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TO: Disability/Health Insurance Carriers in the Individual and Group Supplemental Market

FROM: Dean L. Cameron, Director

SUBJECT: Guidance Concerning Idaho Minimum Standards Rule and ACA Excepted Benefits

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This bulletin to carriers in the individual health and group supplemental health insurance markets provides guidance concerning the requirements applicable to insurance policies that are not considered to be "health benefit plans," per Chapters 47 and 52 of Title 41, Idaho Code. In particular, this bulletin explains the criteria required by hospital confinement indemnity, accident-only, and specified disease insurance to qualify as "excepted benefits" under the federal Affordable Care Act ("ACA"), and what the Department will consider compliant with the applicable provisions of Title 41 and IDAPA 18.04.08[i] in reviewing filings of these insurance types.

The ACA introduced into Title 45 of the United States Code of Federal Regulations ("C.F.R.") a set of broad definitions and requirements for "group health insurance coverage" and "individual health insurance coverage," and then excepted certain types of medical policies from those federal regulations (*See* 45 C.F.R. §§ 146.145 and 148.220). These policies are generally known as "excepted benefits" policies. This exception does not preempt state regulation of excepted benefits. Consequently, carriers wishing to make available policies and certificates that are considered "excepted benefits" must also comply with all applicable state laws and rules.

Idaho Code defines a health benefit plan in both the group and individual health insurance markets per Chapters 47 and 52, Title 41, to include "any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care organization subscriber contract," except for "policies or certificates of insurance for specific disease, hospital confinement indemnity, accident-only, credit, dental, vision, medicare supplement, long-term care, or disability income insurance, student health benefits only, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, automobile medical payment insurance or nonrenewable short-term coverage issued for a period of twelve (12) months or less." Idaho Code §§ 41-4703(15), 41-5203(12).

Specific disease, hospital confinement indemnity, and accident-only insurance may, under some circumstances, constitute excepted benefits under federal law and may be exempt from restrictions on health benefit plans under Idaho law. The Department has received various

questions regarding compliance with state laws and rules in light of those federal exceptions. The Department therefore is providing the guidance contained herein regarding such insurance policies, and recommends carriers review against this guidance both existing policies and any policies that will be filed with the Department.

Hospital Confinement Indemnity Coverage

Concerning the group market, 45 C.F.R. § 146.145 states that, in order to qualify as an excepted benefit, hospital indemnity coverage must pay a fixed amount per day (or other period) for hospitalization or illness, regardless of expenses incurred. Additionally, benefits provided under the coverage must:

- Be provided under a separate policy, certificate, or contract of insurance;
- Not be coordinated with benefits provided by any group health plan offered by the same plan sponsor; and
- Be paid with respect to an event regardless of whether benefits are provided for the event under any group health plan offered by the same plan sponsor.

Guidance issued in 2013 by the Center for Consumer Information & Insurance Oversight ("CCIIO") indicates that coverage basing reimbursement on specific services provided does not qualify as hospital indemnity and is therefore not an excepted benefit. "Various situations have come to the attention of the Departments [of Labor, Health and Human Services, and the Treasury] where a health insurance policy is advertised as fixed indemnity coverage, but then covers doctors' visits at $50 per visit, hospitalization at $100 per day, various surgical procedures at different dollar rates per procedure, and/or prescription drugs at $15 per prescription… Because office visits and surgery are not paid based on "a fixed dollar amount per day (or per other period) [of hospitalization or illness]," a policy such as this is not hospital indemnity or other fixed indemnity insurance, and is therefore not excepted benefits…it is in practice a form of health coverage instead of an income replacement policy. Accordingly, it does not meet the conditions for excepted benefits." Center for Consumer Information & Insurance Oversight, "Affordable Care Act Implementation FAQs – Set 11" (Jan. 24, 2013), *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html.

Therefore, the Department does not consider any group health fixed indemnity coverage that includes reimbursement based on the type of service or procedure received (rather than on an event of hospitalization or illness) to be an excepted benefit under 45 C.F.R. § 146.145.

Concerning individual hospital confinement indemnity coverage, 45 C.F.R. § 148.220 (b)(4)(iii) indicates that hospital indemnity coverage may be exempt from ACA requirements if benefits are paid "in a fixed dollar amount per period of hospitalization or illness and/or per service (for example, $100/day or $50/visit) regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage."

