



Government of the District of Columbia  
Vincent C. Gray, Mayor  
Department of Insurance, Securities and Banking



Chester A. McPherson  
Acting Commissioner

**BULLETIN**  
**06-IB-004-8/29**  
**REVISED**

**TO:** Insurers and Other Entities Licensed to Do Business in the District of Columbia  
**FROM:** Chester A. McPherson, Acting Commissioner  
**RE:** Summary and Disclosure Notice for Supplemental Health Policies  
**DATE:** October 23, 2014

---

This Bulletin is being reissued with revisions to clarify the Department of Insurance, Securities and Banking's ("Department") position regarding the application of D.C. Official Code (§ 31-3171), as well as Federal Law and Federal Rulemaking (45 CFR §148.220 – Excepted Benefits), as they pertain to insurance companies writing health insurance in the District of Columbia.<sup>1</sup> The purpose of this bulletin is to clarify that limited benefit health plans, hospital indemnity, or other supplemental health policies shall not be marketed or represented as substitutes for health benefit plans, and that such plans do not provide sufficient coverage to qualify as minimum essential coverage, within the meaning of section 5000A(f) of the Internal Revenue Code, as mandated by the Patient Protection and Affordable Care Act ("ACA" – Public Law 111-148). These types of plans are exempt from the consumer protections required by the ACA, including the requirement that health benefit plans be guarantee issue products. The purpose of this bulletin is to also provide guidance to individual and group carriers offering hospital indemnity and other fixed indemnity policies that are considered HIPAA-exempt policies pursuant to federal and state regulations.

The intent of this bulletin is to prevent fixed indemnity health plans from being marketed to consumers as a substitute for a health benefit plan that provides minimum essential coverage as mandated by the ACA. Carriers must not bundle various benefits or coverages together into a fixed indemnity health plan to be marketed to consumers as meeting the federal benefit requirements of a health benefit plan.

---

<sup>1</sup> The Department's reference to "writing health insurance in the District of Columbia" would include policies situated, delivered or negotiated in the District of Columbia and subject to its health insurance laws. Such policies would include those commercial policies issued in the individual and small and large group markets, including those issued to associations. Qualified plans under the Employment Retirement Income Security Act ("ERISA") remain exempt from state health insurance laws.

These bundled limited benefit health plans, upon initial examination, may appear to include the necessary federally mandated essential health benefits, but they are not major medical insurance or comprehensive policies and do not provide the necessary ACA-compliant coverage. Not having ACA-compliant coverage leaves the consumer liable for the federal tax penalty for not having qualified coverage.

It is imperative that consumers know that such fixed indemnity health plans, though they may appear to provide the necessary health coverage required under the ACA, do not meet the “minimum essential coverage” standard required by federal law. Therefore, the purchase of a fixed indemnity health plan may leave the consumer liable for the tax penalty that is to be assessed to those who do not have ACA-compliant health coverage.

It is the position of the DISB that any carrier selling fixed indemnity health plans, or limited benefit health plan packages, that are marketed as a substitute for or equivalent to an ACA compliant health benefit plan may be found in violation of District law prohibiting misleading and deceptive practices. Likewise, a carrier is prohibited from representing, naming, or including in the name of any new fixed indemnity health plan the terms “Bronze”, “Silver”, “Gold”, or “Platinum” tier level of health coverage or any other ACA-compliant health benefit term or description of benefits, such as “essential” benefits, unless that policy is a health benefits plan as specified in §31-3301 (20). Use of these terms for a plan that does not provide minimum essential coverage may be found to violate District law. Under Final Rulemaking published in the Federal Register Vol. 79 No. 101 Tuesday, May 27, 2014 fixed indemnity insurance may “be sold only to individuals who have other coverage that is minimum essential coverage to be considered an excepted benefit.”<sup>2</sup> Carriers who sell fixed indemnity insurance must provide notice that the fixed indemnity insurance does not provide the minimum essential coverage as mandated by the ACA, and that consumers may be liable for a federal tax penalty unless they purchase health benefit plans that provide minimum essential coverage. The notice must also inform consumers that such fixed indemnity health plans cannot coordinate benefits with health benefit plans.

Carriers selling hospital indemnity or other fixed indemnity policies must provide notice that such policies do not provide the minimum essential coverage as mandated by the ACA, and that consumers may be liable for a federal tax penalty unless they purchase a health benefit plan that provides minimum essential coverage. The notice must also inform consumers that such limited benefit plans do not coordinate benefits with health benefit plans.

