely to be employed by small entities.

²⁸³ A similar preemption provision was established for the Exchange and other federal health insurance requirements that are codified outside of title XXVII of the PHS Act. See section 1311(k) and 1321(d) of the ACA.

²⁸⁴ See House Conf. Rep. No. 104–736, at 205, reprinted in 1996 U.S. Code Cong. & Admin. News 2018 and available at <https://www.congress.gov/congressional-report/104th-congress/house-report/736/1>.

be preempted.²⁸⁵ Accordingly, States have significant latitude to impose requirements on health insurance issuers that are more restrictive or more consumer protective than the Federal requirements.²⁸⁶ States that have current requirements for STLDI or fixed indemnity excepted benefits coverage that are the same as or more restrictive or consumer protective than the Federal standards in these proposed rules could thus continue to apply such State law requirements. States would also have the flexibility to require additional consumer disclosures and to establish additional restrictions under State law in response to market-specific needs or concerns, as long as those requirements would not prevent the application of the Federal requirements. For example, a State law or regulation cannot require issuers to remove language from the Federal consumer notice, as that would prevent the application of the Federal notice requirements.

These proposed rules, if finalized, would not impose requirements on STLDI. Rather, they would define STLDI. Therefore, to the extent a State were to permit or require an issuer of STLDI to issue a policy, certificate, or contract of

insurance that has a longer initial contract term or a longer total coverage period than these proposed rules, if finalized, would specify, that would not constitute a State law that is more generous or consumer-protective than Federal requirements. Rather, any such policy would not fall within the Federal definition of STLDI, and the policy would therefore be subject to all the Federal consumer protections and requirements that apply to individual health insurance coverage.

The Departments are of the view that there is a need for regulatory action at the Federal level given, among other factors, the prevalence of marketing of and enrollment in STLDI through out-of-State associations, and the potential inability of States to regulate and collect information about these associations.²⁸⁷ There is also limited State-level information about STLDI enrollment and premiums.²⁸⁸

While developing these proposed rules, to the extent feasible within the applicable preemption provisions, the Departments have attempted to balance States' interests in regulating health insurance issuers and their health insurance markets, with Congress' intent to provide

uniform minimum protections to consumers in every State. By doing so, it is the Departments' view that they have complied with the requirements of Executive Order 13132.

Douglas W. O'Donnell,
*Deputy Commissioner for Services
and Enforcement,
Internal Revenue Service.*

Lisa M. Gomez,
*Assistant Secretary, Employee Benefits
Security Administration, Department of
Labor.*

Chiquita Brooks-LaSure,
*Administrator,
Centers for Medicare & Medicaid
Services.*

Xavier Becerra,
*Secretary
Department of Health and Human
Services.*

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²⁸⁵ See, e.g., 62 FR 16904 (April 8, 1997), 69 FR 78739 (Dec. 30, 2004), 79 FR 10303 (Feb. 24, 2014), and 86 FR 36872, 36887 (July 13, 2021).

²⁸⁶ *Ibid.*

²⁸⁷ Keith, Katie (2020). "New Congressional Investigation of Short-Term Plans," *Health Affairs*, available at: <https://www.healthaffairs.org/doi/10.1377/forefront.20200626.227261/full/>. See also Curran, Emily, Dania Palanker, and Sabrina Corlette (2019). "Short-Term Health Plans Sold Through Out-of-State Associations Threaten Consumer Protections," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2019/short-term-health-plans-sold-through-out-of-state-associations-threaten-consumer-protections>.

²⁸⁸ Government Accountability Office (2022). "Private Health Insurance: Limited Data Hinders Understanding of Short-Term Plans' Role and Value During the COVID-19 Pandemic," available at: <https://www.gao.gov/products/gao-22-104683>. See also Palanker, Dania and Christina Goe (2020). "States Don't Know What's Happening in Their Short-Term Health Plan Markets and That's a Problem," Commonwealth Fund, available at: <https://www.commonwealthfund.org/blog/2020/states-dont-know-whats-happening-their-short-term-health-plan-markets-and-thats-problem>. See also Congressional Budget Office (2020). "CBO's Estimates of Enrollment in Short-Term, Limited-Duration Insurance," available at: <https://www.cbo.gov/publication/56622>.

List of Subjects

26 CFR Part 1

Income taxes, Reporting and recordkeeping requirements

26 CFR Part 54

Excise taxes, Health care, Health Insurance, Pensions, Reporting and recordkeeping requirements.

29 CFR Part 2590

Child support, Employee benefit plans, Health care, Health insurance, Maternal and child health, Penalties, Pensions, Privacy, Reporting and recordkeeping requirements.

45 CFR Part 144

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 146

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 148

Administrative practice and procedure, Health care, Health insurance, Insurance companies, Penalties, Reporting and recordkeeping requirements.

