

**HOSPITAL CONFINEMENT - INDEMNITY - LIMITED BENEFIT PLANS**  
**Oregon Health Insurance Rates and Forms Filings**

**I. APPLICABLE OREGON REVISED STATUTES AND OREGON ADMINISTRATIVE RULES**

**A. Oregon Revised Statute (ORS) 743.730 Defines a Health Benefit Plan**

(Please be advised that the key terms are bolded for emphasis only.)

ORS 743.730(19)(a) states, "Health benefit plan" means any hospital **expense**, medical **expense** or hospital or medical **expense** policy or certificate, health care service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement or by another benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

ORS 743.730(19)(b) states, "Health benefit plan" **does not include** coverage for **accident only, specific disease or condition only**, credit, disability income, coverage of Medicare services pursuant to contracts with the federal government, Medicare supplement insurance policies, coverage of CHAMPUS services Pursuant to contracts with the federal government, benefits delivered through a Flexible spending arrangement established pursuant to section 125 of the Internal Revenue Code of 1986, as amended, when the benefits are provided in addition to a group health benefit plan, long term care insurance, **hospital indemnity only**, short term health insurance policies (the duration of which does not exceed six months including renewals), student accident and health insurance policies, **dental only, vision only**, a policy of stop-loss coverage that meets the requirements of ORS 742.065, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

**B. Oregon Administrative Rule (OAR) 836-020-0775, COB Definitions**

OAR 836-020-0775 (11)(d) indicates that the definition of "Plan" as used for Coordination of Benefits (COB) rules does not include the following.

(Please note: the key terms are bolded for emphasis only.)

- “(A) **Hospital indemnity** coverage benefits or other **fixed indemnity** coverage;
- (B) **Accident only** coverage;
- (C) **Specified disease** or **specified accident** coverage;
- (D) **School** accident-type coverages that cover students for **accidents only**...;
- (E) Benefits provided in group **long-term care** insurance policies ... or for contracts that pay a **fixed daily benefit** without regard to expenses incurred ...;
- (F) Medicare supplement policies;

## **I. OREGON ADMINISTRATIVE RULES (continued)**

### **B. Oregon Administrative Rule (OAR) 836-020-0775, COB Definitions (cont'd)**

(G) A state plan under Medicaid; or

(H) A governmental plan..."

OAR 836-020-0775 (1)(a) indicates that "Allowable Expense" is health care expense, including coinsurance or co-payments and without reduction for deductibles.

(1)(c) states, "An expense or a portion of an expense that is not covered by any of the plans is not an allowable expense."

(1)(e) (D) indicates that the following are not "Allowable Expense"  
usual and customary fees or relative value schedule reimbursement  
negotiated fees or payment amounts

(1)(e)(D)(e) indicates that "Allowable Expense" excludes the following types of  
coverage dental care and vision care

## **II. NAIC MODEL LAW**

The National Association of Insurance Commissioners (NAIC) Accident and Sickness Insurance Minimum Standards Model Act applies to hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage, dental, and vision.

That Model addresses the importance of full and fair disclosure. The reasoning in the Model is that this type of insurance can be misleading and confusing, as related to purchasing coverage and claims payment. That Model also authorizes the state insurance commissioner to review contract language as possibly being unjust, unfair, or unfairly discriminatory. That Model also indicates that coverage restrictions of benefit amounts and frequency limitations are indicative of limited benefits.

## **III. EXPLANATION OF OREGON RATES AND FORMS FILING REQUIREMENTS**

### **A. Expense Versus Event**

Per ORS 743.730(19)(a), "Health benefit plan" means hospital expenses, medical expenses, or hospital or medical expense policy or certificate.

Per ORS 743.730(19)(b), "Health benefit plan" does not include coverage for accident only, specific disease or condition only, hospital indemnity only, dental only, or vision only.

Therefore, the key difference is an expense based policy, versus an event based policy. Examples of an event incurred are an injury, diagnosis of a specified disease, confinement in a hospital, and surgery.

**III. EXPLANATION OF FILING REQUIREMENTS (continued)****B. Flat Dollar Amount for Benefit**

Plans that provide benefits based on an event incurred and pay a flat dollar amount, rather than expenses incurred paid at a coinsurance amount, are considered an indemnity plan, also called limited benefit plan.

