555 12th St. NW, Ste. 1001
Washington, D.C. 20004

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September 6, 2023

Hon. Janet Yellen, Secretary of the Treasury
Hon. Xavier Becerra, Secretary of Health and Human Services
Hon. Julie A. Su, Acting Secretary of Labor
c/o Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-9904-P, P.O. Box 8010, Baltimore, MD 21244-8010

Dear Madam Secretary, Mr. Secretary, and Madam Acting Secretary:

RE: Treasury/Labor/HHS Notice of Proposed Rulemaking titled "Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance," CMS-9904-P, 88 *Fed. Reg.* 44596 (July 12, 2023)

This letter presents comments of the National Federation of Independent Business (NFIB)[1] on the Departments of the Treasury, Labor, and Health and Human Services ("the Departments") notice of proposed rulemaking titled "Short-Term, Limited-Duration Insurance; Independent, Noncoordinated Excepted Benefits Coverage; Level-Funded Plan Arrangements; and Tax Treatment of Certain Accident and Health Insurance" and published in the *Federal Register* of July 12, 2023. According to a recent survey of small businesses with employees, 56% offer health insurance to those employees and 44% percent do not. The size of the organization matters; 89% of small businesses with 30 or more employees offer those employees health insurance, while only 39% of small businesses with fewer than 10 employees do. Of the 44% of small businesses with employees that do not offer health insurance to those employees, 65% report that offering health insurance would be too expensive.[2] Given this information, the Departments should focus on (1) ensuring that small businesses, and especially those with fewer than 10 employees, can provide to employees or otherwise assist employees to obtain affordable, flexible, and predictable health benefits that they want and need, and (2) making the funding and administration of employer-provided health benefits as easy as possible for small businesses. Regrettably, the proposed rules hinder achievement of these objectives. NFIB asks that the Departments withdraw the proposed rules.

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[1] NFIB is an incorporated nonprofit association representing small and independent businesses. NFIB protects and advances the ability of Americans to own, operate, and grow their businesses and ensures that governments of the United States and the fifty states hear the voice of small business as they formulate public policies.

[2] NFIB Research Center, "Small Business Health Insurance Survey" (March 2023), pages 2 and 4, available at https://strgnfibcom.blob.core.windows.net/nfibcom/Health-insurance-survey-NFIB.pdf (visited August 24, 2023).

1. Need Availability of Short-Term, Limited-Duration Health Insurance for Up to Three Years

Section 2791(b)(5) of the Public Health Service Act states: "The 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." [3] As a result of this statutory exclusion, short-term, limited-duration health insurance (STLDI) need not comply with many federal mandates applicable to individual health insurance coverage that hike the cost to consumers of health insurance coverage. Examples of the cost-hiking mandates that do not apply to STLDI include: (1) coverage of pre-existing conditions, maternity and pediatric care, mental health and substance abuse care, preventive care, and prescription drug costs; (2) prohibitions on annual dollar limits on coverage; and (3) restrictions on discounts based on health status, age, gender, and tobacco non-use.[4] Thus, STLDI offers a choice of more affordable, flexible, and predictable health insurance coverage for small business employers to offer their employees or for those employees to obtain on their own.

Under current sections 54.9801-2 of title 26, 2590.701-2 of title 29, and 144.103 of title 45 of the Code of Federal Regulations, an STLDI contract "[h]as an expiration date 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," and bears a mandated notice alerting consumers about the limitations of the policy. The Departments propose to take away much of the benefit to consumers of STLDI by revising the definition of STLDI to read in part: "[h]as 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."[5] In short, current rules give consumers a choice of more affordable, flexible, and predictable STLDI for a maximum of 3 years, but the Departments propose to cut that down to a maximum of 4 months, taking away from consumers 32 months of potential STLDI health insurance coverage.

The Departments say why they want to force consumers to give up STLDI after 4 months:

> 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 individual health insurance coverage.[6]

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[3] 42 U.S.C. 300gg-91(b)(5).

