MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

This page is intentionally left blank

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama	ALA. ADMIN. CODE r. 482-1-071-.01 to 482-1-071-.26 (1992/2018).	BULLETIN 9-1-2009 (2009).
Alaska		ALASKA ADMIN. CODE tit. 3, §§ 28.410 to 28.510 (1982/2011) (previous version of model); BULLETIN 5-19-2009 (2009).
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. ADMIN. CODE §§ 20-6-1101 (2009) (previous version of model); BULLETIN 2009 2 (2009).
Arkansas	27 ARK. CODE R. §§ 1 to 27 (1981/2018).	
California		CAL. HEALTH & SAFETY CODE §§ 1358 to 1358.21 (1992/2009) (HMOs) (previous version of model); CAL. INS. CODE §§ 10192.1 to 10198.5 (1981/2006); CAL. CODE REGS. tit. 10, §§ 2220.50 to 2220.57 (1983/1989); §§ 2221.50 to 2221.51 (1988).
Colorado		3 COLO. CODE REGS. § 4-3-1 (1992/2010); BULLETIN B-4.23 (2008) (incorporates substance of previous model by reference); BULLETIN B-4.33 (2010).

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Connecticut		CONN. AGENCIES REGS. §§ 38a-495a-1 to 38a-495a-21 (1992/2013) (previous version of model); CONN. AGENCIES REGS §§ 38a-474-1 to 38a-474-4 (1995/2012) (review of rates).
Delaware		18 DEL. CODE REGS. § 1501 (1990/2009) (previous version of model).
District of Columbia		D.C. MUN. REGS. tit. 26, §§ 22.2200 to 22.2279 (1993/2012) (previous version of model).
Florida		FLA. ADMIN. CODE ANN. r. 69O-156.001 to 69O-156.050 (1981/2010) (previous version of model); Memorandum 2009-005 (2009).
Georgia		GA. COMP. R. & REGS. 120-2-8-.01 to 120-2-8-.25 (1992/2009) (previous version of model).
Guam	NO CURRENT ACTIVITY	
Hawaii		HAW. CODE R. §§ 16-12-1 to 16-12-11 (1982/2009) (previous version of model).
Idaho		IDAHO ADMIN. CODE r. 18.01.54.000 to 18.01.54.032 (1992/2010) (previous version of model); BULLETIN 2009-10 (2009).
Illinois		ILL. ADMIN. CODE tit. 50, §§ 2008.10 to 2008.110 (1983/2009) (previous version of model); BULLETIN 2011-15 (2011).
Indiana		760 IND. ADMIN. CODE 3-1-1 to 3-20-1 (2007/2012) (previous version of model).
Iowa		IOWA ADMIN. CODE r. 191-37.1 to 191-37.24 (1992/2009) (previous version of model).
Kansas	KAN. ADMIN. REGS. § 40-4-35 (1982/2017).	
Kentucky		806 KY. ADMIN. REGS. 17:570 (2009) (previous version of model); Advisory Opinion 2014-4 (2014).

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Louisiana		LA. ADMIN. CODE tit. 37, § XIII.501 to XIII.599 (Regulation 33) (1992/2009) (previous version of model).
Maine		02-031-275 ME. CODE R. §§ 1 to 26 (1992/2014) (previous version of model).
Maryland		MD. CODE REGS. §§ 31.10.06.01 to 31.10.06.30 (1992/2010) (previous version of model).
Massachusetts		211 MASS. CODE REGS. 71.01 to 71.89 (1996/2014) (previous version of model); BULLETIN 01-15 (2001).
Michigan		MICH. COMP. LAWS §§ 500.3801 to 500.3861 (1992/2010) (previous version of model).
Minnesota		MINN. STAT. §§ 62A.31 to 62A.44 (1981/2009) (previous version of model); BULLETIN 2009-1 (2009).
Mississippi		19-3-10 CODE MISS R. §§ 1 to 29 (2009) (previous version of model).
Missouri		MO. CODE REGS. ANN. tit. 20, § 400-3.650 (1992/2010) (previous version of model).
Montana	MONT. ADMIN. R. §§ 6.6.503 to 6.6.522 (1982/2018).	MONT. ADMIN. R. §§ 6.6.601 to 6.6.614 (1996/2005).
Nebraska		210 NEB. ADMIN. CODE §§ 36-001 to 36-029 (1992/2009) (previous version of model).
Nevada		NEV. ADMIN. CODE §§ 687B.200 to 687B.735 (1989/2009) (previous version of model); LCB File No. R078-05 (2005); BULLETIN 92-2 (1992).
New Hampshire	N.H. CODE ADMIN. R. ANN. §§ 1905.01 to 1905.25 (1992/2018); N.H. CODE ADMIN. R. ANN. § 1902.06 (2016); N.H. CODE ADMIN. R. ANN. § 1903.04 (2006).	BULLETIN 06-039-AB; BULLETIN 10-003-AB (2010).

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
New Jersey		N.J. ADMIN. CODE §§ 11:4-23.1 to 11:4-23.22 (2007/2009) (previous version of model); N.J. ADMIN. CODE §§ 11:4-23A.2 to 11:4-23A.12 (1996/2004) (disability).
New Mexico		N.M. CODE R. §§ 13.10.25.1 to 13.10.25.32 (2009) (previous version of model); N.M. CODE R. §§ 13.10.24.1 to 13.10.24.10 (2009); N.M. CODE R. §§ 13.10.8.1 to 13.10.8.74 (1992/2009).
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.11 to 52.95 (1982/2010) (previous version of model).
North Carolina		N.C. GEN. STAT. § 58-3-215 (2009); 11 N.C. ADMIN. CODE §§ 12.0815 to 12.0843 (1990/2005) (previous version of model).
North Dakota		N.D. ADMIN. CODE §§ 45-06-01.1-01 to 45-06-01/1-22 (1994/2009) (previous version of model); Memorandum 2-12-2009 (2009); Memorandum 5-13-2009 (2009).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO ADMIN. CODE 3901:8-08 (2014) (previous version of model).
Oklahoma		OKLA. ADMIN. CODE §§ 365:10-5-120 to 365:10-5-142 (1993/2012) (previous version of model); BULLETIN 12-3-2009 (2009).
Oregon	OR. ADMIN. R. 836-052-0103 to 836-052-0194 (1982/2018).	
Pennsylvania	31 PA. CODE §§ 89.770 to 89.789 (1990/2009).	
Puerto Rico		P.R.R. RULE L §§ 1 TO 27 (1982/2009) (previous version of model).
Rhode Island		32-1 R.I. CODE R. §§ 8:1 to 8:26 (2009) (previous version of model).

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
South Carolina	S.C. CODE ANN. REGS. 69-46 §§ 1 to 26 (1992/2018).	S.C. CODE ANN. REGS. 69-34.2 (1980) (Replacement coverage); BULLETIN 6-2012 (2012).
South Dakota		S.D. ADMIN. R. 20:06:13:02 to 20:06:13:92 (1982/2014) (previous version of model); BULLETIN 90-2 (1990); BULLETIN 2010-2 (2010); Memorandum 6-14-2010 (2010).
Tennessee		TENN. COMP. R. & REGS. 0780-1-58 (1992/2009) (previous version of model); BULLETIN 7-29-2013 (2013).
Texas		28 TEX. ADMIN. CODE §§ 3.3301 to 3.3325 (1982/2009) (previous version of model); 28 TEX. ADMIN. CODE §§ 4004.151 to 4004.155 (2009); BULLETIN B-0004-09 (2009); BULLETIN B-0031-11 (2011); BULLETIN B-0021-12 (2012).
Utah		UTAH ADMIN. CODE r. 590-146-1 to 590-146-26 (1996/2012) (previous version of model); UTAH ADMIN. CODE r. 590-85-1 to 590-85-7 (2012).
Vermont		VT. CODE R. 21-040-013 (2009) (previous version of model).
Virgin Islands		V.I. REG. §§ 1453-1 to 1453-19 (1990/2007) (previous version of model).
Virginia	14 VA. ADMIN. CODE §§ 5-170-10 to 5-170-220 (1992/2018).	
Washington		WASH. ADMIN. CODE 284-66-010 to 284-66-400 (1990/2010) (previous version of model).
West Virginia		W. VA. CODE R. §§ 114-24-1 to 114-24-21 (1981/2009) (previous version of model).
Wisconsin		WIS. ADMIN. CODE INS. § 3.39 (1989/2010) (previous version of model); BULLETIN 4-20-2010 (2010); BULLETIN 10-17-2006.
Wyoming		35 WYO. CODE R. §§ 1 to 25 (1980/2009) (previous version of model).

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

This page is intentionally left blank

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

See the legislative history to the Minimum Standards Act beginning at 650-11 for general background information.

The Medicare Prescription Drug, Improvement and Modernizaiton Act of 2003 (MMA) was signed by the President on Dec. 8, 2003. Among other things, it added Part D to Medicare, providing prescription drug benefits. It also required the NAIC to make several changes to the Medicare Supplement Model Regulation to conform to the federal law. The bill provided a nine-month time frame for the NAIC to amend its model regulation to conform to MMA. The NAIC met this deadline by conducting an electronic vote on Sept. 8, 2004. The specific revisions to the model regulation required by MMA included: (1) Add two new plans (called K and L in the amendments) to the standard Medigap plans A through J; (2) Revise the standard H, I and J plans to eliminate prescription drug coverage for those who enroll in Medicare Part D; (3) Prohibit the sale of prescription drug coverage in Medigap after Dec. 30, 2005 (i.e. when Part D comes into effect); and (4) Make any other changes to the model regulation that might be required as a result of the legislation. The task force only considered changes that were directly related to the unambiguous changes NAIC needed to make as a result of the bill, with some minor exceptions for clarification purposes. **2004 Proc. 3rd Quarter 84.**

Section 1. Purpose

The regulation was developed to assist states in complying with the federal Baucas Amendment (P.L. 96-265). **1980 Proc. II 593.**

The task force deleted "by reason of age" when drafting amendments in response to the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). This made the model applicable to policies sold to individuals who are eligible for Medicare by reason of disability. It does not mean that companies would be required to sell a Medicare supplement policy to these individuals. A representative of the Health Care Financing Administration recommended that the federal statute and the NAIC model should be consistent and she believed the intention of the Baucas Amendment was to concentrate on the entire Medicare population. The advisory committee expressed concern that deletion of the age criteria would require companies to issue buyer's guides to those under 65 and to place a statement on policies stating that it is not a Medicare supplement policy. Another concern was increased exposure. Individuals who are covered under Part B because of disability are considered higher risks. **1991 Proc. IIB 908-909**.

The task force reached a consensus to delete "by reason of age" language from the model act and regulation except with respect to disclosure requirements. The decided it should remain intact with respect to delivery of the buyer's guide to health insurance for people on Medicare, with respect to placing the notice on the policy of accident and sickness insurance stating that these policies are not Medicare supplement policies, and with respect to replacement notices. **1991 Proc. IIB 886**.

Section 2. Authority

Section 3. Applicability and Scope

This section, added in 1987, provided that Medicare supplement standards would apply to all policies marketed as Medicare supplement policies, including employer groups previously exempted. **1988 Proc. I 652, 666.**

At the September 1988 meeting the working group restored the employer and labor organization exclusion in the act and regulation to be consistent with the federal Baucas Amendment. It was noted, however, that the working group recommended the appropriateness of including employer groups within the departments' jurisdiction and encouraged the federal government to add employers to the scope of the Baucas Amendment to the Social Security Act. **1989 Proc. I 813.**

Section 4. Definitions

During the drafting of extensive revisions to the model in 1991, several new definitions were added. **1992 Proc. IA 17**.

Several new definitions were added as a result of the amendments drafted in response to the federal Balanced Budget Act of 1997. **1997 Proc. 4th Quarter 931**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 4 (cont.)

B. A federal regulator suggested a change in the language regarding bankruptcy. There was some discussion of bankruptcy versus insolvency, in that the term bankruptcy, as used in the Balanced Budget Act of 1997, did not apply to insurers. The working group agreed to the revised definition. **1998 Proc. 1st Quarter 772**.

E. An interested party pointed out that the term "continuous period of creditable coverage" may need to be included. He suggested that the concept of a period of continuous coverage being at least 63 days needed to be reflected in the model as a definition. **1997 Proc. 4th Quarter 931**.

F. The drafting note following Subsection F was included in the technical revisions of 2000. The amendment inserts a citation to the interim final rule issued by the Secretary of the U.S. Department of Health and Human Services. **2000 Proc. 2nd Quarter 272**.

During the revisions of 2004, the term "Medicare+Choice was changed to Medicare Advantage, based on changes in the terminology in federal law. **2004 Proc. 3rd Quarter 752.**

L. When drafting amendments to respond to the federal law passed late in 2003, the task force decided to update the definition of a Medicare supplement policy to exclude Medicare Advantage plans and prescription drug plans under Part D and to correct the drafting note after the definition of a Medicare supplement policy, as Health Care Prepayment Plans were no longer subject to regulation as Medicare supplement policies, irrespective of whether they were non-group or group-based. **2004 Proc. 1st Quarter 544.**

A representative from the Centers for Medicare and Medicaid Services (CMS) suggested that modification of the definition of Medicare supplement policy should include addressing the question of how to incorporate and categorize stand alone drug, dental or other types of benefit riders in light of certain provisions in MMA that proscribe this duplication of benefits provided by Medicare Part D. The CMS suggestion was that these riders be incorporated into the definition to preserve them for renewal by beneficiaries. The chair expressed concern about altering the definition of Medicare supplement plans from that contained in the model, since current state laws required minimum standards for Medigap plans, and the prospect of creating exceptions to the rule to accommodate inconsistent policy interpretations by CMS was incompatible with achieving administrative simplification as described by the NAIC Model Regulation. **2004 Proc. 2nd Quarter 767.**

Section 5. Policy Definitions and Terms

C. The definition of "convalescent nursing home" was revised to track the definition contained in the Medicare law. **1992 Proc. IA 18**.

