Compliance Rule Book for Worksite Supplemental Products

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Disclaimer

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Getting to Know You

Overview

- What are Supplemental Benefits?
- Coordination with ACA
- Filing and Actuarial Issues with States
- Product Trends

What are Supplemental Benefits?

What are Supplemental Benefits?

- Not major medical insurance
- Can fill the gaps
- Can provide cash benefits
- Available through an employer (worksite) or directly from an insurer

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What are Supplemental Benefits?

- Includes:
  - Vision
  - Dental
  - Cancer
  - Disability
  - Accident
  - Critical illness
  - And more!

What are Supplemental Benefits?

- Product focus
  - Critical illness (CI)
  - Accident
  - Hospital Indemnity (HI)
- Market focus
  - Worksite

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Supplemental Benefits: CI

- Lump sum benefit
- Common benefit triggers:
  - Cancer
  - Heart Attack
  - Stroke
  - Major Organ Failure
  - Renal Failure
- Pay independent of and in addition to any other insurance

Supplemental Benefits: Accident

- Benefits payable for a covered accident
- Can pay indemnity benefits or for actual costs incurred
  - We will focus on indemnity
- Benefits may include:
  - Hospitalization
  - Broken bones
  - Ambulance
- Pay independent of and in addition to any other insurance

Supplemental Benefits: HI

- Benefit per a defined period of time (e.g. per day)
- Base benefit requires hospitalization
- Additional benefits may include:
  - Emergency room or urgent care
  - Diagnostic testing
  - Surgery
- Pay independent of and in addition to any other insurance

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Supplemental Benefits

- Risk selection
- Distribution
- Pricing/design
- Assumptions

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Coordination with ACA

Okay…

Not okay…

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Excepted Benefits: CI

- Code of Federal Regulations (CFR): 45 CFR 146.145
  - (b) Excepted benefits
    - (4) Noncoordinated benefits
      - (i) "Coverage for only a specified disease or illness (for example, cancer-only policies)…"
- This code is applicable to group coverage.

Excepted Benefits: CI

- Code of Federal Regulations (CFR): 45 CFR 148.220
  - (b) Other excepted benefits
    - (3) “Coverage only for a specified disease or illness (for example, cancer policies)…”
- This code is applicable to individual coverage.
- There must be no coordination of benefits.

Excepted Benefits: Accident

- Code of Federal Regulations (CFR): 45 CFR 146.145
  - (b) Excepted benefits
    - (2) Benefits excepted in all circumstances
      - (i) “Coverage only for accident (including accidental death and dismemberment”
- This code is applicable to group coverage.

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Excepted Benefits: Accident

- Code of Federal Regulations (CFR): 45 CFR 148.220
  - (a) Benefits excepted in all circumstances
    - (1) “Coverage only for accident (including accidental death and dismemberment)”
- This code is applicable to individual coverage.

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Excepted Benefits: HI

- Code of Federal Regulations (CFR): 45 CFR 146.145
  - (b) Excepted benefits
    - (4) Noncoordinated benefits
      - (i) “Coverage for…hospital indemnity or other fixed indemnity insurance…”
- This code is applicable to group coverage.
- The insurance must pay a fixed dollar amount per day (or other period) of hospitalization or illness regardless of the amount of expenses incurred.

Excepted Benefits: HI

- Code of Federal Regulations (CFR): 45 CFR 148.220
  - (b) Other excepted benefits
    - (4) “Hospital indemnity or other fixed indemnity insurance”
- This code is applicable to individual coverage.

Excepted Benefits: HI

- Code of Federal Regulations (CFR): 45 CFR 148.220(b)(4)
  - Applicants must attest that they have minimum essential health coverage
  - No coordination of benefits
  - Benefits are paid in a fixed dollar amount per period of hospitalization or illness and/or per service
  - Application material must include: “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.”

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Compatibility with HSAs

- Internal Revenue Code (IRC): 26 U.S. Code 223
  - (c) Definitions and special rules
    - (1) Eligible individual
      - (B) Certain coverage disregarded
        - (i) “coverage for any benefit provided by permitted insurance”
        - (ii) “coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care”
- Permitted insurance includes:
  - “insurance for a specified disease or illness”
  - “insurance paying a fixed amount per day (or other period) of hospitalization

Filing and Actuarial Issues with States

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States and Excepted Benefit Status

- Not always "excepted benefit" for state requirements
- May require support filed as to why "excepted benefit"

States and Excepted Benefit Status

- Hospital indemnity
  - Individual can provide a fixed benefit per time period or per service
  - Group must be defined as per period of time
  - Some states have adopted the requirements consistent with the CFRs
  - Some states require both individual and group to be defined as per period of time

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States and Excepted Benefit Status

- Wellness benefit
  - Some states will challenge the excepted benefit status
    - Especially if sold with CI
  - Accident and HI do not have the same hurdle as CI
  - Two approaches for filing with CI if challenged
    - “specified disease or illness”
    - “other fixed indemnity”
  - Few states may not approve

States and Excepted Benefit Status

- Additional disclosure
  - 45 CFR 148.220(b)(4)
    - Applies to individual hospital indemnity and other fixed indemnity
  - Some states are applying to both group and individual
  - Some states are applying to products other than just HI

State ARCs and Actuarial Memoranda

- Annual rate certifications (not product specific)
  - FL, NC
  - CA requires an annual filing that includes filing the average annual premium or range of premiums for specified disease products
  - This is not an all inclusive list and other ARCs may be required

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State ARCs and Actuarial Memoranda

- Specific format for actuarial memorandum (not product specific)
  - FL, MN, CO, NY
    - Additional states are likely
  - Some states may require:
    - Detailed expense information
    - Average annual premium

