Supplemental Health Insurance

Hospital or Other Fixed Indemnity, Accident-Only, Critical Illness

What Supplemental Health Insurance Is

Supplemental health insurance typically refers to products that are designed to supplement comprehensive major medical insurance. These products are considered "excepted benefits" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This means that because they are not intended to pay providers directly for medical expenses, they are not subject to many of the requirements for major medical health coverage under the Affordable Care Act (ACA). These plans typically:

- Pay benefits directly to an individual, instead of paying providers directly for medical claims. This allows you to pay expenses that can arise when you are sick or injured, such as cost sharing or expenses not related to your medical bills.
- Can be renewed as long as premiums are paid.
- Pay benefits regardless of other coverage that you have.
- Are not limited to doctors in a specific network.
- Can include waiting or "look-back" periods before the benefits start.

Hospital or Other Fixed Indemnity coverage typically pays a specified dollar amount each day an individual is hospitalized or has another medical event. Most modern hospital and fixed indemnity plans provide benefits not only when someone is admitted to a hospital, but also when someone has a diagnostic procedure, outpatient surgery, transportation by ambulance, or other procedures performed in an office or outpatient setting. There can be per day and per service payment limits, and premiums often remain steady or experience very small increases throughout the life of the policy.

Accident-Only coverage is for expenses associated with an accident. It can help pay for cost-sharing due to emergency room visits, ambulance rides, and other out-of-pocket costs that people face after an accident. Depending on the type of accident-only policy you have, benefits may be received as a lump sum, or as a fixed dollar amount paid as a result of the accident or as specific services are received.

Critical Illness coverage pays a lump sum when an individual is diagnosed with one or more of a pre-determined list of critical illnesses. A subset of critical illness coverage is called **Specified Disease** coverage, which pays a lump sum upon diagnosis for a specified condition (e.g., cancer), plus additional benefits (fixed-dollar amount) as services for treating that disease are received.

Limited Benefit Plan Or Limited Medical Benefit Plan?

People often confuse Limited Benefit Plans, which are HIPAA excepted supplemental benefits, with Limited *Medical* Benefit Plans, which are not HIPAA excepted and are not considered supplemental coverage.

Limited benefit plans are policies comprised of HIPAA-excepted benefits. That means they are exempt from having to cover certain services that might otherwise be required by state regulators. Such exemption authority is meant to allow state regulators to recognize changing market needs and innovative products. Typically, "limited benefit plans" do not include long-term care or Medicare Supplement benefits. "Limited benefit plans" usually require some type of disclosure, which explains that the benefits are supplemental and not intended to cover medical expense claims (this disclosure generally applies to all excepted-benefit policy types).

Limited medical benefit plans (including mini-med plans and short-term plans) are NOT HIPAA excepted benefits and are not considered supplemental coverage. Limited medical benefit plans are typically designed and marketed as a substitute for major medical coverage. In other words, they serve as primary health insurance. Premiums are typically lower than major medical coverage, but benefits also could be restricted and there could be annual limits for covered services.

What Supplemental Health Insurance Is Not

Supplemental health insurance is intended to provide additional financial protection beyond what is covered under traditional comprehensive major medical insurance. In addition to major medical, there are other types of coverage that are marketed as a substitute for, not as a supplement to, major medical insurance. These coverages include short-term limited duration insurance and mini-med plans. Supplemental health insurance, however, is not intended as a substitute for major medical coverage. It can be a tool to help consumers supplement the coverage provided by major medical coverage or other limited medical benefit plan.

Comprehensive major medical coverage. These plans cover a wide variety of health care services with varying plan designs, benefit levels, and cost sharing. Under the Affordable Care Act, these plans must cover essential health benefits, premiums cannot vary based on health status, pre-existing condition exclusions are prohibited, and they cannot have annual or lifetime benefit limits. Benefits are paid directly to the provider based on the medical expenses incurred for major medical services. Because the provider is paid directly, these products do not allow the covered person to use the money for household and other expenses related to his or her illness or injury.

Mini-meds. The term "mini-med" is broad and can encompass plan designs that may look in the future very different than they do today or did before the ACA. The major characteristic that is universal for mini-med-type plans—they are marketed as major medical coverage as opposed to a supplement to major medical, although they do not have the protections HIPAA and the ACA provide. They typically have low lifetime and annual limits and are more likely to cover less expensive, common medical expenses, and most of these plans have reduced or no coverage for out-of-network provider services.

Short-term limited duration insurance (STLDI). These plans are also expense-based like comprehensive major medical coverage. These plans are often used during transitional periods (e.g., between jobs, new graduates) and are only allowed to be in force for a limited time, currently up to 36 months, depending on state law. STLDI products typically also have pre-existing condition exclusions that would reset if the policies are renewed.