D. While it was clear that the Medicare supplement minimum standards applied also to health maintenance organizations, certain modifications were necessary because of the differences between HMOs and indemnity plans. The task force considered this issue when making the modifications required by the Catastrophic Care Act of 1988. **1988 Proc. I 654.** One adjustment was a special definition of health care expenses for HMOs. There was discussion on allowing health maintenance organizations to include incurred health care expenses in the calculation of loss ratios. An attempt was made to define "health care expenses" and itemize the items which should and should not be included. It was suggested that claims processing costs not be included because they would not be included in the insurance companies' calculations; therefore, it would be unfair to allow HMOs to utilize them. **1989 Proc. I 829.**

E. The definition of "hospital" was revised when the amendments of 1991 were adopted to make it consistent with federal law. The original model referred to the various state laws defining hospitals. **1991 Proc. IIB 909, 1992 Proc. IB 1073**.

The First Church of Christ, Scientist expressed a concern over the reimbursement for services for Christian Science sanitariums. The task force unanimously agreed that the definition in the model law revisions which mirrors the Medicare definition of hospital would cover care provided in these facilities. **1991 Proc IIB 843**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 5 (cont.)

F. In 1994 the federal definition of Medicare supplement was amended to delete reference to Section 1833 plans, commonly known as health care prepayment plans. A federal regulator clarified that the plans were essentially a hybrid between a risk and a cost contract and taking away the exception subjects them to the requirements that apply to Medicare supplement policies. A state regulator pointed out that they provide benefits in a managed care setting, so would no longer be allowed because managed care supplemental benefits could only be provided as Medicare Select polices. **1995 Proc. 1st Quarter 586-587.**

A drafting note was added regarding health care prepayment plans (HCPP) after the subsection defining a Medicare supplement policy. An insurer representative asked if the drafting note was intended to state that HCPPs were not permitted to renew their existing block of business. A federal representative said this was not required by the federal law. A state regulator noted that, if the Medicare Select program was expanded to all states, the HCPP program could be allowed if it met the qualifications as a Medicare Select policy. **1995 Proc. 1st Quarter 585.**

G. Advisors expressed concern that the definition of "eligible expenses" as revised in response to OBRA 1990 would require companies to pay in situations in which Medicare would not. The task force agreed to maintain the concept of the original model to require payment only when Medicare pays. This concept runs throughout the model and affects the definitions of many of the benefits. **1991 Proc. IIB 909.**

Section 6. Policy Provisions

A. For many years the model contained a laundry list of permitted exclusions. When amendments were adopted in 1991, the task force decided to explore rewriting the list of allowable exclusions and clarifying Section 6A. **1991 Proc. IIB 909**. The adopted version deleted the entire list of permitted exclusions and simply stated that the policy could not contain limitations or restrictions more restrictive than those of Medicare. **1992 Proc. I 19-20**.

D. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) required Medigap issuers to terminate the drug coverage in policies that included prescription drug coverage where the beneficiary elected to enroll in Medicare Part D. Federal autorities were authorized to levy a substantial fine on Medigap issuers for each instance this provision was violated, irrespective of any knowledge of a violation by the issuer. The issuers pointed out that there was no way for them to find out that a beneficiary had elected to enroll in Medicare Part D because there was no notification requirement of enrollment. A representative from the Center for Medicare and Medicaid Services (CMS) added that CMS has no solution to this issue at the present time, as there was presently no central repository of data from which Medigap issuers might research to confirm whether or not a beneficiary had, or was planning to, enroll in Medicare Part D. **2004 Proc. 1st Quarter 545.**

Section 7. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to [insert effective date adopted by state]

The contents of what had been Section 7 were deleted when the model was changed in response to the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). What had been Section 8's provisions on current benefits became the basis for the section on benefits for policies issued prior to the effective date of the new regulation. **1992 Proc. IA 20-22**.

When amendments to the model were made in response to OBRA 1990, it was suggested that a drafting note be added to the model to recommend that states adopt the amendments within one year after the NAIC model was adopted. **1991 Proc. IIB 909**.

Staff members prepared a section by section analysis and interpretive guideline to assist states in interpretation and implementation of the model. This analysis was adopted by the task force. **1992 Proc. IB 1067-1079.**

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 7 (cont.)

A. Paragraph (5) was added as part of the consumer protection amendments of 1989. An insurance company representative asked whether the proposal addresses the situation in which certificate holders of a major employer are located in various states, which state authorizes cancellation. The task force chair responded that the proposal should reflect which state has jurisdiction to authorize cancellation and nonrenewal. She indicated that the state in which the company is domiciled makes some sense, but that where the policyholder resides would be another option. **1990 Proc. IB 608.**

One of the purposes of this section is to address companies that have to get out of the business because of solvency concerns. **1990 Proc. IB 609.**

Section 7A(5)(b) does not prohibit nonrenewal or cancellation, but does make clear that if there is a termination, conversion or continuation must be offered. One person suggested that clarification was needed to make sure that it was clear that either continuation or conversion could be offered, but both are not required. **1990 Proc. IB 611.**

There was also concern expressed about whether insurers would be required to get permission to cancel or not renew policies for individuals who voluntarily dropped Part B coverage. This may not truly qualify as a cancellation because the contract would pay as if they were enrolled in Part B. **1990 Proc. IB 608.**

When considering amendments in response to the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the task force decided that reinstitution of a suspended Medigap policy with drug coverage was not a "new" policy offering prescription drug coverage—and thereby prohibited by MMA—but was a resumption of a previously held policy. Therefore, the task force decided to include language allowing beneficiaries with suspended Medigap policies containing prescription drug coverage to resume their plans, provided the beneficiary was not enrolled in Medicare Part D. **2004 Proc. 2nd Quarter 523.**

B. Paragraph (6) was revised during the drafting of 2001 amendments. **2001 Proc. 2nd Quarter 182**.

Section 8. Benefit Standards for Policies or Certificates Issued or Delivered on or After [insert effective date adopted by state]

A. In 1980, shortly after the model was adopted, the preexisting condition limitation was changed from the twelve-month limitation of the Accident and Health Minimum Standards Regulation to a six-month limitation for Medicare supplement policies. **1981 Proc. I 446.**

For a time the NAIC considered allowing the sale of policies to supplement only Part A or Part B of Medicare, and presented an exposure draft to incorporate such changes in the minimum standards. The task force realized this would require changes in federal law. **1982 Proc. II 635.** Because of the unlikeliness of an amendment to federal law, the task force agreed to drop consideration of such amendments to the NAIC models. **1983 Proc. I 721.**

The NAIC standards in place before OBRA 1990 regarding cancellation or nonrenewal were incorporated into the federal standards except that they do not authorize the commissioner to permit cancellation or nonrenewal. An insurer may not cancel or nonrenew except for nonpayment of premium or material misrepresentation. Group policies must provide for continuation of coverage or conversion. **1991 Proc. IB 727**.

The task force included a provision in the amended model to provide a special rule for persons who became eligible for Medicaid while being covered under a Medicare supplement policy. Just before adoption of the revised model they included language to clarify that individuals will pay premiums from the date the reinstitution occurs. **1992 Proc. IB 1084-1085**.

Along with the technical amendments developed in 1999, the regulators considered amendments in relation to changes in Medicare as a result of the Balance Budget Refinement Act of 1999 and the Ticket-to-Work and Work Incentives Improvement Act of 1999. Paragraph (7)(c) was added to allow disabled beneficiaries to elect to suspend coverage under a Medigap policy when covered under a group health plan. The period allowed for suspension had not yet been specified by the

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 8A (cont.)

relevant federal agency, but the proposed amendment provided for the period of suspension that is specified in the federal regulation. **2000 Proc. 1st Quarter 321-322**.

The federal act did not specify a maximum length of time for suspension of a Medigap policy under its provisions, so the working group inserted a phrase specifying the period of time provided by federal regulation. By the time the group was next developing amendments, it had become clear that this phrase could be misconstrued to state that there was a federal regulation that provided such a time period, when in fact there was not. The 2001 amendments rephrased the sentence to avoid that wrong impression. **2001 Proc. 1st Quarter 187**.

A second proposed amendment to Paragraph (7)(c) was deletion of the last sentence, which provided that, upon restitution of coverage, an insured must pay the premium attributable to the period as of the date of termination of entitlement to coverage under the group health plan. The language was not in federal law, but was added by the working group in 2000 for clarification. The Health Care Financing Administration requested that the working group delete the sentence and insert a sentence in the drafting note. The drafting note following was also revised. **2001 Proc. 1st Quarter 187**.

Paragraph (7)(d) was also revised as part of the 2001 amendments to add a phrase "as described in Subparagraphs (b) and (c). This change was made to specify that the application of Subparagraph (d) is limited to the circumstances described in Subparagraphs (b) and (c). **2001 Proc. 1st Quarter 187**.

Paragraph 5(f) was added and other provisions of Subsection A were revised during the redraft in 2004. **2004 Proc. 3rd Quarter 758.**

B. A charge was given to the Medicare Supplement Standardization Working Group in 1990 to review, discuss and develop a Medicare supplement insurance standardization/simplification program. Several states already had such programs in place and these were reviewed by the working group. **1991 Proc IB 788-789**.

In considering the wisdom of development of a standardized benefit approach, the drafters discussed the trade-offs between allowing companies freedom of choice and restricting consumers' options. One state's benefits specialists preferred a standardized system because it allows "apple to apple" type of comparisons. A fundamental issue was how to determine the value of a national standardization approach in terms of the flexibility that should be built in for each state to accommodate local innovation. The chair of the advisory committee commented on the significance of developing interchangeable packages which can be marketed in all states. **1991 Proc. IB 789-790**.

The working group saw their objective as the development of a framework which could consist of either a core policy plus riders or a certain number of prepackaged policies, and identification of the benefits which should be included in that framework. **1991 Proc. IB 790**.

The drafting committee considered the framework of the standardization effort to be of prime importance. It was suggested that the core package could contain the Baucas minimums and clusters of benefits could be added to the minimum package. One consumer advocate suggested that there be no more than four standard packages. Even though it would limit flexibility it would provide consumer ease in comparison shopping. **1991 Proc IB 790-791**.

At the NAIC zone meeting in the fall of 1990, the working group developing a standardized approach reported on their work to date. They were leaning toward a "core plus rider" approach rather than packaged plans. There was a clear consensus that the core policy should contain the minimum standards of the Baucas Amendment. The working group held discussions on whether to allow "bundling" of benefits or not, particularly with respect to the prescription drug benefit because it appeared to the group that this was an uninsurable benefit. One comment received in the open meeting was that without bundling a great disservice would be done to the public. Antiselection would be the key for fashioning any approach. **1991 Proc. IB 768**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 8B (cont.)

In order to determine which approach to standardization would be most useful to consumers, a survey was conducted of senior health insurance counseling programs. One drafter suggested that, if the NAIC developed a core plus riders approach, a state could still go to prepackaging by taking the core and making packages out of that approach. The most important objective is comparability. One drafter noted that if a core package with riders system was adopted, choices could still exceed 200 and the working group would not have accomplished its goal which is to simplify comparison for the consumers. **1991 Proc. IB 772**.

The committee decided an actual survey of consumers was needed to determine the structure and the benefits to be included in a standardization/simplification approach. **1991 Proc. IB 772-773**.

A consultant was hired to conduct a study of consumers to determine what older Americans preferred to see in a Medicare supplement policy. The final results of the test were included in the *Proceedings.* **1992 Proc. IB 996B-1065.**

On November 5, 1990 federal law changes were adopted as part of the Omnibus Budget Reconciliation Act of 1990 (OBRA 1990). Under the Act, the NAIC was given nine months to devise new minimum benefit standards to standardize/simplify policies. The NAIC was required to devise a core group of basic benefits common to all policies, as one of a maximum of ten benefit packages. Under the new language, no state could permit any benefits, language or format other than that prescribed in the NAIC standards. States could restrict the groups of benefits to less than the ten, but must require the core group of benefits to be offered. **1991 Proc. I 761-762**.

When the task force set down the list of what would be included in each of the ten plans, the core package included skilled nursing facility care from days 21-100. Much discussion was generated by this inclusion. The task force initially included it, being of the opinion that it was a low cost benefit in high demand. A consumer representative on the advisory committee stated there was a lack of information on the cost and possible utilization of the benefit, and she was leaning toward the idea of excluding the skilled nursing facility benefit from the core to keep the core package as lean as possible. **1991 Proc. IIB 919**.

In connection with the task force's work on deciding whether to include skilled nursing facility coinsurance in the core benefits, they considered statistics presented by one provider that the costs per subscriber had increased significantly in the prior three years. Costs were projected to increase even more for the current year. The company's experience did not support the contention of some that the skilled nursing facility (SNF) benefit was relatively low in cost. To keep the core policy affordable, they recommended excluding SNF from the core and including it in some but not all of the packages. Both for reasons of cost and to avoid any confusion with long-term care, they recommended that there be no coverage for SNF beyond 100 days. This would make a useful benefit available, while helping to keep more packages within the midrange of costs. **1991 Proc. IIB 904**.

When the task force was nearly finished drafting amendments, they made final decisions on packaging the benefits. The first issue was whether to include the skilled nursing facility copayment for days 21 through 100 in the core package. The task force agreed to accept the core package without the SNF coverage. Therefore the core package will include Part A hospital days 61-90, lifetime reserve days 91-150, coverage for 365 lifetime hospital days, coverage for blood under parts A and B and part B coinsurance of 20%. **1991 Proc IIB 888**.

