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

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Section 1. Purpose

The purpose of this regulation is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

Section 2. Authority

This regulation is issued pursuant to the authority vested in the commissioner under [cite appropriate section of state law providing authority for minimum benefit standards regulations or the NAIC *Medicare Supplement Insurance Minimum Standards Model Act* (#650)].

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Editor's Note: Wherever the term "commissioner" appears, the title of the chief insurance regulatory official of the state should be inserted.

Section 3. Applicability and Scope

A. Except as otherwise specifically provided in Sections 7, 13, 14, 17 and 22, this regulation shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this regulation; and

(2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This regulation shall not apply to 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 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.

Section 4. Definitions

For purposes of this regulation:

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 certificate holder.

B. "Bankruptcy" means when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

C. "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

D. "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

E. "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

F. (1) "Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

(a) A group health plan;

(b) Health insurance coverage;

(c) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(d) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

(e) Chapter 55 of Title 10 United States Code (CHAMPUS);

(f) A medical care program of the Indian Health Service or of a tribal organization;

(g) A state health benefits risk pool;

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(h) A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

(i) A public health plan as defined in federal regulation; and

(j) A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

(2) "Creditable coverage" shall not include one or more, or any combination of, the following:

(a) Coverage only for accident or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; and

(h) Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

(c) Such other similar, limited benefits as are specified in federal regulations.

(4) "Creditable coverage" shall not include the following benefits if offered as independent, non-coordinated benefits:

(a) Coverage only for a specified disease or illness; and

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; and

(c) Similar supplemental coverage provided to coverage under a group health plan.

Drafting Note: The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically addresses separate, non-coordinated benefits in the group market at PHSA Section 2721(d)(2) and the individual market at Section 2791(c)(3). HIPAA also references excepted benefits at PHSA Sections 2701(c)(1), 2721(d), 2763(b) and 2791(c). In addition, creditable coverage has been addressed in an interim final rule (62 Fed. Reg. at 16960-16962 (April 8, 1997)) issued by the Secretary pursuant to HIPAA, and may be addressed in subsequent regulations.

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G. "Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

H. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

Drafting Note: If the state law definition of insolvency differs from the above definition, please insert the state law definition.

I. "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.

J. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

K. "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in [refer to definition of Medicare Advantage plan in 42 U.S.C. 1395w-28(b)(1)], and includes:

(1) Coordinated care plans that provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(2) Medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account; and

(3) Medicare Advantage private fee-for-service plans.

Drafting Note: The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) redesignates "Medicare + Choice" as "Medicare Advantage" effective January 1, 2004.

L. "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. Section 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. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

Drafting Note: Under Section 104(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage Plans (established under Medicare Part C) must comply with the Medicare supplement requirements of Section 1882(o) of the Social Security Act.

M. "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan" or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to [insert effective date on which the state made its revisions to conform to the Omnibus Budget Reconciliation Act of 1990].

N. "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan" or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after [insert effective date of 1990 plan] and prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

O. "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan" or "2010 plan" means a group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

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P. "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

Q. "Secretary" means the Secretary of the United States Department of Health and Human Services.

Section 5. Policy Definitions and Terms

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to the requirements of this section.

A. "Accident," "accidental injury," or "accidental means" shall be defined to employ "result" language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(1) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(2) The definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

B. "Benefit period" or "Medicare benefit period" shall not be defined more restrictively than as defined in the Medicare program.

C. "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall not be defined more restrictively than as defined in the Medicare program.

D. "Health care expenses" means, for purposes of Section 14, expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

E. "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

F. "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

G. "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

H. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

I. "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 6. Policy Provisions

A. Except for permitted preexisting condition clauses as described in Section 7A(1), Section 8A(1), and Section 8.1A(1) of this regulation, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

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B. No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

C. No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

D. (1) Subject to Sections 7A(4), (5) and (7), and 8A(4) and (5) of this regulation, a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(a) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

(b) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

Drafting Note: After December 31, 2005, MMA prohibits issuers of Medicare supplement policies from renewing outpatient prescription drug benefits for both pre-standardized and standardized Medicare supplement policyholders who enroll in Medicare Part D. Before May 15, 2006, these beneficiaries have two options: retain their current plan with outpatient prescription drug coverage removed and premiums adjusted appropriately; or enroll in a different policy as guaranteed for beneficiaries affected by these changes mandated by MMA and outlined in Section 12, "Guaranteed Issue for Eligible Persons." After May 15, 2006, however, these beneficiaries will only retain a right to keep their original policies, stripped of outpatient prescription drug coverage, and lose the right to guaranteed issue of the plans described in Section 12.

Section 7. Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to [insert effective date adopted by state]

No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

Drafting Note: This section has been retained for transitional purposes. The purpose of this section is to govern all policies issued prior to the date a state makes its revisions to conform to the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508).

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses 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.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

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Drafting Note: This provision was prepared so that premium changes can be made based upon the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision so as to coincide with their particular authority.

(4) A "non-cancellable," "guaranteed renewable," or "non-cancellable and guaranteed renewable" Medicare supplement policy shall not:

(a) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(b) Be cancelled or non-renewed by the issuer solely on the grounds of deterioration of health.

(5) (a) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor non-renew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(b) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in Paragraph (5)(d), the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

(i) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 8.1B of this regulation.

Drafting Note: Group contracts in force prior to the effective date of the Omnibus Budget Reconciliation Act (OBRA) of 1990 may have existing contractual obligations to continue benefits contained in the group contract. This section is not intended to impair such obligations.

(c) If membership in a group is terminated, the issuer shall:

(i) Offer the certificate holder the conversion opportunities described in Subparagraph (b); or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(d) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

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(7) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subsection.

B. Minimum Benefit Standards.

(1) 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;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

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

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) 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;

(6) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment 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 [$203];

(7) 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.