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Amendments to the Regulations

Accordingly, the Treasury Department and the IRS propose to amend 26 CFR parts 1 and 54 as follows:

PART 1—INCOME TAXES

Paragraph 1. The authority citation for part 1 continues to read in part as follows:

Authority: 26 U.S.C. 7805. * * *

Par 2. Section 1.105-2 is revised to read as follows:

§ 1.105-2 Amounts expended for medical care.

(a) *In general.* Section 105(b) provides an exclusion from gross income with respect to the amounts referred to in section 105(a) (see § 1.105-1) which are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred for the medical care (as defined in section 213(d)) of the taxpayer, the taxpayer's spouse, the taxpayer's dependents (as defined in section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof) (dependents), and any child of the taxpayer who, as of the end of the taxable year, has not attained age 27. Any child to whom section 152(e) applies shall be treated as a dependent of both parents for purposes of section 105(b). (All references to the taxpayer's medical expenses in this section include the medical expenses of the taxpayer, the taxpayer's spouse, the taxpayer's dependents, and any child of the taxpayer who, as of the end of the taxable year, has not attained age 27.) However, the exclusion does not apply to amounts which are attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year. See section 213 and the regulations thereunder. Section 105(b) applies only to amounts which are paid specifically to reimburse the taxpayer for section 213(d) medical care expenses that have been incurred by the taxpayer and that are substantiated

by the plan. Thus, section 105(b) does not apply to amounts that the taxpayer would be entitled to receive irrespective of the amount of medical care expenses the taxpayer incurs or that are paid to reimburse the taxpayer for incurred section 213(d) medical care expenses if the medical care expenses have not been substantiated by the plan. For example, if under a wage continuation plan the taxpayer is entitled to regular wages during a period of absence from work due to sickness or injury, amounts received under such plan are not excludable from the taxpayer's gross income under section 105(b) even though the taxpayer may have incurred medical expenses during the period of illness. Any amounts received under a fixed indemnity plan treated as an excepted benefit under section 9832(c)(3), or any plan that pays amounts regardless of the amount of section 213(d) medical care expenses actually incurred, are not payments for medical care under section 105(b) and are included in the employee's gross income under section 105(a). If the taxpayer incurs an obligation for medical care, payment to the obligee in discharge of such obligation shall constitute indirect payment to the taxpayer as reimbursement for medical care. Similarly, payment to or on behalf of the taxpayer's spouse or dependents or any child of the taxpayer who, as of the end of the taxable year, has not attained age 27 shall constitute indirect payment to the taxpayer.

(b) *Applicability date.* These regulations apply as of the later of the date of the publication of the final regulations or January 1, 2024.

PART 54—PENSION AND EXCISE TAX

Par 3. The authority citation for part 54 continues to read as follows:

Authority: 26 U.S.C. 7805 * * *

Par. 4. Section 54.9801-2 is amended by revising the definition of "Short-term, limited-duration insurance" to read as follows:

§ 54.9801-2 Definitions.

* * * * *

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a policy, certificate, or contract of insurance with an issuer that:

(1) Has an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date of the policy, certificate, or contract of insurance, and taking into account any renewals or extensions, has a duration no longer than 4 months in total. For purposes of this paragraph (1), a renewal or extension includes the term of a new short-term, limited-duration insurance policy, certificate, or contract of insurance issued by the same issuer to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance; and

(2) Displays prominently on the first page (in either paper or electronic form, including on a website) of the policy, certificate, or contract of insurance, and in any marketing, application, and enrollment materials (including reenrollment materials) provided to individuals at or before the time an individual has the opportunity to enroll (or reenroll) in the coverage, in at least 14-point font, the language in the following notice:

"Notice to Consumers About Short-Term, Limited-Duration Insurance

IMPORTANT: This is short-term, limited-duration insurance. **This is temporary insurance. It isn't comprehensive health insurance.** Review your policy carefully to make sure you understand what is covered and any limitations on coverage.

- This insurance might not cover or might limit coverage for:
 - preexisting conditions; or
 - essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, and substance use services, prescription drugs, or preventive care).
- You won't qualify for Federal financial help to pay for premiums or out-of-pocket costs.
- You aren't protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment

period to get comprehensive health insurance.

Visit 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 eligible for coverage through your employer or a family member's employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy."

(3) If any provision of this definition of "short-term, limited-duration insurance" is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of the definition and shall not affect the remainder thereof.

* * * * *

Par. 5. Section 54.9831-1 is amended by:

- a. Revising paragraph (c)(4)(i);
- b. Adding paragraph (c)(4)(ii)(D);
- c. Revising paragraph (c)(4)(iii); and
- d. Adding paragraphs (c)(4)(iv) and (c)(4)(v).

The revisions and additions read as follows:

§ 54.9831-1 Special rules relating to group health plans.

* * * * *

(c) * * *

(4) * * *

(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the applicable conditions specified in paragraph (c)(4)(ii) of this section.