Since the coverage is based on the event incurred, rather than the expenses for services and treatment, indemnity plans are not reimbursement type plans. Although the policy form can require that expenses are incurred, that is merely to ensure that coverage is provided for services and treatment, and the insured is not indemnified for free treatment. The benefit amounts are flat dollar fixed amounts and are unrelated to the typical (or usual, customary and reasonable) expenses, or negotiated fees, for such services and treatment. Since the benefit amounts are typically very small amounts as compared to the typical expenses, such plans are called limited benefit plans. For example, a typical hospital confinement indemnity policy will pay the flat dollar fixed amount of only \$200 per day.

The Oregon Insurance Division Rates and Forms Health Analysts don't allow a combination of flat dollar amounts and coinsurance. Indemnity policies need to be written with fixed flat dollar amounts for ALL benefits. The only exception is a benefit that is related and pays a percentage for the fixed dollar benefit. For example, if the surgery benefit for an accident is limited to a fixed benefit of \$500 and the anesthesiologist benefit is 20% of that surgery benefit, or \$100, then it is still a fixed and flat dollar benefit amount. That example also illustrates that coverage is limited because expenses for surgery are typically more than \$500 and expenses for anesthesia are typically more than \$100.

Use of the terminology of "Actual Cost up to" or "up to" are considered to be misleading and deceptive because they both imply that the amount of expenses, up to a maximum benefit amount, is covered. Since the benefit needs to be a fixed dollar amount, regardless of the expense amount, the exact dollar amount, without the use of "up to" language, needs to be accurately stated on the Policy Schedule page of the Policy.

If only one amount of coverage is provided, such as \$50 for ground ambulance service, then there should not be brackets for variability.

**C. Flat Dollar Amount Applies to Rider Forms Too**

The requirement of ALL benefits being at fixed flat dollar amounts also applies to the benefit amounts in optional riders. For example, an optional rider of vision coverage at 80% of expenses, a dental coverage rider at 80% of expenses, or a disability income rider at 60% of pre-disability earnings, are all not allowed for attachment to a fixed/limited benefit/indemnity policy coverage form.

**III. EXPLANATION OF FILING REQUIREMENTS (continued)****C. Flat Dollar Amount Applies to Rider Forms Too (continued)**

However, it's possible to convert those percentages of expenses to flat dollar amounts of fixed benefits. To illustrate, a hypothetical example for dental coverage initially proposed was, "Reimbursement percentage: 80% of expenses, up to \$500 maximum per calendar year, and a maximum of 5 visits per year." It could be changed to "Benefit: \$100 per visit, maximum of 5 visits per year."

To illustrate, a hypothetical example for vision coverage initially proposed was, "Reimbursement percentage: 80% of expenses, up to \$200 maximum per calendar year." It could be changed to "Benefit: \$40 for eye examination, \$160 for glasses (frames and lenses)."

To illustrate, a hypothetical example for disability income coverage initially proposed was, "Disability Benefits: 60% of pre-disability earnings, maximum monthly benefit of \$200." It could be changed to "Benefit: \$200 per month."

Also, the Company/Insurer has the option of submitting a separate policy for vision only, dental only, or disability income only, at the percentage of expenses benefit plan.

**D. Indemnity Plans with Separate Schedule for Surgical Procedures**

It is common for indemnity plans to have the surgical benefit amounts based on a Schedule for Surgical Procedures that is separate from the Schedule of Benefits page of the Policy form.

Please note that the policy form needs to explain the benefit determination for all surgeries that are not listed in the Schedule for Surgical Procedures. For example, the statement of, "...shall be determined by the Company in amounts consistent with those listed in the Schedule of Surgical Benefits." is too vague, non specific, and therefore discretionary and open to interpretation by the insurer at the time of claims payment, rather than being paid on an objective and consistent basis.

It needs to be clarified in the contract language (policy and certificate) how Benefits and coverage amounts for unlisted surgeries will be determined by the Company/Insurer. For example, is it based on the CPT code, and if so, how does that code correspond with other surgical CPT codes? In other words, if the CPT codes for Cysts are a range of numerical CPT codes, then that numerical CPT range could be listed, next to the Procedure category in the policy and certificate forms. Also, if there are any surgical procedures that would not be covered by the limited indemnity policy, such as an organ transplant, then each one needs to be specified in the Surgical Indemnity Benefit provision and/or the Exclusions provision in the policy and certificate forms.