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Various State Issues

- Waiting period: Many states limit and some do not allow
- Benefit reduction not allowed in all states
- Limitation on lookback periods for underwriting questions
- Pre-existing condition exclusion
  - NAIC Model 171 has 6/6 pre-ex limitation that many states follow
  - Many states will allow a 12/12 pre-ex

Various State Issues

- For issue age rates:
  - May need to file a sample ALR calculation
  - May need to file a durational loss ratio exhibit
- Combining indemnity benefits such as CI with accident, HI, wellness, or another additional benefit
  - Some states require separate filings or do not allow at all

Various State Issues

- Loss ratio requirements
  - For guaranteed renewable forms, many states will accept a 50% minimum loss ratio based on the NAIC guidelines for type of coverage and renewability
  - Some states will apply the individual requirements to group products
  - Almost all states will approve a 55% minimum loss ratio for guaranteed renewable forms

Various State Issues

- Premium rates
  - WA and FL: Do not allow filing both issue age and attained age rates on the same form
  - FL: Restrictions on the rates that must be filed
    - Cannot market attained age bands
    - Issue age rates must be filed, regardless of the group size

Various State Issues

- For CI, separation period between benefit triggers
  - Reoccurrence
  - Additional occurrence
  - NJ and NY do not allow
    - There may be others states

State Issues: California

- Filing fees
- Annual certification required for CI and HI
  - California Code, Section 10198.61
  - Does not apply to accident

State Issues: District of Columbia

- Exchange assessment
- For CI, single disease requirement

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State Issues: Georgia

- CI
  - Desk draw rules
  - “Specified disease” vs. “Critical illness”
  - Lump sum cancer

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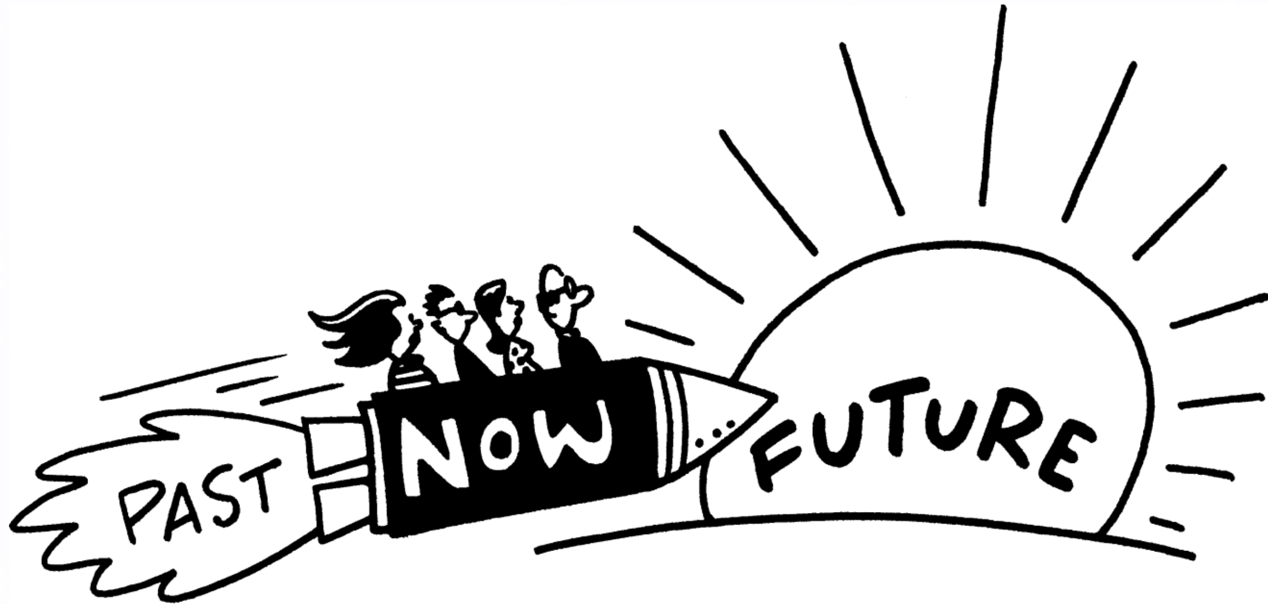
State Issues: New York

- Accident: Annual attestation of coverage
  - Does not require the insured to respond, but required to send annual disclosure to insured
  - Still require comprehensive coverage at the time of application and disclosure at application and renewal
- CI
  - Limited to a maximum of 7 benefit triggers
  - Must cover all forms of a disease
    - Must cover skin cancer if cancer is covered

State Issues: Ohio

- Imposing NAIC Model 134 loss ratios to both individual and group
  - Optionally renewable: 60%
  - Conditionally renewable: 55%
  - Guaranteed renewable: 50%

Product Trends



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Worksite Product Trends

- Reduced underwriting
  - Increased guaranteed issue amounts
  - Make sure exclusions are appropriate
  - If simplified issue, make the questions count
- Electronic platforms
  - E-sign and UETA
  - May need to file web screens
- Issue age rates

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Worksite Product Trends: CI

- Covering more conditions
  - Alzheimer’s, Parkinson’s, ALS, MS
  - Accident-like triggers
  - Children’s conditions
  - These can create claims and pricing challenges; potential for overlap

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Worksite Product Trends: CI

- Addition of cancer-like benefits
  - Care based, lodging, transportation
  - CI triggered
  - Can trigger additional mandates

Worksite Product Trends: Accident

- Additional exclusions
  - Zorbing
- Benefit triggers
  - Some triggers are being included more frequently
- Smaller monthly premiums
  - Slimming down benefits

Worksite Product Trends: HI

- HSA compliant plans
  - Designing plans that require confinement as a trigger to the benefit

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Questions?