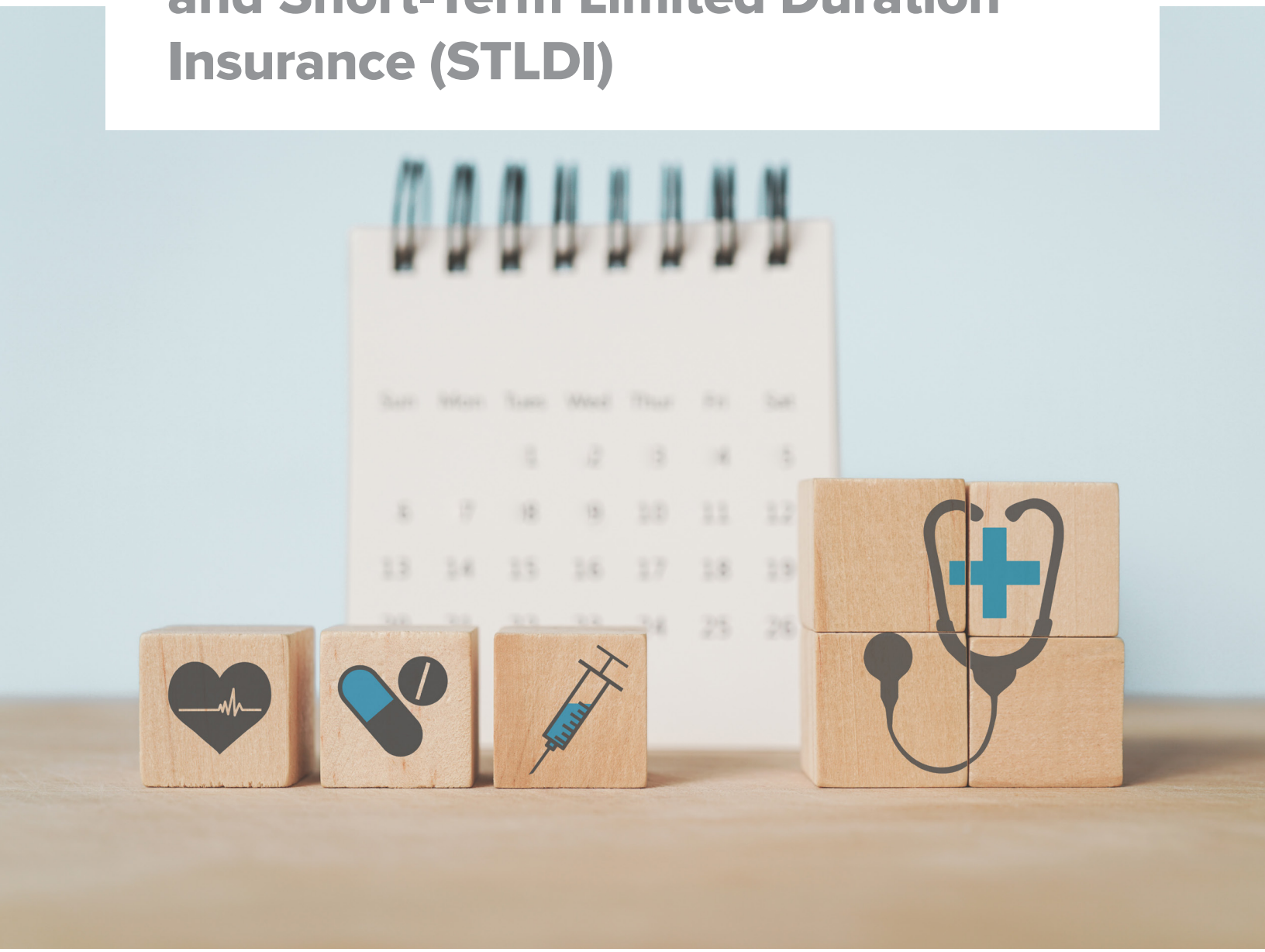
AUGUST 2023

Aflac | Federal Relations Advisory

Changes Proposed for Supplemental Fixed Indemnity Health Benefits and Short-Term Limited Duration Insurance (STLDI)



New federal limits on the maximum permitted period for short-term limited duration insurance (STLDI) have been expected for some time. A proposed rule published by federal regulators on July 12, 2023 would cut back the current 36-month limit on STLDI. However, the proposed rule would also impose new restrictions on certain supplemental fixed indemnity health benefits. In particular, it would impose significant limitations on the structure of hospital indemnity and other fixed indemnity supplemental benefits. It also proposes to change the tax treatment of benefits under all health indemnity plans (fixed indemnity as well as benefits under specified disease plans like cancer or critical illness plans). Additionally, the proposed rule also requests comments on other issues.

