

MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Definitions

- A. “Applicant” means:
- (1) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and
 - (2) In the case of a group Medicare supplement policy, the proposed certificateholder.
- B. “Certificate” means, for the purposes of this Act, any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.
- C. “Certificate form” means the form on which the certificate is delivered or issued for delivery by the issuer.
- D. “Issuer” includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

Drafting Note: It is intended that nonprofit hospital and medical service associations be subject to this model act. In those states where such associations are prohibited from issuing subscriber contracts that include all of the benefits required by Section 3 of this Act, they shall include so much of those benefits as are permitted and they shall be issued in conjunction with another contract including at least the remainder of the minimum benefits required. In such event, the combination of contracts will be considered to have been issued in compliance with Section 3 of this Act.

- E. “Medicare” means the “Health Insurance for the Aged Act,” Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.
- F. “Medicare supplement policy” means a group or individual policy of [accident and sickness] insurance or a subscriber contract [of hospital and medical service associations or health maintenance organizations], other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.), or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), 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.

Drafting Note: OBRA 1990 contained an exception from this definition for policies issued pursuant to an agreement under Section 1833 (42 U.S.C. 1395l) of the federal Social Security Act. The Social Security Act Amendments of 1994 eliminated the exemption for Section 1833 plans effective December 31, 1995. These plans, commonly known as health care prepayment plans (HCPPs), arrange for certain Part B services on a pre-paid basis. The federal law continues to authorize HCPP agreements. However, since they are now included in the federal definition of a Medicare supplement policy, HCPPs are subject to the requirements of this model, unless they are exempt under Section 2B. In states authorized for the Medicare Select program, these plans may be able to comply with Medicare supplement requirements.

- G. “Policy form” means the form on which the policy is delivered or issued for delivery by the issuer.

Section 2. Applicability and Scope

- A. Except as otherwise specifically provided this Act shall apply to:
 - (1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this Act, and
 - (2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.
- B. This Act shall not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.
- C. Except as otherwise specifically provided in section 5D, the provisions of this Act are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons when the policies are not marketed or held to be Medicare supplement policies or benefit plans.

Section 3. Standards for Policy Provisions and Authority to Promulgate Regulations

- A. No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.
- B. Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate shall not exclude or limit benefits for loss incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.
- C. The commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates. The standards shall be in addition to and in accordance with applicable laws of this state, including Sections [insert the applicable statutory reference, if any, to the NAIC Uniform Accident and Sickness Policy Provision Law]. No requirement of the Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in this Act, shall apply to Medicare supplement policies and certificates. The standards may cover, but not be limited to:

Drafting Note: Wherever the term “commissioner” appears, the title of the chief insurance regulatory official of the state should be inserted.

- (1) Terms of renewability;
- (2) Initial and subsequent conditions of eligibility;
- (3) Nonduplication of coverage;
- (4) Probationary periods;
- (5) Benefit limitations, exceptions and reductions;
- (6) Elimination periods;
- (7) Requirements for replacement;
- (8) Recurrent conditions; and
- (9) Definitions of terms.

- D. The commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements and reporting practices, for Medicare supplement policies and certificates.
- E. The commissioner may adopt from time to time reasonable regulations necessary to confirm Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including but not limited to:
 - (1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;
 - (2) Establishing a uniform methodology for calculating and reporting loss ratios;
 - (3) Assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance;
 - (4) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;
 - (5) Establishing a policy for holding public hearings prior to approval of premium increases; and
 - (6) Establishing standards for Medicare Select policies and certificates.
- F. The commissioner may adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

Drafting Note: Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

Section 4. Loss Ratio Standards

Medicare supplement policies shall return to policyholders' benefits which are reasonable in relation to the premium charged. The commissioner shall issue reasonable regulations to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

Section 5. Disclosure Standards

- A. In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.
- B. The commissioner shall prescribe the format and content of the outline of coverage required by Subsection A. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. The outline of coverage shall include:
 - (1) A description of the principal benefits and coverage provided in the policy;
 - (2) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age.
 - (3) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

- C. The commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.
- D. The commissioner may adopt regulations for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for Medicare, other than:
 - (1) Medicare supplement policies; or
 - (2) Disability income policies.
- E. The commissioner may adopt reasonable regulations to govern the full and fair disclosure of the information in connection with the replacement of accident and sickness policies, subscriber contracts or certificates by persons eligible for Medicare.