(ii) * * *

(D) With respect to hospital indemnity or other fixed indemnity insurance –

(1) The benefits are paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, \$100/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, or other characteristics particular to a course of treatment received by a covered participant or beneficiary, and not on any other basis (such as on a per-item or per-service basis).

(2) The plan or issuer displays prominently on the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll in the coverage, in at least 14-point font, the language in the following notice:

"Notice to Consumers About Fixed Indemnity Insurance

IMPORTANT: This is fixed indemnity insurance. **This isn't comprehensive health insurance coverage and doesn't** have to include most Federal consumer protections for health insurance.

Visit 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 eligible for coverage through your employer or a family member's employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy."

(3) If participants are required to reenroll (in either paper or electronic form) for purposes of renewal or reissuance of the insurance, the notice described in paragraph (c)(4)(ii)(D)(2) of this section is displayed in any marketing and reenrollment materials provided at or before the time participants are given the opportunity to reenroll in coverage.

(4) If a plan or issuer provides a notice satisfying the requirements in paragraph (c)(4)(ii)(D)(2) and (3) of this section to a participant, the obligation to provide the notice is considered to be satisfied for both the plan and issuer.

(iii) *Examples.* The rules of this paragraph (c)(4) are illustrated by the following examples:

(A) Example 1—

(1) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only related to hospital stays at a fixed percentage of hospital expenses up to a maximum of \$100 a day.

(2) *Conclusion.* Even if the other conditions in paragraph (c)(4)(ii) of this section are satisfied, because benefits are paid based on a percentage of expenses incurred rather than a fixed dollar amount per day (or per other time period, such as per week), the policy does not qualify as an excepted benefit under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of \$100 for every day of hospitalization.

(B) Example 2—

(1) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits when a person receives certain specific items and services in a fixed amount, such as \$50 per blood test or \$100 per visit. The fixed amounts apply to each specific item or service and are not paid per day or per other time period of hospitalization or illness.

(2) *Conclusion.* Even if the other conditions in paragraph (c)(4)(ii) of this section are satisfied, the policy does not qualify as an excepted benefit under this paragraph (c)(4) because the benefits are not paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness, and are not paid without regard to the services or items received. The conclusion would be the same even if the policy added a per day (or per other time period) term to the benefit description (for example, "\$50 per blood test per day"), because the benefits are not paid regardless of the services or items received.

(C) Example 3—

(1) *Facts.* 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 the first benefit package. The two benefit packages are offered to employees at the same time and can be elected together. The benefit packages are not subject to a formal coordination of benefits arrangement.

(2) *Conclusion.* Even if the other conditions in paragraph (c)(4)(ii) of this section are satisfied, the second benefit package's insurance policy does not qualify as an excepted benefit under this paragraph (c)(4) because the benefits under the second benefit package are coordinated with an exclusion of benefits under another group health plan maintained by the same plan sponsor (that is, the preventive-services-only benefit package). The conclusion would be the same even if the benefit packages were not offered to employees at the same time or if the second benefit package's insurance policy did not pay benefits associated with a wide variety of illnesses.

(iv) *Applicability date*— (A) For hospital indemnity or other fixed indemnity

insurance sold or issued on or after a date 75 days after the date of publication of the final rule, the requirements of this paragraph (c)(4) apply for plan years beginning on or after the date 75 days after the date of publication of the final rule.

(B) For hospital indemnity or other fixed indemnity insurance sold or issued before [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL], the requirements of this paragraph (c)(4) apply for plan years beginning on or after January 1, 2027, except that the requirements of paragraphs (c)(4)(ii)(D)(2)-(4) and (c)(4)(v) of this section, apply for plan years beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL].

(C) Until the relevant applicability date for the requirements of this paragraph (c) (4), plans and issuers are required to continue to comply with the corresponding section of § 54.9831-1(c)(4) contained in the 26 CFR, part 54, edition revised as of April 1, 2023.

(v) *Severability.* If any provision of this paragraph (c)(4) is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of this paragraph (c)(4) and shall not affect the remainder thereof.

DEPARTMENT OF LABOR

Employee Benefits Security Administration

29 CFR Chapter XXV

For the reasons stated in the preamble, the Department of Labor proposes to amend 29 CFR part 2590 as set forth below:

PART 2590—RULES AND REGULATIONS FOR GROUP HEALTH PLANS

6. The authority citation for part 2590 continues to read as follows:

Authority: 29 U.S.C. 1027, 1059, 1135, 1161-1168, 1169, 1181-1183, 1181 note, 1185, 1185a, 1185b, 1191, 1191a, 1191b, and 1191c; sec. 101(g), Pub. L. 104-191, 110 Stat. 1936; sec. 401(b), Pub. L. 105-200, 112 Stat. 645 (42 U.S.C. 651 note); sec. 512(d), Pub. L. 110-343, 122 Stat. 3881; sec. 1001, 1201, and 1562(e), Pub. L. 111-148, 124 Stat. 119, as amended by Pub. L. 111-152, 124 Stat. 1029; Division M, Pub. L. 113-235, 128 Stat. 2130; Secretary of Labor’s Order 1-2011, 77 FR 1088 (Jan. 9, 2012).

