



July 31, 2017

The Honorable Steven Mnuchin  
Secretary of the Treasury  
1500 Pennsylvania Avenue, N.W.  
Washington, D.C. 20220

RE: 82 FR 27217; Document Number 2017-12319

*Submitted Electronically Via Regulations.Gov*

Dear Secretary Mnuchin:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists. We are pleased to have the opportunity to respond to the Department of Treasury's request for information about regulations that could be eliminated, modified or streamlined to reduce the compliance burden on individual Americans and American businesses that was published in the *Federal Register* on June 14, 2017.

The members of NAHU work on a daily basis to help millions of individuals and employers purchase, administer and utilize health insurance coverage. Over the past seven years, since the passage of the Patient Protection and Affordable Care Act (ACA), our members have worked directly and tirelessly with millions of individuals and employers of all sizes to help them obtain new coverage necessitated by the ACA and to assist them with the many health reform implementation and compliance changes the ACA has required. As such, we truly appreciate this request for information about reducing the regulatory burden for individuals and employers. We believe that there is much the Trump Administration and the Department of Treasury can do to serve consumers better, as well as lower costs and create greater private health insurance market stability via regulatory changes, new sub-regulatory guidance and reframed strategies regarding ACA implementation policies.

To ensure our response to your request was both thorough and reflective of the real-world experiences and views of insurance agents and brokers and their individual and employer clients, NAHU convened a working group of members from around the country. Members included those who sell and service health insurance coverage to individual and business consumers and experts who specialize in health reform compliance. The group reviewed all of NAHU's past comment letters to the Obama and Trump Administrations about ACA-related regulatory issues and noted how these matters have or have not been handled to date by the Treasury Department or other federal departments or agencies. They also



discussed how private health insurance markets and consumers have been affected by specific ACA regulatory provisions to date, and whether making changes to specific in-force requirements would still have a beneficial impact. These discussions formed the basis for NAHU's detailed suggestions, as did the direct observations of experts in the fields of health insurance plan administration and consumer service.

Additionally, we note that while this request for information originated from Treasury, many ACA-related regulations issued between 2010 and 2016 were promulgated jointly with the Departments of Labor and Health and Human Services. In order to provide the most comprehensive suggestions possible, NAHU has purposefully elected to include information about some problematic policies or requirements that Treasury has issued in conjunction with HHS and/or the DOL.

NAHU has divided our detailed comments by topic for your convenience. However, as a general comment, over the past seven years of ACA implementation, one area where the Obama Administration was very inconsistent, and NAHU feels the Trump Administration could easily achieve regulatory improvement, is in providing ACA compliance education and support to employer-sponsored health plans. While Treasury, as well as the DOL and HHS, did provide some instructional materials and resources to group plans, they often were lengthy, confusing and hard to interpret. NAHU feels that Treasury would do well to focus on helping employers and issuers comply with the ACA's myriad requirements by providing reasonable deadlines, lengthy transition periods and ample time for public comment, as well as utilizing a good-faith compliance enforcement standard with employers and health plans whenever possible. Additionally, as the ACA changes and evolves, we hope that you will focus on educating the public about any plan changes they need to make, including always providing detailed public information support, model documents and extensive compliance examples.

### **Information Reporting Requirements**

The ACA requires applicable large employers (ALEs) and health insurance issuers to report extensive health coverage information to the federal government annually to effectively enforce the law's individual and employer mandates and help verify individual eligibility for health insurance premium tax credit subsidies. IRC §§ 6055 and 6056 require employers and insurance carriers to gather numerous pieces of data on a monthly basis and report them annually to the Internal Revenue Service and individuals. The information reporting is intended to verify compliance with the individual and employer mandates, and administer premium tax credits and cost-sharing subsidies under the state and federally facilitated insurance exchanges. Section 6055 requires employers that offer self-funded plans and insurers to file a return with the IRS and provide a statement to each individual who is covered by plans that constitute minimum essential coverage. Section 6056 requires ALEs subject to the ACA's employer mandate to file a return with the IRS and provide a statement to each full-time employee with information regarding the offer of employer-sponsored healthcare coverage.



NAHU believes that the IRC §§6055-56 reporting process could be substantially improved to the benefit of employers and issuers, the Administration and affected health insurance consumers. Changes could reduce costs for employers and issuers and make subsidy administration and verification much simpler and more effective.