Although federal regulators give various reasons for proposing these changes, a primary concern is that consumers may not fully understand the difference between the comprehensive major medical coverage provided through an ACA-compliant policy and the more limited coverage provided through supplemental benefits (or STLDI). The proposals, however, are very broad, and would essentially reduce and even eliminate the types of supplemental products available today.

If finalized, **recently proposed rules targeted primarily at STLDI would also impact supplemental benefits that have been an important option to help provide additional financial protection in the event of a covered accident or illness. For now, there is no change and these proposals might not be finalized or, if they are, may be revised.**

Supplemental coverage

No major medical policy, no matter how robust, covers all the expenses associated with an accident or illness. Major medical plans generally have deductibles and co-payments as well as other exclusions and limits on benefits. Further, there are many expenses associated with an accident or illness that major medical is not intended to cover, such as medical-related travel, childcare needed when going to the doctor, or other expenses. Supplemental products are not major medical coverage or a substitute for major medical coverage, rather they are intended to provide additional financial protection when a covered accident or illness occurs. There are various types of supplemental coverage, including accident, disability, cancer or critical illness, and hospital and other medical fixed indemnity products. These products are also referred to as "excepted benefits" because by law they are "excepted" from the ACA and certain other federal health coverage mandates, provided certain requirements are met. Like other types of insurance, supplemental benefits are subject to regulation under state law.

Proposed changes to hospital indemnity or other fixed indemnity supplemental coverage

Hospital indemnity and other fixed indemnity is one type of supplemental or "excepted" benefit. These plans typically pay a cash benefit directly to the insured (unless otherwise assigned) based on a medical trigger, which may be used for any purpose at the discretion of the insured. The policy sets forth covered medical events (e.g., hospitalization, visit to a doctor, x-ray) and the fixed payment applicable to that medical event. The proposed rule, if adopted, would significantly impact the way that benefits under these plans are structured.

If finalized, the proposed rules would eliminate the ability to vary the amount of benefits by the services or items received, severity of illness or injury, or any other characteristics particular to a course of treatment. This change would apply in both the individual and group markets. Currently, individual market regulations allow benefits to vary on a per service and/or per period basis. The group market regulations are different but still allow the ability to pay benefits that include a per period limitation and also vary the fixed payment by the specific triggering event. Benefits structured in this way reflect the fact that different health events present different risks of financial loss and varying needs for additional financial protection. States have regularly approved products structured in this way because of the value they provide to consumers.

If finalized, the proposed rules would reinterpret and expand the meaning of "noncoordinated" benefits in group and individual markets.

- One of the current requirements for hospital indemnity and other fixed indemnity excepted benefits coverage in the group market is that it cannot be coordinated with other coverage offered by the same plan sponsor. In addition, such excepted benefits plans must pay benefits for an event without regard to whether benefits are also paid under any group health plan maintained by the plan sponsor.
- Coordination of benefits, or "COB", is a term used in the insurance industry that is commonly understood to mean coordinating specific payments between plans when an individual has coverage under more than one plan.
- The proposed rule would significantly broaden the interpretation of this rule beyond the current COB rules and practices and apply the prohibition to hospital indemnity and other fixed indemnity excepted benefits coverage that complement other health coverage offered by the same plan sponsor (or same insurer in the individual market). As illustrated by an example in the group market proposed rule, this new interpretation would prohibit the practice of offering two benefit packages where one package covers preventive services but excludes most other services, and the second package provides hospital indemnity or other fixed indemnity excepted benefits coverage for items or services that are excluded from the first package.
- The plan described in the example is not a very common design. Thus, the example might lead to the mistaken conclusion that this new interpretation applies in only limited circumstances. However, the discussion regarding the proposed rule makes it clear that this is merely one example and that the concept could be applied so broadly so as to impact any two plans offered by the same employer (or same insurer in the individual market). It is very common for employers to offer both a major medical plan that provides broad medical expense reimbursement coverage and a hospital indemnity or other fixed indemnity excepted benefit plan such as voluntary supplemental coverage to help with unanticipated costs.
- The end result of this expansive interpretation would mean that supplemental hospital indemnity or other fixed indemnity coverage can only be offered to employees (or individuals) with no other health coverage. Such a result would be a complete disruption of how supplemental coverage is offered today and would restrict the ability of individuals with comprehensive coverage to also have supplemental coverage.