Section 8. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered on or After [insert effective date adopted by state] and Prior to June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after [insert effective date] and prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

Drafting Note: This Section has been retained for transitional purposes. The purpose of this section is to govern policies issued subsequent to the adoption of 1990 Standardized benefit plans and prior to June 1, 2010. Standards for 2010 Standardized benefit plans issued for effective dates on or after June 1, 2010, are included in Section 8.1 of this regulation.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may 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.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

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(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Drafting Note: This provision was prepared so that premium changes can be made based on the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision to conform to their particular authority.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8A(5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder)

(i) Provides for continuation of the benefits contained in the group policy, or

(ii) Provides for benefits that otherwise meet the requirements of this subsection.

(d) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(i) Offer the certificate holder the conversion opportunity described in Section 8A(5)(c), or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(f) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

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(7) (a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

Drafting Note: The Ticket to Work and Work Incentives Improvement Act failed to provide for payment of the policy premiums in order to reinstitute coverage retroactively. States should consider adding the following language at the end of the last sentence in Subparagraph (c): "and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan." This addition will clarify that issuers are entitled to collect the premium in this situation, as they are under Subparagraph (b). Also, the Ticket to Work and Work Incentives Improvement Act of 1999 does not specify the period of time that a policy may be suspended under Section 8A(7)(c). In the event that the Centers for Medicare & Medicaid Services (CMS) provides states with guidance on this issue, the phrase "for any period that may be provided by federal law" has been inserted into this provision in parentheses so that any time period prescribed is incorporated by reference.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(8) If an issuer makes a written offer to the Medicare Supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her [1990 Standardized plan] (as described in Section 9 of this regulation) to a [2010 Standardized plan] (as described in Section 9.1 of this regulation), the offer and subsequent exchange shall comply with the following requirements:

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(a) An issuer need not provide justification to the [commissioner] if the insured replaces a [1990 Standardized] policy or certificate with an issue age rated [2010 Standardized] policy or certificate at the insured's original issue age [and duration]. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner [----- according to the state's rate filing procedure -----].

(b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(c) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged [1990 Standardized] policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new [2010 Standardized] policy or certificate not contained in the exchanged policy.

(d) The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

Drafting Note: The options an issuer may offer its policyholders or certificate holders may be (a) to only selected existing Plans or (b) to only certain new Plans for a particular existing Plan. For example, an exchange of a new Plan F for an old Plan F is an acceptable option. An offer to only policyholders with existing Plans with no reduction in benefits is also acceptable.

B. Standards for Basic (Core) Benefits Common to Benefit Plans A to J. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) 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;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Drafting Note: The issuer is required to pay whatever amount Medicare would have paid as if Medicare was covering the hospitalization. The "or other appropriate Medicare standard of payment" provision means the manner in which Medicare would have paid. The issuer stands in the place of Medicare, and so the provider must accept the issuer's payment as payment in full. The Outline of Coverage specifies that the beneficiary will pay "$0," and the provider cannot balance bill the insured.

(4) Coverage under Medicare Parts A and 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;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

Drafting Note: In all cases involving hospital outpatient department services paid under a prospective payment system, the issuer is required to pay the co-payment amount established by CMS, which will be either the amount established for the Ambulatory Payment Classification (APC) group, or a provider-elected reduced co-payment amount.

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C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this regulation.

(1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(9) (a) Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures;

(ii) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

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(b) Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(a) For purposes of this benefit, the following definitions shall apply:

(i) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(ii) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(iii) "Home" shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four-hour period of services provided by a care provider is one visit.

(b) Coverage Requirements and Limitations.

(i) At-home recovery services provided must be primarily services which assist in activities of daily living.

(ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(iii) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(II) The actual charges for each visit up to a maximum reimbursement of $40 per visit;

(III) $1,600 per calendar year;

(IV) Seven (7) visits in any one week;

(V) Care furnished on a visiting basis in the insured's home;

(VI) Services provided by a care provider as defined in this section;

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(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

Drafting Note: The Omnibus Budget Reconciliation Act 1990, 42 U.S.C. Section 1395ss(p)(7), does not prohibit the issuers of Medicare supplement policies, through an arrangement with a vendor for discounts from the vendor, from making available discounts from the vendor to the policyholder or certificate holder for the purchase of items or services not covered under its Medicare supplement policies (for example: discounts on hearing aids or eyeglasses).

Drafting Note: The NAIC discussed including inflation protection for at-home recovery benefits, and preventive care benefits. However, because of the lack of an appropriate mechanism for indexing these benefits, NAIC has not included indexing at this point in time. However, NAIC is committed to evaluating the effectiveness of these benefits without inflation protection, and will revisit the issue. NAIC has determined that OBRA does not authorize NAIC to delegate the authority for indexing these benefits to a federal agency without an amendment to federal law.

D. Standards for Plans K and L.

(1) Standardized Medicare supplement benefit plan "K" shall consist of the following:

(a) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (j);

(g) Coverage for fifty percent (50%), under Medicare Part A or B, of 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 until the out-of-pocket limitation is met as described in Subparagraph (j);

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(h) Except for coverage provided in Subparagraph (i) below, coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j) below;

(i) Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(2) Standardized Medicare supplement benefit plan "L" shall consist of the following:

(a) The benefits described in Paragraphs (1)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs (1)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph (1)(j) but substituting $2000 for $4000.

Section 8.1 Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any [1990 Standardized Medicare supplement benefit plan] for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of [insert proper citation].

Drafting Note. Each state should insert the proper citation(s) to its statutes or rules that govern Medicare supplement insurance policies and certificates issued prior to the June 1, 2010, effective date of 2010 Standardized benefit plan standards found in Sections 8.1 and 9.1 of this regulation. It is recommended that each state's applicable statutes or rules for Medicare supplement policies and certificates issued prior to June 1, 2010, be retained and that this section of the regulation be adopted in its entirety as a new section to govern policies issued on and after June 1, 2010.

A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may 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.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

(2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

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Drafting Note: This provision was prepared so that premium changes can be made based on the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision to conform to their particular authority.

(4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Each Medicare supplement policy shall be guaranteed renewable.

