STATUTORY BACKGROUND: HOSPITAL INDEMNITY AND OTHER FIXED INDEMNITY EXCEPTED BENEFITS

Legislative History

- Excepted benefits were first recognized in federal law in 1996 as part of the Health Insurance Portability and Accountability Act (HIPAA).
  - HIPAA defined four categories of benefits and "excepted" these benefits from the application of HIPAA's health coverage mandates. Each category has different requirements that must be met in order for the benefits in that category to be "excepted".
  - HIPAA added the same provisions to each of ERISA (sec. 733(c)), the Internal Revenue Code (sec. 9832(c)), and the Public Health Service Act (sec. 2791(c)).
- Subsequent federal legislation has reconfirmed the different treatment for excepted benefits and continued in place without change the HIPAA definition of excepted benefits and the exclusion of such benefits from new health coverage mandates, including the following.
  - No Surprises Act (2020)
  - Affordable Care Act
  - Michelle's Law (2008)
  - Paul Wellstone and Pete Domenici Mental Health Parity and Equity Additional Act of 2008 (MHPAEA)
  - Genetic Information Nondiscrimination Act of 2008 (GINA)
  - Newborns' and Mothers' Health Protection Act of 1996 (NMHPA)
  - The Mental Health Parity Act of 1996

Requirements for Excepted Benefit Status: Hospital Indemnity and other Fixed Indemnity Benefits

- Hospital indemnity and other fixed indemnity benefits are one of the statutorily recognized categories of excepted benefits. The category is generally referred to as "independent, noncoordinated benefits".
- The statute contains three requirements for such benefits:
  - The benefits are provided under 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.
  - Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor.

Case Law

- *Central United v. Burwell* addressed the scope of regulatory authority to revise the requirements for excepted benefits. The U.S. Court of Appeals for the DC Circuit held invalid a 2016 HHS regulation requiring that individual market fixed indemnity excepted benefit plans could only be provided to individuals who attest that they have minimum essential coverage. In holding this requirement invalid, the court stated that "HHS lacked authority to demand more of fixed indemnity providers than Congress required".

Definition of "Independent, Noncoordinated" Excepted Benefits

"Independent, noncoordinated" benefits are one of four statutory classes of excepted benefits. The definition of such benefits is the same in PHS Act section 2791(c)(3), Code section 9832(c)(3), and ERISA section 733(c)(3). The specific requirements applicable to each class are set forth in PHS Act section 2722, Code section 9831, and ERISA section 732. The tri-agencies, the Department of Health and Human Services (HHS), Treasury/IRS, and the Department of Labor (DOL), have issued similar regulations with respect to the group market corresponding to the statutory categories, at 45 CFR 146.145, 26 CFR 54.9831-1, and 29 CFR 2590.732 respectively. HHS regulations relating to excepted benefits in the individual market are at 45 CFR 148.220

Statutory definitions of the four classes of excepted benefits

"For purposes of [referenced sections of title XXVII of the PHSA, part 7 of ERISA, and chapter 100 of the Code], the term 'excepted benefits' means benefits under one or more (or any combination thereof) of the following:

"(1) Benefits not subject to requirements. [accident, disability, etc..]…

"(2) Benefits not subject to requirements if offered separately [dental, vision, certain long-term care benefits]…

"(3) Benefits not subject to requirements if offered as independent, noncoordinated benefits.

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

"(4) Benefits not subject to requirements if offered as separate insurance policy [Medical supplemental and other similar coverage supplemental to a group health plans]…"

Statutory requirements for independent, noncoordinated excepted benefits: PHS Act section 2722(c)(2), Code section 9831, ERISA section 732.

"NONCOORDINATED, EXCEPTED BENEFITS.—The requirements of [referenced sections of title XXVII of the PHS Act, part 7 of ERISA and chapter 100 of the Code] shall not apply to any individual coverage or any group health plan (and group health insurance coverage offered in connection with a group health plan) in relation to its provision of excepted benefits described in section 2791(c)(3) [Code section 9832(c)(3), and ERISA section 733(c)(3)] if all of the following conditions are met:

(A) The benefits are provided under a separate policy, certificate, or contract of insurance.

(B) 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.

(C) Such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer."

Group Market Regulations regarding independent, noncoordinated benefits: 45 CFR 146.145(b)(4), 26 CFR 54.9831-1(c)(4), and 29 CFR 2590.732(c)(4).

Noncoordinated benefits –

(i) ***Excepted benefits that are not coordinated.*** Coverage for only a specified disease or illness (for example, cancer-only policies) or hospital indemnity or other fixed indemnity insurance is excepted only if it meets each of the conditions specified in paragraph (b)(4)(ii) of this section. To be hospital indemnity or other fixed indemnity insurance, the insurance must pay a fixed dollar amount per day (or per other period) of hospitalization or illness (for example, $100/day) regardless of the amount of expenses incurred.

(ii) ***Conditions.*** Benefits are described in paragraph (b)(4)(i) of this section only if -

(A) The benefits are provided under a separate policy, certificate, or contract of insurance;

(B) There is no coordination between the provision of the benefits and an exclusion of benefits under any group health plan maintained by the same plan sponsor; and

(C) The benefits are paid with respect to an event without regard to whether benefits are provided with respect to the event under any group health plan maintained by the same plan sponsor.

(iii) ***Example.*** The rules of this paragraph (b)(4) [(c)(4) in Treasury and DOL regulations] are illustrated by the following example:

Example.

(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,* even though the benefits under the policy satisfy the conditions in paragraph (b)(4)(ii) of this section, because the policy pays a percentage of expenses incurred rather than a fixed dollar amount, the benefits under the policy are not excepted benefits under this paragraph (b)(4). This is the result even if, in practice, the policy pays the maximum of $100 for every day of hospitalization.

Individual Market Regulations regarding independent, noncoordinated benefits: 45 CFR 148.220(b)(3) and (4).

"(3) Coverage only for a specified disease or illness (for example, cancer policies) if the policies meet the requirements of [group market regulations in] § 146.145(b)(4)(ii)(B) and (C) of this subchapter regarding noncoordination of benefits.

"(4) Hospital indemnity or other fixed indemnity insurance only if -

"(i) The benefits are provided only to individuals who attest, in their fixed indemnity insurance application, that they have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or that they are treated as having minimum essential coverage due to their status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B)". ***[This provision was held invalid in Central United Life v Burwell and so is no longer in effect.]***

"(ii) There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage.

"(iii) The 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.

"(iv) A notice is displayed prominently in the application materials in at least 14 point type that has the following language: '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.'

"(v) The requirement of paragraph (b)(4)(iv) of this section applies to all hospital or other fixed indemnity insurance policy years beginning on or after January 1, 2015, and the requirement of paragraph (b)(4)(i) of this section applies to hospital or other fixed indemnity insurance policies issued on or after January 1, 2015, and to hospital or other fixed indemnity policies issued before that date, upon their first renewal occurring on or after October 1, 2016."