[4] 88 *Fed. Reg.* at 44598, col. 3. See 42 U.S.C. 300gg, 300gg-3, 300gg-4, 300gg-11, and 18022.

[5] 88 *Fed. Reg.* at 44650, col. 2 (proposed Department of the Treasury rule), 44652, col. 3 (proposed Department of Labor rule), 44655, col. 2 (proposed Department of Health and Human Services rule).

[6] 88 *Fed. Reg.* at 44608, col. 3. Congress lacks constitutional power to compel the purchase of insurance. *NFIB v. Sebelius*, 567 U.S. 519, 555 (2012) ("The Framers gave Congress the power to *regulate* commerce, not to *compel* it . . . ."). And since Congress has no such power, neither do the Departments. *NFIB v. Department of Labor, OSHA*, 142 S. Ct. 661, 665 (2022) ("Administrative agencies are creatures of statute. They accordingly possess only the authority that Congress has provided.").

Thus, the Departments say that if they allow people to stay on STLDI for more than 4 months, it will result in "increased premiums for individuals seeking to purchase individual health insurance coverage." Of course, the Departments fail to say that forcing people off STLDI after 4 months would result in increased health insurance premiums for them (or, in some circumstances, no health insurance coverage at all). The Departments pick winners and losers with their proposed rules, and they have decided that consumers who would like to have STLDI coverage will be the losers.

The decisions of free people acting in a free market -- and not the government -- should determine what types of insurance coverage companies offer and what prices people will pay for such coverage. The Departments should cease heavy-handed regulation of the health insurance market and allow health insurance companies to offer, and consumers to choose, short-term, limited-duration health insurance policies for up to a total of three years, as the current rules of the Departments provide.

2. Need Level-Funded Plan Arrangements for Small Businesses

The Departments noted increasing use by small business employers of "level-funded plan arrangements" (LFPA or "level-funded plan"), which the Departments described as follows: "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)."[7] The Departments cited survey data that, of small employers (defined for purposes of the survey as having 3 to 199 employees), 13% in 2020, 42% in 2021, and 38% in 2022 offered a level-funded plan.[8] The Departments noted that they have "heard concerns" and "received questions from interested parties" relating to "level-funded arrangements' status as self-funded plans."[9]

The Departments state that the unidentified interested parties have raised a concern 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."[10] First, the inapplicability of the Federal consumer protections and requirements (a departmental code phrase for some mandates enacted by the Obamacare statute[11]) is a feature, and not a bug, of LFPAs because it helps control the costs of such arrangements. Secondly, the Departments' statement reflects no concern about LFPAs if large employers use them, but finds it necessary to address concerns raised by unidentified interested parties with respect to LFPAs when small businesses use them. The pro-big

[7] 88 *Fed. Reg.* at 44604, col. 2.

[8] 88 *Fed. Reg.* at 44632, cols. 2 and 3.

[9] 88 *Fed. Reg.* at 44632, col. 3.

[10] 88 *Fed. Reg.* at 44633, col. 1.

[11] Patient Protection and Affordable Care Act, Public Law 111-148 (March 23, 2010), as amended.

business, anti-small business statement of the Departments conflicts with their duty under the Regulatory Flexibility Act to take special account of the needs of small businesses.[12]

The Departments also cite the unnamed interested parties as having 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."[13] Once again, the specter of government picking winners and losers rears its ugly head. The Departments should not seek to force small businesses and their employees into the State's small group health insurance market. Small businesses that wish to remain outside the small group health insurance market and instead use LFPAs should have the freedom to make that choice in the insurance market.