(a) The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

(b) The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

(c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8.1A(5)(e) of this regulation, the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

(i) Provides for continuation of the benefits contained in the group policy; or

(ii) Provides for benefits that otherwise meet the requirements of this subsection.

(d) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

(i) Offer the certificate holder the conversion opportunity described in Section 8.1A(5)(c) of this regulation; or

(ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

(6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(7) (a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

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(b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

Drafting Note: The Ticket to Work and Work Incentives Improvement Act failed to provide for payment of the policy premiums in order to reinstitute coverage retroactively. States should consider adding the following language at the end of the last sentence in Subparagraph (c): "and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan." This addition will clarify that issuers are entitled to collect the premium in this situation, as they are under Subparagraph (b). Also, the Ticket to Work and Work Incentives Improvement Act of 1999 does not specify the period of time that a policy may be suspended under Section 8A(7)(c). In the period that may event that the Centers for Medicare & Medicaid Services (CMS) provides states with guidance on this issue, the phrase "for any be provided by federal law" has been inserted into this provision in parentheses so that any time period prescribed is incorporated by reference.

(d) Reinstitution of coverages as described in Subparagraphs (b) and (c):

(i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

(iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

B. Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(1) 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;

(2) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Drafting Note: The issuer is required to pay whatever amount Medicare would have paid as if Medicare was covering the hospitalization. The "or other appropriate Medicare standard of payment" provision means the manner in which Medicare would have paid. The issuer stands in the place of Medicare, and so the provider must accept the issuer's payment as payment in full. The Outline of Coverage specifies that the beneficiary will pay "$0," and the provider cannot balance bill the insured.

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(4) Coverage under Medicare Parts A and 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;

(5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

(6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Drafting Note: In all cases involving hospital outpatient department services paid under a prospective payment system, the issuer is required to pay the co-payment amount established by CMS, which will be either the amount established for the Ambulatory Payment Classification (APC) group, or a provider-elected reduced co-payment amount.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 9.1 of this regulation.

Drafting Note: Benefits for Plans K and L are set by The Medicare Prescription Drug, Improvement and Modernization. Act of 2003, and can be found in Sections 9.1E(8) and (9) of this regulation.

(1) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(2) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

(3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

(4) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(6) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

Drafting Note: The Omnibus Budget Reconciliation Act 1990, 42 U.S.C. Section 1395ss(p)(7), does not prohibit the issuers of Medicare supplement policies, through an arrangement with a vendor for discounts from the vendor, from making available discounts from the vendor to the policyholder or certificate holder for the purchase of items or services not covered under its Medicare supplement policies (for example: discounts on hearing aids or eyeglasses).

Drafting Note: The descriptions of Plans K and L are contained in Section 9.1E(8) and (9) of this regulation.

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Section 9. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After [insert effective date adopted by state] and Prior to June 1, 2010

Drafting Note: This section has been retained for transitional purposes. The purpose of this Section is to govern policies issued subsequent to the adoption of 1990 Standardized benefit plans and prior to June 1, 2010. Standards for 2010 Standardized benefit plans issued for effective dates on or after June 1, 2010, are included in Section 9.1 of this regulation.

A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in Section 8B of this regulation.

B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9G and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8B and 8C,or 8D and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

Drafting Note: It is anticipated that if a state determines that it will authorize the sale of only some of these benefit plans, the letter codes used in this regulation will be preserved. The *Guide to Health Insurance for People with Medicare* published jointly by the NAIC and CMS will contain a chart comparing the possible combinations. In order for consumers to compare specific policy choices, it will be important that a uniform "naming" system be used. Thus, if only plans "A," "B," "D," "F (including F with a high deductible)" and "H" (for example) are authorized in a state, these plans should retain these alphabetical designations. However, an issuer may use, in addition to these alphabetical designations, other designations as provided in Section 9D of this regulation.

E. Make-up of benefit plans:

(1) Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in Section 8B of this regulation.

(2) Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible as defined in Section 8C(1).

(3) Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3) and (8) respectively.

(4) Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit (as defined in Section 8B of this regulation), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as defined in Sections 8C(1), (2), (8) and (10) respectively.

(5) Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Sections 8C(1), (2), (8) and (9) respectively.

(6) Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively.

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(7) Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3), (5) and (8) respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Sections 8C(1), (2), (4), (8) and (10) respectively.

(9) Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (6) and (8) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in Sections 8C(1), (2), (5), (6), (8) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

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F. Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);

(1) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Section 8 D(1).

(2) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Section 8 D(2).

G. New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

Drafting Note: Use of new or innovative benefits may be appropriate to add coverage or access if they offer uniquely different or significantly expanded coverage.

Drafting Note: A state may determine by statute or regulation which of the above benefit plans may be sold in that state. The core benefit plan must be made available by all issuers. Therefore, the core benefit plan must be one of the authorized benefit plans adopted by a state. In no event, however, may a state authorize the sale of more than 10 standardized Medicare supplement benefit plans (that is, 9 plus the core policy), plus the two (2) high deductible plans, and the two (2) benefit plans K and L, mandated by MMA at the same time. Further, the modified versions of plans H, I, J as required by MMA after December 31, 2005, will not count as additional plans toward the limitations on the total number of plans discussed above.

Drafting Note: The Omnibus Budget Reconciliation Act of 1990 preempts state mandated benefits in Medicare supplement policies or certificates, except for those states which have been granted a waiver for non-standardized plans.

Drafting Note: After December 31, 2005, MMA prohibits Medicare supplement issuers from offering policies with outpatient prescription drug coverage, and from renewing outpatient prescription drug coverage for insureds enrolled in Medicare Part D. Consequently, plans with an outpatient prescription drug benefit will not be offered to new enrollees after that time.

Drafting Note: Pursuant to the enactment of MMA, two new benefit packages, called K and L, were added to plans A through J. The two new packages have higher co-payments and coinsurance contributions from the Medicare beneficiary.

Section 9.1 Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of [insert proper citation].