NAHU urges the Trump Administration to allow for a voluntary certification system that complements the ACA's information reporting requirements under IRC §§6055-56 so that employers could report to the IRS that they are offering ACA-compliant coverage to full-time employees. Under such a system, employers could confidentially attest that they offer coverage that meets the ACA's employer shared-responsibility provisions and could certify that they offer at least one plan that meets one of the affordability safe harbors that the Treasury Department provided in the final rules under IRC §4980H. HHS could amend its data-sharing agreement with the IRS to allow state-based exchanges and the federally facilitated marketplace to access such information in helping to make accurate eligibility determinations for premium tax credits and cost-sharing reductions.

Additionally, NAHU urges Treasury to extend the IRC §§6055-56 regulatory deadline permanently for issuers and employers to distribute Forms 1095 B and C to individuals to March 1 of each year. We also recommend that you make the deadline to submit these forms to the IRS to March 31 annually. Originally the Obama Administration's IRS specified via regulatory guidance that these forms must be distributed by January 31 of each year but, for the reporting years 2015 and 2016, they later revised these deadlines and issued a delay for employers and issuers midway through the reporting season. NAHU believes employers and the Administration need greater certainty in deadlines. Furthermore, the originally proposed January 31 deadline is unrealistic as businesses and the IRS are already under deadlines for W-2s and other end-of-year reporting. A declaration of permanent March deadlines would provide sufficient time for both employers and the Administration and be a welcome relief for everyone.

### **Guaranteed Availability of Coverage Issues Related to IRC §4980H**

While NAHU does not believe that employers should be legally required to offer health insurance to their employees or be fined if they do not do so, we do believe that if a company wants to provide group health insurance benefits, then the policies of the federal government should not be a barrier to entry. Accordingly, we would welcome additional regulatory action or guidance from Treasury, working in conjunction with HHS, to help employers and issuers resolve a series of guaranteed availability of coverage issues that NAHU members have observed while helping companies implement the employer shared responsibility requirements outlined in IRC §4980H.

Many of these issues concern CFR §147.104, which establishes that small employers purchasing coverage, either through the traditional small-group market or the SHOP exchange, must meet state and issuer employee participation requirements, except for a one-month annual plan participation requirement holiday, which falls between November 15 and December 15. Large-group plans may



purchase new coverage at any time of the year without having to meet participation standards to ensure that such employers can also meet IRC §4980H obligations. However, an issuer may impose participation requirements upon renewal, and issuers may impose a premium surcharge if a large group does not comply with an issuer's or state's specific participation requirements.

Many small businesses are subject to IRC §4980H because they employ many part-time employees or could be part of a controlled group. Given that the majority of states have elected to keep the size of their small-group markets as 2-50 employees, many midsize American companies that are subject to the IRC §4980H requirements must also buy coverage through the small-group market. To make sure that these groups can never be subject to barriers to entering and staying in the group health insurance market, NAHU recommends that Treasury and HHS amend §147.104. The Administration should exempt any employer that can document that it is subject to IRC §4980H regardless of employee count from having to meet small-group participation requirements at any time during that plan year.

Additionally, particularly in some areas of the country, health plans increase rates for large groups that cannot meet traditional participation standards. In some cases, these premium surcharges are as high as 250%, so they effectively act as a denial of coverage. NAHU requests that Treasury and HHS develop a reasonable national ceiling for premium adjustments based on low employee participation so that large employers subject to IRC §4980H are always able to purchase health insurance coverage within a reasonable range of the average market price. NAHU recognizes that issuers need to protect themselves from adverse selection, but they also should not be allowed to use low participation as a means of market manipulation.

Similarly, while large employers purchasing fully insured coverage in the large-group market do not have to meet participation thresholds when they buy new coverage, existing rules allow carriers to impose participation standards on renewal in some cases. Small groups also may need to meet participation standards again each year when their plan renews or face a loss of coverage. NAHU members have reported incidents of carriers imposing participation audits at renewal unevenly, arbitrarily and sometimes following significant health claims. Particular issuers have been observed electing to rate-up certain groups that cannot meet participation standards but not others, refusing to continue coverage for undesirable groups and allowing healthier groups to continue coverage without any penalty. All of this inconsistency and unfairness has caused coverage instability in both the large- and small-group markets and has forced many employers to switch health insurance carriers needlessly. NAHU would appreciate clarification from Treasury and HHS that issuers may only impose renewal-participation requirements on business groups subject to IRC §4980H if state law requires a minimum participation standard for such employers.