Section 6. Notice of Free Examination

Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. A refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

Section 7. Filing Requirements for Advertising

Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law.

Drafting Note: States should examine their existing laws regarding the filing of advertisements to determine the extent to which review or approval is required.

Section 8. Administrative Procedures

Regulations adopted pursuant to this Act shall be subject to the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 9. Penalties

In addition to any other applicable penalties for violations of the Insurance Code, the commissioner may require issuers violating any provision of this Act or regulations promulgated pursuant to this Act to cease marketing any Medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require the issuer to take actions necessary to comply with the provisions of this Act, or both.

Section 10. Separability

If any provision of this Act or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of the Act and the application of the provision to other persons or circumstances shall not be affected.

Section 11. Effective Date

The Act shall be effective on [insert date].

Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1980 Proc. II 22, 26, 588, 591, 593, 603-605 (adopted).

1981 Proc. I 47, 51, 420, 424, 446, 453-456 (amended and reprinted).

1988 Proc. I 9, 20-21, 629-630, 652-654, 665-668 (amended and reprinted).

1988 Proc. II 5, 13, 568, 601, 604, 624-626 (amended and reprinted).

1989 Proc. I 14, 813-814, 836.1-836.4 (amended at special plenary session September 1988).

1990 Proc. I 6, 27-28, 477, 574-575, 577-580 (amended and reprinted).

1992 Proc. I 12, 12-16, 1085 (amended at special plenary in July 1991).

1995 Proc. 1st Quarter 7, 12, 501, 575, 586, 588-591 (amended and reprinted).

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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.

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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. CODE §§ 27-19-50 to 27-19-59 (1981/2000). | |
| Alaska | | ALASKA ADMIN. CODE tit. 3, §§ 28.410 to 28.510 (1982/2009); BULLETIN 5-19-2009 (2009). |
| American Samoa | NO CURRENT ACTIVITY | |
| Arizona | | ARIZ. REV. STAT. ANN. § 20-1133 (1981/1989) (Directs the adoption of rules). |
| Arkansas | ARK. CODE ANN. §§ 23-79-401 to 23-79-410 (1992). | |
| California | CAL. INS. CODE §§ 10192.1 to 10198.5 (1981/2005) (Includes regulation). | CAL. HEALTH & SAFETY §§ 1358.1 to 1358.23 (2001/2009). |
| Colorado | COLO. REV. STAT. §§ 10-18-101 to 10-18-107 (1981/2013). | 3 COLO. CODE REGS. § 702-4:4-3-1 (1982/2015); BULLETIN B-4.33 (2010). |
| Connecticut | CONN. GEN. STAT. §§ 38a-495 to 38a-495a (1992/2015). | CONN. GEN. STAT. § 38a-495c (1993/2014). |
| Delaware | DEL. CODE ANN. tit. 18, §§ 3401 to 3410 (1992). | |
| District of Columbia | D.C. CODE §§ 31-3701 to 31-3710 (1992/2000). | |

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| NAIC MEMBER | MODEL ADOPTION | RELATED STATE ACTIVITY |
|--------------------|--|--|
| Florida | FLA. STAT. ANN. §§ 627.671 to 627.675 (1980/2010) (portions of model). | Memorandum 2009-005 (2009). |
| Georgia | GA. CODE ANN. §§ 33-43-1 to 33-43-9 (1992/2010). | |
| Guam | NO CURRENT ACTIVITY | |
| Hawaii | HAWAII REV. ANN. §§ 431:10A-301 to 431:10A-311 (1988/2003). | |
| Idaho | IDAHO CODE ANN. §§ 41-4401 to 41-4411 (1981/1999). | |
| Illinois | 215 ILL. COMP. STAT. 5/363; 5/363a (1982/2003). | BULLETIN 2011-15 (2011). |
| Indiana | IND. CODE ANN. §§ 27-8-13-3 to 27-8-13-19 (1990/2003). | |
| Iowa | | IOWA CODE ANN. § 509.13 (1981); § 514D.9 (1990) (Authority to adopt Regulation). |
| Kansas | | KAN. STAT. ANN. § 40-2221 (1981/1996). |
| Kentucky | KY. REV. STAT. §§ 304.14-500 to 304.14-550 (1982/2010). | Advisory Opinion 2014-3 (2014). |
| Louisiana | LA. REV. STAT. ANN. § 22:224 (1981/1997). | |
| Maine | ME. REV. STAT. ANN. tit. 24-A, §§ 5001 to 5013 (1981/2013). | |
| Maryland | MD. CODE ANN. INS. §§ 15-901 to 15-928 (1980/2010); MD. CODE REGS. 13.10.05.01 TO 13.10.05.11 (1982/2009). | |
| Massachusetts | NO CURRENT ACTIVITY | |
| Michigan | MICH. COMP. LAWS §§ 500.3801 to 500.3861 (1992/2002) (Includes Regulation). | MICH. COMP. LAWS. §§ 500.3701 to 500.3728 (1956/2013) entitled “Group Health Insurance for Persons 65 or Over”; §§ 333.21054c to 333.21054t (1990) (Medicare supplement policies from HMOs). |
| Minnesota | | MINN. STAT. ANN. §§ 62A.31 to 62A.44 (1981/2005); §§ 62A. 451 to 62A. 4528 (2005/2010) (Medicare Part D Plans). |