Drafting Note. Each state should insert the proper citation(s) to its statutes or rules that govern Medicare supplement insurance policies and certificates issued prior to the June 1, 2010, effective date of the 2010 Standardized benefit plan standards found in Sections 8.1 and 9.1 of this regulation. It is recommended that each state's applicable statutes or rules for Medicare supplement benefit plans for policies and certificates issued prior to June 1, 2010, be retained and that this section of the Model be adopted in its entirety as a new section to govern policies and certificates issued on and after June 1, 2010. (The benefit plan standards of the Medicare Supplement Model Regulation for policies issued prior to June 1, 2010, are found in Section 9 of this regulation.)

A. (1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in Section 8.1B of this regulation.

(2) If an issuer makes available any of the additional benefits described in Section 8.1C, or offers standardized benefit Plans K or L (as described in Sections 9.1E(8) and (9) of this regulation), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in Subsection A(1) above, a policy form or certificate form containing either standardized benefit Plan C (as described in Section 9.1E(3) of this regulation) or standardized benefit Plan F (as described in 9.1E(5) of this regulation).

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B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9.1F and in Section 10 of this regulation.

C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8.1B and 8.1C of this regulation; or, in the case of plans K or L, in Sections 9.1E(8) or (9) of this regulation and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

D. In addition to the benefit plan designations required in Subsection C of this section, an issuer may use other designations to the extent permitted by law.

Drafting Note: It is anticipated that if a state determines that it will authorize the sale of only some of these benefit plans, the letter codes used in this regulation will be preserved. The *Guide to Health Insurance for People with Medicare* published jointly by the NAIC and CMS will contain a chart comparing the possible combinations. In order for consumers to compare specific policy choices, it will be important that a uniform "naming" system be used. Thus, if only Plans A, B, D, F, F with High Deductible, and K (for example) are authorized in a state, these plans must retain their alphabetical designations. An issuer may use, in addition to these alphabetical designations, other designations as provided in Section 9.1D of this regulation.

E. Make-up of 2010 Standardized Benefit Plans:

(1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Section 8.1B of this regulation.

(2) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Section 8.1C(1) of this regulation.

(3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), and (6) of this regulation, respectively.

(4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in Section 8.1B of this regulation), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in Sections 8.1C(1), (3), and (6) of this regulation, respectively.

(5) Standardized Medicare supplement [regular] Plan F shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6), respectively.

(6) Standardized Medicare supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph (b).

(a) The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (4), (5), and (6) of this regulation, respectively.

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(b) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by [regular] Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10).

(7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3), (5), and (6), respectively. Effective January 1, 2020, the standardized benefit plans described in Section 9.2 A. (4) of this regulation (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(b) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(c) Part A Hospitalization After Lifetime Reserve Days are Exhausted: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in Subparagraph (j);

(e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);

(f) Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in Subparagraph (j);

(g) Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of 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 until the out-of-pocket limitation is met as described in Subparagraph (j);

(h) Part B Cost Sharing: Except for coverage provided in Subparagraph (i), coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph (j);

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(i) Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(9) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(a) The benefits described in Paragraphs 9.1E(8)(a), (b), (c) and (i);

(b) The benefit described in Paragraphs 9.1E(8)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

(c) The benefit described in Paragraph 9.1E(8)(j), but substituting $2000 for $4000.

(10) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(2), (3) and (6) of this regulation, respectively.

(11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Sections 8.1C(1), (3) and (6) of this regulation, respectively, with co-payments in the following amounts:

(a) The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and

(b) The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

Drafting Note: The NAIC expects to periodically review the co-payment levels for Medicare supplement Plan N and make adjustments to this regulation as necessary.

F. New or Innovative Benefits: An issuer may, with the prior approval of the [commissioner], offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Drafting Note: Recognizing the challenge in maintaining standardization while ensuring availability of new or innovative benefits, the drafters have included additional guidance to states in the NAIC Medicare Supplement Insurance Model Regulation Compliance Manual.. This guidance includes a recommendation that states consider making publicly available all approved new or innovative benefits, and requests states to report the approval of all new or innovative benefits to the NAIC Senior Issues Task Force, who will maintain a record of these benefits for use by regulators and others. The Senior Issues Task Force will periodically review state approved benefits and consider whether to recommend that they be made part of standard benefit plan designs in this regulation.

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Drafting Note: A state may determine by statute or regulation which of the above benefit plans may be sold in that state. Plan A, which consists of the basic (core) benefits must be made available by all issuers. Therefore, Plan A must be one of the authorized benefit plans adopted by a state. If an issuer offers any benefit plan in addition to Plan A, then the issuer must also offer either Plan C or Plan F. Therefore, if any benefit plan is authorized by a state other than Plan A, then either Plan C or Plan F must be among the authorized benefit plans adopted by a state. Except where a new or innovative benefit is approved by the [commissioner] for sale in a state, a state may not authorize the sale of any Medicare supplement plan other than the standardized Medicare supplement benefit plans (that is, Plans A, B, C, D, F, F With High Deductible, G, K, L, M and N) set forth in this regulation.

Drafting Note: The Omnibus Budget Reconciliation Act of 1990 preempts state mandated benefits in Medicare supplement policies or certificates, except for those states which have been granted a waiver for non-standardized plans.

Section 9.2. Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to Individuals Newly Eligible for Medicare on or After January 1, 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of [-insert proper state citation-].

A. Benefit Requirements. The standards and requirements of Section 9.1 shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(1) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Section 9.1E(3) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(2) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Section 9.1E(5) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible.

(3) Standardized Medicare supplement benefit plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(4) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in Section 9.1E(6) of this regulation but shall not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

Drafting Note: Subsection A(4), above implements the High Deductible Plan G as a redesignation of the prior High Deductible Plan F because federal law "deems" any reference to Plan F as Plan G for "newly eligible" Medicare beneficiaries. High Deductible Plan G is the same as the High Deductible Plan F except that where the annual out-of-pocket expenses are met with Medicare Part A expenses only, any subsequent Medicare Part B deductible expense incurred by the beneficiary after the required annual out-of-pocket expenses is met may not be paid for by the High Deductible Plan G. Federal law prohibits the sale or issuance of any Medigap policy that provides coverage (i.e. third party payment) of the Part B deductible to a "newly eligible" Medicare beneficiary and was enacted for the purpose of increasing cost-sharing and reducing "first dollar coverage". Treating the Medicare Part B deductible as an out-of-pocket expense of the beneficiary under Plan G High Deductible meets this purpose.