Please do not try to fix what is not broken. Use by small businesses of LFPAs under the current statutory and regulatory regime helps furnish health care protection for the employees of those businesses.[14]

3. Need Hospital Indemnity or Other Fixed Indemnity Insurance as Excepted Benefit

Under federal law,[15] "hospital indemnity or other fixed indemnity insurance" provided under a separate insurance policy, that does not coordinate provision of the benefits upon occurrence

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[12] The Regulatory Flexibility Act (RFA), Public Law 96-354, 5 U.S.C. 601 note, calls for the Departments to take proper account of the concerns of small businesses. In paragraph 2(a)(4) of the RFA, Congress declared that "the failure to recognize differences in the scale and resources of regulated entities has in numerous instances adversely affected competition in the marketplace, discouraged innovation and restricted improvements in productivity . . . ." Congress also noted in paragraph 2(a)(6) of the RFA that "the practice of treating all regulated businesses, organizations, and governmental jurisdictions as equivalent may lead to inefficient use of regulatory agency resources, enforcement problems, and, in some cases, to actions inconsistent with the legislative intent of health, safety, environmental and economic welfare legislation . . . ." The Departments also make unwarranted general assumptions that small business employers may not be well-informed about their LFPAs: (1) "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," 88 *Fed. Reg.* at 44633, col. 1, and (2) "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," 88 *Fed. Reg.* at 44633, col. 2. If the Departments genuinely believe that small businesses do not understand their stop-loss coverage, the solution would be to require clarity from big insurance businesses as they sell stop-loss coverage to small businesses.

[13] 88 *Fed. Reg.* at 44633, col. 2.

[14] Separately, the Departments should reconsider the lack of transparency in their practice of accepting off-the-record attacks on the practices of small businesses from "interested parties" and then using those attacks as the basis for calling for comments on the record from small businesses to defend against the attacks, all while affording anonymity to the "interested parties." To ensure transparency in the rulemaking process, the Departments should identify on the record the "interested parties" and the concerns each of them expressed when the Departments call for responses on the record from others to those concerns.

[15] See sections 9832(c)(3) and 9831(c)(2) of the Internal Revenue Code (26 U.S.C. 9832(c)(3) and 9831(c)(2)); sections 733(c)(3) and 732(c)(2) of the Employee Retirement Income Security Act (29 U.S.C. 1191b(c)(3) and 1191a(c)(2)); and sections 2791(c)(3) and 2722(c)(2) of the Public Health Service Act (42 U.S.C. 300gg-91(c)(3) and 300gg-21(c)(2)).

of a health-related event with an exclusion of benefits under a group health plan of the same plan sponsor, and that provides for payment of benefits without regard to whether benefits are provided with respect to such event under such a group health plan is an "excepted benefit" and is therefore not subject to Federal consumer protections and requirements for comprehensive coverage (again, meaning some Obamacare mandates). Hospital indemnity or other fixed indemnity insurance that qualifies as an excepted benefit provides a fixed, predetermined level of cash benefits that become payable upon the occurrence of a specified health-related event, such as a period of hospitalization or illness.[16] As with STLDI and

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[16] 88 *Fed. Reg.* at 44622, col. 1. Section 105(b) of the Internal Revenue Code (IRC), 26 U.S.C. 105(b), provides (with various exceptions) that gross income does not include amounts an employee receives through accident or health insurance for personal injuries or sickness if the amounts "are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by him for the medical care . . . of the taxpayer, his spouse, his dependents . . ., and any child . . . of the taxpayer who as of the end of the taxable year has not attained age 27." The Treasury regulation at 26 CFR 1.105-2 that implements section 105(b) states in part:

> Section 105(b) applies only to amounts which are paid specifically to reimburse the taxpayer for expenses incurred by him for the prescribed medical care. Thus, section 105(b) does not apply to amounts which the taxpayer would be entitled to receive irrespective of whether or not he incurs expenses for medical care.

The Treasury-proposed 26 CFR 1.105-2, 88 *Fed. Reg.* at 44649, col. 3 to 44650, col. 1, states in part:

> 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.