The regulators discussed amending the model regulation in mid-1998 to clarify that balance billing is not allowed. The procedure the working group planned to follow was to send a letter to the Health Care Financing Administration (later renamed the Center for Medicare and Medicare Services) and, if there was no reply, the NAIC would go ahead and amend the model. **1998 Proc. 2nd Quarter II 890-891**.

The purpose of the amendments was to address the situation where some providers of hospital services to Medicare beneficiaries bill above the Medicare-approved amount after the exhaustion of hospital reserve days. If the beneficiary has Medicare supplement insurance, the provider attempts to collect the full billed charge from the insurer. The amendments clarified that the provider must accept the issuer's payment as payment in full and could not bill the insured for any balance.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 8B (cont.)

The amendments also clarified that the insurer was liable only for payment of the Medicare-approved amount. **1998 Proc. 3rd Quarter 700**.

A regulator asked if the NAIC needed approval from the federal agency to make these changes. A representative from HCFA said that agency could not support the working group's position because the Social Security Act was silent on provider billing beyond the reserve 150 days. The HCFA representative pointed out that one court had held that the Medigap insurer did not have to pay beyond what Medicare would have paid. Consequently, he believed states could adopt the amendments even if HCFA did not approve them. **1998 Proc. 3rd Quarter 700**.

The working group discussed the inability of states to regulate providers and wondered whether a more appropriate approach was to ask the federal agency to pursue an amendment to the Social Security Act to prohibit balance billing. The group agreed that the NAIC action was appropriate and that actions at the state level could put pressure on Congress to amend the Social Security Act. **1998 Proc. 3rd Quarter 700**.

The parent committee recommended continued dialogue with the federal agency to let the agency know of regulators' dismay at their interpretation and urging a change in position. **1998 Proc. 3rd Quarter 701**.

An amendment was added to Subsection B(5) as a result of the anticipated implementation by the Health Care Financing Administration (later the Center for Medicare and Medicaid Services) of a prospective payment system for hospital outpatient department services under Part B of Medicare. **2000 Proc 1st Quarter 322**.

A drafting note was added to Paragraph (5) to explain the meaning of the term "copayment" in connection with the applicable copayment terminology used under the prospective payment system. The drafting note explained that the term meant the least of three terms used in applicable federal law and regulation. The drafting note also provides that regulations governing copayment for hospital outpatient department services under a prospective payment system apply to all Medicare supplement policies or certificates issued prior to and after the effective date of the prospective payment system. **2000 Proc. 2nd Quarter 272**.

When the working group was considering amendments in 2001, the amendment of the drafting note was included at the request of the Health Care Financing Administration (now known as the Center for Medicare and Medicaid Services) to clarify issuer liability for hospital outpatient department services paid under the Medicare prospective payment system. **2001 Proc. 2nd Quarter 182**.

When the NAIC again considered the model regulation as a response to the Medicare Drug, Improvement and Modernization Act of 2003, comments from interested parties on this section focused primarily on Subsection B, which described the "core package" of benefits that must be included in all Medigap policies. The subsection outlined the obligations of a Medigap policy to pay for hospital inpatient coverage upon exhaustion of Medicare Part A coverage for eligible expenses, and the basis for such payments. Discussion of this issue centered around whether or not clarification of the language in this section and the accompanying drafting note was required to better delineate the payment obligation of Medigap plans in these scenarios, and whether "balance billing" to the beneficiary should be allowed. **2004 Proc. 1st Quarter 546**.

C. The task force considered a stair-step approach in developing the list of benefits which would be included in each benefit plan, but rejected it in favor of an arrangement that would not require consumers to buy one benefit in order to acquire another. The task force believed the packages it selected were more reflective of what consumers had desired. **1991 Proc. IIB 920.**

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 8C (cont.)

Further questions were raised about why the configuration of the packages did not follow a stair-step approach. The task force, upon strong recommendations from an actuary on the drafting committee, decided the stair-step approach did not achieve the optimal mix in terms of consumer desire, circumstances and affordability. The advisory committee also concluded that attempting to provide consumers a middle of the road package balancing affordability and choice precluded application of the stair-step approach. If the stair-step approach were utilized, more than ten packages would be necessary. **1991 Proc. IIB 912**.

The task force considered the number of standardized packages which should contain the Part B deductible. One member of the advisory committee suggested that the Part B deductible benefit was just dollar trading and that the amount charged for that particular benefit exceeds the benefit itself. He stated that it is a difficult benefit to justify but that certain individuals do prefer to purchase it. Another advisory committee member commented that she never believed inclusion of the benefit was a good idea; however OBRA 1990 requests the task force to preserve the benefits that are currently offered in the marketplace. **1991 Proc. IIB 911-912**.

The task force considered whether a definition of usual and customary should be developed. Motions were made, but failed of adoption, to define excess benefits as 100% of the difference between what the doctors charge and what Medicare allows; and that excess benefits be defined as a fixed percentage of the Medicare-approved charge. The group did endorse the concept of an objective excess charges rider. **1991 Proc. IB 775**.

It was suggested that "part B excess charges" should be revised to "part B balance billing." Others disagreed because the term "balance billing" means nothing to the average consumers. It was pointed out the "balance billing" is the terminology that will be used by the Medicare program in the explanation of benefits. The task force decided not to make this change. **1991 Proc. IIB 881**.

When the task force presented its first chart of the benefits which would be included in each of the ten plans, only two packages contained a foreign travel benefit. Insurer representatives to the drafting committee urged that the foreign travel benefit be included in more packages. They stated it was a very low cost item and a popular benefit. The task force was asked if the foreign travel benefit was for emergencies only and they responded that that was the case. **1991 Proc. IIB 919, 922**.

One consumer representative was of the opinion that benefit plan C would be the must commonly purchased package. It was recommended that the foreign travel benefit be included. **1991 Proc. IIB 889**.

The task force considered making the foreign travel benefit extend to 90 or 180 days, but decided to leave it at 60 days. They also clarified that the benefit related to billed charges and that an individual who incurred an illness on the 59th day of the 60-day period would continue to receive benefits throughout the illness. **1991 Proc. IIB 843**.

The task force had agreed to place the foreign travel benefit in all the packages except the core, but as a result of a consumer survey, they voted to remove it from plan B. **1992 Proc. IB 1087-1088**

One state department representative reported that his state mandated cancer screenings. It was suggested that because Medicare does not cover routine exams, this area should be explored. Preventive health services including immunizations and cancer screenings were adopted for inclusion as an additional benefit. **1991 Proc. I 776**.

The drafters spent a considerable amount of time discussing what things should be included in the list of preventive health services. One preferred a benefit including influenza immunizations, while another speculated that most immunizations could be obtained for free. The drafters also considered whether there should be a cap on the amount of benefits provided. The advisory committee urged inclusion of a $120 a year cap because without a cap the benefits' costs would be increased significantly. The proposal adopted was narrowed significantly from the initial proposal. **1991 Proc. IIB 919**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 8C (cont.)

While the drafters were preparing the list of preventive medical care benefits, they solicited the opinion of the U.S. Department of Health on whether to include the benefit, and what the components of such a benefit should be. The doctor consulted recommended that the cholesterol screening, screening for glaucoma and cataracts and hematocrit testing be eliminated from the proposal and suggested adding tetanus and diphtheria boosters, hearing screening, dipstick urinalysis and thyroid functions tests. One of the drafters suggested eliminating any reference to usual, customary and reasonable charges as was done with the rest of the draft. **1991 Proc. IIB 883**.

Task force members and interested parties discussed at length whether to include a counseling component in the preventive care benefit. A second visit would probably be required because the counseling portion would follow the testing period. There was concern about how the benefit's $120 cap would be apportioned between the counseling portion and the testing portion. One drafter suggested that the counseling component may already be a natural part of this benefit without specifying it. One advisory committee member suggested that the counseling benefit is an innovative benefit and that is why it should not be a part of the preventive care benefit plan. There are no insurance regulatory standards for counseling. The counseling component of the benefit was removed from the draft. **1991 Proc. IIB 883**.

One task force member suggested that the preventive care benefit be expanded to include future tests as recommended by the U.S. Department of Health. The task force discussed whether such an amendment could be accomplished and suggested that the Health Care Financing Administration be consulted to obtain its opinion on the ability of the NAIC to make such revisions. One staff member gave the opinion that the OBRA language would not allow the NAIC to incorporate future benefits. Another committee member pointed out that the drafters had made a commitment to review some of the benefits over time. She urged the task force to retain the same concept which was adopted with respect to the at-home recovery benefit, preventive care benefit and prescription drugs benefit. **1991 Proc. IIB 881**.

Further discussion was held in June 1991 regarding the preventive care benefit. One drafter suggested delegating authority to develop a list of appropriate tests to an outside party, such as the U.S. Department of Health and Human Services. Task force members agreed that the NAIC does not have the expertise to determine what tests are appropriate. There was considerable discussion about
leaving it to the authority of the attending physician. The task force agreed to broaden the benefit, leaving the $120 cap in place. The concern that this benefit is pure dollar trading led the task force to conclude that broadening the benefit would not be detrimental. **1992 Proc. IB 1088, 1090**.

In fashioning the preventive care benefit, the draft was changed at one point to mention screenings and tests in a more general fashion with the decision to be made by the attending physician. Upon reflection, the task force decided that the policyholders must be given direction with respect to this benefit. This decision was made after considerable discussion on whether a listing of preventive services is easier for consumers to understand and whether it should be broad enough to allow the physician discretion to prescribe appropriate screenings. **1992 Proc. IB 1088**.

The working group considered the value of a rider for home health care. Some considered the benefit more appropriate to a long-term care insurance policy. It was suggested that this benefit would confuse consumers and actually cause more difficulty. Other drafters saw it useful as a short-term benefit. **1991 Proc. IB 776**.

At the first drafting session of 1991, a considerable amount of discussion was held on the inclusion of a home health care benefit. One consumer representative reported that his association believed the benefit should be included. There is considerable consumer demand to supplement this Medicare benefit. One insurer representative on the advisory committee stated that his company offered the benefit at a reasonable cost and it was extremely well received. It is one of the benefits worth the attention necessary and it should be placed in a number of the packages. The committee discussedwhether this benefit should be tied to Medicare or to hospitalization. One regulator suggested that tying the benefits to Medicare might result in an illusory benefit, while a consumer advocate did not think tying the benefit to hospitalization was a good idea. **1991 Proc. IIB 940**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 8C (cont.)

In the earlier proposals, home health care was only available in two packages. Some of the committee members expressed concern that this benefit was only available in plans which also contained a prescription drug benefit. The combination of these two benefits might cause the cost of the package to rise significantly. Others were concerned about the trigger for the benefit, or even the advisability of including it at all. There was the possibility of confusion with long-term care insurance benefits. The benefit must be separate from long-term care and easy to understand. **1991 Proc. IIB 920**.

One of the drafters summarized this proposal as a short-term benefit that supplements the home health care services provided by Medicare. He explained that the benefit would follow an acute situation. The plan must be certified by a physician stating that the additional benefit supplied by the Medicare supplement policy is required for that individual to continue recovery. An advisory committee member suggested it was not sufficient to require prospective certification, but a memberof the drafting committee responded that prospective certification was the only workable approach because consumers must know at the time they are incurring the expense whether they will receive coverage. The task force chair stated it is very important to call this benefit an at-home recovery benefit rather than a home health care benefit. **1991 Proc. IIB 882**.

The task force was careful to define "home" in such a way that it did not preclude furnishing of care in a congregate care facility. They also indicated their intent to make sure the definition coincided with Medicare's definition. **1991 Proc. IIB 887**

The at home recovery benefit could run concurrently with Medicare in the situation where an individual receives medical care and home care of the personal type. However, there would not be duplication of benefits. **1991 Proc. IIB 887**.

An amendment to the at home recovery benefit proposed at one point restricted delivery of care to Medicare certified agencies. One consumer representative to the advisory committee expressed concern that this would limit access to care. Some members of the advisory committee spoke in favor of keeping the benefit narrow and sufficiently controlled, while others were in favor of expanding to improve access. Members discussed the adequacy of state licensure of home health aides and others who would be delivering the personal care. The task force agreed to use their original definition of care provider which only required that the provider be "duly qualified or licensed." **1992 Proc. I 1087**.

The task force discussed whether the at home recovery benefit should be indexed for inflation. In order for the benefit to be meaningful it must be affordable. Since the task force had attempted to address the issue of rising costs by loosening the class of providers, they decided not to add inflation protection to this benefit. **1992 Proc. I 1087**.

At a meeting of the task force drafters there was discussion on the effect of the OBRA 1990 language that allows a new or innovative benefit to be approved by the commissioner in addition to the ten packages. It was concluded that an innovative benefit could be approved for each policy. Task force members expressed concern over how this would accomplish simplification of the existing marketplace. One member stated it was his belief that there were not many new benefits that could be offered so it should not be a significant problem. He suggested that the task force define "new and innovative" to assist the states in administering this provision. **1991 Proc. IIB 925**.

The task force continued to struggle to reach a consensus on developing a definition of what constituted a "new and innovative" benefit. One advisory committee member suggested the term should be left undefined. The task force expressed the concern that this phrase weakened the standardization and that any proposals for additions to the benefit package should be closely evaluated. Every state that commented on the draft recommended that NAIC develop a definition. **1991 Proc. IIB 910**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 8C (cont.)