(5) The reference to Plans C or F contained in Section 9.1A(2) is deemed a reference to Plans D or G for purposes of this section.

B. Applicability to Certain Individuals. This Section 9.2, applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:

(1) By reason of attaining age 65 on or after January 1, 2020; or

(2) By reason of entitlement to benefits under part A pursuant to Section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under Section 226(a) of the Social Security Act on or after January 1, 2020.

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C. Guaranteed Issue for Eligible Persons. For purposes of Section 12.E, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible), respectively, that meet the requirements of this Section 9.2A.

D. Applicability to Waivered States. In the case of a State described in Section 1882(p)(6) of the Social Security Act ("waivered" alternative simplification states) MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.

E. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Subparagraph A(4), above may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in Section 9.1E of this regulation.

Drafting Note: The standardized benefit plans described in Subparagraphs A(1) and A(2), above in this Section are also included as benefit plans D and G in Section 9.1E(4) and (7).

Section 10. Medicare Select Policies and Certificates

A. (1) This section shall apply to Medicare Select policies and certificates, as defined in this section.

Drafting Note: This section should be adopted by all states approving Medicare Select policies.

(2) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

B. For the purposes of this section:

(1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) "Grievance" means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(3) "Medicare Select issuer" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

(5) "Network provider" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

(6) "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) "Service area" means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

C. The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the commissioner finds that the issuer has satisfied all of the requirements of this regulation.

D. A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

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E. A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(a) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(b) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

(i) To deliver adequately all services that are subject to a restricted network provision; or

(ii) To make appropriate referrals.

(c) There are written agreements with network providers describing specific responsibilities.

(d) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

(e) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the quality assurance program, including:

(a) The formal organizational structure;

(b) The written criteria for selection, retention and removal of network providers; and

(c) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) A list and description, by specialty, of the network providers.

(6) Copies of the written information proposed to be used by the issuer to comply with Subsection I.

(7) Any other information requested by the commissioner.

F. (1) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.

(2) An updated list of network providers shall be filed with the commissioner at least quarterly.

G. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

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(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

(2) It is not reasonable to obtain services through a network provider.

H. A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

I. A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(a) Other Medicare supplement policies or certificates offered by the issuer; and

(b) Other Medicare Select policies or certificates.

(2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

J. Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to Subsection I of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

K. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

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(6) The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

L. At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

M. (1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

N. Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

O. A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

Section 11. Open Enrollment

A. An issuer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

B. (1) If an applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

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(2) If the applicant qualifies under Subsection A and submits an application during the time period referenced in Subsection A and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The Secretary shall specify the manner of the reduction under this subsection.

Drafting Note: The Secretary has developed regulations pursuant to HIPAA regarding methods of counting creditable coverage, which govern the way the reduction is to be applied in Section 11B(2).

C. Except as provided in Subsection B and Sections 12 and 23, Subsection A shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

Section 12. Guaranteed Issue for Eligible Persons

A. Guaranteed Issue.

(1) Eligible persons are those individuals described in Subsection B who seek to enroll under the policy during the period specified in Subsection C, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection E that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

B. Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual;

Drafting Note: Paragraph (1) above uses the federal legislative language from the Balanced Budget Act of 1997 (P.L. 105-33) that defines an eligible person as an individual with respect to whom an employee welfare benefit plan terminates, or ceases to provide "all" health benefits that supplement Medicare. There was protracted discussion among the drafters about the interpretation of "all" in this context: if the employer drops some supplemental benefits, but not all such benefits, from its welfare plan, should the individual be eligible for a guaranteed issue Medicare supplement product? This question may become crucial to certain individuals depending on the benefits dropped by the employer. Federal legislative history appears to indicate the intention that the word "all" be strictly construed so as to require termination or cessation of all supplemental health benefits. States, however, can provide greater protections to beneficiaries and may wish to include, as eligible persons, individuals who have lost "some or all" or "substantially all" of their supplemental health benefits, to encompass situations where a change is made in an employee welfare benefit plan that reduces the amount of supplemental health benefits available to the individual. States that consider alternative language are reminded to consider the impact of issues such as plan changes that result in adverse selection, duplicate coverage, triggering the requirement for plan administrator notice (see Section 12D) and other issues.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) The certification of the organization or plan has been terminated;

(b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

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(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area;

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) The individual meets such other exceptional conditions as the Secretary may provide.

(3) (a) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

(iii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(iv) An organization under a Medicare Select policy; and

(b) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 12B(2).

Drafting Note: Paragraph (3)(a)(iv) above is not required if there is a provision in state law or regulation that provides for the continuation or conversion of Medicare Select policies or certificates.

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(a) (i) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or

(ii) Of other involuntary termination of coverage or enrollment under the policy;

(b) The issuer of the policy substantially violated a material provision of the policy; or

(c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

Drafting Note: The reference to "insolvency of the issuer" in Paragraph 4(a) above is not required if there is a provision in state law or regulation that provides for the continuation or conversion of Medicare supplement policies or certificates.

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(5) (a) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select policy; and

(b) The subsequent enrollment under Subparagraph (a) is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

(6) The individual, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection E(4).

Drafting Note: Federal law provides a guaranteed issue right to a Medicare supplement insurance product to individuals who enroll in Medicare Part B at age 65. States may wish to consider extending this right to other classes of individuals, such as those who postpone enrollment in Medicare Part B until after age 65 because they are working and are enrolled in a group health insurance plan.

Drafting Note: Paragraph (7) does not preclude an individual from applying for a new Medigap policy without drug coverage while still enrolled in the policy with drug coverage. The issuer will terminate the drug policy when it issues the new policy without drug coverage.

