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B U L L E T I N NO. 90-1

SPECIAL NOTICE TO: MEDICARE SUPPLEMENTAL INSURERS IN THE STATE OF IDAHO

FROM: ANTHONY J. FAGIANO, DIRECTOR
DEPARTMENT OF INSURANCE

SUBJECT: MEDICARE SUPPLEMENTAL INSURANCE POLICIES: MEDICARE CATASTROPHIC REPEAL ACT OF 1989

DATE: JANUARY 9, 1990

The Catastrophic Repeal Act's effect on Medicare beneficiaries is to return Medicare benefits and the Medicare Part B monthly premium to what they would have been without passage of the 1988 Catastrophic Act.

On December 7, 1989, the National Association of Insurance Commissioners (NAIC) adopted and approved a revised model act and revised model regulation in conformance with the Medicare Catastrophic Repeal Act of 1989. The states have one year from the date the NAIC approved its revised models to adopt standards at least as stringent as those contained in the NAIC's revised models. The Department of Insurance is currently preparing proposed legislation and a regulation which would be in conformance to the standards enunciated in the NAIC's revised models. Prior to Idaho's adoption of the appropriate standards in conformance to the changes provided in the Medicare Catastrophic Repeal Act of 1989, the Department of Insurance would request that all Medicare supplemental insurers adopt and conduct their business in conformance with the NAIC approved transition rule, which, is as follows:

1. Definitions

For purposes of this transitional rule:

a. "Applicant" means:

i. In the case of an individual Medicare supplement policy or contract, the person who seeks to contract for insurance benefits, and

ii. In the case of a group Medicare supplement policy or contract, the proposed certificateholder.

b. "Certificate" means any certificate issued under a group Medicare supplement policy.

c. "Medicare Supplement Policy" or "Policy" means a group, blanket or individual policy of disability insurance or a subscriber contract or hospital and medical service associations or health maintenance organizations which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. Such term does not include:

i. A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organization, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations, or

ii. A policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

has been maintained in good faith for purposes other than obtaining insurance; and

has been in existence for at least two (2) years prior to the date of its initial offering of such policy or plan to its members.

iii. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this rule.

2. Benefit Conversion Requirements

a. Effective January 1, 1990, no Medicare supplement insurance policy, contract or certificate in force in this

State shall contain benefits which duplicate benefits provided by Medicare.

b. Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

c. For Medicare supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be:

i. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

ii. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

iii. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

v. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B.

Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$75].

Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

3. General Requirements

a. No later than January 31, 1990, every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this State shall notify its policyholders, contract holders and certificateholders of modifications it has made to Medicare supplement insurance policies or contracts. Such notice should include the following:

i. Such notice shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy or contract.

The notice shall inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be effective.

The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

Such notice shall not contain or be accompanied by any solicitation.

b. No modifications to an existing Medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this rule except to the extent necessary to accomplish the purposes articulated in Section 2 of this rule.

4. Form and Rate Filing Requirements

a. As soon as practicable but no longer than forty-five (45) days after the effective date of the Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this State should file with the Department, in accordance with the applicable filing procedures of this State.

i. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

ii. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare and to provide the benefits required by Section 2. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

b. Upon satisfying the filing requirements of this State, every insurer, health care service plan or other entity providing Medicare supplement insurance in this State shall provide each covered person with any rider, endorsement or policy form necessary to make the adjustments outlined in Section 2 above.

c. Any premium adjustments shall produce an expected loss ratio under such policy or contract as will conform with minimum loss ratio standards for Medicare supplement policies and shall result in an expected loss ratio at least as great as that originally anticipated by the insurer, health care service plan or other entity for such Medicare supplement insurance policies or contracts. Premium adjustments may be calculated for the period commencing with Medicare benefit changes.

Accelerated Policy Adjustment Procedures

Require that such filing made pursuant to State laws and rules be accompanied by the certification of an officer of the filing entity that the filing complies with all the requirements of the Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of the Medicare Catastrophic Coverage Act (transition rule), and that any portion of the filing found by the Director not to comply with any requirement of the transition rule should be modified by the filing entity when notified by the Director of the failure to comply with the transition rule. The filing entity should further certify that any such modification requested by the Director will be made effective as of the effective implementation date of the filing to which the original certification applies and that the entity will promptly notify affected insureds of the modification.