Accordingly, individual market indemnity coverage that provides benefits on a per-service basis may constitute excepted benefits if properly designed. However, since all accident and sickness policies must also comply with IDAPA 18.04.08 and meet the requirements of one of the coverage types therein, the Department must evaluate any indemnity insurance policy against those minimum standards. IDAPA 18.04.08 defines hospital confinement indemnity coverage as an accident and sickness plan that provides a fixed payment on a daily basis during a period of confinement. IDAPA 18.04.08.017.01. A policy that includes benefits paid per service, per illness, per visit or on any basis other than per day of confinement does not meet this definition.

Such a policy, which fails to meet the requirements of hospital confinement indemnity coverage, must instead be subject to either the minimum standards for another exception to the definition of health benefit plan under IDAPA 18.04.08 or to all of the requirements for health benefit plans as defined at sections 41-4706 and 41-5203, Idaho Code.

IDAPA 18.04.08 considers a fixed indemnity policy that pays "a fixed dollar amount per day (or per other period) of […] illness" (and not of confinement) to be a form of specified disease coverage. Therefore, such filings for "other fixed indemnity insurance" must comply with IDAPA 18.04.08 regarding specified disease coverage (IDAPA 18.04.08.021), and carriers should submit such filings with the appropriate Type of Insurance ("TOI") designation.

In general, for hospital confinement indemnity coverage in the group and individual market (IDAPA 18.04.08.017), the Department will allow policies to vary reimbursement rates based on the type of facility or setting in which the individual is confined, such as intensive care, NICU/PICU, mental health/substance abuse facilities, rehabilitation facilities or skilled nursing facilities. In addition, policies may reimburse certain days, such as the day of admission, higher than the ongoing confinement. Reimbursement based on a diagnosis, service or treatment will not be allowed, nor will reimbursement for physician's office visits or other non-confinement settings. Nor can hospital confinement indemnity coverage reimburse differently based on the specific facility in which the individual is confined: the daily rate paid for confinement in a NICU at hospital A cannot differ from the rate paid for confinement in a NICU at hospital B.

Accident-only and Specified Disease

In the group and individual markets, federal law treats accident-only coverage as excepted from ACA requirements in all circumstances (45 C.F.R. § 146.145(b)(2)(i) and 45 C.F.R. § 148.220(a)(1)). Coverage for only a specified disease or illness is excepted so long as benefits are provided under a separate policy, certificate, or contract of insurance and so long as there is no coordination of benefits with those provided under another health plan.

IDAPA 18.04.08 defines specified disease coverage as a policy which pays for the diagnosis and treatment of one or more specifically named diseases. IDAPA 18.04.08.021. Benefits under a specified disease policy must be provided on the basis of a particular diagnosis, rather than a broad category such as "mental illness" or "heart procedures."

Specified disease coverage is exempt from the general IDAPA 18.04.08 provision prohibiting probationary or waiting periods other than preexisting condition exclusion periods. Specified

disease coverage policies may contain a probationary or waiting period that shall not exceed thirty (30) days. In the case of a policy that combines specified disease coverage with one or more types of coverage, the waiting period may be applied only to the specified disease benefits.

Basic Hospital Expense, Basic Medical-surgical Expense, and Major Medical Expense Coverage

Basic hospital expense, basic medical-surgical expense, and major medical expense coverage are not excepted benefits and are not excluded from the types of coverage that are deemed health benefit plans. Therefore, any policy that contains benefits that in conjunction form or imitate basic hospital expense, basic medical-surgical expense, or major medical expense coverage will be considered a "health benefit plan" and must comply with the requirements of Chapters 22 and 47 (group market) or Chapters 21 and 52 (individual market), Title 41, Idaho Code. A policy that would be considered to imitate such coverage may include, for example, reimbursements or payments contingent upon the policyholder or certificate holder receiving inpatient or outpatient (including physician, facility, or pharmacy) services that fall outside of the definition of hospital confinement indemnity, accident-only or specified disease coverages.

Riders

Any riders providing additional coverage must meet the requirements of one of the categories of coverage described in IDAPA 18.04.08 to the same extent as must a stand-alone policy.

If you have questions concerning this bulletin, please contact the Department of Insurance at (208) 334-4250.

[i] As of July 1, 2019, IDAPA 18.01.30 was renumbered as IDAPA 18.04.08.