C. Guaranteed Issue Time Periods.

(1) In the case of an individual described in Subsection B(1), the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Subsection B(2), B(3), B(5) or B(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in Subsection B(4)(a), the guaranteed issue period begins on the earlier of: (i) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated;

(4) In the case of an individual described in Subsection B(2), B(4)(b), B(4)(c), B(5) or B(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

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(5) In the case of an individual described in Subsection B(7), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in Subsection B but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

D. Extended Medigap Access for Interrupted Trial Periods.

(1) In the case of an individual described in Subsection B(5) (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Subsection B(5)(a) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(5);

(2) In the case of an individual described in Subsection B(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Subsection B(6) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 12B(6); and

(3) For purposes of Subsections B(5) and B(6), no enrollment of an individual with an organization or provider described in Subsection B(5)(a), or with a plan or in a program described in Subsection B(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

E. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under:

(1) Section 12B(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

(2) (a) Subject to Subparagraph (b), Section 12B(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph (1);

(b) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this Subparagraph is:

(i) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(ii) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer;

(3) Section 12B(6) shall include any Medicare supplement policy offered by any issuer;

(4) Section 12B(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

Drafting Note: Under federal law, for states that have an alternative form of standardization under a federal waiver and offer benefit packages other than Plans A, B, C, D, F, F with High Deductible, G, K, L, M and N, the references to benefit packages above are deemed references to comparable benefit packages offered in that state. Those states should amend the language accordingly.

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F. Notification provisions.

(1) At the time of an event described in Subsection B of this section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection A. Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Subsection B of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 12A. Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

Drafting Note: States should ensure that educational and public information materials it develops related to Medicare includes a thorough description of the rights outlined in Section 12F.

Section 13. Standards for Claims Payment

A. An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

(1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(3) Paying the participating physician or supplier directly;

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(5) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

B. Compliance with the requirements set forth in Subsection A above shall be certified on the Medicare supplement insurance experience reporting form.

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

A. Loss Ratio Standards.

(1) (a) A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(i) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

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(ii) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies;

(b) Calculated 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 for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) Home office and overhead costs;

(ii) Advertising costs;

(iii) Commissions and other acquisition costs;

(iv) Taxes;

(v) Capital costs;

(vi) Administrative costs; and

(vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying Subsection A(1) of this section and Subsection C(3) of Section 15 only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

Drafting Note: Subsection A(3) replicates language contained in the Omnibus Budget Reconciliation Act of 1990 (Pub. L. No. 101-508). It allows direct mail group policies sold on an individual basis to meet the minimum loss ratio required of individual business (65%) rather than that required of group business (75%). The NAIC eliminated this concept from this regulation in 1987 (I *Proceedings of the NAIC*, pp. 651, 673 (1988)). At that time, NAIC required direct mail group business to meet the same loss ratio requirement as other group business, regardless of whether the business was sold on an individual basis. The NAIC encourages states to apply the 75% loss ratio to all group business. Although NAIC is restricted from making revisions to its models that are not in conformance with OBRA 1990, states are free to impose more stringent requirements than OBRA.

(4) For policies issued prior to [insert effective date from Section 26 of this model, the effective date of the state's regulation implementing the requirements of OBRA 1990], expected claims in relation to premiums shall meet:

(a) The originally filed anticipated loss ratio when combined with the actual experience since inception;

(b) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) when combined with actual experience beginning with [insert effective date of this revision] to date; and

(c) The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) over the entire future period for which the rates are computed to provide coverage.

Drafting Note: The appropriate loss ratio requirement from Subsection A(1)(a)(i) and (ii) for all group policies subject to an individual loss ratio standard when issued is 65 percent. States may amend Section 13A(4) to permit or require aggregation of closed blocks of business upon approval of CMS.

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B. Refund or Credit Calculation.

(1) An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(3) For the purposes of this section, policies or certificates issued prior to [insert effective date from Section 26 of this model, the effective date of the states regulation implementing the requirements of OBRA 1990], the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after the [insert effective date of this amendment]. The first report shall be due by May 31, [insert (effective year + 2) of this amendment].

Drafting Note: Subsection B(3) implements the requirements of Section 171 of the Social Security Act Amendments of 1994 that require a refund or credit calculation for pre-standardized Medicare supplement policies, but only for experience subsequent to the date the state amends its regulation.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a *de minimis* level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for thirteen-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

C. Annual filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of [insert citation to state's regulation] in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(1) (a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

(b) An issuer shall make premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

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(c) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

D. Public Hearings. The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of [insert citation to state's regulation] if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the commissioner.

Drafting Note: This section does not in any way restrict a commissioner's statutory authority, elsewhere granted, to approve or disapprove rates.

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

A. An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

B. An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

C. An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

D. (1) Except as provided in Paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage;

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

Drafting Note: As a result of MMA, issuers now may have H, I, and J (including J with a high deductible) both with and without outpatient prescription drug coverage. The language in Subsection D is flexible enough to allow the issuer and regulator to incorporate this factor to allow for additional policy forms.

Drafting Note: The filing of 2010 Standardized plans policy forms to take the place of 1990 Standardized plans policy forms prior to the actual withdrawal of the 1990 standardized plans policy forms should be permitted.

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E. (1) Except as provided in Paragraph (1)(a), an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

(a) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(b) An issuer that discontinues the availability of a policy form or certificate form pursuant to Subparagraph (a) shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered discontinuance under Paragraph (1) unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

F. (1) Except as provided in Paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in [insert citation to Section 14 of NAIC Medicare Supplement Insurance Model Regulation].

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

Drafting Note: It has come to the attention of the NAIC that the use of attained age rating in the determination of rates in Medicare supplement policies may result in situations to which a regulatory response is desirable. States should assess their Medicare supplement marketplace to determine whether a regulatory response is needed. The following provisions may be included as a new subsection to Section 15. The first option prohibits insurers from attained age rating as a methodology for setting rates. The second option does not prohibit the use of attained age rating but requires Medicare supplement insurers who do use attained age rating as a rate setting methodology to apply the age component to its rates annually. The effective date of the regulation should provide sufficient time for insurers to re-rate approved policy forms in accordance with Section 15A and for the insurance department to approve (according to its rate filing practices and procedures), such re-ratings prior to the effective date of the regulation.