If finalized, proposed rules would impose new notice requirements. A core purpose of the proposed rules is to reduce possible confusion and help employees and individuals understand the nature of the coverage they buy. New notice requirements go directly to this purpose. There is already a notice requirement in the individual market, that notice would be revised and a new notice requirement would apply in the group market. In general, the notice is designed to make it clear that the supplemental coverage is not comprehensive coverage and is not required to include most federal consumer protections. The details of the notice can be found in the proposed rule.

Proposed changes to the tax treatment of supplemental health benefits

The proposed rule would make major changes to the tax treatment of supplemental health benefits that pay on a fixed indemnity basis (i.e., a set cash amount), including both specified disease plans (e.g., cancer only or critical illness) and hospital indemnity or other fixed indemnity plans. Although described as a "clarification" the proposed rule is actually a significant change and will result in increased income taxes on employees, as well as increased FICA and FUTA taxes on employees and employers.

Currently, the tax treatment of benefits paid under fixed indemnity health plans is well established and depends on whether the premium was paid on an after-tax or pretax basis.

- If the premiums for the plan are paid by the individual on an after-tax basis, then the benefits received are not subject to tax.
- If the premiums are paid on a pretax basis through employer contributions or employee pretax salary reduction through a cafeteria plan, then whether the benefits are taxable depends on the individual's unreimbursed medical expenses. If the amount paid under the plan does not exceed the individual's related unreimbursed medical expenses, then the amount received is not includible in the employee's income. However, if the amount received under the fixed indemnity plan is more than the individual's related unreimbursed medical expenses, then the "excess benefit," meaning the amount in excess of such unreimbursed medical expenses, is taxable.
    - IRS Revenue Ruling 69-154 sets forth the "excess benefit" rule and includes some detailed examples. Under Revenue Ruling 69-154, determining the amount, if any, of taxable benefits under a fixed indemnity health plan paid for with pretax dollars involves a variety of factors which are known only to the employee (and not the employer or insurer). These factors include what other coverage the individual has, the total amount of medical expenses and the amount of reimbursed medical expenses. If the employee has more than one fixed indemnity plan, such as a plan paid with post-tax dollars, the calculation may be more involved, as the employee may need to allocate expenses between the various plans. The employee will make this determination with their tax advisor when filing their personal income taxes for the year in question.

Under the proposal, if premiums are paid on a pretax basis (either by the employer or by employee pretax salary reduction), then the entire amount of the benefit would be taxable income regardless of the amount of the employee's unreimbursed medical expenses. In other words, currently only the "excess benefit" is subject to tax. Under the proposal, the entire benefit would be subject to tax.

The explanation of the proposed rule also indicates that when the premium is paid on a pretax basis, then the benefits are also subject to employment taxes, although there is no clear mechanism for determining or withholding such taxes.

If the proposal is finalized, then many employers may prefer to offer the benefits on an after-tax basis, in which case the benefit will be tax free.

Proposed changes to the permitted length of STLDI

Unlike supplemental excepted benefit coverage discussed above, STLDI is considered a form of primary medical coverage, generally intended to fill temporary gaps in coverage, for example, between jobs or between school and a job. STLDI is available in the individual market only. Because STLDI is intended to be temporary in nature, it is exempt from the ACA and other federal health coverage mandates. The identifying feature of STLDI is that it must be "short-term". Federal regulations have varied over time as to what time period is considered to be "short-term". Initially, in 1997, STLDI was generally limited to a coverage period of less than 12 months. Regulations adopted in 2016 further restricted STLDI to less than 3 months. The current regulations, adopted in 2018, provide for an initial coverage period of less-than 12 months and, with renewals, a total coverage period of 36 months.