The Departments of Labor, the Treasury and HHS (the Departments) released an FAQ on January 9, 2014 clarifying that, with respect to group health insurance coverage that does not meet the definition of fixed indemnity excepted benefits, coverage that supplements other group health plan coverage may, nonetheless, qualify as supplemental excepted benefits. To do so, Field Assistance Bulletin No. 2007-04 requires the following: (1) the supplemental policy must be issued by an entity that does not provide

---

<sup>2</sup> Sections 2722 and 2763 of the PHS Act, as implemented in 45 CFR 146.145(b) and 148.220, provide that the requirements of parts A and B of title XXVII of the PHS Act shall not apply to any individual coverage or any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits. Excepted benefits are described in section 2791(c) of the PHS Act. One category of excepted benefits, called “non-coordinated excepted benefits,” includes coverage for only a specified disease or illness, and hospital indemnity or other fixed indemnity insurance. Benefits in this category are excepted only if they meet certain conditions specified in the statute and regulations.

the primary coverage under the plan, (2) the supplemental policy must be specifically designed to fill gaps in primary coverage, but does not include a policy that becomes secondary or supplemental only under a coordination-of-benefits provision, (3) the cost of coverage under the supplemental policy must not exceed 15 percent of the cost of primary coverage, and (4) the supplemental policy that is group health insurance coverage must not differentiate among individuals in eligibility, benefits, or premiums based on any health factor of an individual. The DC Department of Insurance, Securities and Banking recognizes that its position may be more restrictive than the insurance market standards set forth in the final rulemaking issued by the Centers for Medicare & Medicaid Services (CMS) at the US Department of Health and Human Services (HHS) in May of 2014; the actions prescribed in this bulletin exist to protect District residents to the fullest extent possible.

The plans that are considered to provide supplemental benefits under this bulletin include, but are not limited to, the following:

- Accident Only
- Accident and Sickness
- Specified Disease, including policies which cover more than one disease
- Intensive Care (Limited Benefit)
- Organ & Tissue Transplant (Limited Benefit)
- Accidental Death / Dismemberment
- Fixed indemnity hospital or surgical policies

The following types of plans are not considered to provide supplemental benefits as contemplated under this bulletin:

- Dental
- Vision
- Medicare supplement
- CHAMPUS supplement
- Long-term Care
- Disability Income
- Workers Compensation
- PIP or other similar benefits included in an automobile policy
- Liability
- Credit
- Student Health

### **Supplemental Policy Notice**

All carriers issuing a fixed indemnity health plan, or issuing a hospital indemnity policy, or issuing any other supplemental benefit policy, shall include in the application for such policy the following statement in at least 14-point type:

“NOTICE TO CONSUMER: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE

(OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.”

This notice shall be affixed to all applications for individual hospital indemnity or other fixed indemnity insurance policies issued on or after January 1, 2015.

### **Attestation**

Individual hospital or other fixed indemnity insurance policies issued on or after January 1, 2015, shall be provided only to individuals who attest, in their fixed indemnity insurance application, that they have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or they are treated as having minimum essential coverage due to their status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). For any policy referenced in this bulletin beyond fixed indemnity contemplated by the May 2014 Federal rulemaking carriers shall have until April 1, 2015 to make changes to their applications to allow for the attestation; whereas there is no flexibility for fixed indemnity where the Federal rulemaking sets the January 1, 2015 date.

In DISB Bulletin 06-IB-004-8/29, the Department implemented a questionnaire asking a consumer if they had a comprehensive medical policy. For fixed indemnity and other supplemental insurance policies, the questionnaire shall serve as the attestation, which shall be amended as follows, and included in the application:

**NOTICE:** This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to you status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately.

- (1) Do you have comprehensive medical coverage including the minimum essential coverage required by the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States?
- YES  No

*If you answered NO to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insurance.*

- (2) Do you understand most supplemental only policies may not pay full benefits if your ACA compliant minimum essential coverage plan is not in force?  YES  No

- (3) Do you understand that the benefits provide under this policy may be limited?  YES  No

### **Fixed Indemnity Plans Issued Prior to January 1, 2015**

Any hospital or fixed indemnity insurance issued prior to January 1, 2015 may remain in effect at the option of the insured or the carrier, as permitted by law and provided the policy otherwise complies with District of Columbia laws and regulations; the benefits and advertisements were not misleading; and the policy was not subject to any unfair trade practice. While the DISB implemented a questionnaire in August 2006, prior to the passage of the ACA, requiring applicants to indicate they had a “comprehensive medical policy”, such terms may not be construed to meet the definition or standard of “minimum essential coverage”. Any policy owner of a fixed indemnity policy issued prior to January 1, 2015, including policies that are guaranteed renewable, shall be issued the aforementioned Supplemental Policy Notice upon first renewal, but no later than April 1, 2016. Such notice may be attached to the premium notice, whether distributed via mail or electronic methods. The notice should make it clear that consumers have the opportunity to make changes to their policies until October 1, 2016. No response to this notice and payment of premium by the consumer will qualify as attestation.

### **District of Columbia Residents Age 65 or Older**

The government-sponsored Medicare program meets minimum essential coverage requirements. Medicare covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) considered medically necessary to treat a disease or condition. If a District resident is in a Medicare Advantage Plan or other alternative Medicare plan, the programs may have different rules, but their plan must give them at least the same coverage as ‘original’ Medicare. Since most District residents age 65 and older are eligible for Medicare benefits, the Department of Insurance, Securities and Banking shall deem those age 65 and older to be exempt from the aforementioned disclosure and attestation requirements. Insurers shall not be required to issue notice or collect attestation from residents age 65 or older regardless of the date the policy was or will be issued.

If you have any questions or comments concerning this bulletin, please contact the Department of Insurance, Securities and Banking at (202) 727-8000 or email [disb@dc.gov](mailto:disb@dc.gov).