7. Section 2590.701-2 is amended by revising the definition of “short-term, limited-duration insurance” to read as follows:

§ 2590.701-2 Definitions.

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a policy, certificate, or contract of insurance with an issuer that:

(1) Has an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date of the policy, certificate, or contract of insurance, and taking into account any renewals or extensions, has a duration no longer than 4 months in total. For purposes of this paragraph (1), a renewal or extension includes the term of a new short-term, limited-duration insurance policy, certificate, or contract of insurance issued by the same issuer to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance; and

(2) Displays prominently on the first page (in either paper or electronic form, including on a website) of the policy, certificate, or contract of insurance, and in any marketing, application, and enrollment materials (including reenrollment materials) provided to individuals at or before the time an individual has the opportunity to enroll (or reenroll) in the coverage, in

at least 14-point font, the language in the following notice:

“Notice to Consumers About Short-Term, Limited-Duration Insurance

IMPORTANT: This is short-term, limited-duration insurance. **This is temporary insurance. It isn’t comprehensive health insurance.** Review your policy carefully to make sure you understand what is covered and any limitations on coverage.

- This insurance might not cover or might limit coverage for:
 - preexisting conditions; or
 - essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, and substance use services, prescription drugs, or preventive care).
- You won’t qualify for Federal financial help to pay for premiums or out-of-pocket costs.
- You aren’t protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

Visit [HealthCare.gov](https://www.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 eligible for coverage through your employer or a family member’s employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy.”

(3) If any provision of this definition of “short-term, limited-duration insurance” is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of the definition and shall not affect the remainder thereof.

8. Section 2590.732 is amended by:
- a. Revising paragraph (c)(4)(i);
 - b. Adding paragraph (c)(4)(ii)(D);
 - c. Revising paragraph (c)(4)(iii); and
 - d. Adding paragraphs (c)(4)(iv) and (c)(4)(v).

The revisions and additions read as follows:

§ 2590.732 Special rules relating to group health plans.

* * * * *

(c) * * *

(4) * * *

(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the applicable conditions specified in paragraph (c)(4)(ii) of this section.

(ii) * * *

(D) With respect to hospital indemnity or other fixed indemnity insurance –

(1) The benefits are paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, \$100/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, or other characteristics particular to a course of treatment received by a covered participant or beneficiary, and not on any other basis (such as on a per-item or per-service basis).

(2) The plan or issuer displays prominently on the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll in the coverage, in at least 14-point font, the language in the following notice:

“Notice to Consumers About Fixed Indemnity Insurance

IMPORTANT: This is fixed indemnity insurance. **This isn’t comprehensive health insurance coverage and doesn’t** have to include most Federal consumer protections for health insurance.

Visit 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 eligible for coverage through your employer or a family member’s employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy.”

(3) If participants are required to reenroll (in either paper or electronic form) for purposes of renewal or reissuance of the insurance, the notice described in paragraph (c)(4)(ii)(D)(2) of this section is displayed in any marketing and reenrollment materials provided at or before the time participants are given the opportunity to reenroll in coverage.

(4) If a plan or issuer provides a notice satisfying the requirements in paragraph (c)(4)(ii)(D)(2) and (3) of this section to a participant, the obligation to provide the notice is considered to be satisfied for both the plan and issuer.

(iii) *Examples.* The rules of this paragraph (c)(4) are illustrated by the following examples:

(A) Example 1—

(1) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only related to hospital stays at a fixed percentage of hospital expenses up to a maximum of \$100 a day.

(2) *Conclusion.* Even if the other conditions in paragraph (c)(4)(ii) of this section are satisfied, because benefits are paid based on a percentage of expenses incurred rather than a fixed dollar amount per day (or per other time period, such as per week), the policy does not qualify as an excepted benefit under this paragraph (c)(4). This is the result even if, in practice, the policy pays the maximum of \$100 for every day of hospitalization.

(B) Example 2—

(1) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits when a person receives certain specific items and services in a fixed amount, such as \$50 per blood test or \$100 per visit. The fixed amounts apply to each specific item or service and are not paid per day or per other time period of hospitalization or illness.

(2) *Conclusion.* Even if the other conditions in paragraph (c)(4)(ii) of this section are satisfied, the policy does not qualify as an excepted benefit under this paragraph (c)(4) because the benefits are not paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness, and are not paid without regard to the services or items received. The conclusion would be the same even if the policy added a per day (or per other time period) term to the benefit description (for example, “\$50 per blood test

per day”), because the benefits are not paid regardless of the services or items received.