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| NAIC MEMBER | MODEL ADOPTION | RELATED STATE ACTIVITY |
|--------------------|--|--|
| Mississippi | MISS. CODE ANN. §§ 83-9-101 to 83-9-113 (1981/1996). | |
| Missouri | MO. REV. STAT. ANN. §§ 376.850 to 376.890 (1981/1996). | |
| Montana | MONT. CODE ANN. §§ 33-22-901 to 33-22-909 (1981/1993). | |
| Nebraska | NEB. REV. STAT. ANN. §§ 44-3601 to 44-3610 (1981/1996). | |
| Nevada | NO CURRENT ACTIVITY | |
| New Hampshire | N.H. REV. STAT. ANN. §§ 415-F:1 to 415-F:8 (1995/1996). | |
| New Jersey | N.J. REV. STAT. ANN. §§ 17B:26A-1 to 17B:26A-8 (1982/1992). | N.J. REV. STAT. ANN. §§ 17B:26A-12 to 17B:26A-17 (1995). |
| New Mexico | N.M. STAT. ANN. §§ 59A-24A-1 to 59A-24A-16 (1989/1992). | |
| New York | | N.Y. INS. LAW § 3218 (1984). |
| North Carolina | N.C. GEN. STAT. §§ 58-54-1 to 58-54-40 (1989/1998). | N.C. GEN. STAT. § 58-3-215 (2009). |
| North Dakota | N.D. CENT. CODE §§ 26.1-36.1-01 to 26.1-36.1-09 (1991/1997). | |
| Northern Marianas | NO CURRENT ACTIVITY | |
| Ohio | OHIO REV. CODE ANN. §§ 3923.33 to 3923.339 (1992). | |
| Oklahoma | OKLA. STAT. tit. 36, § 3611.1 (1982/1994). | |
| Oregon | OR. REV. STAT. §§ 743.680 to 743.689 (1989/1997). | OR. ADMIN. R. 836-052-0103 to 836-052-0194 (1989/2014). |
| Pennsylvania | | PA. CONS. STAT. §§ 40-39-601 to 40-39-611 (1983). |
| Puerto Rico | NO CURRENT ACTIVITY | |
| Rhode Island | R.I. GEN. LAWS §§ 27-18.2-1 to 27-18.2-9 (1984/2005). | |
| South Carolina | | S.C. CODE ANN. § 38-71-730(6) (1988/1992) (Authority to adopt regulation). |

