Published on *The National Law Review* https://natlawreview.com

Hospital and Fixed Indemnity and Disease-Specific Policies in Cross Hairs: Tri-Agency Proposed Rule Portends Some Disruption

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On June 10, the ***Departments of Treasury, Labor,*** and ***Health and Human Services (***The ***"Departments")*** issued a set of proposed regulations dealing with expatriate health plans, excepted benefits, lifetime and annual limits, and short-term, limited-duration insurance. While the media initially focused on the short-term, limited-duration insurance, the provisions in the proposed regulations addressing hospital and fixed indemnity, disease-specific, and supplemental polices merit attention. These polices generally seek to avoid application of the ***Affordable Care Act's (ACA)*** insurance market reforms and other substantive requirements by qualifying as "excepted benefits." For manufacturers and sellers of excepted benefit products, the challenge is to create a product that will gain traction in the market—i.e., has the requisite "sizzle"—while at the same time avoiding being treated as a "group health plan" that fails to qualify as "excepted." The proposed rules, if adopted as final, will make this challenge marginally if not significantly more difficult.

In future posts, we will turn our attention to expatriate health plans, lifetime and annual limits, and short-term, limited-duration insurance. This post examines the provisions of the proposed regulations' treatment of excepted benefits, with a particular focus on accident, hospital and fixed indemnity, disease-specific, and supplemental products and policies.

General Categories of Excepted Benefits

The concept of "excepted benefits" was first introduced in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to designate a set of benefits that was *excluded* from that law's substantive portability and nondiscrimination requirements. HIPAA sets out four discrete categories of excepted benefits:

1. ***Benefits that are generally not health coverage*.**

This category includes benefits that are excepted in all circumstances, including automobile insurance, liability insurance, workers compensation, and accidental death and dismemberment coverage. This category of excepted benefits also includes "[o]ther similar insurance coverage,

specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits." These include liability insurance, workers compensation, and accidental death and dismemberment coverage.

2. *Limited excepted benefits*.

The second category of excepted benefits is limited excepted benefits, which include limited scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community-based care. The Secretaries of HHS, Labor and Treasury may by regulation establish other, similar limited benefits as excepted benefits. Pursuant to this grant of regulatory authority, certain health flexible spending arrangements have been designated as excepted benefits. To be an excepted benefit under this second category, these limited benefits must either provided under a separate policy, certificate, or contract of insurance; or otherwise not be an integral part of a group health plan, whether insured or self-insured.

3. *Non-coordinated excepted benefits*.

The third category of excepted benefits, referred to as "non-coordinated excepted benefits," includes both coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. These benefits are excepted only if:

- The benefits are provided under a separate policy, certificate, or contract of insurance;
- There is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and
- The benefits are paid with respect to any event without regard to whether benefits are provided under any group health plan maintained by the same plan sponsor.

4. *Supplemental excepted benefits*.

The fourth category is supplemental excepted benefits. Benefits are supplemental excepted benefits only if they are provided under a separate policy, certificate, or contract of insurance and are Medicare supplemental health insurance (also known as Medigap), TRICARE supplemental programs, or "similar supplemental coverage provided to coverage under a group health plan."

The commercial marketplace for excepted benefit coverage generally relies on the third and fourth categories—i.e., non-coordinated excepted benefits and supplemental excepted benefits. The contours of each of these exceptions establish the boundaries for, and farthest reaches of, product design. Regulatory attention in recent years has focused on the following handful of narrow but important issues.

Group Market Hospital/Fixed Indemnity and Disease-Specific Insurance

Regulations implementing the exception for non-coordinated excepted benefits in the group market require that, to be hospital indemnity or other fixed indemnity insurance, the insurance must pay a

fixed dollar amount per day (or per other time period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred. Subsequent "sub-regulatory" guidance has "clarified" that group health insurance coverage in which benefits are provided in varying amounts based on the type of procedure or item, such as the type of surgery actually performed or prescription drug provided, is not a hospital indemnity or other fixed indemnity insurance excepted benefit because it does not meet the condition that benefits be provided on a per day (or per other time period, such as per week) basis, regardless of the amount of expenses incurred.