(C) Example 3—

(1) *Facts.* 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 the first benefit package. The two benefit packages are offered to employees at the same time and can be elected together. The benefit packages are not subject to a formal coordination of benefits arrangement.

(2) *Conclusion.* Even if the other conditions in paragraph (c)(4)(ii) of this section are satisfied, the second benefit package’s insurance policy does not qualify as an excepted benefit under this paragraph (c)(4) because the benefits under the second benefit package are coordinated with an exclusion of benefits under another group health plan maintained by the same plan sponsor (that is, the preventive-services-only benefit package). The conclusion would be the same even if the benefit packages were not offered to employees at the same time or if the second benefit package’s insurance policy did not pay benefits associated with a wide variety of illnesses.

(iv) *Applicability dates.*

(A) For hospital indemnity or other fixed indemnity insurance sold or issued on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL], the requirements of this paragraph (c)(4) apply for plans beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL].

(B) For hospital indemnity or other fixed indemnity insurance sold or issued before [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL], the requirements of this paragraph (c)(4) apply for plan years beginning on or after January 1, 2027, except that the requirements of paragraphs (c)(4)(ii)(D)(2)-(4) and (c)(4)(iii)(A) of this section, apply for plan years beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL].

(C) Until the relevant applicability date for the requirements of this paragraph (c)(4), plans and issuers are required to continue to comply with the corresponding section of § 2590.732(c)(4) contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2022.

(v) *Severability*. If any provision of this paragraph (c)(4) is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of this paragraph (c)(4) and shall not affect the remainder thereof.

9. Section 2590.736 is revised to read as follows:

§ 2590.736 Applicability dates.

Sections 2590.701–1 through 2590.701–8 and 2590.731 through 2590.736 are applicable for plan years beginning on or after July 1, 2005. Until the applicability date for this regulation, plans and issuers are required to continue to comply with the corresponding sections of 29 CFR part 2590, contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2022. Notwithstanding the previous sentence, for short-term, limited-duration insurance sold or issued on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL], the definition of “short-term, limited-duration insurance” in § 2590.701–2 applies for coverage periods beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL]. For short-term, limited-duration insurance sold or issued before [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL] (including any subsequent renewal or extension consistent with applicable law), the definition of “short-term, limited-duration insurance” in the corresponding section of § 2590.701–2 of this subchapter contained in the 29 CFR, parts 1927 to end, edition revised as of July 1, 2022, continues to apply, except that paragraph

(2) of the definition of short-term, limited-duration insurance in § 2590.701–2 of this subchapter applies for coverage periods beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL].

DEPARTMENT OF HEALTH AND HUMAN SERVICES

For the reasons stated in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 144, 146, and 148 as set forth below:

PART 144—REQUIREMENTS RELATING TO HEALTH INSURANCE COVERAGE

10. The authority citation for part 144 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act, 42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92.

11. Section 144.103 is amended by revising the definition of “short-term, limited-duration insurance” to read as follows:

§ 144.103 Definitions.

Short-term, limited-duration insurance means health insurance coverage provided pursuant to a policy, certificate, or contract of insurance with an issuer that:

(1) Has an expiration date specified in the policy, certificate, or contract of insurance that is no more than 3 months after the original effective date of the policy, certificate, or contract of insurance, and taking into account any renewals or extensions, has a duration no longer than 4 months in total. For purposes of this paragraph (1), a renewal or extension includes the term of a new short-term, limited-duration insurance policy, certificate, or contract of insurance issued by the same issuer to the same policyholder within the 12-month period beginning on the original effective date of the initial policy, certificate, or contract of insurance; and

(2) Displays prominently on the first page (in either paper or electronic form, including on a website) of the policy,

certificate, or contract of insurance, and in any marketing, application, and enrollment materials (including reenrollment materials) provided to individuals at or before the time an individual has the opportunity to enroll (or reenroll) in the coverage, in at least 14-point font, the language in the following notice:

“Notice to Consumers About Short-Term, Limited-Duration Insurance

IMPORTANT: This is short-term, limited-duration insurance. **This is temporary insurance. It isn’t comprehensive health insurance.** Review your policy carefully to make sure you understand what is covered and any limitations on coverage.

- This insurance might not cover or might limit coverage for:
 - preexisting conditions; or
 - essential health benefits (such as pediatric, hospital, emergency, maternity, mental health, and substance use services, prescription drugs, or preventive care).
- You won’t qualify for Federal financial help to pay for premiums or out-of-pocket costs.
- You aren’t protected from surprise medical bills.
- When this policy ends, you might have to wait until an open enrollment period to get comprehensive health insurance.

Visit [HealthCare.gov](https://www.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 eligible for coverage through your employer or a family member’s employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy.”

(3) If any provision of this definition of “short-term, limited-duration insurance” is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found

invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of the definition and shall not affect the remainder thereof.