Option 1.

G. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after the effective date of the amendment of this regulation based upon attained age rating as a structure or methodology.

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Option 2.

G. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after the effective date of the amendment of this regulation based upon a structure or methodology with any groupings of attained ages greater than one year. The ratio between rates for successive ages shall increase smoothly as age increases.

Drafting Note: State insurance regulators are encouraged to consider whether it is necessary to require issuers to file new forms where the only changes in the forms reflect year-to-year modifications in Medicare deductible and coinsurance amounts.

Section 16. Permitted Compensation Arrangements

A. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

B. The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

C. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

D. For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders' fees.

Section 17. Required Disclosure Provisions

A. General Rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

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(5) 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 policyholder or certificate holder 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 insured person is not satisfied for any reason.

(6) (a) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and CMS and in a type size no smaller than 12 point type. Delivery of the *Guide* shall be made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this regulation. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgement of receipt of the *Guide* shall be obtained by the issuer. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered.

(b) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

B. Notice Requirements.

(1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner. The notice shall:

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

(b) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

(2) 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.

(3) The notices shall not contain or be accompanied by any solicitation.

C. MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

D. Outline of Coverage Requirements for Medicare Supplement Policies.

(1) Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

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(3) The outline of coverage provided to applicants pursuant to this section consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12) point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) The following items shall be included in the outline of coverage in the order prescribed below.

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Benefit Chart of Medicare Supplement Plans Sold on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Basic Benefits:

- **Hospitalization –**Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses –**Part B coinsurance (generally 20% of Medicare-approved expenses) or co-payments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or co-payments.
- **Blood –**First three pints of blood each year.
- **Hospice—** Part A coinsurance

A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

K	L	M	N
Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-pocket limit $[6220]; paid at 100% after limit reached	Out-of-pocket limit $[3110]; paid at 100% after limit reached		

***Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [$2370] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$2370]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.**

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PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]
Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]
[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this regulation. An issuer may use additional benefit plan designations on these charts pursuant to Section 9.1D of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

Benefit Chart of Medicare Supplement Plans Sold on or after January 1, 2020

This chart shows the benefits included in each of the standard Medicare supplement plans. Some plans may not be available. Only applicants' **first** eligible for Medicare before 2020 may purchase Plans C, F, and high deductible F.

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Note: A ✔means 100% of the benefit is paid.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Medicare Part B coinsurance or Copayment	✔	✔	✔	✔	50%	75%	✔	✔ copays apply[3]	✔	✔
Blood (first three pints)	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Part A hospice care coinsurance or copayment	✔	✔	✔	✔	50%	75%	✔	✔	✔	✔
Skilled nursing facility coinsurance			✔	✔	50%	75%	✔	✔	✔	✔
Medicare Part A deductible		✔	✔	✔	50%	75%	50%	✔	✔	✔
Medicare Part B deductible									✔	✔
Medicare Part B excess charges				✔						✔
Foreign travel emergency (up to plan limits)			✔	✔			✔	✔	✔	✔
Out-of-pocket limit in [2020][2]					**[$6220][2]**	**[$3110][2]**				

1 Plans F and G also have a high deductible option which require first paying a plan deductible of [$2370] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

2 Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

3 Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

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PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1484]	$0	$[1484] (Part A deductible)
61st thru 90th day	All but $[371] a day	$[371] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[185.50] a day	$0	Up to $[185.50] a day
101st day and after	$0	$0	All costs

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PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[203] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PLAN A

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
- Remainder of Medicare Approved Amounts	80%	20%	$0

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PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1484]	$[1484] (Part A deductible)	$0
61st thru 90th day	All but $[371] a day	$[371] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[185.50] a day	$0	Up to $[185.50] a day
101st day and after	$0	$0	All costs

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PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

***** Once you have been billed $[203] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PLAN B

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	$0

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PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1484]	$[1484] (Part A deductible)	$0
61st thru 90th day	All but $[371] a day	$[371] a day	$0
91st day and after:	All but $[742] a day	$[742] a day	$0
– While using 60 lifetime reserve days			
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[185.50] a day	Up to $[185.50] a day	$0
101st day and after	$0	$0	All costs

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PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

***** Once you have been billed $[203] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[203] of Medicare Approved Amounts*	$0	$[203] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[203] of Medicare Approved Amounts*	$0	$[203] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PLAN C

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[203] of Medicare Approved Amounts*	$0	$[203] (Part B deductible)	$0
-Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1484]	$[1484] (Part A deductible)	$0
61st thru 90th day	All but $[371] a day	$[371] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[185.50] a day	Up to $[185.50] a day	$0
101st day and after	$0	$0	All costs

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PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

***** Once you have been billed $[203] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PLAN D

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN D

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [$2370] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2370]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2370] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2370] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1484]	$[1484] (Part A deductible)	$0
61st thru 90th day	All but $[371] a day	$[371] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
– Once lifetime reserve days are used:			
– Additional 365 days	$0	100% of Medicare eligible expenses	$0***
– Beyond the additional 365 days	$0	$0	All costs

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PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2370] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2370] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[185.50] a day	Up to $[185.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for out- patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[203] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[** This high deductible plan pays the same benefits as Plan F after you have paid a calendar year [$2370] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are [$2370]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2370] DEDUCTIBLE,*] PLAN PAYS	[IN ADDITION TO $[2370] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[203] of Medicare Approved Amounts*	$0	$[203] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B excess charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[203] of Medicare Approved Amounts*	$0	$[203] (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—-TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PLAN F or HIGH DEDUCTIBLE PLAN F

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2370] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2370] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[203] of Medicare Approved Amounts*	$0	$[203] (Part B deductible)	$0
-Remainder of Medicare — Approved Amounts	80%	20%	$0

