Recurring Issues: Supplemental Health Insurance

The Vermont Rates & Forms Section receives a large number of supplemental health insurance form filings (e.g., hospital indemnity, critical illness, blanket accident and health) that fail to comply with Vermont law and established Department policy. Not only does the review of such filings consume a disproportionate amount of time for the Section's small staff, but speed-to-market is also adversely impacted when filers fail to review Vermont law and submit policy forms that require multiple objection letters from the Department before they can be approved.

In an effort to address this problem, the Rates & Forms Section is publishing the following list of the regulatory issues most frequently encountered in the review of supplemental health insurance form filings. Before submitting a supplemental health insurance policy form to the Department, filers should review this list and make any corrections necessary to bring the filing into compliance with these requirements. Please note that this is not a comprehensive list of Vermont requirements, merely the most common errors, and that filers should also review Vermont's health care statutes and regulations before submitting a filing.

Filers should also complete the certification required under the SERFF Filing Instructions stating that they have read this list and made any necessary changes. Beginning April 1, 2015, supplemental health insurance filings that do not contain such a certification or do not comply with the following requirements may be subject to final disapproval without the opportunity to file a response.

Questions about the following requirements should be directed to Emily Brown, Director of Rates and Forms, at (802) 828-4871, or Anna Van Fleet, Assistant Director, at (802) 828-4843.

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Arbitration: Filings may not contain a requirement that disputes be submitted to binding arbitration, as such provisions deprive the insured of access to a court. Binding arbitration is permitted only if both parties agree to the arbitration process at the time a dispute arises.

Blanket insurance: The relevant statutes for blanket health insurance are 8 V.S.A. §§ 4081 and 4082.

Civil Unions: Insurers must provide dependent coverage to parties to a civil union that is equivalent to that provided to parties to a marriage. 8 V.S.A. § 4063a.

Combination rate & form filings: Rate filings may not be submitted until after the form filing has been approved. The reason for this requirement is that changes necessary to bring a form into compliance with Vermont law may necessitate a change in the corresponding rates. When submitting a rate filing, please reference the SERFF and state tracking numbers of the associated approved form. Rate filings submitted prior to form filing approval may be disapproved-final..

Cover page disclosure: For all supplemental health insurance, the cover page of the policy (and, if group insurance, of the certificate as well) must contain the following disclosure: "THIS POLICY DOES NOT MEET THE MINIMUM COVERAGE REQUIREMENTS OF THE AFFORDABLE CARE ACT. YOU SHOULD NOT PURCHASE THIS POLICY UNLESS YOU ARE ALREADY COVERED BY COMPREHENSIVE MAJOR MEDICAL INSURANCE."

Coverage limits: Filings for individual and group supplemental health insurance policies should specifically set forth the coverage limits that may be purchased for each benefit (e.g., daily hospital benefit, travel expenses, etc.). Since Vermont law prohibits the sale of unsuitable policies, the Department will not approve filings where the available coverage limits are so high that the policy appears intended to be a substitute for major medical insurance rather than supplemental in nature. An example of such a filing would be a hospital indemnity policy that combines high daily in-patient payments (e.g., $3,000 per day) with separate high surgical, diagnostic testing and outpatient care benefits. Given the wide variety of benefit configurations seen by the Department, it is impossible to specify a precise threshold at which particular benefit limits may become unsuitable, but filers of policies with high coverage limits should be prepared to demonstrate that the premiums charged at such levels would not make the purchase of comprehensive health insurance cost prohibitive for median wage earners.

Coverage of newborns: Effective July 1, 2013, individual and group health insurance policies that provide coverage on an expense incurred basis must cover newly born children without notice or additional premium for at least 60 days after the date of birth. 8 V.S.A. § 4092(b).

Definition of Covered Accident: The definition of a covered accident or accidental injuries must be consistent with the requirements of Section 5(D) of Department Regulation 80-1 and may not include words or phrases that establish an accidental means test such as "sudden," "violent," "unforeseeable," "visible injuries," etc.

Discretionary clauses: Vermont law does not allow health insurance or disability insurance policies to contain discretionary clauses that reserve to the insurer the right to interpret the terms of the contract. 8 V.S.A. § 4062f.