The task force continued to be concerned about innovative benefits right up to the time of the adoption of amendments in 1991. There was considerable discussion about whether the task force had the ability to define this benefit. A representative from the Health Care Financing Administration stated that OBRA provides that a new and innovative benefit is what the commissioners define it to be. HCFA is not able to express further opinion on that except that this provision in OBRA cannot be used to undermine anything else that exists in law. Suggested language to further define innovative benefits was rejected. The chair reiterated the belief that states would be strict in interpreting what is a new and innovative benefit. **1992 Proc. IB 1089**.

As the deadline for adoption of the model draft drew near, the drafters still discussed the provision for innovative benefits and decided to add a drafting note. They decided it was appropriate for the innovative benefit to include prescription drugs, at home recovery and preventive care. It would not be appropriate for an innovative benefit to be 50% of the Part A deductible. It would be directly at odds with the goal of simplification to split the benefits that are in the traditional format. **1992 Proc. IB 1090**.

When the drafters were nearly finished with the draft, they ironed out the details of which benefits should be included in which packages. One person speaking on behalf of consumer representatives presented a proposal reflecting their interest in balancing consumer preferences with availability and affordability. Benefit plans B, C, D and E could be referred to as moderate plans, F, G, H and I would be richer benefit plans; and benefit plan J was the Cadillac version. **1991 Proc. IIB 888**.

The group considered several benefits that were rejected for inclusion in the standardized benefits design. They did not think a benefit for social work should be included as either a core benefit or rider. They rejected pediatric care, long-term care, skilled nursing facility care in a facility not certified by Medicare, home health care, hospice care and respite care. They discussed adding vision, hearing and dental benefits but decided to request further input on the desirability of doing so. The group also decided to consider further the possibility of benefits for ambulance and outpatient physical therapy. **1991 Proc. IB 776-777**.

When crafting technical amendments in 1999, staff was asked to check with the Health Care Financing Administration with regard to removal of flu shots and mammograms from the list of preventive services in the outline of coverage. **1999 Proc. 2nd Quarter 648**.

D. The task force considered CMS' recommendation to add an entirely new Subsection D to outline the two new benefit plans created by the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA), designated as "K" and "L." The task force agreed that since K and L would be significantly different from plans A through J, description of these two new plans merited a separate subsection in the model regulation. The task force discussed the proposed Medigap standard plan overview chart and discussed how to incorporate the two new benefit plans K and L into the existing chart. Concern was expressed about the appropriateness of having these two new plans added to the current chart, given the fundamental lack of similarity between them and the traditional standard plans. Interested parties suggested that the chart include the two new plans, but employ a "break" in space on the chart between the ten original standard plans and the two new ones in order to facilitate differentiation among the summaries. **2004 Proc. 1st Quarter 547-548.**

Section 9. Standard Medicare Supplement Benefit Plans

One of the issues of concern to the drafters was whether OBRA 1990 allowed states to adopt less than ten packages. Some concern was expressed that a state adopting less than ten packages would not be certified by the Secretary of Health and Human Services. Interested parties recommended that the NAIC adopt ten packages and encourage states to adopt all ten packages. The task force chair stated that to achieve simplification while providing meaningful consumer choice was a difficult issue. The task force agreed to evaluate the recommendations and to carefully articulate the basis for their decision. **1991 Proc. IIB 941**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 9 (cont.)

One association commented that the NAIC is required by law, to the extent possible, to design benefits that offer consumers the ability to purchase currently available benefits while facilitating comparison, minimizing adverse selection, providing consumer choice and market stability, and promoting competition. **1991 Proc IIB 950**.

Interested parties discussed whether state mandates would apply to the core package only or to the other benefit packages. He stated that the advisory committee concluded that OBRA 1990 prevents state mandates from applying. A regulator disagreed and said the federal law was unclear and that state law would control. An HCFA representative suggested that their organization would decide whether state mandates should apply or not, and the task force chair disagreed. He felt the courts could be utilized to resolve a dispute. Several comments were heard that it had been the intent of Congress to not include state mandates, and this should be corrected through a technical corrections bill. **1991 Proc. IIB 942**.

Interested parties concluded that the intent of the law was to achieve overall standardization of products which would only be achieved by not allowing individual states' mandated benefits to be added to the proposed packages. **1991 Proc. IIB 946**.

At a drafting session of the task force members, a memorandum was distributed on the issue of whether OBRA 1990 precluded application of state mandates to Medicare supplement policies to be developed by the NAIC. OBRA language clearly stated that no benefits other than the ten packages developed by NAIC were authorized except for new and innovative benefits approved by the commissioner. Even if the language seemed fairly clear, another issue that should be addressed was what constituted a "state mandate?" Mandates are of two types: (1) legislation requiring the inclusion of certain benefits in certain policies, and (2) legislation which prohibits discrimination among providers. An exemption from the latter would be a difficult issue for state insurance departments. One staffer mentioned that an additional issue was significant: Whether HCFA would approve state regulatory programs if states doe not include specific language stating that mandates do not apply. The task force members agreed that this was not necessary in light of the OBRA 1990 language, and that it would be very difficult for states to accomplish. **1991 Proc. IIB 924**.

A letter was received from one state department of aging expressing concern over the possibility that certain benefits required by state law would not now be required in Medicare supplement policies. The task force agreed to insert a drafting note at the end of Section 9 to explain OBRA 1990 preemption of state mandated benefits. **1992 Proc. IB 1091, 1095**.

D. The task force agreed to clarify that, in addition to the designation required in Subsection C, as insurer may use other designations permitted by law. This amendment would permit the use of a product name such as "Policy Blue Star" in addition to the use of the name "Plan J." **1992 Proc. IB 1091**.

E. In addition to the ten standard plans A-J adopted in 1991, the federal Balanced Budget Act of 1997 required the addition of two new high deductible standardized Medicare supplement plans. The new plans provided for a high deductible plan "F" and a high deductible plan "J." **1997 Proc. 3rd Quarter 1348**.

A regulator expressed concern about calling the new plans "high deductible plan F" and "high deductible plan J" because the insured person may confuse the new plans with the current plan F and plan J standardized plan. He stated he was in favor of naming the new plans "plan K" and "plan L." An interested party stated that congressional staff considered that approach but decided against it. A regulator pointed out that the new plans did not provide a change in benefit structure, so should be designated as a subset of the current standardized plans so that consumers would be less likely confused. A consumer advocate suggested deleting two of the current ten plans. The chair responded that he did not think the working group had authority to do that. **1997 Proc. 4th Quarter 931**.

The chair of the working group asked how the high deductible plans would work. Working group members and interested parties had several views of how the deductible and copayments might work. It appeared the consensus of the working group was that once an individual had $1,500 in out-of-pocket expenses, the policy began to provide benefits as a standard plan. **1997 Proc. 4th Quarter 931-932**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 9E (cont.)

The working group decided to add to the drafting note following Subsection E to reflect the fact that high deductible plans and state laws in waived states were not preempted on benefits. **1998 Proc. 1st Quarter 777**.

NAIC staff summarized the major provisions of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), that had recently been passed by Congress. The prescription drug benefit, the transition drug discount card and the Medigap provisions of the bill would require changes to the NAIC's Model Regulation to Implement the Medicare Supplement Insurance Minimum Standards Model Act. The NAIC was tasked with certain specific items: (1) Add two new plans to the standard Medigap plans; (2) Revise the standard H, I and J plans to eliminate prescription drug coverage for those who enroll in Medicare Part D; (3) Make any other changes to the model regulation that might be required as a result of the legislation; and in doing items one through three above, utilize the process set forth in OBRA 1990, which required the NAIC to appoint a balanced interested party working group composed of insurers, consumers and Medicare beneficiaries. **2003 Proc. 4th Quarter 576.**

During its first review, the group focused much of its attention on the potential inconsistencies and ambiguities in the legislation. MMA required that Medigap plans with prescription drug benefits (standardized plans H, I, and J) be modified after Jan. 1, 2006 for Part D enrollees to remove those benefits and adjust premiums accordingly. However, the language was unclear as to whether the unmodified Medigap plans H, I, and J would be prohibited for sale entirely after Jan. 1, 2006, or whether they could still be offered to Medicare beneficiaries who choose not to enroll in Medicare Part D. **2003 Proc. 4th Quarter 577.**

The task force began its discussion of the model regulation by focusing on two preliminary issues: whether the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allowed issuers to sell new Medigap H, I or J policies with prescription drug benefits after Dec. 31, 2005. A letter was expected soon from the Centers for Medicare and Medicaid Services (CMS) to the NAIC and was expected to indicate its interpretation of MMA that a Medigap policy with a prescription drug benefit could not be sold after Dec. 31, 2005. The chair suggested that, while an official letter from CMS on this topic had not yet been received by the NAIC, the task force had in fact received CMS' position on this matter through a comment letter on the draft amendments to the model regulation.

The comments submitted by CMS took the position that any new Medigap policies with prescription drug benefits could not be issued after Dec. 31, 2005—only renewal of existing policies for those Medicare beneficiaries who are not enrolled in Medicare Part D at that time would be permitted. He suggested that for practical purposes, despite the interests of issuers to the contrary, reservations by some regulators, and the potential public policy complications derived from CMS' position on this matter, it would be best for the task force to accept CMS' position to avoid market confusion after Dec. 31, 2005. The task force agreed to accept the position espoused by CMS on this matter. **2004 Proc. 1st Quarter 543.**

The second preliminary issue to be discussed was whether the statutory limit of "10 + 2" Medigap plans set forth in Section1882 (p)(2)(C) of the Social Security Act (SSA) required the deletion of two existing Medigap plans in order to make room for the two new plans to be added under MMA, "K" and "L" respectively. NAIC staff noted that Congressional staffers indicated it was a drafting error. A consumer advocate indicated that she would like to see the elimination of some plans, but another interested party stated that, since Congress did not specifically call for the elimination of two existing plans to make room for the two new ones under the MMA, it was a generally-assumed consensus that the two new plans were to be added, not substituted into the Medigap standard plans. **2004 Proc. 1st Quarter 543-544.**

At an interim meeting called to discuss the draft regulation, the chair invited discussion on whether collapsing two of the currently existing Medigap standardized plans was required by the provisions of MMA and the Social Security Act, or if it was not required by statute, whether it would be desirable to do so. A consumer advocate expressed concern that the addition of the two new plans, K and L, mandated by MMA would add to the already significant likelihood of confusion among current and future Medigap beneficiaries. Without eliminating two existing plans, she noted that senior citizens would be choosing among seventeen separate Medigap plans, many with only subtle differences between them. The added complexity would make efforts to accurately educate senior citizens to make informed decision even more difficult than they were already. An industry representative voiced concern that an undesirable and unnecessary consequence of collapsing two

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 9E (cont.)

current plans would be the forced migration of Medigap enrollees in the cancelled plans to new ones, without respect to whether or not these beneficiaries would accept paying more or less for coverage that exceeded or fell below their needs. Another interested party added that the differences between the new plans K and L were significant enough not to add to the potential for confusion among new enrollees, and that any transition period incidental to collapsing the plans would add more confusion to the mix of choices faced by future enrollees. Another pointed out that few—if any—Medigap carriers issue all statutorily designed plans, and that it was likely none would offer all possible plans when K and L were established in 2006. Thus the failure to collapse two of the current plans by 2006 would not add significantly to the potential for confusion facing current and future Medigap enrollees. **2004 Proc. 2nd Quarter 766.**

The chair then raised the question of whether MMA granted the NAIC the authority to collapse any existing plans, noting that doing so might be permissible for future sales, but to eliminate two of the existing plans raised serious concerns involving closed blocks of business. NAIC staff stated that the focus of the MMA was not specifically on the collapsing of plans, but rather on wholesale "modernization" of all the Medigap standard plans.

Further, she noted that the instruction to the NAIC to modernize the standard plans was not contained within the statute itself, but rather in the conference report accompanying the enacted legislation. An attorney added that conference reports were typically used by legislators in the conference committee to express opinions that were not adopted into the final version of the legislation. **2004 Proc. 2nd Quarter 767.**

The chair also raised a concern about the limited time frame the task force had to accomplish the substantive changes to the model regulation. He asked whether any provisions in MMA or the Social Security Act precluded the NAIC from modernizing the model regulation in the future. Staff responded that MMA did not restrict the NAIC from revising its model, but certain changes might require amendments to the Social Security Act. The chair suggested that the task force maintain its current focus on implementing only those changes specifically resulting from MMA, and that modernization of the Medicare supplement insurance market as a whole would be postponed for consideration after completing the current round of revisions. The task force agreed. **2004 Proc. 2nd Quarter 767.**

F. The new draft adopted in 2004 included a description of new plans K and L. **2004 Proc. 3rd Quarter 773.**

G. One topic raised by the Centers for Medicare and Medicaid Services was an assertion that innovative benefits could not be issued with Medigap plans K and L, and that the prohibition was based in MMA. Participants in the drafting process did not agree with CMS' rationale for the position, and the task force decided to retain in the draft that K and L could have innovative benefits with the approval of the commissioner. **2004 Proc. 3rd Quarter 870-871.**

Section 10. Medicare Select Policies and Certificates

A representative from the federal Office of Prepaid Health explained the new Medicare Select program after adoption of OBRA 1990 mandated that the NAIC include provisions. She said it was a program that would provide benefits if an individual went outside the network, and could be considered a preferred provider arrangement. It was the belief of the plan's proponents that Medicare beneficiaries should not be locked into a health maintenance organization, and should be
Section 10 (cont.)

allowed flexibility to take advantage of reduced premiums if choice of provider were limited. Fifteen states would be selected to test the program from 1992 to 1995. Three specific requirements of the legislation are: the network must provide sufficient access, there must be ongoing quality of insurance, and beneficiaries must be adequately protected. Beneficiaries must be offered a choice of a Medicare supplement policy and a Medicare Select policy. **1991 Proc. IB 725**.