Even a cursory Internet search of hospital indemnity or other fixed indemnity insurance yields a dizzying array of products with long schedules of benefits. It is not uncommon, for example, for such policies to pay benefits in the case of doctors' visits, surgery, or prescription drugs, none of which are on a per-period basis. Rather, payment is based on the type of procedure or item. Because office visits and surgery are not paid based on "a fixed dollar amount per day (or per other period)," the Departments has previously opined—in informal, sub-regulatory guidance—that such a policy does not qualify as "hospital indemnity or other fixed indemnity insurance." It is instead health coverage, which fails to qualify as an excepted benefit.

The preamble to the newly proposed regulations explains that:

> "The Departments have become aware of some hospital indemnity and other fixed indemnity insurance policies that provide comprehensive benefits related to health care costs."

One might infer from this passage that the regulators are planning to focus their attention on enforcing a much narrower view of hospital indemnity or other fixed indemnity insurance than the industry has heretofore been willing to embrace.

The preamble to goes on to cite an additional concern:

> "The Departments are concerned that some individuals may incorrectly understand these policies to be comprehensive major medical coverage that would be considered minimum essential coverage."

To avoid confusion among group health plan enrollees and potential enrollees, the proposed regulations require notice to participants in the form of a statement that the coverage is a supplement to, rather than a substitute for, major medical coverage and that a lack of minimum essential coverage may result in an additional tax payment. The proposed regulations include a model statement.

The Departments raised, but did not propose, a rule on the subject of whether a policy covering multiple specified diseases or illnesses may be considered to be excepted benefits. Benefit designs covering multiple specified diseases or illnesses are common in our experience. The statute provides that the non-coordinated excepted benefits category includes "coverage of *a specified disease or illness*" (emphasis added) if the coverage meets the conditions for being offered as independent, non-coordinated benefits. It is the implementing regulations that identify cancer-only policies as one

example of specified disease coverage. Concerned that individuals who purchase a specified disease policy covering multiple diseases or illnesses may incorrectly believe they are purchasing comprehensive medical coverage, the Departments opted to invite comments rather than propose a rule.

Supplemental Excepted Benefits

Regulations implementing the exception for similar supplemental coverage require that the coverage be "specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles." Subsequent, sub-regulatory guidance established factors that the Departments will apply when evaluating whether supplemental health insurance qualifies as "similar supplemental coverage provided to coverage under a group health plan." Specifically, supplemental health insurance will be considered an excepted benefit if it is provided through a policy, certificate, or contract of insurance separate from the primary coverage under the plan and meets all of the following requirements:

- The supplemental policy, certificate, or contract of insurance is issued by an entity that does not provide the primary coverage under the plan;
- The supplemental policy, certificate, or contract of insurance is specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles, but does not include a policy, certificate, or contract of insurance that becomes secondary or supplemental only under a coordination of benefits provision;
- The cost of the supplemental coverage is 15 percent or less of the cost of primary coverage (determined in the same manner as the applicable premium is calculated under a COBRA continuation provision); and
- The supplemental coverage sold in the group health insurance market does not differentiate among individuals in eligibility, benefits, or premiums based upon any health factor of the individual (or any dependents of the individual).

Further clarification, in the form of an FAQ, was provided in February 2015 in which the Departments signaled their intent to propose regulations under which coverage would be considered to be designed to "fill in the gaps" of the primary coverage only if the benefits covered by the supplemental insurance product are not essential health benefits (EHB) in the State in which the product is being marketed. The FAQ said, until regulations are issued and effective, the Departments will not take enforcement action under certain conditions for failure to comply with the applicable insurance market reforms with respect to group or individual health insurance coverage that provides coverage of additional categories of benefits that are not EHBs in the applicable State. That guidance is now on the horizon.

