SIGNIFICANT CHANGES PROPOSED TO VOLUNTARY BENEFIT PLAN RULES

The federal Departments of Health and Human Services, Labor, and Treasury recently issued a proposed regulation that would significantly change how many employer-sponsored hospital indemnity, specified disease, and other fixed indemnity insurance plans are designed. These plans are generally known as fixed indemnity plans.

Proposed Changes to Fixed Indemnity Coverage Generally

Currently, fixed indemnity medical coverage offered to group health plan participants is an "excepted benefit," meaning that HIPAA and ACA requirements for traditional group health coverage do not apply. To maintain excepted benefit status, fixed indemnity policies must:

- Be offered separately from other group coverage.
- Not coordinate with other group coverage. If a group health plan excludes certain benefits and services, the fixed indemnity plan may not be specifically designed to plug those holes in coverage.
- Pay benefits even if the employee has other health coverage that pays benefits related to the same event.
- Pay out a fixed dollar amount per day based on a specific event (such as hospitalization) or condition (such as a particular diagnosis).

The proposed rule would: (1) update the standard for what constitutes a "fixed payment" and (2) drastically broaden the standard of what constitutes coordination with other coverage to include any informal coordination with other group policies that the plan might offer.

Concerning the fixed payment criteria, the proposed regulation clarifies that all benefits must be paid in a fixed dollar amount per day (or other time period), hospitalization, or illness (for example, $100/day), regardless of actual costs incurred. Payments based on a per item or per service basis would be impermissible. With respect to the coordination of policies with other group plans, an example is provided stating that it would be impermissible to offer a hospital reimbursement plan alongside a preventive care-only plan. If finalized, this would make the relatively common practice of providing a fixed indemnity plan alongside a preventive care-only MEC plan (to satisfy ACA requirements) impermissible.

As proposed, this section of the regulations would not become effective for those policies already in place until the rules are finalized beginning January 1, 2027. For policies issued after the regulations are finalized, the new rules would be effective at the start of the first plan year after the regulations are finalized.

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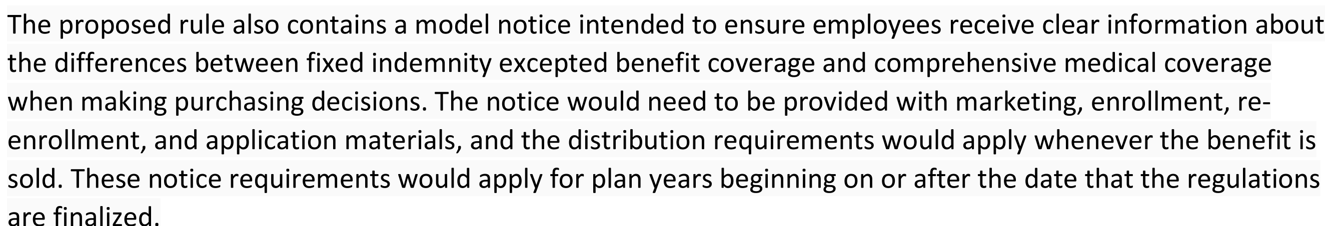

The proposed rule also contains a model notice intended to ensure employees receive clear information about the differences between fixed indemnity excepted benefit coverage and comprehensive medical coverage when making purchasing decisions. The notice would need to be provided with marketing, enrollment, re-enrollment, and application materials, and the distribution requirements would apply whenever the benefit is sold. These notice requirements would apply for plan years beginning on or after the date that the regulations are finalized.

Clarification of Tax Treatment

The proposed regulations also clarify that reimbursements made under a fixed indemnity plan are not considered “medical benefits.” Thus, employees cannot pay for the premiums and receive the benefits under these plans without paying taxes. This is the case because benefits under the plans are paid out regardless of the participant’s actual medical condition (i.e., merely being hospitalized would qualify for a benefit regardless of the reason for hospitalization).

Effective the later of the publication date of a final rule or January 1, 2024, this means that for fixed indemnity plans, either premiums can be paid on a pre-tax basis, or benefits can be paid without being subject to tax, but not both.

Additional Provisions

The proposed rule would also limit the period that short-term medical insurance coverage could be sold in the individual market to an initial coverage period of three months or less, with a maximum coverage period of four months if coverage was renewed. It also includes sections requesting more information about both level-funded group health plans and disease-specific coverage, but no new requirements are proposed for either type of coverage. Instead, the information collected could be used to direct future regulatory policy.

What Happens Now?

It is important to note that this is a proposed regulation, not a final one, so it has no current legal impact on any group benefit plan or health insurance coverage. The Departments will accept comments on the draft measure through September 11, 2023. After the comment period, federal regulators may choose to: 1) issue a final regulation at a later date, potentially with revisions based on the comments received; 2) issue a partial final regulation, potentially revised based on proposed comments, and indicate that they may address other sections of the original rule at a later date; 3) issue another revised proposed draft, seeking comments again; 4) cease action on the proposal, either by never issuing a final rule or by formally withdrawing the measure.

We will continue to monitor the status of this proposed rule and bring any additional information to you as it becomes available.

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