When drafters met in early 1991 to develop model provisions in accordance with OBRA 1990, there was considerable confusion as to the ability to offer managed care programs other than Medicare Select. One commentator stressed that the task force should allow managed care in addition to the benefits articulated in the packages chosen by the task force. The task force chair expressed the belief that managed care could be incorporated into each of the ten plans.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 10 (cont.)

It was also suggested that it would not be prudent to use up one of the ten plans by specifying that it is a managed care plan. One person commented that he did not want to see the Medicare Select program as the only mechanism by which a managed care program could be offered and a representative from HCFA stated his belief that Medicare Select was the only mechanism by which a managed care program could be offered. One regulator pointed to a section of OBRA 1990 which stated a managed care organization was a delivery system and not a benefit. A Congressional assistant stated that the drafters intended that offering of a PPO/managed care product would not be allowed. The task force chair suggested that in spite of the intent of the drafters, OBRA 1990 does not restrict insurance commissioners from approving PPO products. He suggested a court determination might be required. **1991 Proc. IIB 942**.

By February of 1991 the NAIC received unofficial comments from HCFA on its position regarding managed care products. It was their position that the only managed care products which are authorized under OBRA 1990 are those in the Medicare Select program. It was the position of HCFA that if a state does not explicitly state that position in its legislation, it will not become an approved state for regulatory certification purposed and HCFA will handle all Medicare supplement filings. Members of the task force felt the issue should be raised in the technical corrections process explaining the marketplace dislocation that will occur if HCFA's interpretation is followed. **1991 Proc. IIB 925**.

Task force drafters wondered if the NAIC was obligated to develop an intricate process for regulating the Medicare Select program. It was suggested that existing state laws and regulations on access and quality assurance may be sufficient. Task force members agreed that this area was appropriately left to the state and that OBRA 1990 legislation did not place an obligation on the NAIC to develop detailed regulations other than those currently existing in the HMO area. **1991 Proc. IIB 926**.

In order for states to participate in the Medicare Select program, they must have an approved Medicare supplement regulatory program, have experience with regulating health maintenance organization products, and possess a beneficiary assistance program. Medicare Select policies must be offered in conjunction with one of the approved packages. The federal law requires that there must be a choice to the beneficiary of an indemnity product. The task force chair commented that support for the program had diminished in light of HCFA's interpretation that the program would limit the offering of an HMO product to the 15 demonstration states. There was a consensus that Congress did not intend to preclude offering of managed care products outside of the 15 states designated in the Medicare Select program. Health Care Financing Administration was open to addressing the issue in a technical corrections bill. **1991 Proc. IIB 911**.

A representative from the Health Care Financing Administration indicated that adoption of the Medicare Select provision by a state would not be necessary for approval of the regulation by the Secretary of Health and Human Services. One interested party commented that the draft proposal for this section was not very specific and a drafter responded that it was drafted with the level of specificity that would conform to OBRA.

The question was asked whether the replacement standards in the current model would apply to existing policies replaced with an HMO product and a drafter responded that they would. That was one reason the working group chose to include those requirements for Medicare Select in the regulation rather than prepare a separate regulation governing Medicare Select products. **1991 Proc. IIB 884-885**.

I. The last sentence of Paragraph (3) was added during the redraft in 2004. **2004 Proc. 3rd Quarter 778.**

M. The task force considered at length how to address an industry association concern that Medicare Select enrollees would pay lower PPO premiums until they got sick and then change policies to have freedom of access to the providers of their choice. This was because the model draft states Medicare Select enrollees have a right to cancel coverage at any time and purchase comparable non-PPO coverage from the same insurer without any evidence of insurability. After considerable discussion the task force concluded there was no one solution to this problem. The consensus was that the language as drafted is required in order to preserve a conversion right for individuals not trying to take advantage of the system. They added a sentence limiting the availability of such comparable policies after the Medicare Select policy had been in force six months. **1992 Proc. IB 1091-1092**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 10M (cont.)

An insurance association proposed the addition of a drafting note which would allow the operation of HMOs in all 50 states without application of the regulation. It was repeated that the Health Care Financing Administration believes the NAIC model is applicable to HMOs except for risk and cost contracts. The Medicare Select program is the only vehicle for managed care products to operate in the 15 states selected. OBRA will force HMOs to conduct business only on a risk or cost contract basis or as a Medicare Select issuer in the 15 states. This difficulty was created by OBRA, so the proposal would be contrary to the intent of OBRA. This issue must be resolved by Congress. **1992 Proc. IB 1092**.

At a special plenary session on September 17, 1991, the NAIC adopted a resolution supporting a technical corrections amendment to OBRA 1990 eliminating the 15-state limitation. It was important to advise Congress that the NAIC believed the 15-state limitation was contrary to the best interests of consumers. The result was apparently unintended by Congress. The conference report accompanying the legislation indicated that the Medicare Select Program was intended primarily to authorize preferred provider organizations to offer Medicare supplement policies. However, the statutory language of the federal law arguably covered HMOs as well as PPOs. The NAIC was concerned from the outset about the disruption that will be caused by limiting future HMO participation in this market to 15 states. **1992 Proc. IA 77, 84-85**.

Section 11. Open Enrollment

The requirements of OBRA 1990 included a provision that prohibited underwriting for six months after individuals become eligible for Part B benefits; however a six-month preexisting condition limitation is allowed. **1991 Proc. IB 762**.

One insurer commented that the issue of open enrollment should be clarified in the federal technical corrections bill. He commented that the new requirement would significantly contribute to the cost of the policies. He suggested that the conference report language indicated that the open enrollment requirement only applied to a standard plan as opposed to all prepackaged plans developed by the NAIC. However, it was pointed out that the actual language of the statute takes clear precedence if a conflict arises between the statute and the conference report. **1991 Proc. IB 724**.

A number of provisions in the federal law relating to open enrollment became effective on November 5, 1991. A memorandum from the task force chair detailed these provisions for the states. **1992 Proc. IB 996-996B**.

The task force voiced concern that companies might be engaging in activities designed to discourage an applicant from seeking coverage under the open enrollment provisions. Such practices are contrary to the spirit and intent of the federal law and are prohibited by the model. The task force adopted a bulletin detailing actions by companies which would be considered violations. **1992 Proc. IB 993, 995.**

A drafting note was added at the end of the section when amendments were adopted in 1995. The note was included to clarify the revisions made to the section. One of the changes intended to be accomplished with this revision was to clarify the fact that persons who apply within the three-month period prior to their 65th birthday should be entitled to the open enrollment period. The working group decided to point out to states that they might wish to consider expanding the open enrollment period to persons under the age of 65. The NAIC was prohibited from making changes to the model that were more restrictive than the federal standards, but states could do so. **1995 Proc. 1st Quarter 587.**

B. Subsection B was adopted as a result of the Balanced Budget Act of 1997. That federal law eliminated the ability of insurance companies to impose a preexisting condition exclusion during the six-month open enrollment period. **1997 Proc. 3rd Quarter 1348**.

The working group decided to add a drafting note following Section 11B regarding the Secretary of Health and Human Services specifying the manner of reduction of a preexisting condition exclusion when there was a period of creditable coverage pursuant to HIPAA regulations. **1998 Proc. 1st Quarter 777, 901.**

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 12. Guaranteed Issue for Eligible Persons

This section was added as a result of the Balanced Budget Act of 1997. It represented a real drafting challenge because the federal law was unclear. The members of the drafting group proposed various interpretations of the federal law.The chair said he was in favor of copying the federal legislative language as closely as possible. A staff member responded that copying the federal language into the model regulation may not adequately address the issue of an employer that eliminates some of the benefits offered in the employer's supplemental plan of benefits. **1997 Proc. 4th Quarter 932**.

A. A federal regulator questioned whether there should be more specificity in the regulation regarding "evidence" in Subsection A. She suggested more specificity on the type of document that would be sufficient. Regulators did not believe that would be a problem, based on experience in related matters. One regulator said just having the word "evidence" gave him more leeway for enforcement purposes. **1998 Proc. 1st Quarter 901**.

While the technical changes adopted in 2000 were under development, regulators decided to add a phrase to Paragraph (1), which allowed eligible persons to elect to use their guaranteed issue right upon notice of impending termination of a Medicare+Choice plan. **2000 Proc. 2nd Quarter 272**.

A phrase in Paragraph (1) was deleted from the paragraph explaining the time period in which a beneficiary must exercise his or her guaranteed issue of a Medigap policy. New language was substituted to conform to the federal Benefits Improvement and Protection Act (BIPA). **2001 Proc. 1st Quarter 188**.

B. The working group decided to write Subsection B(2) into four different areas, one for each of the provisions listed. It also decided to follow the federal legislation language as closely as possible. **1997 Proc. 4th Quarter 932-933**.

There was some discussion regarding the situation envisioned by Subsection B(1). There a person was entitled to a guaranteed issue Medicare supplement product if the employer plan ceased to provide all supplemental benefits. It was determined that the subsection applied to employer termination of benefits only, not voluntary termination by the beneficiary. There was also discussion about the scope of the scale back of benefits by the employer. It concerned regulators that employers could selectively cut back on important benefits, and the employee would not have a guaranteed issue Medicare supplement option. It was decided to articulate these concerns in an expansive drafting note following Subsection B(1). **1998 Proc. 1st Quarter 778, 901-902**.

Paragraph (2)(a) was amended as a result of the Balance Budget Refinement Act of 1999. It expanded the class of persons eligible for guaranteed issue of a Medigap policy to include individuals who are 65 years of age or older and enrolled in a Program for All-Inclusive Care for the Elderly (PACE). These persons were eligible for guaranteed issue of Medigap plans A, B, C or F if their enrollment with a PACE provider ceased under circumstances similar to those that provided guaranteed issue rights to beneficiaries enrolled in a Medicare+Choice plan. **2000 Proc. 1st Quarter 322**.

Additional provisions were added to provide a guaranteed issue right to a beneficiary upon notice of termination of certification of a Medicare+Choice plan. The Balance Budget Refinement Act provision allowed beneficiaries to elect to withdraw from a Medicare+Choice plan upon notice of termination of certification and avail themselves of the guaranteed right of issue of specified Medigap plans then, or to wait until the plan's certification is actually terminated. **2000 Proc. 1st Quarter 322**.

The drafters discussed the concept of insurer insolvency, which appears in Paragraph (4)(a)(i). One regulator expressed concern as to when an insurer is considered insolvent. He stated the NAIC models are quite specific as to what constitutes impairment and insolvency. The chair said the real key was that the guaranteed issue of a new policy was only triggered when there was an involuntary termination of coverage. The working group decided to give further consideration to the drafting note following Paragraph (4). **1997 Proc. 4th Quarter 933**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 12B (cont.)

The Balanced Budget Act of 1997 created a guaranteed issue Medicare supplement option where the issuer substantially violated a material provision of the policy. The working group agreed to expand the drafting note following Subsection B(4)(c) to reflect an anticipated regulation by the Secretary of Health and Human Services covering the meaning of that term. **1998 Proc. 1st Quarter 779**.

Language that had been added to Paragraph (2) in 2000 was deleted in the 2001 amendment as a result of amendments to federal law. **2001 Proc. 1st Quarter 188**.

Paragraph (5) was also the subject of amendments in response to the Benefits Improvement and Protection Act of 2000 (BIPA). **2001 Proc. 1st Quarter 188**.

Paragraph (7) was added during the redraft in 2004 in response to the new Medicare Part D provisions in the Medicare Prescription Drug, Improvement and Modernization Act of 2003. **2004 Proc. 3rd Quarter 784.**

C. This subsection was added in 2001 as a result of new requirements in BIPA. **2001 Proc. 1st Quarter 193-194**.

Paragraph (5) was added in 2004 as part of the Medicare Part D revision. **2004 Proc. 3rd Quarter 785.**

D. A new Paragraph D was added pursuant to BIPA, which extended Medigap access for interrupted time periods. The language provided that a beneficiary who was within his 12-month trial period could enroll in another plan if his managed care plan did not renew coverage. **2001 Proc. 1st Quarter 188**.

E. The working group discussed whether Section 1833 plans should also be included as a plan that covered persons should have the option to move in and out of under this provision. The working group decided that the model regulation should reflect the fact that the insured has the right to reenroll with the same insurer and same Medigap plan under which he or she was most recently insured. **1997 Proc. 4th Quarter 933**.

One regulator asked how long an individual had to enroll in the guaranteed issue Medicare supplement product. Another regulator responded that under Section 12A(2), the individual had to apply not later than 63 days after the date of termination of enrollment in the prior plan. **1998 Proc. 1st Quarter 779**.

Extensive changes to Subsection E were included in the redraft resulting from the Medicare Prescription Drug, Improvement and Modernization Act of 2003. **2004 Proc. 3rd Quarter 786.**

F. While drafting this section, the working group recommended adding a provision to clarify the fact that an individual may elect to purchase a Medigap policy offered by any issuer. **1997 Proc. 4th Quarter 933**.

Subsection F was drafted in two parts to address separately situations where disenrollment was voluntary and where it was involuntary. Subsection F(1) described a situation where an individual involuntarily lost coverage, and the plan or employer must notify the beneficiary of certain rights. Under Subsection F(2), which covered the situation where an individual voluntarily ceased enrollment, the issuer of the policy or the administrator of the plan had certain notification duties. **1998 Proc. 1st Quarter 779-780**.