* * * * *

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

12. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg-1 through 300gg-5, 300gg-11 through 300gg-23, 300gg-91, and 300gg-92).

13. Section 146.125 is revised to read as follows:

§ 146.125 Applicability dates.

Section 144.103, §§ 146.111 through 146.119, 146.143, and 146.145 are applicable for plan years beginning on or after July 1, 2005 (*But see* § 146.145(b)(4)(iv) for the applicability dates for hospital indemnity or other fixed indemnity insurance offered in the group market). Notwithstanding the previous sentence, for short-term, limited-duration insurance sold or issued on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL], the definition of “short-term, limited-duration insurance” in § 144.103 of this subchapter applies for coverage periods beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL]. For short-term, limited-duration insurance sold or issued before [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL] (including any subsequent renewal or extension consistent with applicable law), the definition of “short-term, limited-duration insurance” in the corresponding section of § 144.103 of this subchapter contained in the 45 CFR, parts 1 to 199,

edition revised as of October 1, 2021, continues to apply, except that paragraph (2) of the definition of short-term, limited-duration insurance in § 144.103 of this subchapter applies for coverage periods beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL].

14. Section 146.145 is amended by—
- a. Revising paragraph (b)(4)(i);
 - b. Adding paragraph (b)(4)(ii)(D);
 - c. Revising paragraph (b)(4)(iii); and
 - d. Adding paragraphs (b)(4)(iv) and (b)(4)(v).

The revisions and additions read as follows:

§ 146.145 Special rules relating to group health plans.

* * * * *

(b) * * *

(4) * * *

(i) *Excepted benefits that are not coordinated.* Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the applicable conditions specified in paragraph (b)(4)(ii) of this section.

(ii) * * *

(D) With respect to hospital indemnity or other fixed indemnity insurance –

(1) The benefits are paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, \$100/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, or other characteristics particular to a course of treatment received by a covered participant or beneficiary, and not on any other basis (such as on a per-item or per-service basis).

(2) The plan or issuer displays prominently on the first page (in either paper or electronic form, including on a website) of any marketing, application, and enrollment materials that are provided to participants at or before the time participants are given the opportunity to enroll in the coverage, in at least 14-point font, the language in the following notice:

“Notice to Consumers About Fixed Indemnity Insurance

IMPORTANT: This is fixed indemnity insurance. This **isn’t comprehensive health insurance coverage** and **doesn’t** have to include most Federal consumer protections for health insurance.

Visit 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 eligible for coverage through your employer or a family member’s employer, contact the employer for more information. Contact your State department of insurance if you have questions or complaints about this policy.”

(3) If participants are required to reenroll (in either paper or electronic form) for purposes of renewal or reissuance of the insurance, the notice described in paragraph (b)(4)(ii)(D)(2) of this section is displayed in any marketing and reenrollment materials provided at or before the time participants are given the opportunity to reenroll in coverage.

(4) If a plan or issuer provides a notice satisfying the requirements in paragraph (b)(4)(ii)(D)(2) and (3) of this section to a participant, the obligation to provide the notice is considered to be satisfied for both the plan and issuer.

(iii) *Examples.* The rules of this paragraph (b)(4) are illustrated by the following examples:

(A) Example 1—

(1) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only related to hospital stays at a fixed percentage of hospital expenses up to a maximum of \$100 a day.

(2) *Conclusion.* Even if the other conditions in paragraph (b)(4)(ii) of this section are satisfied, because benefits are paid based on a percentage of expenses incurred rather than a fixed dollar amount per day (or per other time period, such as per week), the policy does not qualify as an excepted benefit under this paragraph (b)(4). This is the result even if, in practice, the policy pays the maximum of \$100 for every day of hospitalization.

(B) Example 2—

(1) *Facts.* An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits when a person receives certain specific items and services in a fixed amount, such as \$50 per blood test or \$100 per visit. The fixed amounts apply to each specific item or service and are not paid per day or per other time period of hospitalization or illness.

(2) *Conclusion.* Even if the other conditions in paragraph (b)(4)(ii) of this section are satisfied, the policy does not qualify as an excepted benefit under this paragraph (b)(4) because the benefits are not paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness, and are not paid without regard to the services or items received. The conclusion would be the same even if the policy added a per day (or per other time period) term to the benefit description (for example, “\$50 per blood test per day”), because the benefits are not paid regardless of the services or items received.

(C) Example 3—

(1) *Facts.* 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 the first benefit package. The two benefit packages are offered to employees at the same time and can be elected together. The benefit packages are not subject to a formal coordination of benefits arrangement.

(2) *Conclusion.* Even if the other conditions in paragraph (b)(4)(ii) of this section are satisfied, the second benefit package’s insurance policy does not qualify as an excepted benefit under this paragraph (b)(4) because the benefits under the second benefit package are coordinated with an exclusion of benefits under another group health plan maintained by the same plan sponsor (that is, the preventive-services-only benefit package). The conclusion would be the same even if the benefit packages were not offered to employees at the same time or if the second benefit package’s insurance policy did not pay benefits associated with a wide variety of illnesses.

