STATE OF MICHIGAN
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Bulletin 2016-23-INS

In the matter of

Hospital Indemnity and Fixed Indemnity
Policy Requirements
_____/

Issued and entered
this 22nd day of December 2016
by Patrick M. McPharlin
Director

This bulletin supersedes Bulletin 2014-3-INS.

On February 20, 2014, the Department of Insurance and Financial Services (DIFS) issued Bulletin 2014-3-INS, which set forth the federal requirements for fixed indemnity (also known as "hospital indemnity") plans to be considered excepted benefits. Among these was a requirement that individual market fixed indemnity plans could only be issued to persons who had purchased "minimum essential coverage" within the meaning of Section 5000A(f) of the Internal Revenue Code. Subsequently, on May 27, 2014, the federal government issued final regulations that imposed, among other things, a requirement that a person applying for an individual fixed indemnity policy attest that they had purchased minimum essential coverage (the "attestation requirement").[1]

On October 14, 2016, the parties to the case titled *Central United Life Insurance Co. v. Burwell* entered into an agreement under which the United States District Court for the District of Columbia declared that individual market fixed indemnity plans could be sold and issued regardless of whether the policyholder had purchased minimum essential coverage, and that therefore the attestation requirement was not enforceable.

However, all other requirements applicable to fixed indemnity plans remain enforceable. Accordingly, this bulletin sets forth the requirements that currently apply to fixed indemnity and hospital indemnity policies in the individual market.

Individual Market Fixed Indemnity and Hospital Indemnity Plans

Individual market fixed indemnity plans qualify as excepted benefits so long as the following conditions are met:

1) There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;
2) The benefits are paid in a fixed dollar amount per day or other time period of hospitalization or illness, regardless of the amount of expenses incurred or the type of items or services received; and

[1] Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond (May 27, 2014), 79 Fed. Reg. 30239 (May 27, 2014).

3) For individual market fixed indemnity policies issued with an effective date on or after January 1, 2015, the following notice must be displayed prominently in the application materials in at least 14-point type: "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."[2]

Regarding the notice requirement (#3 above): for in-force coverage that has an effective date prior to January 1, 2015, this notice requirement applied to the first renewal application with an effective date on or after October 1, 2016, if an application was required in order to renew the coverage. If no application for renewal is required (e.g., if the policy renews automatically upon continued payment of premiums), then the above-described notice requirement does not apply. However, no later than February 1, 2016, the issuer shall send, to each insured who was not given notice at the point of sale, a notice in clear, conspicuous, and ordinary language that the fixed indemnity policy does not constitute "minimum essential coverage." DIFS recognizes that most issuers will have already provided this notice in response to the requirement set forth in Bulletin 2014-3-INS, page 2, but reiterates the requirement here for clarity. Issuers are not required to notify DIFS that these notices have been sent, but should maintain documentation demonstrating that this requirement was satisfied.

Group Market Fixed Indemnity and Hospital Indemnity Plans

Group market fixed indemnity or hospital indemnity plans qualify as excepted benefits only if the following conditions are met:

- the benefits are provided under a separate policy, certificate, or contract of insurance;
- there is no coordination between the benefits provided and an exclusion of benefits under any group health plan maintained by the same sponsor; and
- 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 sponsor; and
- the plan pays a fixed dollar amount per day (or other period of time) of hospitalization or illness, regardless of the amount of expenses incurred.[3]

Any questions regarding this bulletin should be directed to:

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[2] 45 CFR 148.220(b)(4).
[3] 45 CFR 146.145(b)(4).