The chair of the working group said state regulators have an obligation to inform their citizens of the various rights that arise in these situations. He requested the addition of a drafting note that encouraged states to make sure their informational packets and educational pieces for Medicare beneficiaries included these rights. **1998 Proc. 1st Quarter 772**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 13. Standards for Claims Payment

The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) required yet another minimum standard which applies to claims which are submitted on behalf of participating physicians. The section originally detailed how to comply with OBRA requirements. **1988 Proc. II 568, 619.**

The revisions adopted in September 1988 included a completely revised section which simply required compliance with OBRA and, in addition, required that such compliance be certified on the Medicare supplement insurance experience reporting form. **1989 Proc. I 831, 836.9.**

The NAIC developed a form to allow reporting so the NAIC could collect information and send it to the Health Care Financing Administration on behalf of the states. **1990 Proc. II 659.**

It was announced at the NAIC meeting in December 1990 that federal regulations had recently been promulgated pursuant to OBRA 1987. The regulations address issues related to Medicare carriers and Medicare supplement insurance companies, regarding electronic transmittal of claims and payment of fees on assigned claims. **1991 Proc. IB 722**.

Section 14. Loss Ratio Standards and Refund or Credit of Premium

A. In 1982 the NAIC began the process of adding a supplemental form to the annual statement for the purpose of monitoring compliance with required loss ratios for Medicare supplement policies. They realized the desirability of a standardized reporting format. **1983 Proc. I 722.**

Medicare supplement expense exhibits were required of all insurers to develop loss ratio and experience information. **1987 Proc. II 728.**

When adopted originally, the loss ratio standards were met if the policies were "expected to return" to policyholders benefits reasonable in relation to the premium charged. In the extensive improvements to the model adopted in 1987, the "expected to return" language was deleted so that loss ratios were to be based on an insurer's actual experience and not anticipated performance. The loss ratio standards were improved to provide enforceable requirements under which Medicare supplement policies would produce loss ratios at least equal to the model loss ratio benchmarks after three years, as well as over the lifetime of the policy. The benchmarks were also enhanced to permit a state to choose either 60 percent or 65 percent for individual policies, but retaining the 75 percent ratio for all group policies. Direct mail groups would meet the same loss ratio requirements as other groups, because the sentence which said direct mail policies would be treated as individual policies was deleted. **1988 Proc. I 652, 673.**

The alternative 60/65 percent loss ratio for individual policies was to provide an option for the states and did not constitute endorsement of 65 percent by the NAIC. The drafting note included emphasized that the states should consider market differences in a given geographical location. **1988 Proc. I 653.**

As part of OBRA 1990, loss ratios on individual Medicare supplement policies were raised to 65 percent. Group loss ratios remained at 75 percent. **1991 Proc. IB 762**.

A question about the applicability of the 65 percent loss ratio standard to all policies issued by direct mail solicitation arose because the federal language provides direct mail solicitors must meet the standards for individual policies. This provision had been eliminated from the NAIC model two years earlier. An immediate question which arose when the drafters began work was whether the NAIC's more stringent provision applied. **1991 Proc. IB 763**.

The task force voted to add a drafting note explaining that states are encouraged to be more stringent than the federal law with respect to treatment of direct mail group policies sold on an individual basis. The federal law in OBRA 1990 applies the lower 65 percent ratio to policies sold by direct mail. Task force members felt strongly that, although this language must be reinserted in the model because of OBRA, states should be encouraged to enforce the higher loss ratio of 75 percent. **1991 Proc. IIB 879**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 14A (cont.)

Working group members discussed whether there was sufficient discretion in the model language to address the concern that rate adjustments would have to be made in years in which the loss ratio was unusually low. A consensus was that the model currently allows enough flexibility to address this. **1989 Proc. I 833.**

Two issues regarding loss ratios needed to be addressed as a result of the changes in the federal law in 1994. First, the minimum expected loss ratio used for pricing these products will be the 1990 federal requirements of 65% and 75%. Pre-1990 policies must meet, for experience after the effective date of a state's adoption of these changes, the higher loss ratio standards. These policies must still demonstrate compliance with the lifetime loss ratio requirements that applied to the policy at the time it was originally issued. **1995 Proc. 1st Quarter 587.**

An insurance association representative questioned the provisions of Paragraph (4)(b). He said that requirement should not be applied on a per policy form basis. He indicated that the requirements of this section would apply to closed blocks of business where many of these blocks may not be credible. A state regulator noted this would have to be reviewed by federal regulators to determine that it complied with the federal standards. **1995 Proc. 1st Quarter 585.**

B. When the Catastrophic Care Act of 1988 was adopted, a subsection was added referring to refunds because it was anticipated many insureds would be entitled to refunds of premiums paid. The subsection provided a mechanism for those payments or credits. The premium adjustment section affected policies for which premiums had already been charged. The only adjustment to be made was downward, i.e. refund or credit. **1989 Proc. I 829.**

Due to the repeal of the Catastrophic Care Act this section was revised again to remove reference to a refund. Language in the regulation on automatic adjustments would take care of increases in premium necessitated by the federal law changes. **1990 Proc. IB 587.**

Language regarding refunds was again added to the regulation when the amendments necessitated by OBRA 1990 were added. **1992 Proc. IA 31**.

The requirements of OBRA 1990 included a provision that refunds must be furnished to individuals if companies do not meet the loss ratio minimum standards. **1991 Proc. IB 762**.

One state regulator asked if the refund provision of the federal law would violate the state anti-rebate laws. Another staffer responded with the opinion that the anti-rebate statutes deal with agent rebates to the consumer as opposed to companies being required to give refunds or credits as a result of not meeting loss ration standards. **1991 Proc. IB 723.**

A request was made to the task force to include a provision regarding a de minimus refund. The task force concurred that this should be pursued. The "policyholder" to whom the refund should be made is defined under OBRA 1990 as each policyholder insured under the applicable policy as of the last day of the year involved. It was suggested that refunds or credits should both be included as alternatives. One person present suggested HCFA attorneys would not consider a premium adjustment sufficient to satisfy OBRA. The task force chair responded that the purpose of refunds was to give consumers their value back so the task force should arrive at an appropriate manner to do this. **1991 Proc. IIB 885**.

Earlier drafts of the loss ratio refund calculation referred to a nationwide calculation. The Health Care Financing Administration did not believe the apportioning of refunds based on a nationwide calculation will comply with OBRA. The task force chair suggested the members consider apportioning the refunds strictly on a statewide basis to satisfy OBRA, indicating, however, that it is possible a technical correction to OBRA could be made to correct this matter. **1991 Proc. IIB 881**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 14B (cont.)

The task force considered a two-fold approach which would involve calculation of the loss ratio experience and determination of refunds on a national basis per benefit package, with a resulting allocation of the OBRA-required refunds on a state basis relative to each state's own benchmarks. HCFA was comfortable with that approach except for the allocating of the experience on a national basis. The task force considered maintaining the methodology but apportioning the refunds on a state by state basis. **1991 Proc. IIB 879**.

One item that needed to be addressed by the task force was whether loss ratios are calculated per benefit plan or whether companies should be allowed to use several policy forms per plan. OBRA 1990 requires examination of experience under each form and calculation of the loss ratios by policy by number. The issue for the task force to consider was whether companies should be allowed to issue more than one policy form per plan. The task force chair asked if a differential could be allowed for group business but not for individual. A staff actuary responded that the small group rating model allows classes of business to be rated differently according to four different characteristics. It was suggested that policy forms could be combined for rating purposes but not for refund calculation purposes. **1991 Proc. IIB 879**.

A conference call of several department actuaries was held to discuss the most workable approach on calculation of loss ratio reporting and refund calculations. The participants concluded that one form per package should be the standard on both individual and group business. Companies should be allowed to write only one policy form per benefit plan and must meet the targeted loss ratio within each benefit plan. Allowing several policy forms within a benefit plan could cause individuals to be steered toward a particular benefit plan. Allowing several classifications within a policy form, such as the NAIC small group model provides, was considered but enforceability of these factors in the Medicare supplement market would be difficult. One task force member expressed concerns over credibility of data on a statewide basis, and the staff actuary responded that some credibility standards were built into the existing methodology. **1991 Proc. IIB 877**.

The issue was raised as to whether there would be separate loss ratio and refund calculations for Medicare Select products, because there is a difference in the Medicare Select and non-Medicare Select forms pricing due to the restricted network providers. The consensus of the task force was to require separate reporting of Medicare Select products for loss ratio and refund calculations. **1991 Proc. IIB 878**.

By the June 1991 meeting the draft had been revised to show statewide rather than nationwide calculation of loss ratios and refunds. An industry representative presented illustrations of the consequences of this change, which he said would undermine the companies' distribution system.

The task force chair indicated that the task force is limited in the approach it designs by the language of OBRA which will not allow a nationwide calculation. Congress in its drafting of OBRA, set forth the loss ratio methodology with such specificity that it restricts the use of the most rational approach. **1991 Proc. IIB 841**.

The task force clarified that earned premiums should be reduced by refunds or credits already paid. **1992 Proc. IB 1089**.

A further amendment was made to Subsection B to implement the requirements of the federal law changes of 1994. Paragraph (3) and the drafting note were added without specific discussion. **1995 Proc. 1st Quarter 605.**

C. In the fall of 1990 the NAIC began consideration of alternatives to the existing loss ratio standards. The NAIC had compiled information on loss ratios and it was decided an examiner team would review this information to assist the states in examining the results before amendments to the regulation were recommended. **1991 Proc. IB 769**.

D. This subsection was added to satisfy OBRA 1990. It allows the commissioner to hold a public hearing on any rate filing for a policy which did not comply with the loss ratio standards in the previous reporting period. This approach was preferred over an alternative approach that allowed a hearing in any case in which the rate increase exceeded 25%. It would be more fruitful to hold a hearing on a rate increase if the company had not met the loss ratio on that particular policy. **1991 Proc. IIB 885**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 15. Filing and Approval of Policies and Certificates and Premium Rates

A. One of the changes to the model act adopted in December of 1987 was to apply the Medicare supplement standards to out-of-state group policies and to provide filing requirements for those policies within 30 days after use. **1988 Proc. I 652.** That section was eliminated in the extensive revisions adopted in July 1991 in favor of general filing requirements. **1992 Proc. IA 32**.

B. Subsection B was added during the redraft in 2004. **2004 Proc. 3rd Quarter 792.**

C. The task force incorporated the OBRA 1990 requirement that states adopt a procedure for approval of rates. Although prior approval is not necessary under the legislation, a "policy" for rate approval was added to the revised model. **1991 Proc. IIB 917**.

The recommendations adopted by the task force were summarized as follows: (1) Only one policy form per benefit package would be allowed. (However, one form for individual business and another for group business, if the company writes group business, is allowed); (2) A restriction would be imposed on companies that close off a policy form. Companies could not reopen that policy form for a five-year period; (3) Loss ratio calculations will be based on a benefit plan basis, i.e., one policy form for group and one policy form for individual. The task force concluded it was better to pursue these recommendations than to attempt insertion of language into a federal technical corrections bill requiring a nationwide approach to loss ratio calculations. **1991 Proc. IIB 878**.

D. In June of 1991 the task force considered a proposal to address the concerns raised with respect to restricting the number of policy forms that can exist within each standardized Medicare supplement benefit plan. One of the task force's concerns was to address the assessment spiral that results or is caused by companies that close blocks of business. The industry suggestion was to add the following language: "For purposes of completing the reporting form required by Section B of the model regulation, all policy forms of each type for each standard Medicare supplement benefit plan must be combined in the determination of tolerance values." The task force chair stated that he did not believe this addressed the abuses identified. He thought a reasonable compromise might be to acknowledge that different marketing structures may be entitled to different rating schedules. He also stated the he, at the outset of the discussion many months ago, never believed that there would be more than one form allowed per benefit plan. There was further discussion on whether the task force's proposal to limit the number of benefit forms would assist consumers' ability to comparison shop. The task force chair indicated an intention to fashion a proposal that would limit the abuses but contain enough flexibility to accommodate different marketing and rating methods currently allowed. **1991 Proc. IIB 842**.

A new section was added to the model requiring filing policy and certificate forms, prohibiting using or changing rates unless they are filed with the commissioner, and outlining how many forms are allowed within each benefit plan. This section is required because OBRA 1990 requires approval or disapproval of rates. A maximum of five benefit forms per benefit plan is allowed. The minutes of the task force reflected that waiving preexisting condition limitations is not prohibited by this section. **1992 Proc. IB 1089**.

G. In 1995 the NAIC looked at the appropriateness of attained age rating in Medicare supplement policies. One regulator said that his state had passed a bill prohibiting the use of attained age rating if 50 percent of the policy sales are to persons age 65. He said one of the difficulties is whether this rating structure can be disclosed in such a manner that consumers understand it. The regulator indicated attained age rating was generally less expensive in the first three years, but by the end of a six-year period, the person had cumulatively paid more premiums than he would have under an issue age structure. He suggested that, if states allowed attained age rating, they should consider prohibiting the banding of those rates and reduce the increase that occurs in incremented rating bands, such as for five years. **1995 Proc. 3rd Quarter 802**.

A representative from an insurance association said there was relatively small differences between the two rating structures and encouraged regulators to allow both to facilitate consumer choice. The working group chair said the regulators had four options: (1) leave the model as it is; (2) prohibit attained age rating; (3) prohibit the use of five-year step rating; or (4) enhance the disclosure requirements of the model. **1995 Proc. 3rd Quarter 802-803**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 15G

After a review of draft language, the working group decided not to recommend a prohibition of attained age rating, but rather to provide the states with options. The language drafted gives states two regulatory responses to attained age rating: (1) outright prohibition of its use; or (2) a regulatory response to "bracket jump." **1995 Proc. 4th Quarter 891-892**.