(iv) *Applicability dates.*

(A) For hospital indemnity or other fixed indemnity insurance sold or issued on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL], the requirements of this paragraph (b)(4) apply for plan years beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL].

(B) For hospital indemnity or other fixed indemnity insurance sold or issued before [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL], the requirements of this paragraph (b)(4) apply for plan years beginning on or after January 1, 2027, except that the requirements of paragraphs (b)(4)(ii)(D)(2)-(4) of this section apply for plan years beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL].

(C) Until the relevant applicability date for the requirements of this paragraph (b)(4), plans and issuers are required to continue to comply with the corresponding section of § 146.145(b)(4) contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2021.

(v) *Severability.* If any provision of this paragraph (b)(4) is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of this paragraph (b)(4) and shall not affect the remainder thereof.

* * * * *

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

15. The authority citation for part 148 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

16. Section 148.102 is amended by revising paragraph (b) to read as follows:

§ 148.102 Scope and applicability dates.

* * * * *

(b) *Applicability dates.* Except as provided in § 148.124 (certificate of creditable coverage), § 148.170 (standards relating to benefits for mothers and newborns), and § 148.180 (prohibition of health discrimination based on genetic information), the requirements of this part apply to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997. Notwithstanding the previous sentence, for short-term, limited-duration insurance sold or issued on or after

[THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL], the definition of “short-term, limited-duration insurance” in § 144.103 of this subchapter applies for coverage periods beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL]. For short-term, limited-duration insurance sold or issued before [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL] (including any subsequent renewal or extension consistent with applicable law), the definition of “short-term, limited-duration insurance” in the corresponding section of § 144.103 of this subchapter contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2021, continues to apply, except that paragraph (2) of the definition of “short-term, limited-duration insurance” in § 144.103 of this subchapter applies for coverage periods beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL].

17. Section 148.220 is amended by revising paragraph (b)(4) to read as follows:

§ 148.220 Excepted benefits.

* * * * *

(b) * * *

(4) Hospital indemnity or other fixed indemnity insurance only if -

(i) 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.

(ii) The benefits are paid in a fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, \$100/day) regardless of the actual or estimated amount of expenses incurred, services or items received, severity of illness or injury experienced by a covered individual, or any other characteristics particular to a course of treatment received by the covered individual and not on any other basis (such as on a per-item or per-service basis), and without regard to whether benefits are provided with respect to the event under any other

health insurance coverage maintained by the same health insurance issuer with respect to the same policyholder.

(iii) The issuer displays prominently on the first page of any marketing, application, and enrollment or reenrollment materials that are provided at or before the time an individual has the opportunity to apply, enroll or reenroll in coverage, and on the first page of the policy, certificate, or contract of insurance, in at least 14-point font, the language in the following notice:

“Notice to Consumers About Fixed Indemnity Insurance

IMPORTANT: This is fixed indemnity insurance. This **isn’t comprehensive health insurance coverage** and **doesn’t** have to include most Federal consumer protections for health insurance.

Visit [HealthCare.gov](https://www.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 eligible for coverage through your employer or a

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

(iv)(A) For hospital indemnity or other fixed indemnity insurance sold or issued on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL], the requirements of this paragraph (b)(4) apply for coverage periods beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL].

(B) For hospital indemnity or other fixed indemnity insurance sold or issued before [THE DATE THAT IS 75 DAYS AFTER THE DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL], the requirements of this paragraph (b)(4) apply for coverage periods beginning on or after January 1, 2027, except that the requirements of paragraph (b)(4)(iii) of this section apply for coverage periods beginning on or after [THE DATE THAT IS 75 DAYS AFTER THE

DATE OF PUBLICATION OF THESE REGULATIONS AS FINAL].

(C) Until the relevant applicability date for the requirements of this paragraph (b)(4), issuers are required to continue to comply with the corresponding section of § 148.220(b)(4) contained in the 45 CFR, parts 1 to 199, edition revised as of October 1, 2021.

(v) *Severability.* If any provision of this paragraph (b)(4) is held to be invalid or unenforceable by its terms, or as applied to any entity or circumstance, or stayed pending further agency action, the provision shall be construed so as to continue to give the maximum effect to the provision permitted by law, along with other provisions not found invalid or unenforceable, including as applied to entities not similarly situated or to dissimilar circumstances, unless such holding is that the provision is invalid and unenforceable in all circumstances, in which event the provision shall be severable from the remainder of this paragraph (b)(4) and shall not affect the remainder thereof.