Upon receipt of a Medicare supplement insurance filing made solely for the purpose of implementing adjustments to Medicare supplement insurance necessary to provide a transition of benefits and premiums to conform to repeal of the Medicare Catastrophic Act and to the requirements

of this transition rule, the Director deems approved for immediate use such filed adjustments as comply with all requirements of the transition rule.

(3) Upon completion of review of the filings received pursuant to these accelerated policy adjustment procedures and after the State of Idaho has adopted by statute and regulation the minimum standards enunciated by the NAIC, the Director shall order such modifications as are necessary to bring the filing into compliance with the statute and regulation adopted by the State of Idaho.

5. Offer of Reinstitution of Coverage

a. Except as provided in Subsection b., in the case of an individual who had in effect, as of December 31, 1988, a Medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificateholder) and the individual terminated coverage under such policy before the date of the enactment of the repeal of the Medicare Catastrophic Coverage Act of 1988, the insurer shall:

i. Provide written notice no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificateholder (at the most recent available address) of the offer described below, and

ii. Offer the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstitution of coverage (with coverage effective as of January 1, 1990), under the terms which:

Does not provide for any waiting period with respect to treatment of preexisting conditions;

Provides for coverage which is substantially equivalent to coverage in effect before the date of such termination; and

Provides for classification of premiums on which terms are at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage never terminated.

b. An insurer is not required to make the offer under Paragraph ii. above in the case of an individual who is a policyholder or certificateholder in another Medicare supplemental policy as of January 1, 1990, if the

individual is not subject to a waiting period with respect to treatment of a preexisting condition under such other policy.

6. Requirements for New Policies and Certificates

a. Effective January 1, 1990, no Medicare supplement insurance policy, contract or certificate shall be delivered or issued for delivery in this State which provides benefits which duplicate benefits provided by Medicare. No such policy, contract or certificate shall provide less benefits than those required under the existing Medicare Supplement Insurance Minimum Standards Model Act or Regulation except where duplication of Medicare benefits would result and except as required by these transition provisions.

b. General Requirements

i. Within ninety (90) days of the date of this bulletin, every insurer, health care service plan or other entity required to file its policies or contracts with this State should file new Medicare supplement insurance policies or contracts which eliminate any duplication of Medicare supplement benefits with benefits provided by Medicare, which adjust minimum required benefits to changes in Medicare benefits and which provide a clear description of the policy or contract benefit.

ii. The filing required under Section 4a(i) shall provide for loss ratios which are in compliance with all minimum standards.

iii. Every applicant for a Medicare supplement insurance policy, contract or certificate shall be provided with an outline of coverage which simplifies and accurately describes benefits provided by Medicare and policy or contract benefits along with benefit limitations.

7 Filing Requirements for Advertising

Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this State shall provide a copy of any advertisement intended for use in this State whether through written, radio or television to the Department of Insurance of the State of Idaho for review or approval by the Director. Such advertisement shall comply with Regulation No. 24 and all other applicable laws of this State.

8. Buyer's Guide

No insurer, health care service plan or other entity shall make use of or otherwise disseminate any Buyer's Guide or informational brochure which does not accurately outline current Medicare benefits and which has not been adopted by the Director.

Pending passage in Idaho of legislation and a regulation which complies with the NAIC's revised models, it is imperative that Medicare supplemental insurers voluntarily adopt and conduct their business in compliance with the transitional rules outlined in this bulletin. Failure to adopt these transitional rules could result in the insurance-buying public being seriously harmed because insureds may purchase coverage that duplicates Medicare benefits or otherwise does not meet the needs of Medicare beneficiaries. In addition, voluntary compliance with the above stated transition rules will benefit Medicare supplemental insurers by ensuring a smoother transition once permanent legislation is passed and regulations are adopted by the Department of Insurance in conformance with the NAIC models.

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