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Requirements for Fixed Indemnity Insurance Under the Affordable Care Act

This bulletin is directed to all insurers writing hospital indemnity policies or other fixed indemnity policies sold in the individual market in Maine, including association coverage and other coverage that is issued through non-employer groups. Its purpose is to provide guidance regarding the Bureau's implementation and enforcement of the Final Rule recently issued by the federal Centers for Medicare and Medicaid Services (CMS),[1] establishing requirements for individual hospital and other fixed indemnity insurance coverage in the individual market.

In particular, coverage subject to the Final Rule may be:

> "provided only to individuals who attest, in their hospital or other fixed indemnity insurance application, that they have other health coverage that is considered minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code."[2]

The Final Rule also requires application materials to display the following notice in at least 14-point type:

> "THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES."[3]

All policies and certificates with effective dates on or after January 1, 2015, are subject to the Final Rule. In addition, the notice requirement applies to renewals for all policy years beginning on or after January 1, 2015. The attestation requirement applies to all renewal applications for coverage effective on or after October 1, 2016.

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[1] CMS Final Rule on the Exchange and Insurance Market Standards for 2015 and Beyond, promulgated May 27, 2014 (79 FR 30240). The provisions on fixed indemnity insurance are found at 42 CFR § 148.220(b)(4).

[2] 42 CFR § 148.220(b)(4)(i). Coverage may also be sold to individuals who are exempt from the minimum essential coverage requirement because they are residents of U.S. territories or possessions.

[3] 42 CFR § 148.220(b)(4)(iv).

New Sales Effective On or After January 1, 2015

All applications for new coverage with an effective date on or after January 1, 2015, must contain both the notice and the attestation. This requirement applies only to the initial application, and does not need to be repeated when coverage is renewed. The Bureau suggests that carriers issuing hospital or fixed indemnity coverage in the individual market (meaning all such coverage that is not offered as an employee benefit) use the following attestation language, immediately following the notice:

> "I hereby attest that I have Medicare or major medical health insurance that meets the requirement of 'minimum essential coverage' as defined by the Affordable Care Act."

In letters of August 27 and October 8, 2014, addressed to the National Association of Insurance Commissioners, CMS has indicated that no enforcement action would be taken against issuers (carriers) that file policy form amendments or amendments to application materials with the Bureau for approval by October 1, 2014. This safe-harbor provision requires approved amendments or revised application materials to be in use no later than May 1, 2015. Carriers are advised to pay particular attention to the requirements of the CMS letters, which are attached as an appendix to this Bulletin. The Bureau will follow the same safe-harbor guidance.

Contracts with Effective Dates Before January 1, 2015

For policies and certificates that are already in force or that will take effect later in 2014, the same one-time notice and attestation requirements apply to the first renewal application with an effective date on or after October 1, 2016, if an application is required in order to renew the coverage. Alternatively, the carrier has the option to provide the notice and collect the attestation at any earlier date.

If no application for renewal is required because the policy or certificate renews automatically upon continued payment of premiums, then no later than October 1, 2016, the carrier shall send notice to each insured who was not given notice at the point of sale, in clear, conspicuous, and ordinary language, that the hospital or other fixed indemnity insurance does not meet the minimum essential coverage requirements of the Affordable Care Act. The Bureau suggests that carriers use language substantially similar to the following notice:

> THIS INSURANCE POLICY DOES NOT MEET THE AFFORDABLE CARE ACT'S REQUIREMENT THAT YOU MAINTAIN MINIMUM ESSENTIAL COVERAGE, ALSO KNOWN AS MAJOR MEDICAL INSURANCE. FAILURE TO MAINTAIN MINIMUM ESSENTIAL HEALTH COVERAGE MAY RESULT IN ADDITIONAL PAYMENT WITH YOUR TAXES. THIS INSURANCE COVERAGE WILL REMAIN IN FORCE AS LONG AS YOU CONTINUE TO PAY YOUR PREMIUMS.

Inquiries About Minimum Essential Coverage Status

Carriers may not make further inquiries to insureds about minimum essential coverage if the purpose of the inquiry is to seek to cancel or terminate a contract because of past or anticipated claims. If a carrier terminates the policies or certificates of insureds who do not maintain minimum essential coverage, the carrier must establish and follow procedures that are applied uniformly without regard to claims experience or any actual or perceived risk factor.

Additional Requirements for Fixed Indemnity Policies

Carriers are reminded that in addition to the notice and attestation requirements, the Final Rule establishes the following additional requirements in order for a fixed indemnity policy to qualify as "excepted benefits" that are exempt from the ACA's guaranteed issue, community rating, and essential benefit package requirements:

- There may not be any coordination between the provision of benefits and an exclusion of benefits under any other health coverage.

- The benefits must be 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.

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NOTE: This Bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties, or privileges, nor is it intended to provide legal advice. Readers should consult applicable statutes and rules and contact the Bureau of Insurance if additional information is needed.