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| NAIC MEMBER | MODEL ADOPTION | RELATED STATE ACTIVITY |
|--------------------|--|---|
| South Dakota | S.D. CODIFIED LAWS ANN. §§ 58-17A-1 to 58-17A-17 (1982/2005). | |
| Tennessee | TENN. CODE ANN. §§ 56-7-1451 to 56-7-1461 (1992/2010). | |
| Texas | TEX. CODE ANN. INS. §§ 1652.001 to 1652.202 (2005). | BULLETIN B-0031-11 (2011). |
| Utah | UTAH CODE ANN. § 31A-22-620 (1992/2005). | |
| Vermont | NO CURRENT ACTIVITY | |
| Virgin Islands | V.I. CODE ANN. tit. 22, §§ 1451 to 1461 (1990/1992). | |
| Virginia | | VA. CODE ANN. §§ 38.2-3600 to 38.2-3608 (1986/1996). |
| Washington | WASH. REV. CODE ANN. §§ 48.66.010 to 48.66.910 (1982/2005). | WASH. REV. CODE ANN. §§ 48.21A.010 to 48.21A.080 (1965) (Extended Health Disability Insurance). |
| West Virginia | W. VA. CODE § 33-16-3d (1992/2006); § 33-28-5b (1992/1996) (Individual). | |
| Wisconsin | | WIS. STAT. § 632.81 (1981/1990); BULLETIN 10-17-2006. |
| Wyoming | WYO. STAT. §§ 26-38-201 to 26-38-209 (1990/1997). | |

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Proceeding Citations

All references are to the Proceedings of the NAIC

The Medicare supplement insurance minimum standards were originally part of the Accident and Health Minimum Standards Act and its accompanying regulation. In 1980, following federal adoption of the Baucus Amendment (P.L. 96-265), the task force voted to make separate models for Medicare supplement insurance for those states which have not enacted the Minimum Standards Act and Regulation, but who wish to consider an independent statute in compliance with the Baucus Amendment. **1980 Proc. II 593.**

In 1990 Congress authorized and required the NAIC to revise the model act and regulation to standardize the policy offerings so that consumers could more easily compare prices between offerings of different issuers. The revisions were completed with input and assistance from an advisory committee consisting of consumer representatives and insurers. A consumer survey was conducted to solicit additional input on consumer preferences. The revisions fell into three categories: (1) Simplification and standardization of Medicare supplement insurance policies; (2) Development of loss ratio and refund methodology; and (3) Notification and disclosure to customers. **1992 Proc. IA 11.**

In October 1994 Congress passed a new law that gave the NAIC 90 days to develop disclosure language to appear on policies that duplicate Medicare and also revised the federal requirements on open enrollment. The NAIC solicited comments from regulators, industry and consumer representatives. Changes to the model act were also necessitated by the federal law. **1994 Proc. 4th Quarter 713.**

Section 1. Definitions

Several new policy definitions were added when the model was revised. **1992 Proc. IA 13.**

D. The definition was modified in 1987 to specifically include health maintenance organizations. Earlier drafters had felt that separate provisions might be necessary to apply the model to HMOs. **1988 Proc. I 665.**

F. Just before adoption of the first Medicare supplement insurance minimum standards, the words “because of age” were added to the end of the definition. The effect of this change was to eliminate any requirement for provision of information to the 2.4 million Americans who are eligible for Medicare by reason of disability, although they face the same Medicare supplement insurance purchase decisions as people over 65. An advisory committee member expressed the hope that state legislatures would extend the requirements to anyone who is eligible for Medicare, whatever the reason. **1979 Proc. II 357.**

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 Baucus Amendment was to concentrate on the entire Medicare population. The advisory committee expressed concern that deletion of the age criterion 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.**

A provision in this definition originally excluded policies issued to employer groups and associations. That language was eliminated in the December 1987 amendments, so that Medicare supplement standards would also be applied to all policies marketed to employer groups previously exempted. **1988 Proc. I 652.** However, see the language added to the scope section (2B) in September 1988. **1989 Proc. I 813.**

In 1994 the federal definition of Medicare supplement was amended to delete reference to Section 1833 plans, commonly known as health care prepayment plans (HCPPs). A federal regulator clarified that the plans were essentially a hybrid between a risk and a cost contract and taking away the exception subjects then 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 policies. **1995 Proc. 1st Quarter 586-587.**

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All references are to the Proceedings of the NAIC

Section 1F (cont.)

