



DECEMBER 2014

WEST VIRGINIA INFORMATIONAL LETTER

NO. 191

**To: All Carriers Writing Hospital Indemnity or Other Fixed Indemnity Policies in West Virginia**

**Re: Hospital Indemnity or Other Fixed Indemnity Policies**

This informational letter is directed to all insurers writing hospital indemnity policies or other fixed indemnity policies sold in the individual and group markets in West Virginia. It is intended to provide assistance regarding the Offices of the Insurance Commissioner's implementation and enforcement of the recently released rules and guidance from the federal government regarding hospital indemnity or other fixed indemnity policies. The guidance originates from the Centers for Medicare and Medicaid Services' (CMS) final rule entitled "Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond" (79 CFR § 30240), issued on May 27, 2014.

The federal rule and this informational letter apply only to hospital indemnity or other fixed indemnity insurance policies sold in the individual market. Neither of them apply to any other type or category of insurance that are listed separately as excepted benefits (e.g., specified disease insurance, accident insurance, etc.) in the Public Health Service Act, 42 U.S.C. §§ 201 *et seq.*, irrespective of whether benefits under such coverage are paid as a fixed dollar amount.

In the federal rule and subsequent guidance, CMS established the following conditions for a hospital indemnity or other fixed indemnity insurance policy sold in the individual market:

1. The benefits are provided only to policyholders who attest, in their hospital indemnity or other fixed indemnity insurance application, that they have other health coverage that is considered minimum essential coverage within the meaning of 26 U.S.C. §5000A(f);
2. There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage;
3. The benefits are paid in a fixed dollar amount per period of hospitalization or illness and/or per service 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; and
4. 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 COVERAGES) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.”

**Policies Issued On or After May 1, 2015**

For policies issued with an effective date beginning on or after May 1, 2015, the insurer must include in the initial insurance application a written attestation that the purchaser has minimum essential coverage as defined by the aforementioned rules and subsequent guidance issued by the federal government. This is a one-time attestation requiring the signature of the insured and the date signed (the attestation cannot be a “check box” or other similar type of notation). The insurer is not required to confirm continuous major medical coverage by the purchaser. The language suggested for the attestation is as follows:

“I hereby certify that I am currently enrolled in a Major Medical or Comprehensive Medical Health Plan that provides Minimum Essential Coverage as mandated under the federal Patient Protection and Affordable Care Act of 2010.

I am aware that I am purchasing a plan that provides *limited benefits* as supplemental coverage to a Major Medical/Comprehensive Medical Health Plan.

Insured’s Signature (Required): \_\_\_\_\_”

Date: \_\_\_\_\_”

Additionally, federal guidance requires that the following notice must be displayed prominently in application materials 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.”

Any printed advertising or other type of consumer educational material relating to hospital indemnity or other fixed indemnity policies must also contain similar language to the above-referenced disclosure language in a prominent location using a font size easily viewable to the consumer.

Moreover, where a hospital indemnity or other fixed indemnity policy requires a notice of renewal to be issued to the insured by the insurer (e.g., when a rate change occurs), West Virginia shall require a disclosure to be delivered to the insured at least thirty (30) days before the renewal. The disclosure shall include the following:

“This product provides limited benefits. This is not major medical or comprehensive health insurance. This product does not provide the minimum essential coverage necessary to avoid penalty under the federal Patient Protection and Affordable Care Act of 2010 and can be included in the regular renewal package.”

**Policies Issued Before May 1, 2015**

For policies issued with an effective date before May 1, 2015, that do not require an application as a condition of renewal but are guaranteed renewable or non-cancellable (with the only condition for renewal being timely payment of premium), the aforementioned requirements do not apply. If an insured is required for any reason to fill out a new application form, the federal mandates of attestation and disclosure contained in the application are applicable.

Please e-mail any questions concerning this Informational Letter to [Informational.Letter@wvinsurance.gov](mailto:Informational.Letter@wvinsurance.gov) or call 304-558-0401.



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Insurance Commissioner