**III. EXPLANATION OF FILING REQUIREMENTS (continued)****D. Indemnity Plans with Separate Schedule for Surgical Procedures (cont'd)**

Also, there is the potential that a policy could be written that excludes certain categories of surgical procedures (e.g., Gynecology), because the Company/Insurer allows the prospective Policyholder/Employer to do so. If that is possible, then the policy could have a provision for Unlisted Surgical Procedures, and it needs to be clear and comprehensive as to surgical procedures that are not listed and not covered, for both the policy and the certificate forms.

The Schedule for Surgical Procedures in the Policy needs to be consistent with the Actual Memorandum explanation of benefits and amounts offered. For example, if the Actuarial memorandum states, "maximum benefit any one surgery is \$2,500" but the highest benefit amount in the Schedule for Surgical Procedures is less than that amount, such as \$1,500, then it needs to be clear in the Policy and Actuarial Memorandum how the Company/Insurer calculates surgical procedures not in the Surgery Schedule. Otherwise, it's unclear and deceptive to have a maximum benefit amount that is much larger than any benefit amount shown in the Schedule for Surgical Procedures.

**E. If Not all Flat Fixed Dollar Benefit Amounts, then Need to File Non-Indemnity Plan**

Again, indemnity policies need to be written with fixed flat dollar amounts for ALL benefits, and no percentage of expense benefits can be included, including rider forms. If the insurer doesn't want to revise all the benefit amounts to flat dollar amounts, rather than some or all at percentage amounts, then there are benefits that are based on expenses. Accordingly, the policy and/or certificate, as well as the other forms, would need to be rewritten and re-filed as a non-indemnity health insurance policy, such as a Health Benefit Plan (HBP), as defined by ORS 743.730 (19). Consequently, for HBP's and some other types of health insurance, several mandated coverages would also need to be included, such as pap smears and prostate examinations.

**F. Premiums For Individual Indemnity Plans**

Please note that the premium charges for individual indemnity plans need to be reasonable in relationship to benefits. For example, if the doctor visit pays only \$20 and there is a maximum of 3 visits paid per calendar year, then the annual premium charge should be considerably less than \$60. First of all, it's limited coverage by paying a fixed benefit that is much lower than typical expenses. Secondly, when buying limited benefit coverage, the premium should be small since the risk of loss is considerably less than a typical Oregon Health Benefit Plan.

**III. EXPLANATION OF FILING REQUIREMENTS (continued)****F. Premiums For Individual Indemnity Plans (continued)**

Example of premium charges submitted in actual filing:

Doctor Visit Rider optional coverage to a hospital confinement indemnity policy, with a maximum benefit of one visit per day and 20 visits per year.

Premium Charges/Rates - individual premium annual charges for age bands 50 and older:

the \$5 benefit is \$109 and higher;  
the \$10 benefit is \$218 and higher; and  
the \$15 benefit is \$327 and higher.

We cannot allow the premium charge to be higher/more than the benefit amount. Also, when premium is only a few dollars less than the benefit, it doesn't meet the definition and intent of insurance. That is especially true for the Doctor Visit benefit because it doesn't even provide full coverage under most circumstances.

**G. Disclosure**

The typical indemnity policy includes an explanation on the first page, or cover sheet, that it provides limited benefits, supplemental coverage, and is not intended to cover all medical expenses. Such a statement makes it clear to the consumer that they are purchasing a plan that is not an Oregon Health Benefit Plan that includes comprehensive coverage of health care expenses. Also, if the policy is for injury coverage only, or for a specified disease only, such information needs to be prominently stated on the first page of the policy. Such disclosure helps to ensure that the insurer is providing clear and unambiguous language, and in compliance with ORS. 742.005. Also see the explanation under NAIC Model Law regarding full disclosure.

**H. Reasonable Package of Coverage**

Please note that a reasonable coverage plan needs to be provided. For example, if a vision policy is submitted, and all coverages are bracketed, it isn't really a complete vision plan. The reason is that it's reasonable that a bare minimum (i.e., limited benefit plan) vision policy should include at least the examination and the choice of contacts or glasses (frames and lenses). The Company/Insurer can offer variable options, such as bi-focal lenses, as long as the core coverage of the examination and corrective lenses are provided.