* * * * *

Definition of Terms

Revenue rulings and revenue procedures (hereinafter referred to as "rulings") that have an effect on previous rulings use the following defined terms to describe the effect:

Amplified describes a situation where no change is being made in a prior published position, but the prior position is being extended to apply to a variation of the fact situation set forth therein. Thus, if an earlier ruling held that a principle applied to A, and the new ruling holds that the same principle also applies to B, the earlier ruling is amplified. (Compare with *modified*, below).

Clarified is used in those instances where the language in a prior ruling is being made clear because the language has caused, or may cause, some confusion. It is not used where a position in a prior ruling is being changed.

Distinguished describes a situation where a ruling mentions a previously published ruling and points out an essential difference between them.

Modified is used where the substance of a previously published position is being changed. Thus, if a prior ruling held that a principle applied to A but not to B, and the

new ruling holds that it applies to both A and B, the prior ruling is modified because it corrects a published position. (Compare with *amplified* and *clarified*, above).

Obsoleted describes a previously published ruling that is not considered determinative with respect to future transactions. This term is most commonly used in a ruling that lists previously published rulings that are obsoleted because of changes in laws or regulations. A ruling may also be obsoleted because the substance has been included in regulations subsequently adopted.

Revoked describes situations where the position in the previously published ruling is not correct and the correct position is being stated in a new ruling.

Superseded describes a situation where the new ruling does nothing more than restate the substance and situation of a previously published ruling (or rulings). Thus, the term is used to republish under the 1986 Code and regulations the same position published under the 1939 Code and regulations. The term is also used when it is desired to republish in a single ruling a series of situations, names, etc., that were previously published over a period of time in separate rulings. If the

new ruling does more than restate the substance of a prior ruling, a combination of terms is used. For example, *modified* and *superseded* describes a situation where the substance of a previously published ruling is being changed in part and is continued without change in part and it is desired to restate the valid portion of the previously published ruling in a new ruling that is self contained. In this case, the previously published ruling is first modified and then, as modified, is superseded.

Supplemented is used in situations in which a list, such as a list of the names of countries, is published in a ruling and that list is expanded by adding further names in subsequent rulings. After the original ruling has been supplemented several times, a new ruling may be published that includes the list in the original ruling and the additions, and supersedes all prior rulings in the series.

Suspended is used in rare situations to show that the previous published rulings will not be applied pending some future action such as the issuance of new or amended regulations, the outcome of cases in litigation, or the outcome of a Service study.

Abbreviations

The following abbreviations in current use and formerly used will appear in material published in the Bulletin.

A—Individual.
Acq.—Acquiescence.
B—Individual.
BE—Beneficiary.
BK—Bank.
B.T.A.—Board of Tax Appeals.
C—Individual.
C.B.—Cumulative Bulletin.
CFR—Code of Federal Regulations.
CI—City.
COOP—Cooperative.
Ct.D.—Court Decision.
CY—County.
D—Decedent.
DC—Dummy Corporation.
DE—Donee.
Del. Order—Delegation Order.
DISC—Domestic International Sales Corporation.
DR—Donor.
E—Estate.
EE—Employee.
E.O.—Executive Order.
ER—Employer.

ERISA—Employee Retirement Income Security Act.
EX—Executor.
F—Fiduciary.
FC—Foreign Country.
FICA—Federal Insurance Contributions Act.
FISC—Foreign International Sales Company.
FPH—Foreign Personal Holding Company.
FR.—Federal Register.
FUTA—Federal Unemployment Tax Act.
FX—Foreign corporation.
G.C.M.—Chief Counsel's Memorandum.
GE—Grantee.
GP—General Partner.
GR—Grantor.
IC—Insurance Company.
I.R.B.—Internal Revenue Bulletin.
LE—Lessee.
LP—Limited Partner.
LR—Lessor.
M—Minor.
Nonacq.—Nonacquiescence.
O—Organization.
P—Parent Corporation.
PHC—Personal Holding Company.
PO—Possession of the U.S.
PR—Partner.
PRS—Partnership.

PTE—Prohibited Transaction Exemption.
Pub. L.—Public Law.
REIT—Real Estate Investment Trust.
Rev. Proc.—Revenue Procedure.
Rev. Rul.—Revenue Ruling.
S—Subsidiary.
S.P.R.—Statement of Procedural Rules.
Stat.—Statutes at Large.
T—Target Corporation.
T.C.—Tax Court.
T.D.—Treasury Decision.
TFE—Transferee.
TFR—Transferor.
T.I.R.—Technical Information Release.
TP—Taxpayer.
TR—Trust.
TT—Trustee.
U.S.C.—United States Code.
X—Corporation.
Y—Corporation.
Z—Corporation.

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¹ A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2023–27 through 2023–52 is in Internal Revenue Bulletin 2023–52, dated December 27, 2023.

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¹ A cumulative list of all revenue rulings, revenue procedures, Treasury decisions, etc., published in Internal Revenue Bulletins 2023–27 through 2023–52 is in Internal Revenue Bulletin 2023–52, dated December 27, 2023.

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