Discretionary groups: Filers that intend to market their policies to discretionary groups under 8 V.S.A. § 4079(4) should identify the discretionary group by name and explain with specificity how the group satisfies the requirements of subsection (4). Insurers may not sell health insurance to a discretionary group until the group has been approved by the Commissioner.

Eligible groups: For group policies, the filing description should specify the eligible groups to which the policy will be sold. 8 V.S.A. § 4079.

Fraud Warning: Vermont does not allow fraud warnings that state that a person who makes false statements on an application "commits" a fraudulent insurance act or "is guilty" of insurance fraud since the question of guilt is a determination for a court. As an alternative, it is

acceptable to use the fraud warning approved by the Product Standards Subcommittee of the Interstate Insurance Product Regulation Commission. This warning states that: "Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law."

HIV/AIDS: Vermont law prohibits an insurer from requesting or requiring that a person reveal having taken HIV-related tests in the past. 8 V.S.A. § 4724(20)(A). The Department does not permit insurers to require that an applicant disclose information relating to AIDS or HIV unless the diagnosis of those conditions has been made by a medical professional. Application questions that ask whether a proposed insured has been diagnosed with or treated for AIDS/HIV must explicitly be limited to diagnoses or treatment by a medical professional.

Maternity: All health insurance policies, except specified disease, accident, or disability income policies, must provide maternity coverage. Regulation 89-1. Maternity coverage means the payment of benefits to insureds for medical expenses resulting from pregnancy, childbirth, prenatal care, and related conditions and complications.

Mental health parity: Vermont's mental health parity law (8 V.S.A. § 4089b) applies to all supplemental and blanket health insurance policies. For this reason, policies may not have lower benefit levels for mental health conditions than for other covered conditions and may not exclude coverage for accidents or sickness caused by mental illness or by alcohol or substance abuse. In addition, policies that provide hospital benefits may not exclude facilities that treat mental illness or alcohol or substance abuse from the definition of a hospital.

Multi-line TOI's to be filed separately: To facilitate speed-to-market and accurate filing review, the Department's policy is that multi-line TOI's be submitted as individual filings in SERFF, and not be combined into a multi-line TOI filing. 8 V.S.A. § 4062. Include tracking numbers for associated filings in the general information field of SERFF.

Out-of-state-groups: Since Vermont asserts extra-territorial jurisdiction (Insurance Division Bulletin No. 61), group health insurance may not be marketed to Vermont residents unless the holder of the master policy qualifies as an eligible group. 8 V.S.A. § 4079. In such cases, the certificate of insurance must be included in the filing and the cover page of the certificate must state, in capital letters, that, in the event of a conflict between the laws of the state where the policy is issued and the laws of Vermont, the laws of Vermont will control.

Part-time employees: Vermont law requires that all group health insurance policies make the offer of coverage for part-time employees available to employers. 8 V.S.A. § 4080(5). For the purposes of this statute, part-time employees are defined as those employees working 17 ½ hours or more per week.

Portability: Although Vermont's eligible group statute for life insurance (8 V.S.A. § 3810a) was amended in 2009 to allow for portability groups, a comparable revision was not made to 8

V.S.A. § 4079, the health insurance eligible group statute. For this reason, the Department does not allow the inclusion of portability provisions in health insurance policies.

Prescription drug expenses: If a supplemental health insurance policy provides reimbursement for actual prescription drug expenses, it must comply with the annual and lifetime maximum-out of-pocket limits set forth in 8 V.S.A. § 4089i.

Suicide/Attempted Suicide/ Self-inflicted Injury Exclusions: Polices may not exclude illness, treatment or medical conditions arising out of: suicide, attempted suicide or intentionally self-inflicted injury caused by a mental condition as defined in 8 V.S.A. § 4089b (2). Since the passage of 8 V.S.A. 4089b and per Bulletin 127, it is the policy of the State of Vermont to prevent unfair discrimination in the business of insurance of those with mental health conditions, including drug and alcohol addiction. In accordance with 8 V.S.A. § 4062, the Commissioner has the authority to disapprove any form which unfairly discriminates against those with mental health conditions.

Time limits for covered treatment: Please remove all limits which require covered treatment to be initiated or completed in fewer than 365 days. The Department finds such limits are unjust and unfair and create illusory coverage for policyholders. In many instances symptoms may not become evident until months after a covered accident occurs, as well, receiving treatment can be dependent on the availability of providers in the area. 8 V.S.A. § 4062.