**I. Proper Terminology throughout all forms**

All benefits are flat fixed dollar amounts that are unrelated to reimbursement of cost/expenses. Therefore, the Policy and other forms (e.g., Application) should not use terminology of "reimbursement", "expenses", "actual charges", or "up to". Proper terminology/contract language would be "coverage" or "benefit amount".

#### **IV. COORDINATION OF BENEFITS, UC&R, DEDUCTIBLES, AND SUBROGATION**

OAR 836-020-0775 indicates that the definition of “Plan” as used for Coordination of Benefits (COB) rules does not include hospital indemnity, fixed indemnity, accident only, specified disease, specified accident, and student/school accident only coverage.

That OAR also indicates that “Allowable Expense” as used for Coordination of Benefits (COB) rules, does not include: reduction for deductibles, expenses not covered by other plans, usual and customary fees, relative value schedule reimbursement, and negotiated fees or payment amounts. Also, “Allowable Expense” excludes dental care and vision care.

The benefits need to be listed as flat dollar amounts of coverage because the limited amount of benefit is not proportionate to the actual expenses and costs of medical care.

For example, if the Schedule of Benefits of the Policy form has the Hospital Room and Board benefit shown as a 100% coinsurance, with a deductible of \$250, and a maximum benefit of \$200 per day, it is providing a limited benefit. In other words, \$200 per day is not realistically actual (i.e., 100%) of Hospital Room and Board expenses. The coinsurance of 100% in that example is not realistic or reasonable, and is therefore deceptive and misleading.

As another example, if the Schedule of Benefits of the Policy form has the Outpatient Only Injury benefit as 100% coinsurance, but the maximum is \$500 per injury, and there is a separate deductible of \$50, it is providing a limited benefit based on an event, rather than on expenses. In other words, \$500 per injury is not realistically actual (i.e., 100%) of expenses for Outpatient services, such as x-rays, the radiology interpretation fee for those x-rays, outpatient surgery, and physicians benefits. The coinsurance of 100% in that example is not realistic or reasonable, and is therefore deceptive and misleading.

Therefore, listing a coinsurance amount, and a corresponding maximum benefit, does not meet the requirements, and isn’t allowed, for indemnity plans.

It’s also misleading and deceptive to have the definition of Covered Expenses as Usual and Customary charges. The low maximum benefit amount payable, the relatively high deductible (in comparison to the low benefit amount) is such limited coverage that it’s unreasonable to also reduce coverage based on usual and customary charges. Those policy provisions are used for expense- based plans because they are related to expenses, and fixed benefit amounts are related to an event and are unrelated to expenses.

**IV. COORDINATION OF BENEFITS (continued)**

Also, the Oregon Revised Statutes and Oregon Administrative Rules don't allow the following provisions in indemnity plans:

- Coinsurance of Expenses;
- Deductibles;
- Usual, Customary, and Reasonable Charges;
- Negotiated Fees or Providers;
- Coordination of Benefits (COB) with other policies/insurers; or
- Subrogation/Right of Reimbursement.

Please note that the above policy provisions (e.g., COB) cannot be added via a Rider or Endorsement form to Indemnity Plans because the language isn't allowed.

Similarly, none of those policy provisions should be included, even with bracketing for variability, on the Table of Contents page because they are not variable and not allowed for indemnity plans.

Some limited benefit plans are intended to provide supplemental coverage, such as the co-payment portion of an office visit because the fixed benefit is \$20, and unrelated to charges or expenses. However, the plan must pay primary since COB rules cannot be applied to indemnity plans. Also, the benefits are fixed, so they can't be reduced if they are greater than actual charges.

**V. MANDATED BENEFITS COVERAGE**

Many mandated benefits are not required for plans that are not Oregon Health Benefit Plans. Therefore, if the insurer is proposing to sell a plan as indemnity or limited, it means that they don't have to include several mandated coverages, such as pap smears, mammograms, colorectal cancer screening, prostate exams, and prosthetic and orthotic devices. Therefore, hospital indemnity, specified disease, et al, plans are limited benefit plans because they don't provide comprehensive coverage required for Oregon Health Benefit Plans.

Therefore, if the health insurance coverage forms submitted have benefits that are based on expenses, then the policy must also provide coverage that is required for the applicable health insurance Policy, such as an Oregon Health Benefit Plan, as defined in ORS 743.730(19).