

Publications

Tri-Agencies Finalize Rule on STLDI, but Kick the Can Down the Road on Fixed Indemnity and the Health Plan Tax Exclusion

ATTORNEYS & PROFESSIONALS

Kathryn Bjornstad Amin

kamin@groom.com

202-861-2604

A. Xavier Baker

xbaker@groom.com

202-861-5419

David Block

dblock@groom.com

202-861-5427

Lisa Campbell

lcampbell@groom.com

202-861-6612

Seth Perretta

sperretta@groom.com

202-861-6335

Ryan C. Temme

rtemme@groom.com

202-861-6659

Brigen Winters

bwinters@groom.com

202-861-6618

PUBLISHED

04/10/2024

SOURCE

Groom Publication

SERVICES

Employers & Sponsors

- [Health & Welfare Programs](#)

Health Services

- [Federal Insurance Regulation](#)

On March 28, 2024, the Departments of Labor, Treasury, and Health and Human Services (the “Tri-Agencies”) issued [final regulations](#) on short-term, limited-duration insurance (“STLDI”), hospital and other fixed indemnity insurance (“Fixed Indemnity”), and the taxation of accident and health plan benefits (the “Final Rule”). The Final Rule’s STLDI provisions are substantially similar to the proposed regulations issued on July 7, 2023 (the “Proposed Rule”). In a surprising move, the Tri-Agencies did not finalize most of the Proposed Rule that imposed new requirements for Fixed Indemnity to be an excepted benefit and did not finalize any of the Proposed Rule provisions with respect to the taxation of accident and health plan benefits, including Fixed Indemnity, under Code section 105(b). (See our previous alerts on the Proposed Rule [here](#) and [here](#).)

Short-Term, Limited-Duration Insurance

The Final Rule makes four main changes to STLDI, effective for policies sold on or after September 1, 2024:

1. The initial contract term must be no more than three months.
2. Taking into account renewals or extensions, the maximum STLDI coverage period must be no more than four months.
3. A renewal or extension includes STLDI sold by the same issuer, or any issuer that is a member of the same controlled group, to the same policyholder within a 12-month period.
4. Updates the language of the required notice to help consumers better distinguish between comprehensive coverage and STLDI and get information on their health coverage options. The notice must be prominently displayed on the first page of the policy, certificate, or contract of insurance, including for renewals and extensions, and included in any marketing, application, and enrollment (or reenrollment) materials.

Fixed Indemnity

The Final Rule finalizes new notice requirements for Fixed Indemnity coverage in the group market to be an excepted benefit and modifies the notice required for Fixed Indemnity in the individual market to be an excepted benefit.

- For group coverage, the plan or issuer must display the notice “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.
- For individual coverage, the issuer must display the notice “prominently” on the first page (in either paper or electronic form, including on a website) 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 purpose of the notice is to “ensure that consumers purchasing fixed indemnity excepted benefits coverage are aware of the type of coverage they are purchasing, including the limitations of the coverage, and that it is not mistakenly purchased as an alternative or replacement for comprehensive coverage.” The new notice requirements apply for plan years and coverage periods beginning on or after January 1, 2025.

In accordance with the D.C. Circuit’s ruling in *Central United Life Ins. Co. v. Burwell*, the Final Rule also finalized certain technical amendments to the individual market rules to remove the requirement individuals must attest that they have other minimum essential coverage.

The Final Rule did not adopt any of the other proposed changes in the Proposed Rule, such as the requirements that Fixed Indemnity could only provide benefits on a per-period basis and not a per-service basis and that Fixed Indemnity must pay benefits without regard to services or items received, the actual or estimated amount of expenses incurred, the severity of the injury/illness, or other characteristics of a particular course of treatment.

Although the Tri-Agencies did not finalize these changes, the preamble states that the Tri-Agencies remain concerned with practices that appear to circumvent federal consumer protections and requirements and emphasizes that, to be fixed indemnity insurance, benefits must be paid only on a per-period basis and that “plans and issuers should not assume that current market practices that are inconsistent with the [proposed regulations] comply with the existing Federal regulations.” The preamble states that the Tri-Agencies intend to address issues that commenters raised in future rulemaking and no inference should be drawn from the decision not to finalize these aspects of the rules.

Tax Exclusion

Treasury and the Internal Revenue Service (“IRS”) did not finalize the portion of the Proposed Rule with respect to the Code section 105(b) exclusion for accident and health plan benefits. Under the Proposed Rule, the Code section 105(b) exclusion would not apply to any amounts that are paid under an accident or health plan, including Fixed Indemnity, that pays benefits without regard to the amount of incurred and substantiated Code section 213(d) medical expenses.

The preamble to the Final Rule states that the Proposed Rule was issued, at least in part, due to the inconsistent application of Code section 105(b) by taxpayers and that some taxpayers applied the exclusion to situations where the amount of medical expenses is unclear or the existence of medical expenses is doubtful. The IRS stated that it is concerned that FICA, FUTA, and federal income taxes are not being paid or withheld from taxable benefit payments. The preamble also stated that the IRS’ concerns have recently escalated after identifying an increasing number of arrangements (some involving fixed indemnity plans and policies) that make cash benefit payments purportedly for medical expenses, even if the expenses were already reimbursed through other coverage or participants did not incur any Code section 213(d) medical expenses.

The preamble also noted that some commenters argued that the exclusion under Code section 105(b) should apply with respect to the amount of any medical expenses associated with the health-related event that precipitates payments under accident or health insurance, even if the amount paid is determined without regard to the amount of actual medical expenses incurred, and that only the amount in excess of medical expenses associated with the health-related event should be included in gross income. Other commenters responded that the proposed amendments would, if finalized, prompt the need for additional guidance regarding collecting and paying employment taxes on amounts paid through accident or health insurance not excluded from gross income and the proper reporting of such amounts on the employee’s W-2, and requested additional clarification on how incurred medical expenses must be substantiated.

The preamble states that IRS needs more time to study the issues and concerns raised by commenters, and the IRS intends to address these issues in more detail in future guidance. The IRS makes clear in the preamble that its decision not to finalize the Proposed Rule at this time is not an indication that it agrees with the tax positions asserted by some commenters.