A drafting note was added at the end of Section 15 to encourage regulators to consider the need for form filings when the only changes were the yearly revisions to coinsurance and deductibles. **2004 Proc. 3rd Quarter 794.**

Section 16. Permitted Compensation Arrangements

In 1987 the NAIC began to address a problem which had been identified regarding "churning" of Medicare supplement policies. In a new section adopted then, the insurer was prohibited from paying first-year commissions more than once if it replaced the policy of an existing policyholder with a new policy with similar benefits. **1988 Proc. I 653, 673.**

The consumer protection amendments of 1989 included provisions on agents' commissions. The task force considered many approaches to the problem of policies being replaced irregardless of the needs of the consumer. They considered level commissions, level commissions for two or three years, and unlimited first year commissions and level commissions thereafter; as well as other suggestions to reduce incentives to replace existing policies. **1990 Proc. IB 656.**

Salaried individuals were not intended to be included in the section. It was decided no change in language was necessary. **1990 Proc. IB 608.**

A representative from an insurance organization requested that the task force eliminate this whole section of the draft being considered. He said it was harsh for conscientious, qualified agents. His organization would advocate a replacement form instead of a section limiting agent compensation. **1990 Proc. IB 613.**

When Congress was considering adoption of OBRA 1990, one amendment considered by the federal regulators would have eliminated the limitations on agent commissions. The NAIC strongly opposed the amendment and it was not part of the bill adopted. **1991 Proc. IB 763**.

In the final adopted version of OBRA 1990, no mention was made of agent commission limitations. That means that the NAIC language is still in effect. However, the conference report suggests that the NAIC should remove the exception in the agent compensation exception which allows a first year commission for policies that provide clearly and substantially greater benefits. **1991 Proc. IB 724**.

B. As originally drafted, the section would have required companies to pay second year commissions for the lifetime of the policy. An industry representative commented that companies traditionally discontinue paying commissions after five or ten years. The draft was amended to require level renewal commissions for a reasonable number of years. **1990 Proc. IB 575.**

When redrafting the model to conform with OBRA 1990, several task force members requested that the reasonable number of years called for in the agents compensation section be defined. The task force chair agreed and stated that defining the number of years that is reasonable for renewals would assist states. The task force agreed that five years was reasonable; that is, the first year plus five years renewal commissions. This conclusion was reached based upon a review of the existing compensation limitation and reflects the experience of several states. **1991 Proc. IIB 891**.

C. When discussing commission structure, one member of the task force suggested it may be unfair to penalize agents by restricting them to renewal commissions if the coverage is substantially more beneficial to the policyholder than the replacement coverage. If an individual wanted to, upgrade coverage the coverage would have to be clearly and substantially more beneficial to the individual in order for the agent to receive first-year commissions on that replacement. However, it was noted that more benefits are not necessarily better. **1990 Proc. IB 607.**

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 16C (cont.)

One commissioner expressed a concern that allowing first year commissions on replacement business only where the benefits of the replacement policy as clearly and substantially greater might lead agents to overinsure. The alternative, however, is to restrict all replacements to renewal commissions. The NAIC should establish a requirement that a company develop audible procedures for determining whether the replacement benefits are clearly and substantially greater for the purpose of determining whether first year commissions are to be awarded. Some spoke out against an NAIC position that created a built-in incentive for Cadillac policies. More coverage is not necessarily better. Alternatives were suggested but did not receive enough votes to be included in the draft. **1990 Proc. IB 611.**

The task force decided to add a drafting note following Subsection C when model language allowed first year commissions if the replacement policy contains benefits "clearly and substantially" greater. The task force members agreed the language should be deleted but OBRA 1991 did not authorized the NAIC to make changes beyond the contemplation of the federal law. The task force agreed to alert states to the fact this language could be eliminated by the states. They were comfortable with the rationale that first year commissions are not appropriate on any sale in the new standardized market. One regulator commented that it may be difficult for states to accomplish this revision if the NAIC does not make the revision in the model. The task force chair agreed, stating it was unfortunate that the NAIC does not have the authority to make this change. **1992 Proc. IB 1084-1085**.

The language that caused regulators discomfort was deleted when the model was revised in 1995. Since the drafting note was no longer needed, it was also deleted. **1995 Proc. 1st Quarter 607**.

D. The task force considered adding a drafting note to this subsection which would clarify the intent of Section 15 with respect to payment of commission to MGAs. The proposal was voted down because many members were of the opinion that the note was unnecessary and might actually assist general agents in churning business. If a general agent is getting an override and this comes directly off the top of the premium, this activity could not be other than related to the sale of a product. **1990 Proc. IB 608.**

Section 17. Required Disclosure Provisions

A. Revisions were made to Paragraph 6 when the model was amended in 1995. The proper title for the buyer's guide was inserted and the words "by reason of age" were deleted after "persons eligible for Medicare." The amendment was made as a result of the requirements for disclosure of policies that duplicate Medicare being applicable to all Medicare eligible persons, regardless of their age. The working group felt that deleting "by reason of age" from this section met the intent of the federal law. An insurance representative stated this change would be very difficult for direct mail issuers as they would essentially be issuing the Guide to Health Insurance for People with Medicare to all applicants. A regulator responded that this was not necessary. **1995 Proc. 1st Quarter 587**.

Several insurers met to discuss the revisions to this section and voiced concern on the part of direct marketers. Their spokesperson said that, in order to comply with the requirements of Section 16A, companies would need to ask about Medicare eligibility in the application. He said many companies may discontinue writing the coverage that is currently issued on a guaranteed issue basis because of this requirement. A regulator responded that asking the question was not an undue regulatory burden. The spokesperson responded that this might encourage companies to underwrite or otherwise risk classify those persons who are eligible for Medicare due to disability. He said it was the industry's opinion that this change in the model went beyond the charge of the working group. The working group was not persuaded by this argument and voted to retain the changes as drafted. **1995 Proc. 1st Quarter 586.**

Subparagraph (b) was added as part of the amendments of 1995 to make clear that the form used for the Guide to Health Insurance for People with Medicare should be presented in the same language, format, type size, etc. as prepared by the NAIC and HCFA. **1995 Proc. 1st Quarter 608.**

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 17 (cont.)

C. This provision was added as part of the redraft in 2004. **2004 Proc. 3rd Quarter 797.**

D. For several years the model contained charts as an appendix to indicate changes in Medicare coverage and the coverage provided by a supplement. **1989 Proc. I 813, 836.20-836.26**. Upon adoption of OBRA 1990 the charts were redesigned to illustrate the variations between policies and made part of Subsection D of this section. **1992 Proc. IA 36**.

The outline of coverage was substantially revised when the model was redrafted in response to OBRA 1990. The issues included the manner of presentation and whether companies should be required to insert "no coverage" for each benefit that was not covered under a plan. It was suggested that the columns illustrating what Medicare pays and what the Medicare supplement policy pays be placed into one column for simplicity. However the consensus of the task force was that this method would not facilitate comparison among policies which was the purpose of the outline of coverage. **1991 Proc. IIB 884**.

One industry representative expressed concern over the requirement that the cover page to the outline of coverage illustrate all ten plans. He indicated that this placed direct response companies at a disadvantage. **1991 Proc IIB 842**.

The task force agreed to adopt a cover page containing word descriptions instead of Xs. They agreed to require the cover page to be printed in 12 point type even if it meant the page must be larger than 8.5 x 11 inches. A suggestion that each plan be labeled in the upper right hand corner to reflect the difference in marketing methods of the policy was rejected. **1992 Proc. IB 1092**.

The task force chair asked the group to consider the following issue: "Does a state that adopts fewer than ten standard Medicare supplement insurance benefit plans need to require all ten of these plans in the outline of coverage?" One state asked that the task force go on record as favoring the ability of the states not to show on the cover sheet, which is part of the outline coverage, the plans that are not available in the state. The task force considered the importance of minimizing consumer confessions. The group voted to be flexible on this point, given the direction in OBRA that states can authorize fewer than ten plans. **1992 Proc. IB 992-993.**

The working group reviewed the outline of coverage charts for Medicare supplement insurance. A regulator recommended that the high deductible plan changes reflect the fact that the $1,500 annual deductible does not apply to each covered service. The group decided to review the charts to make sure the changes in covered benefits under Medicare were incorporated into the charts. **1997 Proc. 4th Quarter 933**.

The task force reviewing a revised model in response to the Balanced Budget Act of 1997 discussed the chart that appears after Subsection D, which is the outline of coverage. The chair stated that when the chart was originally developed, it was meant to show all plans available, no matter what a company sold. After much discussion about present company practice, it was determined that at the top of the chart the line "Benefit Plans_____ [insert letters of plans being offered]" should be placed within a box to draw attention to it. Also the task force decided to split the heading for plans F and J to show the high deductible plans that were available. **1998 Proc. 1st Quarter 782**.

A note was added to each chart to clarify that the provider must accept the issuer's payment as payment in full and may not bill the insured for any balance. The insurer would be liable only for payment of the Medicare-approved amount. **1998 Proc. 3rd Quarter 700**.

Technical corrections to the model were identified in 1999, and staff was asked to compile these in a draft for regulator review. **1999 Proc. 1st Quarter 608**.

One technical change was to insert brackets around reference to the annual deductible amount for high deductible plans F and J in order to allow the NAIC to automatically change this dollar amount annually pursuant to any increase made by the Secretary of the U.S. Department of Health and Human Services. **2000 Proc. 2nd Quarter 272**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 17D (cont.)

After passage of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, changes to the charts were required. Discussion by the task force centered around how to incorporate the two new benefit plans K and L into the existing chart. Concern was expressed about the appropriateness of having the two new plans added to the current chart at all given the fundamental lack of similarity between them and the traditional standard plans. A consumer advocate said that the chart plays an important part in helping consumers select a Medigap plan suitable to their needs in an informed manner. Interested parties suggested that the chart include the two new plans, but employ a "break" in space between the ten original standard plans and the two new ones in order to facilitate differentiation among the summaries. **2004 Proc. 1st Quarter 548.**

It became apparent to the task force that amendments in the format of the outlines of coverage would likely be necessary and were likely to carry over to the outlines of the ten standardized plans. This prospect was raised over discussion of how to properly characterize Medicare Part B excess charges, meaning those provider charges that were above the Medicare-approved amount, and therefore would not be paid for by the plans. Interested parties expressed concern that the explanations and the order of their mention in the outline needed clarification, especially in light of the addition of plans K and L, which referred to out-of-pocket expenditure limits. **2004 Proc. 1st Quarter 548.**

E. Just before adoption the committee chair proposed an amendment which excluded risk contracts from the notice requirements of Section 17E. **1990 Proc. IB 574.**

The federal law revisions of 1994 necessitated changes to this subsection. Several specific types of policies referenced were deleted, reference to Section 1833 polices was deleted, and the reference to "by reason of age" was removed. In addition a Paragraph (2) was added requiring the disclosure statements adopted as Appendix C when the polices described in Paragraph (1) are being offered to persons eligible for Medicare. **1995 Proc. 1st Quarter 609**.

Section 18. Requirements for Application Forms and Replacement Coverage

The task force was asked to consider expanding the application and replacement forms section to require a comparison form. The form would identify the present coverage versus the proposed coverage and would also assist in determining whether the replacement is substantially more beneficial to the policyholder than the existing coverage. **1990 Proc. IB 613.**

A. The 1989 amendments included the addition of questions to ascertain whether a person had another Medicare supplement policy and whether he is covered by Medicaid. One industry spokesperson suggested asking whether a person *receives* Medicaid is better than asking if he is *covered*. An earlier draft had asked if a person was *eligible*, and it was changed to covered because that is more easily ascertainable than whether a person is eligible. The language was not ambiguous and did not impose an additional burden on agents to determine if the person is eligible. **1990 Proc. IB 575.**

Due to the changes in the model being considered in 1991, it was recommended that additional questions be added to the application form and several statements were added also. **1991 Proc. IIB 842, 871-872**.

As part of the 1995 amendments the drafters added questions concerning a qualified Medicare beneficiary (QMB) and specified low-income Medicare beneficiary (SLMB). The federal agency charged to interpret the federal law interpreted the federal law to make it permissible for a company to sell the standardized benefit packages to those who are QMB eligible. **1995 Proc. 1st Quarter 587.**

A small group of drafters met to recommend appropriate revisions to the model to address the modifications in the federal law in regard to the sale of polices to certain Medicaid eligibles and in particular to QMB. The drafters recommended that the model be revised to require applications to include questions as to the eligibility for medical assistance under a state Medicaid program, QMB or SLMB. **1995 Proc. 1st Quarter 585.**

An association representative did not think there was a need for a question relative to other insurance that the applicant may have. The chair responded that this question would deal with the suitability of Medicare supplement insurance, and noted that companies are required to assure that excessive or inadequate coverage is not sold. A consumer representative said it was a

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 18A (cont.)

beneficial crosscheck for current coverage. A regulator suggested changing a reference to "duplicating" Medicare. She was concerned that this might discourage people with a limited plan from purchasing Medicare supplement insurance. **1995 Proc. 1st Quarter 585**.

When drafting amendments in response to the Medicare Prescription Drug, Improvement and Modernizatin Act of 2003 (MMA), the drafters discussed the proper form and content of the questions included in Section 18A. The Centers for Medicare and Medicaid Services (CMS) proposed a longer, more detailed set of questions than those that had been included in Section 18. Interested parties offered a set of revised questions that were more thorough than those currently in the model regulation, but less comprehensive than the questions presented by CMS. Ultimately, the task force opted to combine elements of the two suggestions with those already in the model. **2004 Proc. 2nd Quarter 524.**

E. A federal regulator suggested the replacement form was no longer accurate, given the changes to the federal requirements. A state insurance regulator questioned what changes in the federal law would impact replacement of one Medicare supplement policy with another Medicare supplement policy. **1995 Proc. 1st Quarter 587.**

Section 19. Filing Requirements for Advertising

Just before adoption of the model, drafters changed references to insurers or other entities providing coverage to "issuers." Thus the requirements of this section which had previously applied to insurers, health care service plans, or other entities issuing Medicare supplement insurance could not simply refer to "issuers." **1992 Proc. IA 68**.

