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"EXCEPTED BENEFITS" FOR HOSPITAL INDEMNITY & OTHER FIXED INDEMNITY INSURANCE PLANS

On January 24, 2013, the U.S. Department of Labor, the U.S. Department of Health and Human Services, and the U.S. Department of the Treasury (collectively "federal departments") issued guidance regarding hospital indemnity and other fixed indemnity insurance plans.[1] These health insurance plans are considered "excepted benefits" and, therefore, not subject to requirements of the Patient Protection and Affordable Care Act ("ACA"). This Bulletin explains the impact of the federal departments' guidance and sets forth a Schedule of Compliance.

Since adoption of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), fixed indemnity and hospital indemnity plans have been classified as "excepted benefits" in the Public Health Service Act. 42 U.S.C. § 300gg-91. In subsequent regulations, the federal departments defined hospital or other fixed indemnity insurance as coverage that must:

1) Be paid on a fixed dollar amount;
2) Be paid per day or other period; and
3) Be paid regardless of the amount of expense incurred.

See 45 C.F.R. § 146.145 (special rules relating to group health plans); 26 C.F.R. § 54.9831-1 (same); and 29 C.F.R. § 2590-732(c)(4) (same).

According to the federal departments' recent guidance, hospital indemnity or other fixed indemnity insurance policies under a group health plan provides "excepted benefits" only when the benefits are paid as a fixed dollar amount per day or other period of hospitalization or illness regardless of the amount of expenses incurred, among other requirements. Previously, most state insurance regulators have not required strict adherence to the fixed dollar amount per period because it was not required.

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[1] U.S. Dep't of Health & Human Serv., Ctr. for Consumer Info. & Ins. Oversight, Ctr. for Medicare & Medicaid Serv., Affordable Care Act Implementation FAQs - Set 11 (Jan. 24, 2013), http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html (last visited Dec. 20, 2013).

42 U.S.C. § 300gg-21 (as enacted under HIPAA). However, the final rule implementing portions of HIPAA requires a fixed dollar amount per period. 45 C.F.R. § 146.145 (eff. July 1, 2005). The provisions of the HIPAA regulations defining hospital or other fixed indemnity policies apply to both the individual and the group markets. 45 C.F.R. § 148.220.

As a result, beginning April 1, 2014, the Nevada Division of Insurance will require that health insurance issuers and health maintenance organizations (collectively "Issuers") that offer or market hospital indemnity and other fixed indemnity plans as a substitute or replacement for a "group health plan"[2] or a "health benefit plan",[3] must pay benefits as a fixed dollar amount per day (or per other period) with respect to an event without regard to the amount of expenses incurred. 42 U.S.C. § 300gg-91.[4] Issuers may use the attached Schedule of Compliance to transition their plans.

This Bulletin applies to hospital and other fixed indemnity policies issued or delivered in both the individual and the group markets.

For questions or clarification with regard to this Bulletin, please contact the Life & Health Section at (888-872-3234) or insinfo@doi.nv.

SCOTT J. KIPPER
Commissioner of Insurance

[2] See Nev. Rev. Stat. § 689C.073 (defining "group health plan").
[3] See Nev. Rev. Stat. § 689A.540 (defining "health benefit plan").
[4] See 42 U.S.C. § 300gg-91(c)(1) (identifying benefits not subject to requirements as: coverage only for accident, or disability income insurance, or any combination thereof, coverage issued as a supplement to liability insurance, liability insurance, including general liability insurance and automobile liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, and other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits); 42 U.S.C. § 300gg-91(c)(2) (identifying benefits not subject to requirements if offered separately as: limited scope dental or vision benefits, benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof, and such other similar, limited benefits as are specified in regulations); 42 U.S.C. § 300gg-91(c)(3) (identifying benefits not subject to requirements if offered as independent, non-coordinated benefits as: coverage only for a specified disease or illness, and hospital indemnity or other fixed indemnity insurance); and 42 U.S.C. § 300gg-91(c)(4) (identifying benefits not subject to requirements if offered as separate insurance policy as: Medicare supplemental health insurance (as defined under section 1395ss(g)(1) of this title), coverage supplemental to the coverage provided under chapter 55 of title 10, and similar supplemental coverage provided to coverage under a group health plan).

SCHEDULE OF COMPLIANCE

Plans Issued on or After April 1, 2014

The federal departments' interpretation will be enforced for all hospital indemnity or other fixed indemnity policies that are issued on or after April 1, 2014. Issuers should submit to the Division for review forms that are compliant with the federal departments' interpretation no later than March 1, 2014. Forms must be approved by March 31, 2014, for use beginning on April 1, 2014.

Plans Already Approved - Safe Harbor

Any hospital or other fixed indemnity policies that have already been approved by the Commissioner are granted a safe-harbor period to give Issuers an opportunity to comply with the federal departments' interpretation of "excepted benefits" and to minimize market disruptions. Policies that would otherwise be subject to strict adherence, but which are issued and in force prior to April 1, 2014, may remain in effect at the option of the insured or health insurance issuer, through December 31, 2014. Where group policies are issued and in force prior to April 1, 2014, certificates may continue to be issued to new enrollees on or after April 1, 2014 until the group policy anniversary date following the date of approval of the Issuer's 2014 compliant form.

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