NAIC National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

August 27, 2013

The Honorable Thomas E. Perez
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Jacob J. Lew
Secretary
U.S. Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Dear Secretaries Perez, Sebelius and Lew:

On January 24, 2013, the Department of Labor, the Department and Health and Human Services, and the Department of Treasury together issued "ACA Implementation FAQ #11." Question number 7 addressed the circumstances under which fixed indemnity (or hospital indemnity) plans are to be considered "excepted benefits" under the Public Health Service Act, and therefore exempt from the provisions of the Affordable Care Act (ACA). It is in reference to this question and answer that we write today on behalf of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators in the 50 states, the District of Columbia, and five U.S. territories.

Since adoption of the Health Insurance Portability and Accountability Act of 1996, fixed indemnity and hospital indemnity plans have been classified as "excepted benefits" in the Public Health Service Act. In the subsequent regulations in 1997 and 2005, the 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.

Based on the regulation, and as the regulators responsible for licensing plans in the states, insurance commissioners have approved for sale hospital and other fixed indemnity plans that provide a fixed dollar amount per period, regardless of the amount of expenses incurred, but allowing the fixed amount to vary based on the type of service provided. For example, the policy may cover a fixed $100 amount for a hospital day, but a fixed $50 amount for a physician visit. In the current marketplace these plans have provided options for consumers seeking supplemental coverage or limited coverage.

In "ACA Implementation FAQ #11" the answer to question number 7 states that coverage with variable fixed amounts based on type of service does not meet the definition of a hospital or other fixed indemnity insurance and is not considered "excepted benefits" under the Public Health Service Act. We are concerned about the impact this interpretation will have on consumers.

First, state regulators believe that immediately requiring carriers to modify these plans in order to retain excepted benefit status would unnecessarily strip consumers of their coverage options. To address this issue, the Louisiana Department of Insurance has issued a bulletin to carriers granting them a transition period to come into compliance with the federal regulation. Any new plans are required to meet the standards set forth in the FAQ, but plans already approved by the state are granted a safe-harbor period to prevent market disruptions.

The Louisiana bulletin also requires all hospital and other fixed indemnity plans to notify consumers that the coverage is not "minimum essential coverage" and, therefore, does not, on its own, satisfy the federal individual mandate.

Other states are likely to follow Louisiana's lead to afford a reasonable transition for carriers and consumers.

Second, state regulators believe hospital and other fixed indemnity coverage with variable fixed amounts based on service type could provide important options for consumers as supplemental coverage. Consumers who purchase major medical insurance that meets the definition of "minimum essential coverage" may still wish to buy fixed indemnity coverage to help meet out-of-pocket medical and other costs. Policies with variable fixed amounts have proven to be popular and we see no reason they should be eliminated as options for supplemental coverage. We ask that you reconsider your position on this issue.

Some states have already addressed this issue for supplemental coverage. Examples include requiring a consumer disclosure that the benefits provided are supplemental, requiring a certification to the state insurance commissioner that the coverage is offered and marketed as supplemental health insurance and not a substitute for "primary" health insurance, and restricting issuance of coverage to purchasers that have underlying health insurance coverage.

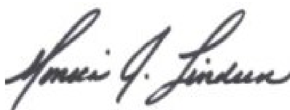
As you know, there will be significant changes to the health insurance marketplace beginning January 1, 2014. All of the reforms must be implemented with due caution to ensure consumers are protected and markets are not unnecessarily disrupted. We believe a modest adjustment to the current interpretation of the regulation, as we have suggested, and a reasonable transition period would achieve these two important goals.

We appreciate your consideration.

Sincerely,

James J. Donelon
NAIC President
Louisiana Insurance Commissioner

Adam Hamm
NAIC President-Elect
North Dakota Insurance Commissioner



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