Notice: Effective March 27, 2024, this Guidance is suspended until further notice while the Bureau of Insurance considers comments received. Accordingly, until such time as this guidance is updated and finalized, any carrier may issue, renew, or continue forms that may not comply with this guidance on and after May 1, 2024, even if the carrier communicated a different plan to the Bureau of Insurance. Carriers may also choose to issue newly approved forms that are compliant with this guidance.

Wellness Benefits in Excepted Benefits Policies
Guidance from the Virginia Bureau of Insurance (the Bureau)

The Bureau has received questions from carriers regarding wellness benefits in or attached to excepted benefits policies. The Bureau has conducted an extensive review of wellness benefits in connection with the adoption of Commission regulations at 14 VAC 5-141, *Rules Governing Accident and Sickness Excepted Benefits Policies; Short-Term Limited Duration Insurance* on January 1, 2023. This regulation applies to all individual and group market insurance policies delivered or issued for delivery in Virginia on or after January 1, 2023, that qualify as accident and sickness excepted benefits. It should be noted that this guidance does not address combining policy types – that is addressed in the regulation.

The Bureau has developed the following guidance to assist in the filing and review of excepted benefits policies and accompanying rates. This guidance applied to ALL excepted benefit policies effective September 2023. The guidance is now being clarified.

All policy forms and rates currently under review or submitted for review must comply with this guidance. In addition, all excepted benefits policies and certificates must comply with this guidance as they are marketed, sold, issued or renewed in Virginia on or after May 1, 2024. As of that date, carriers must cease issuing any policy forms previously approved that are not compliant. In addition, any previously approved policy or certificate that renews on or after May 1, 2024, must be modified to comply with this guidance at renewal. The terms and conditions of the policy identify the renewal period. A policy that is silent on a renewal term shall consider the payment of premium as a renewal (i.e., monthly, quarterly, annually). For example, a policy that does not indicate a renewal date, but where monthly payment of premium is expected to continue the policy, must comply with this guidance on the first premium payment due date on or after May 1, 2024. A rate guarantee period is not a renewal provision.

Carriers are encouraged to review policy forms and rates for new business and renewing policies and certificates well in advance of this deadline to determine what action must be taken. Policy forms and rates must be filed no later than February 1, 2024, in order to be considered for approval prior to the May 1st deadline. Carriers who continue to market, sell, issue, or renew (as described in this guidance) forms that are not in compliance with this guidance on or after May 1, 2024, may be subject to knowing and willful violations of § 38.2-316 A and C 1 as well as § 38.2-3519 B of the Code of Virginia.

It is expected that rates associated with these policy forms may need to be revised to ensure premium rates remain reasonable in relation to the benefits provided per 14 VAC 5-130-75 and 14 VAC 5-130-90.

What is a Wellness Benefit?

I. One or more of the following provided on an outpatient basis under the supervision of a physician, but not medically necessary:

1. a wellness or preventive test;
2. a routine physical exam; or
3. a medically accepted screening test used to evaluate risk or promote prevention of an illness or injury.

II. A medical health assessment survey requesting basic vital statistic and/or lab results (i.e., weight, height, blood pressure, lipid panel results, some metabolic panel results, etc.).

What is NOT a Wellness Benefit?

A medically necessary test or service performed after a triggering event that is necessary to determine information about the sickness or bodily injury that is covered by the policy.

Code and Regulations that are Applicable:

Code of Federal Regulations 45 CFR 148.220
Code of Virginia §§ 38.2-3431, 38.2-3519, 38.2-109
VA Administrative Code 14 VAC 5-141

These federal and state laws outline excepted benefits requirements, which are further defined in Commission regulations at 14 VAC 5-141. Certain and specific requirements for these policies must be met in order for the policy to be "excepted" from the requirements under the Public Health Services Act that pertain to health benefit plans. Benefits that take the policy outside of the rubric of these requirements disqualify a policy from being "excepted" and will be disapproved when filed as such.

General Rules

All excepted benefits form filings shall adhere to the following General Rules (except as noted below) with regard to wellness benefits:

I. Because riders and amendments may contain a large number of wellness benefits that are not compliant with this guidance, NO riders or amendments made for the purpose of adding wellness benefits will be approved. Likewise, existing approved "wellness benefit riders or amendments" will be determined to be non-compliant with this guidance as of May 1, 2024.

II. Wellness benefits may be embedded in the body of the policy *but must comply with specific requirements noted below*.

III. A medically necessary test or service that is performed after the triggering event/injury or the diagnosis of a covered sickness and used to obtain information about the injury or illness is not considered a wellness benefit and may be covered as a benefit in the policy.

Specific Rules for Types of Excepted Benefits:

I. Accident

Wellness benefits cannot be included in Accident Only policies, based on federal and state law and regulation definitions of "Accident Only" policies. The word "*only*" implies that this coverage is limited to coverage for accidents, including accidental death and dismemberment.

The inclusion of any other benefit other than accident benefits in an Accident Only policy takes the policy outside of the rubric of the Accident Only definition under federal and state laws.

II. Specified Disease

Any wellness benefit included in a Specified Disease policy must be (1) related to the disease for which coverage is being provided; AND (2) the monetary amount provided to the enrollee for receiving the service is *related to the cost of the service* (i.e., the payment functions as a partial reimbursement) and is not a "reward" (i.e., a monetary amount unrelated to the cost of the service). A mere "reward" that serves as an incentive for receiving the service but has no connection to the cost of the service is not "coverage."

For instance, in a cancer-only policy:

- A wellness benefit that has nothing to do with cancer is not allowed.
- If the wellness benefit provides a "reward" instead of an amount related to the cost of the service (i.e., a reimbursement), it is not allowed.

III. Hospital or other Fixed Indemnity

In the individual market, wellness benefits may be included in a hospital or other fixed indemnity policy if the terms of 45 CFR 148.220 (b)(4) and 14 VAC 5-141-120 are satisfied. The definition of fixed indemnity in the individual market allows for payment of benefits to be structured on a **fixed dollar amount** "per period" of hospitalization or illness (which can be per day or other period of time) or "per service" (i.e., $100 per day or $50 per service). However, these benefits must be paid regardless of the amount of expenses incurred.

In the group market, no wellness benefits are allowed because the fixed dollar amount provided to the enrollee must be structured on a "per day (or per other period) of hospitalization or illness" basis, regardless of the amount of expenses incurred. "Per service" is not allowed under 45 CFR 146.145 (b)(4) and 14 VAC 5-141-120 C. Any payment for any benefit identified in and covered by the policy must comply with this requirement.

IV. Disability Income

Wellness benefits as defined above are not allowed in a disability income policy. Any benefit that is not a benefit for a disability cannot be added to a disability policy. The policy trigger (disability) must first occur before any benefit may be paid.

V. Limited Scope

Routine dental, hearing or vision exams that are specifically covered in limited scope dental, hearing or vision policies are allowable. Otherwise, limited scope excepted benefits policies may not include wellness benefits that do not adhere to the General Rules above.

Out of State Group Filings

Out-of-state group filings that contain wellness benefits that are not in accordance with Code, regulations or this guidance document will be rejected based on § 38.2-3522.1 A 1 of the Code as contrary to public policy and not substantially similar to the laws in Virginia.

Questions should be sent to Elsie Andy at elsie.andy@scc.virginia.gov