Section 20. Standards for Marketing

This section was added as part of the consumer protection amendments of 1989. The task force had decided the model needed to be strengthened in its regulatory response to market abuses. The working group identified the following areas to be addressed: complaints tracking, twisting, duplicate policies, standardization of benefits, and guaranteed renewability. **1989 Proc. II 523.**

A. The "Notice to Buyer" in Paragraph (3) was required in the application in earlier drafts, but industry comments suggested it would be burdensome and unnecessary, especially for direct response companies. The task force voted to require the information in the outline of coverage and the policy. **1990 Proc. IB 611.**

It was decided to establish a requirement that a company develop auditable procedures for determining whether replacement benefits are clearly and substantially greater for the purpose of determining whether first year commissions were to be awarded. **1990 Proc. IB 611.**

When the requirements for first year commissions if the benefits "were clearly and substantially greater" were deleted from Section 16C in 1995, a requirement that had been part of Subsection A was also deleted. It required a formula to determine if a benefit was substantially greater than that of an earlier policy. **1995 Proc. 1st Quarter 611.**

Section 21. Appropriateness of Recommended Purchase and Excessive Insurance

This section was also part of the consumer protection amendments adopted in December 1989. The task force minutes indicate the members of the group intended that it should be clear that the sale of more than one Medicare supplement policy is prohibited, but that an additional Medicare supplement policy could be sold if that sale, when combined with the individual's health insurance coverage already in force, would insure no more than 100 percent of the actual expenses covered under the combined policies. **1990 Proc. IB 574.**

The federal provisions tightened the non-duplication provisions of the model by prohibiting any duplication whatsoever. Insurers and agents failing to comply with the new law would be subject to civil money penalties. **1991 Proc. IB 726-727**.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 21 (cont.)

When drafting OBRA amendments the language was removed which allowed health coverage other than Medicare supplement coverage if it insured no more than 100 percent of the individual's actual medical expenses. The task force considered adding a new subsection specifically prohibiting Medicare supplement coverage that duplicates any other health insurance coverage. The task force agreed that this was a restrictive reading of OBRA, and unanimously concurred that it should not be included. **1992 Proc. IB 1086**.

C. Subsection C was added during the redrafting effort in 2004. **2004 Proc. 3rd Quarter 845.**

Section 22. Reporting of Multiple Policies

This requirement was part of the consumer protection amendments adopted in 1989. **1990 Proc. IB 597.**

A form was designed to use for the reporting required in this section. (It is Appendix B to the regulation.) **1990 Proc. II 657.**

Section 23. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates

This section is part of the consumer protection amendments adopted in 1989. When originally drafted this provision only applied to preexisting condition limitations on policies issued by the same or an affiliated insurer. **1990 Proc. IB 641.** The task force considered a proposal that preexisting conditions be prohibited on replacement business of all companies. Industry speakers spoke against the proposal, saying it would be difficult to enforce and would add incentive to anti-selection. The task force voted to extend the preexisting condition prohibition proposal to replacement with all companies. **1990 Proc. IB 609.**

When drafting amendments to this section in response to OBRA 1990, the task force considered whether the existing language (current Subsection A) should be clarified. The primary issue was whether the NAIC language means there can be no preexisting condition in a replacement policy if the individual has had a policy in force for six months or longer and replaces it. Health Care Financing Administration interpreted the language to mean that even if an individual had a policy in force for six months or longer, the replacing policy may require the individual to satisfy a preexisting condition waiting period to the extent he developed a health condition during the six-month period prior to the effective date of the replacement policy. The task force concurred that they did not agree with HCFA's interpretation. The sections of OBRA 1990 which address the issue of prohibition on new waiting periods essentially pick up the model language. In addition Congress applied the requirement to state the replacing policy may not provide *any* time period applicable to waiting periods in a new policy if the old policy had been in effect for six months or longer. The language of OBRA 1990 is consistent with the NAIC model but not with HCFA's interpretation. **1991 Proc. IIB 914-916**.

B. The language of OBRA 1990 to clarify the preexisting condition limitations was added to the model as a new subsection. **1992 Proc. I 69**.

One interpretation advanced for the meaning of Section 23 was that preexisting condition limitations could apply only to benefits that were not "similar benefits" to the replacing policy. For example, if the replacement policy offered nursing home coverage, and the original policy did not, the replacement policy could include a six-month preexisting exclusion for nursing home benefits. The task force agreed that this was not the interpretation they wanted and decided to eliminate the words "similar benefits" from the NAIC model. **1991 Proc. IIB 914-915**.

Later the task force decided they could not make that change, and adopted a drafting note suggesting states change the language upon adoption. **1992 Proc. IA 69.**

Section 24. Separability

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Section 25. Effective Date

It was suggested that a drafting note explain when states should implement the revisions to the model act and model regulation necessitated by OBRA 1990 rather than inserting a definite date into the model. One drafter clarified that the definite date is drafted so that states can select their own. **1991 Proc. IIB 909**.

Appendix A

A number of actuaries were involved in preparation of a series of worksheets that could be used for calculation of loss ratio experience to produce a comparison of the loss ratio over the lifetime of the policy. They chose 15 years of computations that would produce a standard that would achieve the benchmark without imposing a level lifetime premium. One actuary commented that this approach actually sets the loss ratio standard above 65%. A staff actuary responded that policies will not have experience in the first calendar year so this concern is addressed. Refunds would start at the end of the second calendar year. The worksheet is solely for weighing the cumulative loss ratio. The factors in column C of the worksheet take the premium earned times a factor which indicates where the company should be in terms of meeting the lifetime standard. **1991 Proc. IIB 885**.

One actuary asked whether the burden could not be just placed on the companies to make loss ratio calculations. A staff actuary explained that if that approach were taken every package submitted by every company would have to be evaluated by the regulator. The intent of the worksheet was that it would be used for each standardized benefit plan. If a company offers ten benefit plans there would be ten different loss ratio filings. **1991 Proc. IIB 885**.

A few changes were made to the calculation forms in response to federal law revisions made in 1994. **1995 Proc. 1st Quarter 613-615.**

Appendix B

This form was added in 1990 to fulfill the reporting requirements of Section 21. **1990 Proc. II 657**.

Appendix C

One of the provisions of the Social Security Act Amendments of 1994 was a requirement that the NAIC develop disclosure language to appear on policies that duplicate Medicare. The working group responsible for drafting a disclosure form began by holding a hearing to solicit input from consumers and insurance industry representatives. The group began with two possible approaches. One was a very simple statement that advised the consumer that the policy duplicated Medicare and the company could complete a block advising to what extent the policy duplicated Medicare. The other approach utilized a short summary of Medicare benefits and required the company to indicate next to the Medicare benefit whether the policy duplicated that benefit. **1994 Proc. 4th Quarter 713, 725.**

The working group reviewed the instructions for the disclosure statements. Instruction 3 was clarified to indicate that replacement of Medicare supplement policies is not prohibited. The working group reworded to remove the implication that life insurance was covered by the federal provisions. A representative of a federal agency said the applicability should be as broad as possible because if a policy is not included in the disclosure language it may not be sold and is subject to federal penalties. **1994 Proc. 4th Quarter 726.**

The working group added instruction 1 to the page at its second meeting to clarify the requirements of the federal law. A federal agency representative suggested adding "…knowingly sells an insurance policy …" but the working group did not think it was necessary to repeat the federal law. **1994 Proc. 4th Quarter 726.**

One regulator stated that consumers would not read a lengthy statement and suggested a bold statement at the top that advised the consumer that the policy duplicated Medicare. Another said that Section 16 of the model regulation required most limited benefit policies to include a statement indicating the policy was not a Medicare supplement policy and suggested adding this requirement to the disclosure statements. **1994 Proc. 4th Quarter 725.**

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations
All references are to the Proceedings of the NAIC

Appendix C (cont.)

An industry association spokesperson said calling a long-term care insurance policy a limited benefit plan may be misleading. Another association representative said comments received by the working group and testimony presented during the public hearing indicated an overwhelming desire to allow a coordination of benefits procedure in long-term care insurance policies. A regulator responded that the federal law clearly said that the policy must pay benefits without regard to other benefits to which a person is entitled. **1994 Proc. 4th Quarter 725-726.**

The federal law allowed separate statements for different types of policies. The working group was not sure it would have time for such a massive effort in the 90-day time period allowed in the federal law. One insurer representative said he thought this was an especially important issue for long-term care policies. He said the industry had spent a number of years educating consumers that the Medicare program does not pay for long-term care services and the current draft appears to contradict this effort. **1994 Proc. 4th Quarter 726-727.**

At the working group's next meeting, it decided to remove the charts to fill in where the policy duplicates Medicare and replace them with a clear and concise statement describing the extent to which the policy duplicates Medicare. One regulator suggested that the title of the disclosure statement be contained in a box and another suggested the title be a simple statement such as "Medicare Duplication Notice." A federal regulator suggested adding the words "to persons eligible for Medicare" to deal with persons who may receive notice but are not eligible for Medicare. **1995 Proc. 1st Quarter 617.**

The working group spent some time discussing the meaning of duplication and how to determine what does or does not duplicate Medicare. There was strong sentiment in the insurance industry that policies that coordinate benefits with Medicare are not duplicative. Research indicated the more likely correct interpretation of the federal law was that polices sold to Medicare beneficiaries had to pay benefits without regard to other benefits the individual has. The task force considering adoption pointed out there was not time to seek clarification of the federal law before adoption; but decided to include in the transmittal document to the Secretary of Health and Human Services a reference to the impact on long-term care insurance of prohibiting coordination of benefits in long-term care policies. **1995 Proc. 1st Quarter 616.**

The federal Balanced Budget Act of 1997 (BBA) had four major provisions that impacted Medicare supplement insurance. The first of these was anti-duplication and disclosure. Amendments were needed to address the changes required by the BBA, and at the same time the disclosure statements were amended because it became clear that long-term care insurance policies were not considered policies that duplicate health insurance, and would be allowed to coordinate with health insurance policies, including Medicare supplement policies. Amendments to the model disclosures reflected the fact that insurance companies could use either the disclosure statements adopted in 1995 or new disclosure statements created by the health Insurance Portability and Accountability Act of 1996. **1997 Proc. 3rd Quarter 1347-1348**.

When the Executive Committee discussed the adoption of the revised model, one commissioner suggested the disclosure statements could be laid out in a better fashion. She suggested deletion of some unnecessary pages and also suggested underlining the second set of disclosure statements to clarify that they were entirely new language. In addition she suggested that language be added at the top of each disclosure statement to clarify that it is either an "original disclosure statement" or an "alternative disclosure statement." The Executive Committee adopted the model with these suggestions. **1998 Proc. 2nd Quarter I 5, 48**.

Chronological Summary of Actions

June 1979: Provisions added to the Accident and Health Insurance Minimum Standards Model Regulation to provide for regulation of Medicare supplement insurance.
June 1980: Adopted "free-standing" Medicare supplement insurance model standards.
December 1980: Added definitions and language on guaranteed renewable policies. Added section on loss ratio standards.
December 1987: Made regulation apply to employee groups. Based loss ratios on actual rather than anticipated performance. Added filing requirement for out-of-state policies. Prohibited compensation greater than renewal commissions on replacement policies with the same company. Free look period made a uniform 30 days.

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations

All references are to the Proceedings of the NAIC

Chronological Summary of Actions (cont.)

June 1988: Added section on claims payment to implement requirements of the Omnibus Budget Reconciliation Act of 1987 (OBRA) regarding information to be reported to the Secretary of Health and Human Services.
September 1988: Removed employer groups from purview of regulation. Model revised to meet the requirements of federal Catastrophic Care Act of 1988. Included notice requirements to tell consumers about Medicare changes and sample notice forms for each year of change. Added section on filing of advertising.
December 1988: Amended appendices to include new and/or corrected information available.
December 1989: Revised model to reflect repeal of Catastrophic Care Act of 1988. Adopted consumer protection amendments which prohibit sales of policies which would result in overinsurance, limit agents' commissions, and impose new requirements upon cancellation or nonrenewal of group policy.
June 1990: Added reporting form as Appendix B.
July 1991: Adopted ten standard policy forms in response to OBRA 1990. Extensive revisions of all parts of the model, most notably the specifications for ten standard policies and improved loss ratio calculation.
March 1995: Added Appendix C and revised model to comply with federal law changes adopted in 1994.
March 1996: Added two options for Section 15F on attained age rating.
April 1998: Revised model to add two high deductible plans. Revised disclosure forms in Appendix C. Added Section 12 (guaranteed issue) and revised open enrollment provisions. These changes were required as a result of the Balanced Budget Act of 1997.
December 1998: Amended Section 8 and the Outline of Coverage to clarify that balance billing is not appropriate after the exhaustion of the hospital reserve days.
September 2000: Made technical corrections to various parts of the model.
October 2001: Adopted amendments to comply with the federal Benefits Improvement and Protection Act of 2000 (BIPA).
September 2004: Adopted amendments to comply with the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

MODEL REGULATION TO IMPLEMENT THE NAIC MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

Proceeding Citations

All references are to the Proceedings of the NAIC

This page is intentionally left blank