A related issue concerns large groups with variable-hour employees. This issue impacts both large companies that are purchasing fully insured coverage and those operating self-funded plans and



purchasing stop-loss coverage. IRC §4980H requirements are quite clear that employers must treat employees who are determined to be full-time for health coverage purposes during a measurement period as full-time employees for health coverage purposes during the entire duration of the subsequent stability period, regardless of the number of hours worked. However, there is no corresponding requirement for the issuers that provide such employers with either fully insured health coverage or stop-loss coverage for a self-funded plan. NAHU members are reporting cases of issuers imposing participation/hours worked audits on large employer plans and then denying claims and coverage, particularly following the review of high-cost claims. The business can wind up with absolutely no recourse relative to its coverage offer requirements and can be forced to absorb high claims costs to ensure coverage for such employees. As IRC §4980H implementation has moved forward, this is becoming an increasingly common issue. It is also one that NAHU believes is an unintended consequence of the way the Obama Administration implemented the ACA that runs afoul of statutory intent. As such, we are requesting that Treasury work with HHS to specify that all issuers, including stop-loss plans providing coverage to employer-sponsored health benefit plans, treat all individuals offered coverage based on their hours worked/full-time status during the employer's measurement period as full-time for coverage participation requirements in the subsequent stability period, regardless of their actual hours worked during the stability period.

Finally, guidance is needed to ensure that carriers accommodate individual enrollments of newly eligible employees based on satisfaction of either the monthly measurement or look-back measurement method. Many insurer systems cannot accommodate these new rules, resulting in individuals being classified as late enrollees and denied coverage until the next open enrollment. Employers have no means of preventing these issues and have no recourse against IRC §4980H excise penalties in all of these cases. Furthermore, individual employee coverage is disrupted or not provided, in conflict with the intention of the ACA statute.

### **Opt-out Requirements**

On July 8, 2016, Treasury issued proposed regulations that address the treatment of cash incentives (commonly referred to as "opt-out payments") provided to employees who waive coverage under an employer's health plan and how they may impact the coverage affordability calculation with regard to an individual's premium tax credit subsidy eligibility and an employer's affordability safe harbor as part of the employer shared responsibility requirements and related reporting obligations. The proposed rule expands upon opt-out payment requirements detailed in IRS Notice 2015-87 issued in late December 2015. In short, the rule proposes that unless an opt-out payment is conditioned on something, such as the employee demonstrating proof of other coverage, the amount of the opt-out payment must be factored into the cost of employer coverage for affordability calculation purposes. The rationale for this proposed requirement is that the employees who accept employer coverage forgo the opt-out cash payment, so that lost income should be factored into their premium costs. The proposed rule sets out very complex conditioning requirements for employers to follow, requires employers to get attestations from





employees, and places liability and requirements on employers to police the veracity of employee attestation. The Obama Administration did not finalize this regulation, and its existence in a proposed state is confusing to employers. NAHU recommends that Treasury rescind this proposed rule.

### **Excise Tax**

The ACA created a 40% excise tax for high-cost employer-sponsored health plans as an attempt to control health plan costs by providing a financial consequence to employers opting to offer their employees very expensive health insurance benefit packages and as a funding mechanism for the law. The stated intention of the tax at the time of the ACA's passage was to only target a very small percentage of health plans. However, due to its structure, when it is ultimately implemented, the excise tax is expected to affect millions of Americans right away and will hit all types of employers and employee benefit plans. Since the tax is designed in such a way that it penalizes employers for healthcare cost factors they cannot control, like having employees with larger families or dependents with high-cost medical conditions and disabilities, locations in high-cost areas and company size, among many others, employers across the country are extremely nervous about its implementation.