The Proposed Regulations

- ***Hospital Indemnity and Other Fixed Indemnity Insurance***

The proposed regulations establish a rule under which hospital Indemnity and other fixed indemnity insurance coverage is excepted only if the coverage meets each of the following conditions:

- The insurance must pay a fixed dollar amount per day (or per other time period, such as per week) of hospitalization or illness (for example, $100/day) without regard to the amount of expenses incurred or the type of items or services received. The Departments make clear that policies that provide fixed amounts based on other metrics (such as per-visit, per-drug or per-service) will not be excepted; and

- The plan or issuer must provide, in any application or enrollment materials provided to participants at or before the time participants are given the opportunity to enroll in the coverage, a notice that prominently displays in at least 14 point type the following language:

  THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. THIS IS NOT QUALIFYING HEALTH COVERAGE (‘‘MINIMUM ESSENTIAL COVERAGE’’) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON’T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

If participants are required to reenroll for renewal or reissuance, this notice must be displayed in the reenrollment materials.

The following examples are drawn from the proposed regulations:

Example 1.

(i) Facts. An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits only for hospital stays at a fixed percentage of hospital expenses up to a maximum of $100 a day.

(ii) Conclusion. In this Example 1, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount per day (or per other time period, such as per week), the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit . . .. This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

Example 2.

(i) Facts. An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits for doctors’ visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar rates per procedure, and prescription drugs at $15 per prescription.

(ii) Conclusion. In this Example 2, for doctors’ visits, surgery, and prescription drugs, payment is not made on a per-period basis, but instead is based on whether a procedure or item is provided, such as whether an individual has surgery or a doctor visit or is prescribed a drug, and the amount of payment varies based on the type of procedure or item. Because benefits related to office visits, surgery, and prescription drugs are not paid based on a fixed dollar amount per day (or per other time period, such as per week) . . . the policy is not hospital indemnity or other fixed indemnity insurance

that is an excepted benefit . . . .

Example 3.

(i) Facts. An employer sponsors a group health plan that provides coverage through an insurance policy. The policy provides benefits for certain services at a fixed dollar amount per day, but the dollar amount varies by the type of service.

(ii) Conclusion. In this Example 3, because the policy provides benefits in a different amount per day depending on the type of service, rather than one specific dollar amount per day regardless of the type of service, the policy is not hospital indemnity or other fixed indemnity insurance that is an excepted benefit. . . .

- ***Supplemental Health Insurance Coverage***

Under the proposed regulations, if group or individual supplemental health insurance coverage provides benefits for items and services not covered by the primary coverage (referred to as providing “additional categories of benefits”), the coverage would be considered to be designed “to fill gaps in primary coverage.” It could, therefore, qualify as being supplemental excepted benefits if none of the benefits provided by the supplemental policy are an EHB in the State in which the coverage is issued. Conversely, if any benefit provided by the supplemental policy is an EHB in the State where the coverage is issued, the insurance coverage would not be supplemental.

Importantly, the proposal applies only to the extent that the supplemental health insurance provides coverage of additional categories of benefits. Thus, supplemental health insurance products that fill in cost sharing in the primary coverage, such as coinsurance or deductibles, would be considered supplemental excepted benefits. Similarly, supplemental health insurance products that both fill in cost sharing in the primary coverage, such as coinsurance or deductibles, and cover additional categories of benefits that are not EHB, also would be considered supplemental excepted benefits, provided all of the other criteria of the rule are satisfied.

- ***Specified Disease Coverage***

Under the Proposed Regulations, the Departments do not propose any specific rules, but rather request comments regarding whether to limit the number of diseases or illnesses that may be covered under a policy as well as whether issuers should be required to disclose that policies are not Minimum Essential Coverage.

Next steps

The market for hospital/fixed indemnity, disease-specific and supplement coverage is large and growing. Up until now, it has not been heavily regulated. But that appears to be about to change. To be clear, nothing in the proposed regulations threatens the existence of these products or their status as excepted benefits under permitted circumstances, but the proposals will, if adopted and enforced, threaten a number of common (and in some instances near universal) benefit design features.

National Law Review, Volume VI, Number 167