A drafting note was added regarding HCPPs 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 a policy met the qualifications of a Medicare Select policy. **1995 Proc. 1st Quarter 585.**

Section 2. Applicability and Scope

The NAIC appointed a Medicare Supplement Insurance Task Force after abuses were reported in 1978. The group was charged with development of a model regulation to address those abuses, and to cover health insurance for the elderly. **1978 Proc. II 317-318.**

A. This section was added to the model in December of 1987. **1988 Proc. I 666.**

B. When adopted, the Medicare standards applied only to individual insurance. Thus a substantial portion of the market for supplemental insurance was unregulated. **1979 Proc. II 357.**

When the federal government adopted the Baucus Amendment, Congress adopted in principal the NAIC model law and regulation regarding Medicare supplement insurance. It expanded those standards, however, to include group policies and to impose loss ratio requirements. **1980 Proc. II 593.**

At the September 18, 1988 working group meeting, the employer and labor organization exclusion was restored to make the NAIC models consistent with federal law. They noted, however, that the working group recommended the appropriateness of including employer groups within the departments' jurisdiction and encouraged the federal government to add the employers to the scope of the Social Security Act. **1989 Proc. I 813.**

Section 3. Standards for Policy Provisions and Authority to Promulgate Regulations

The intent of Medicare legislation was to provide a broad program of hospital insurance protecting the over-65 population against the costs of hospital services. The hospital plan was to be supplemented by a voluntary plan to cover physicians' services. Medicare was intended to be relatively complete and adequate, and when it was first adopted the insurance industry expected there would be little or no room for private insurance. There is clearly a market for policies to supplement Medicare, despite the bleak predictions of health insurers in 1965. **1979 Proc. II 862-863.**

Much of the reported abuse in sales of insurance to the elderly was the extremely high incidence of fraud, misrepresentation and misinformation by agents. Many of the policies sold were duplicative. **1979 Proc. II 356.**

After adoption of the federal Catastrophic Care Act, the NAIC made revisions to the models on Medicare supplement insurance primarily to address elimination of duplicate benefits, to provide for premium adjustments to reflect cost savings, and to contain new minimum standards. **1989 Proc. I 813.**

D. The Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) contained a new federal Medicare supplement policy minimum standard. It requires insurers to provide certain information to the Secretary of Health and Human Services, requires the acceptance of claims assignment and requires payment of user fees. An amendment to this model section provided for regulations for claims payment. **1988 Proc. II 601, 625.**

The section was further amended in 1989 to provide broader authority for the commissioner to adopt regulations. These corresponded to the new provisions adopted in the model regulation at the same time. **1990 Proc. I 578.**

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Section 3 (cont.)

E. The section on promulgation of regulations was combined with the section on policy provisions when the OBRA 1990 amendments were added. What had been the old section became Subsection D and a new Subsection E was developed to specify authority of the insurance commissioner. **1992 Proc. IA 14.**

When changes were required in response to federal law amendments in 1994, NAIC staff suggested that only minimal changes were needed to the model act. The broad authority found in Section 3E would allow states to move forward with changes to their regulations without amending their statutes. **1995 Proc. 1st Quarter 586.**

Section 4. Loss Ratio Standards

When the NAIC first adopted models to regulate Medicare supplement insurance, there was extensive debate over whether there should be a loss ratio benchmark. It was decided to include in the regulation a drafting note with a benchmark percentage designated as discretionary on the part of each commissioner. **1979 Proc. II 337.**

Earlier versions of the model used a standard that policies should be “expected to” return to policyholders benefits which are reasonable in relation to the premium charged. Changes adopted in 1987 provided the loss ratios be based on an insurer’s actual performance and not anticipated performance. **1988 Proc. I 652, 667.**

When the 1988 amendments were adopted, a phrase was added to the model act to designate how the loss ratio would be achieved by health maintenance organizations. Because HMOs do not have incurred claims experience as provided for in Section 5B, it was suggested that a phrase be inserted to refer to incurred health care expenses where coverage is provided on a service rather than a reimbursement basis. It was suggested that health care providers only should be allowed this exception and it should not include preferred provider organizations. The purpose of the amendment was to allow certain providers to include incurred health care expenses in loss ratio determinations. If an organization does not report incurred claims experience, the exception does not apply. **1989 Proc. I 832.**

Section 5. Disclosure Standards

A. When first considering adoption of Medicare supplement insurance provisions, the task force debated at length whether the draft should require delivery of an outline of coverage at the time of solicitation. Based on testimony received at the hearing, they concluded that the outline should be delivered to a prospective insured with the application, not with the policy and that each commissioner should retain the option of requiring the delivery of an approved buyers guide to prospective insureds when the outline of coverage is delivered. **1979 Proc. I 391.**