While Congress has already delayed implementation of the excise tax once, and various health reform proposals have suggested delaying it further to 2026, right now it is slated to go into effect in 2020. Two and a half years is not much time with regard to benefit plan administration. Even though many, including NAHU, hope that the ACA excise tax requirements are repealed by Congress, employers and health plan specialists like NAHU members also need to begin planning for the massive changes that 2020 and excise tax implementation could ultimately bring. As such, we urge Treasury to begin the process of making information available to employers and the public right away about how the Trump Administration plans to handle excise-tax implementation.

Employers make strategic choices that affect the structure of their benefit plans years in advance and they are currently are working on 2018 and 2019 plan year decisions about employee cost-sharing, employee access to account-based plans, plan deductible levels and benefit structures, employee access to enhanced plan components like wellness programs and worksite benefit clinics, and more. Unfortunately, all of these decisions are being made in an information vacuum. In the absence of concrete information about how plan costs will be valued and aggregated, how tax calculations, payments and notifications will be handled, and how allowances for age, gender and high-risk occupations will be applied in 2020, some employers are assuming the worst and making very tough decisions that impact employees. Furthermore, without information on how the excise tax's initial threshold amount levels will be adjusted to account for 2020 costs, employers cannot reasonably predict their initial tax exposure.

Treasury under the Obama Administration issued two notices, 2015-16 and 2015-52, that review some but not all of the issues that will impact employers and those involved in benefit administration if and when the excise tax is ultimately effective. Furthermore, the Obama Administration made it clear that



there would need to be at least one regulation promulgated regarding the application of the excise tax to high-cost plans. We urge the Trump Administration to quickly review the public feedback provided to the Obama Administration about Notices 2015-16 and 2015-52 and provide the employer community with information about their plans for any excise tax implementation regulations moving forward. NAHU also encourages Treasury to make any available information about the excise tax's implementation requirements available to our nation's employers immediately, since they are making benefit decisions for the years ahead right now. In particular, employers need information about how the adjustments will be made to the statutory thresholds to bring them up to current medical care cost levels, how the coverage valuation will be calculated and how adjustments for gender, age and high-risk industries will be applied. Furthermore, clear guidance is needed for aggregated employer plans, and all employers should be assured of safe harbors, transition relief and good-faith enforcement standards.

### **Health Insurance Providers Fee (HIT Tax)**

NAHU members and their employer clients have had longstanding and significant concerns about the health insurance fee imposed by the ACA on all individual and fully insured group health insurance policies sold in this country from 2014 to 2016, and it is scheduled for reinstatement beginning on January 1, 2018. It technically falls on health insurers but, as the Congressional Budget Office predicted when Congress was debating the ACA, it is "largely passed through to consumers in the form of higher premiums for private coverage." It has disproportionately impacted small-business owners and the employees of small businesses, and it has increased the cost of healthcare coverage for consumers and employers in every state. NAHU members know all too well that any requirement that increases the cost of health insurance for small-business owners and the self-employed makes offering affordable coverage, or any coverage at all, to employees more cumbersome.

To help reduce the economic impact this fee is having on individuals and small-business owners, NAHU asks that Treasury make a critical modification to the way the fee amount is calculated. We propose a clarification that health insurance providers' fee collections will no longer be considered as taxable business revenue of issuers. Under the ACA statute, the annual fee on health insurance providers is treated, for tax purposes, as a nondeductible excise tax and the ACA specifically referenced the concept of deductibility as it relates to the treatment of the tax. When Congress was considering the ACA statute, the CBO recognized and informed Congress and the president that a large portion of these fees would be passed through to policyholders in the form of higher premiums, and that prediction was borne out when the tax was levied during 2014-2016. When the Obama Administration was promulgating the regulations to effectuate the health insurance provider fee in 2013, NAHU and many other stakeholders argued that, based on longstanding federal income tax principles, final regulations should permit any fees recovered from policyholders to be excluded from the health insurance companies' gross income if the conditions of the tax policy and rules are met. Instead, the Obama Administration, via the final Health Insurance Premium tax rules promulgated in 2013, chose to "tax the tax" and applied federal income tax to the



health insurance provider fee premiums that insurers collect and forward to the IRS. This excess taxation represents around one-third of the total premium impact of the tax and is not required under the statute.