Under the new proposed rules, the initial coverage period for STLDI would be limited to no more than 3 months, and the total coverage period could be no more than 4 months (including any extensions or renewals).

These proposed changes do not prevent an individual from obtaining a new STLDI plan from a different issuer once a current plan expires; however, there are limitations that would prevent an individual from "stacking" policies from the same issuer. This means that an individual could not obtain a new STLDI plan from the same issuer within 12 months from the effective date of a previous STDLI plan from the same issuer. An individual could purchase another STDLI plan from an issuer that has not provided the individual with STLDI coverage within the previous 12-month period.

The proposed rule would also modify the existing notice requirement for STLDI.

Request for comments

Although not proposing any changes to the structure of specified disease plans, the regulators asked for comments on such plans and list some specific issue areas of interest. This request for comments indicates that they may be considering additional restrictions on such plans, including potentially restrictions similar to those proposed for hospital indemnity and other fixed indemnity supplemental excepted benefits.

Federal regulators are also gathering information on level-funded plan arrangements. In general terms, a level-funded arrangement is a type of self-funded plan in which the plan makes monthly payments to a service provider to cover estimated claims costs and premiums for stop-loss insurance coverage for claims above a certain level (referred to as the attachment point). It is common practice for sponsors of self-funded plans to purchase stop-loss coverage as protection against catastrophic or unpredictable claims. For small employers, self-funded plans may be of interest because certain of the ACA requirements in the small group market do not apply to self-funded plans (e.g., the requirement to offer essential health benefits does not apply to self-funded plans).

In the case of a level-funded arrangement, the self-funded plan is subject to all applicable federal health care mandates. However, the stop-loss coverage is not health coverage, but is regulated at the state level. Different states have different requirements for stop-loss coverage, including the attachment point. The concern of federal regulators with level-funded arrangements centers on small employers that self-fund their health plans using stop-loss insurance at low attachment points. Some of the main concerns expressed by the regulators is that small employers may not fully understand the arrangements (and their obligations) and that increasing use of such arrangements might adversely impact the ACA small employer market.

Next steps and effective dates

The proposed changes are undergoing a comment period, which lasts through September 11, 2023. Federal regulators will review comments and as they consider whether to adopt the rules as proposed, make changes, or only finalize part of the rules. There is no set date for when regulations could become final.

The effective date for the proposed changes varies, but in general are tied to when the rules are finalized. Many of the changes apply to both new and existing plans, but with a later effective date for existing policies. Note that many impacted plans are guaranteed renewable, which could create a conflict between the plan (and state law requirements) and new federal rules.

Proposed change	Proposed effective date
Changes to requirements for hospital indemnity and other fixed indemnity excepted benefit plans	General effective date: Plans sold or issued starting 75 days after a final rule is published. For plans sold or issued before the general effective date, plan years (coverage periods in the individual market) beginning on or after Jan. 1, 2027. However, the notice requirement would apply starting 75 days after a final rule is published.
Changes to tax treatment	The later of the date of publication of the final rule or Jan. 1, 2024.
Changes to the requirements for STLDI	General effective date: Plans sold or issued starting 75 days after a final rule is published. For plans sold or issued before the general effective date, existing plans, the current rules regarding duration would apply, subject to any state law limitations. The notice requirement would apply starting 75 days after publication of a final rule.

Conclusion

If finalized, the proposed changes will have a significant negative impact on the supplemental coverage market, specifically with respect to hospital indemnity and other fixed indemnity coverage and, with respect to the tax changes, specified disease polices as well. The proposals, if finalized, will restrict and could eliminate popular products that have long been available for employers to offer to their employees and for individuals to use to provide an additional layer of financial protection. This advisory has provided a high-level overview of the proposed changes. Employers and others should consult their own advisors as to how they would be impacted if these proposed changes are finalized.

WWHQ | Tier One| 1932 Wynnton Road | Columbus, GA 31999

22 Corporate Woods Boulevard, Suite 2 | Albany, New York 12211

Continental American Insurance Company | Columbia, South Carolina

Aflac | Federal Relations Advisory