The first step in regulation of Medicare supplement insurance was the addition of most of what is now Section 5 in this model to the Individual Accident and Sickness Insurance Minimum Standards Act. **1979 Proc. I 396.**

C. Direct response insurers were concerned about the requirement for distribution of the Buyer’s Guide when the model provisions were first being drafted. **1979 Proc. I 391.**

An advisory committee member suggested it was a flaw in the model act not to require delivery of the buyer’s guide before the issuance of direct response policies. **1979 Proc. II 355.** Representatives of direct response companies testified that the cost of mailing the brochure with the initial mailing would be prohibitive, since it would go to many people (between 95% and 99% of the addressees) who would not respond. According to the advisory committee member, no one attempted to evaluate the consumer benefit of such a requirement. If use of the guide led to informed purchasers, competition could bring down premiums for all buyers, perhaps by amounts far exceeding the cost of providing the information. One insurer suggested the real problem was the content of the draft buyer’s guide, not the costs associated with mailing it out at the same time as the application. **1979 Proc. II 358.**

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Section 5C (cont.)

One of the early drafts of the act *required* the commissioner to prescribe a standard form and content of an informational brochure; the model as adopted only stated he *may* do so. The advisory committee recommended deletion of the phrase “standard form and content” so that the commissioner could require delivery of some brochure. Some industry members stated their promotional materials explained their policies better, and were concerned about the cost of distributing fifty different buyer’s guides in fifty different states. A federal government representative on the advisory committee expressed the hope that legislature would prescribe delivery of a uniform guide, and that by the time legislatures began to act, the NAIC task force would have developed a good, complete, objective uniform guide. **1979 Proc. II 360.**

D. This subsection was added in 1980 when the model was revised after the Baucus Amendment. **1981 Proc. I 451.**

With the tightening of Medicare supplement standards by the adoption of the NAIC model regulation, there was concern that the abuses seen in sales to the elderly would shift from the sale of Medicare supplement to the area of hospital indemnity insurance. However, the NAIC model minimum standards already require disclosure during sales to people over 65 that hospital indemnity policies are not Medicare supplements. The task force decided no further action was necessary, but they would continue to monitor the situation. **1981 Proc. II 562.**

E. During preparation of the amendments adopted in 1980, the task force considered the request of various companies that non-Medicare supplement policies sold to people over age 65 be exempted from the disclosure requirements of the free standing model. After lengthy discussion, the task force declined to act on the request for exemption. **1981 Proc. I 446.**

In 1991 the phrase “by reason of age” was deleted from the model act wherever it occurred. The disclosure requirements thus apply to anyone eligible for Medicare, not just those eligible by reason of age. **1992 Proc. IA 13-15.**

Section 6. Notice of Free Examination

The “free look” provision was added in December 1980. It provided a 10-day free look period for all policies except direct response, which had a 30-day free look period. **1981 Proc. I 452.**

When the model was revised in 1987 to improve protection for purchasers, the free look period was made a uniform 30 days for all policies. **1988 Proc. I 668.**

Section 7. Filing Requirement for Advertising

The working group transferred this section from the transitional rules. Members of the group raised the concern that states may be estopped from sanctioning activity because they have not acted on the material filed. By accepting the filing, the departments may acquire the responsibility to do something with the material. There was some discussion about the possibility of requiring certification from the companies. **1989 Proc. I 833.**

The model was amended to reflect the new federal requirement for submission of advertisements to the state insurance departments as a new minimum benefit standard. **1989 Proc. I 836.**

Section 8. Administrative Procedures

Section 9. Penalties

Section 10. Separability

**MEDICARE SUPPLEMENT INSURANCE
MINIMUM STANDARDS MODEL ACT**

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Section 11. 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.**

On October 27, 1990 the Congress passed the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) which contained significant changes to the “Baucus” state/federal certification program for Medigap policies. The president signed the legislation on November 5, 1990. States need to amend their laws and regulations to incorporate many of these changes if they wish to continue the approval of their regulatory programs under federal law. The legislation gave the NAIC nine months to revise its model standards. States have one year from the adoption of the revised standards to make changes to their regulatory programs and request approval from the Secretary of Health and Human Services. **1991 Proc. IB 725-726.**

The NAIC standards were adopted on July 30, 1991, starting the clock ticking on the deadlines for the states. **1992 Proc. IA 11-12.**

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