Fortunately, NAHU sees a legal path for Treasury and the IRS under the current presidential Administration to significantly reduce the financial impact of the fee on American healthcare consumers in the future. Since there is a direct connection between the tax paid to the government by the insurance companies and the amounts recovered, the payment of the fee and the recovery of the fee amounts should be considered a single integrated transaction. Under the well-established “tax benefit rule,” since the fee is not deductible by the insurance company, the Trump Administration would be well within its authority to specify that any future fees recovered from policyholders should not be included in the insurance company’s gross income. NAHU urges Treasury to issue guidance to that effect immediately so that individuals and employers will see the related premium cost savings during the 2018 benefit plan year and beyond.

#### **PCORI Fee for HRAs**

The ACA established that all employers that sponsor self-insured health plans by commercial group health insurance issuers pay an annual fee to fund the Patient-Centered Outcomes Research Institute (PCORI) through 2019. Treasury rules promulgated by the Obama Administration require that Health Reimbursement Arrangements (HRAs) offered by employers pay this fee too, separate from the fee paid by the employer or issuer on behalf of the group major medical plan. The HRA fee must be determined using distinct and complicated calculation rules for companies that offer HRAs. Many smaller employers use the HRA framework as part of their health coverage offerings, and this policy imposes an unneeded compliance and cost burdens on small businesses and the individuals who work for small companies. This policy is increasing the cost and compliance burden for employers and we urge Treasury to discontinue the practice of requiring HRAs to calculate and pay PCORI fees separately.

#### **Section 105(h) Non-discrimination Provisions Applicable to Insured Group Health Plans**

Section 2716 of the ACA required that existing IRC §105(h) benefit plan non-discrimination requirements and related annual testing requirements that self-funded employer plans must follow be extended to all employer-sponsored health benefit plans of all sizes. However, these existing requirements, designed for large-employer pension plans, cannot easily be expanded in a way that would make any sense for smaller employer and fully insured group health benefit plans. NAHU analysis, done in 2010 in anticipation of this requirement being imposed on small-group benefit plans, showed that up to 80 percent of small-group benefit plans of less than 50 employees would fail the current non-discrimination testing imposed on large self-funded plans. These groups would fail simply because too many of their employees have other forms of MEC, such as a spouse’s plan.

The IRS issued Notice 2011-1 in January of 2011 noting that Treasury, as well as the IRS, DOL and HHS, determined that compliance with §2716 should not be required until after regulations or other





administrative guidance of general applicability has been issued under §2716. To date, no regulations have been issued to enforce compliance with this ACA requirement. NAHU strongly urges the Trump Administration to continue the Obama Administration's policy of not issuing regulations to require expanded compliance with §2716 and to publicly announce its intention to not enforce compliance beyond the requirements currently in force on self-funded employer group plans.

### **Section 125 Plan Regulations**

Almost all group health benefit plans offered in the United States are organized to take advantage of the provisions of IRC §125, which allows employers to offer their employees the benefit of a "cafeteria plan" to pay for their employee benefits on a pre-tax basis. In addition to the governing statute, the IRS proposed regulations to govern §125 plan implementation on August 6, 2007. However, these rules were never finalized, and employers were left with the instruction to use the proposed rule text as implementation guidance. NAHU recommends that the Department of Treasury consider reviewing, potentially revising and reissuing the proposed §125 rule in the near future, with the goal of finalizing the rule under the Trump Administration. Not only would finalizing these rules provide compliance certainty to employee benefit plans, but also a careful review of the rule might yield opportunities for the Trump Administration to provide employees and group benefit plans with new forms of cost and tax relief.

### **W-2 Reporting for Smaller Plans**

While the ACA statute requires virtually all employers that offer health insurance coverage to employees to report information about their benefits to employees via the Form W-2, in 2011 the IRS issued Notice 2011-28. This notice made the reporting optional for smaller employers that file fewer than 250 Forms W-2 for the prior calendar year until notice. The IRS has not issued any further guidance mandating reporting for smaller companies so, for the 2016 tax year W-2 reporting cycle, which is due by January 31, 2017, only employers that issue 250 or more Forms W-2 have to comply. NAHU strongly urges the Trump Administration to continue the Obama Administration's policy of not issuing regulations to require expanded compliance with W-2 reporting for smaller employers for at least the next four years and to make that policy publicly known as soon as possible.