Under both the current and the proposed regulations, the section 105(b) exclusion from gross income does not apply if the benefit is paid without regard to the actual amount of medical expenses the employee incurred, as is the case with benefit payments under hospital indemnity or other fixed indemnity insurance excepted benefits coverage and specified illness or disease excepted benefits coverage. Since the gross income of the taxpayer-employee would include those benefit payment amounts from the employer's plan, the employer would have responsibility for handling income tax withholding, social security taxes, and federal unemployment tax with respect to those amounts.

Setting to one side hospital indemnity or other fixed indemnity insurance excepted benefits coverage and specified illness or disease excepted benefits coverage, and turning to employer-offered health insurance plans that provide reimbursement to employees for medical expenses they incur, the proposed rule makes clear that section 105(b) excludes those medical expense reimbursements from gross income. But the proposed rule imposes a new requirement that, if the employer is to treat those reimbursements as excluded from the employee's gross income, the employer's plan must have substantiation of the medical expenses. As stated above, the proposed rule says, "[t]hus, section 105(b) does not apply to amounts . . . 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."

While the Treasury Department has authority to mandate the keeping of records by anyone liable for a tax, or for the collection of a tax, IRC section 6001, 26 U.S.C. 6001, the Department would exceed its statutory authority in establishing this rule that purports to deprive the taxpayer-employee of the exclusion from gross income because a third party -- the employer's plan -- has failed to substantiate the employer-taxpayer's medical expenses. The Department has no authority to graft its third-party substantiation condition onto the specific, exclusive conditions for exclusion from gross income set forth in the section 105(b). *Defenders of Wildlife v. Salazar*, 729 F. Supp. 2d 1207, 1219 (D. Mont. 2010) ("Neither the Court nor the agency is free to add or subtract words, phrases, or otherwise change what Congress has written . . . .").

LFPAs, hospital indemnity or other fixed indemnity insurance that qualifies as an "excepted benefit" costs less than it otherwise would because the Federal consumer protections and requirements for comprehensive coverage do not apply.

The proposed rules make it harder for hospital indemnity or other fixed indemnity insurance to qualify as an "excepted benefit." For example, under current rules applicable to the individual market, hospital indemnity or other fixed indemnity insurance may offer a benefit that is either a fixed amount per period (e.g., $100 per day) or a fixed amount per service (e.g., $50 per visit),[17] but the proposed HHS rule eliminates the fixed amount per service option.[18] Instead of narrowing the options of small business employers that cannot afford to offer comprehensive health insurance, the Department should expand their options.[19]

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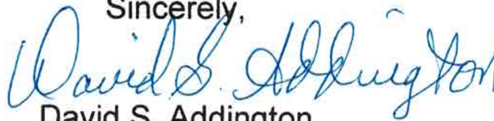
The Departments propose to cut back on three mechanisms -- short-term, limited-duration health insurance, level-funded plan arrangements, and hospital indemnity or other fixed indemnity insurance -- that small business employers can use to assist their employees in meeting the medical costs of those employees and their families. It does not escape notice that the three mechanisms that the Departments seek to cut back have a common feature: affordability due to exemption from many of the Obamacare government mandates. The Biden Administration should not sacrifice the health care benefits of employees of small business on the altar of uniform, government-controlled health care.

Small businesses and their employees need access to affordable, flexible, and predictable health benefits. The last thing they need is their government making it harder, and more expensive, for them to get health benefits. NFIB recommends and requests that the Departments withdraw the proposed rules.

Sincerely,



David S. Addington
Executive Vice President and General Counsel

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[17] 45 CFR 148.220(b)(4)(iii).

[18] Proposed 45 CFR 148.220(b)(4)(ii), 88 *Fed. Reg.* at 44657, col. 3.

[19] Although the Departments did not propose to change rules relating to qualification as an "excepted benefit" of coverage for a specified disease or illness (e.g., a cancer-only policy), the Departments inquired whether new rules might be appropriate. 88 *Fed. Reg.* at 44632, col. 1. The Departments should not discourage employers from offering such coverages to their employees as one of the options the employees are free to choose.