### **HSA Embedded Deductible Confusion**

Under federal law, a prerequisite for a taxpayer to contribute to a Health Savings Account is their coverage through a high-deductible health plan (HDHP) as defined in IRC § 223(c)(2). That statutory requirement states that an individual's deductible and maximum out-of-pocket costs must be two times the amount of self-only coverage. However, during the Obama Administration, Treasury, along with the DOL and HHS, released guidance known as ACA FAQ 27 questions 1-3, which prohibited application of that statutory requirement. The result has been market confusion as to what constitutes an HDHP on the part of regulators, employers and insurers. The inconsistent and confusing implementation of this FAQ by issuers has created the very cumbersome market phenomenon known as an "embedded deductible" and made HDHPs combined with HSAs a much less consumer-friendly market choice. It has also negatively



impacted the cost paid by consumers for these plans. NAHU recommends that the Trump Administration rescind the guidance contained in FAQ 27 questions 1-3, and encourage Congress to address the gap between the HDHP requirements and the ACA's mandates for out-of-pocket limits.

### **Proposed Revision of 5500 Annual Information Returns and Report**

The Obama Administration proposed an enormous overhaul and expansion of the 5500 annual information returns and reports most employer-sponsored group benefit and retirement plans must submit annually to Treasury and the DOL. Not only would the rule require entities that currently have to comply with reporting requirements to drastically expand the amount of information they provide annually to the federal government, but it would also expand health plan reporting obligations to more than 2 million new small businesses. The proposed reporting expansion will be extremely expensive and complicated for employers of all sizes to implement. Furthermore, it is unclear what Treasury and the DOL will even do with the voluminous new data they proposed to collect. Comments were due on this proposed rule on December 5, 2016, but the Obama Administration did not finalize it.

Closure on the Form 5500 proposed rule would be very helpful to employers of all sizes that offer group benefits and group retirement plans. To provide more certainty to these businesses, NAHU suggests that Treasury work with the DOL to finalize this proposed rule with vast modifications. With regard to health benefit plans, NAHU urges the Trump Administration, in the strongest of terms, to eliminate the new proposed "Schedule J" reporting in a final rule and restore the reporting exemption for small welfare plans (i.e., fewer than 100 participants) that provide group health benefits. Additionally, we encourage you to allow a reporting exemption for health plans that qualify for the small plan exception (e.g., retiree medical plans) and those that are excepted benefits under the Health Insurance Portability and Accountability Act of 1996 (e.g., dental, vision and health Flexible Spending Accounts). Such exemption should apply even when such a health or welfare plan is part of a wrap plan with a group health plan.

### **Expatriate Health Plans**

On June 10, 2016, Treasury, the DOL and HHS issued a proposed rule to provide implementation guidance on the Expatriate Health Coverage Clarification Act (EHCCA), which was signed into law on December 16, 2014. In addition, the rule created requirements certain type insurance coverage would have to meet in order to maintain their status as "excepted benefits" and imposed significant limitations on short-term insurance policies. The Obama Administration finalized part of the proposed rule, including the limitations on short-term policies but the sections that address implementation of the EHCCA have not been finalized.

NAHU members appreciate the clarifications the proposed rule provides with regard to implementation of the EHCCA. However, our members who work with expatriates to find coverage both on the group and individual level have identified a number of practical concerns with the rule as proposed. Our members believe that some provisions of the proposed rule, as drafted, would have a burdensome and negative



effect on many expatriates, particularly those doing missionary work overseas. Furthermore, we have concerns that the language in the proposed rule will impair the ability of United States insurance companies to compete with foreign competitors. NAHU urges Treasury to review the comments of all stakeholders with regard to the EHCCA provisions of the proposed rule and make the various suggested amendments that will ensure that American insurers will be on a level playing field with foreign competitors, and that American expatriates doing missionary work will not be penalized.

### **Excepted Benefits and Short-Term Policies**

When the ACA was passed in 2010, it incorporated 42 U.S.C § 201 of the Public Health Service Act's (PHSA) definition of "excepted benefits," which was established by HIPAA. This definition expressly includes supplemental policies, travel coverage and fixed indemnity plans that provide limited and fixed medical coverage in its construct, since such plans were never meant to take the place of major medical coverage. Accordingly, NAHU believes that excepted benefit status should be conditional on that statutory definition.

As part of its proposed rule to implement the EHCCA issued on June 10, 2016, the Obama Administration created requirements certain type insurance coverage would have to meet in order to maintain their status as "excepted benefits" and imposed significant limitations on short-term insurance policies. The Obama Administration finalized part of the proposed rule, but the proposed new requirements that hospital indemnity and other fixed indemnity insurance coverage would have to meet in order to maintain their status as excepted benefits, have not yet been finalized.

With regard to the proposed additional standards for supplemental and fixed indemnity plans through ACA rules, NAHU feels that the Obama Administration has exceeded the bounds of its regulatory authority in this area. The primary responsibility to regulate excepted benefits rests with the states, and therefore the requirements in the proposed rules are wholly inappropriate and unnecessary. As for the proposed design restrictions for these policies, particularly with regard to fixed indemnity policies, the proposed rule will significantly alter common benefit design options already available to employers and employees in the benefit marketplace and negatively impact employee choice. NAHU urges Treasury to refrain from finalizing the excepted benefit provisions of the proposed rule and to rescind those draft requirements.

Treasury and the DOL and HHS did finalize the proposed requirements for short-term health insurance policies in the fall of 2016. They did so partly to preserve the health of the individual-market risk pool. However, our members have concerns that this regulation made attempts at SEP fraud worse by limiting coverage choices for consumers who used to buy short-term coverage to meet a gap in their group coverage options and never intended to seek individual-market coverage. Furthermore, since the primary responsibility to regulate short-term policies rests within the states, NAHU feels that the Obama Administration exceeded the bounds of its regulatory authority in this area.



While short-term medical policies only represent a small fraction of health insurance policies sold, they always had a clear purpose: to serve as a bridge to other, more comprehensive coverage options. Their buyers include not only people seeking individual coverage but also those who have a gap between group coverage options. Agents selling these policies report that at least half of their sales are to people who are transitioning between jobs, have purposely reduced hours or have taken an unpaid leave and cannot afford or do not qualify for COBRA or other group continuation coverage options. Newly retired people who are seeking a temporary bridge to Medicare enrollment, American students studying abroad, individuals temporarily in the United States on VISA programs and undocumented residents all are also common limited-duration health policy consumers. People who qualify for an individual mandate hardship exemption, particularly those who fall into a Medicaid coverage gap, also frequently buy short-term policies because it is all they can afford. None of these individuals ever intend to be part of the traditional individual health insurance market, so their inclusion in the limited-duration coverage marketplace has no potential impact, positive or negative, on the traditional individual market's risk pool. However, all of these consumers have been detrimentally affected by the 2016 short-term policy rule.

NAHU believes states did an excellent job regulating short-term policies for decades, including by imposing appropriate durational limits. The current federal regulation is inappropriate, unnecessary and is having a very detrimental impact on consumers. Furthermore, the National Association of Insurance Commissioners (NAIC) was in the process of improving model legislation and a model regulation establishing minimum standards for limited-duration policies and other types of excepted benefits and other health coverage traditionally under the complete purview of state regulation. The federal action by the Obama Administration on short-term policies only muddled and hindered the collective work of state regulators. NAHU urges Treasury to work with the DOL and HHS to rescind its joint 2016 efforts to regulate short-term health plans and instead encourage the NAIC to continue its work.

## **Conclusion**

NAHU is grateful for the opportunity to provide information to the Department of Treasury. We appreciate your willingness to consider the point of view of brokers, employers and individual health insurance consumers. We particularly appreciate the attention being paid to the impact federal health coverage regulations are having on individual and employer costs, as well as the compliance burdens and the impact on benefit plan choices and administration. The nation's health insurance agents and brokers stand at the ready, willing to provide you with real-world information about the needs and challenges health insurance consumers are experiencing, both at the employer and individual level. We look forward to working with you to reduce the regulatory burden and improve our nation's healthcare delivery and financing systems.

If you have any questions or need additional information about our suggestions, please do not hesitate to contact me at either (202) 595-0787 or [jtrautwein@nahu.org](mailto:jtrautwein@nahu.org).



Sincerely,

A handwritten signature in black ink that reads "Janet Stokes Trautwein". The signature is fluid and cursive, with the first name "Janet" being the most prominent.

Janet Stokes Trautwein  
Executive Vice President and CEO  
National Association of Health Underwriters