PLAN F or HIGH DEDUCTIBLE PLAN F

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2370] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2370] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2370] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2370]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2370] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2370] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1484]	$[1484] (PartA deductible)	$0
61st thru 90th day	All but $[371] a day	$[371] a day	$0
91st day and after:			
— While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
— Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs

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PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2370] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2370] DEDUCTIBLE,**] YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[185.50] a day	Up to $[185.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/ coinsurance for out- patient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN G or HIGH DEDUCTIBLE PLAN G

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

*Once you have been billed $[203] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

[**This high deductible plan pays the same benefits as Plan G after you have paid a calendar year [$2370] deductible. Benefits from the high deductible Plan G will not begin until out-of-pocket expenses are [$2370]. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2370] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[2370] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES —IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[203] of Medicare Approved Amounts*	$0	$0	$203 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[203] of Medicare Approved Amounts*	$0	$0	$203 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PLAN G or HIGH DEDUCTIBLE PLAN G

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2370] DEDUCTIBLE,]** PLAN PAYS	[IN ADDITION TO $[2370] DEDUCTIBLE,]** YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
- First $[203] of Medicare Approved Amounts*	$0	$0	$203 (Unless Part B deductible has been met)
- Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN G or HIGH DEDUCTIBLE PLAN G

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[2370] DEDUCTIBLE,]** PLAN PAYS	[IN ADDITION TO $[2370] DEDUCTIBLE,]** YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary Emergency care services Beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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PLAN K

* You will pay half the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[6220] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare co-payment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1484]	$[742] (50% of Part A deductible)	$[742] (50% of Part A deductible)♦
61st thru 90th day	All but $[371] a day	$[371] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs

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PLAN K

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts.	$0	
21st thru 100th day	All but $[185.50] a day	Up to $[92.75] a day (50% of Part A Coinsurance)	Up to $[92.75] a day (50% of Part A Coinsurance) ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	50% of co-payment/ coinsurance	50% of Medicare co-payment/coinsurance♦

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN K

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[203] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[203] of Medicare Approved Amounts****	$0	$0	$[203] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare Approved Amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$6220])*
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[203] of Medicare Approved Amounts****	$0	$0	$[203] (Part B deductible)**** ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[6220] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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PLAN K

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[203] of Medicare Approved Amounts*****	$0	$0	$[203] (Part B deductible) ♦
-Remainder of Medicare Approved Amounts	80%	10%	10%♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

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PLAN L

* You will pay one-fourth of the cost-sharing of some covered services until you reach the annual out-of-pocket limit of $[3110] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1484]	$[1113] (75% of Part A deductible)	$[371] (25% of Part A deductible)♦
61st thru 90th day	All but $[371] a day	$[371] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0***
— Beyond the additional 365 days	$0	$0	All costs

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PLAN L

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[185.50] a day	Up to $[139.12] a day (75% of Part A Coinsurance)	Up to $[46.38] a day (25% of Part A Coinsurance)♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	75% of co-payment/ coinsurance	25% of co-payment/ coinsurance ♦

*** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN L

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[203] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[203] of Medicare Approved Amounts****	$0	$0	$[203] (Part B deductible)**** ♦
Preventive Benefits for Medicare covered services	Generally 80% or more of Medicare Approved Amounts	Remainder of Medicare Approved Amounts	All costs above Medicare Approved Amounts
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of [$3110])*
BLOOD First 3 pints	$0	75%	25%♦
Next $[203] of Medicare Approved Amounts****	$0	$0	$[203] (Part B deductible) ♦
Remainder of Medicare Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[3110] per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

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PLAN L

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[203] of Medicare Approved Amounts*****	$0	$0	$[203] (Part B deductible) ♦
-Remainder of Medicare Approved Amounts	80%	15%	5% ♦

*****Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

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PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1484]	$[742] (50% of Part A deductible)	$[742] (50% of Part A deductible)
61st thru 90th day	All but $[371] a day	$[371] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs

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PLAN M

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[185.50] a day	Up to $[185.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN M

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

* Once you have been billed $[203] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PLAN M

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN M

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

***** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[1484]	$[1484] (Part A deductible)	$0
61st thru 90th day	All but $[371] a day	$[371] a day	$0
91st day and after:			
– While using 60 lifetime reserve days	All but $[742] a day	$[742] a day	$0
– Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare eligible expenses	$0**
— Beyond the additional 365 days	$0	$0	All costs

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PLAN N

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD (cont.)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[185.50] a day	Up to $[185.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited co-payment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	$0

**** NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

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PLAN N

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $[203] of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to [$20] per office visit and up to [$50] per emergency room visit. The co-payment of up to [$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

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PLAN N

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
-First $[203] of Medicare Approved Amounts*	$0	$0	$[203] (Part B deductible)
-Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN N

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL— NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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E. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

(1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Section 3B of this regulation, issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Subsection D(1) shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

Section 18. Requirements for Application Forms and Replacement Coverage

A. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

[Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[Questions]

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes____ No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____ No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

Yes____ No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____ No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____ No____

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(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____ No____

(c) Was this your first time in this type of Medicare plan?

Yes____ No____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes____ No____

(4) (a) Do you have another Medicare supplement policy in force?

Yes____ No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____ No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____ No____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

B. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

(2) List policies sold in the past five (5) years that are no longer in force.

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C. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

D. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

E. The notice required by Subsection D above for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:

**NOTICE TO APPLICANT REGARDING REPLACMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE**

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits.

____ No change in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

____ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

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2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative) *
[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature

_____
(Date)
*Signature not required for direct response sales.

F. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

Section 19. Filing Requirements for Advertising

An issuer 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 20. Standards for Marketing

A. An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:
"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

(5) Establish auditable procedures for verifying compliance with this Subsection A.

B. In addition to the practices prohibited in [insert citation to state unfair trade practices act], the following acts and practices are prohibited:

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(1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

C. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this regulation.

Drafting Note: Remember that the Unfair Trade Practice Act in your state applies to Medicare supplement insurance policies and certificates.

Section 21. Appropriateness of Recommended Purchase and Excessive Insurance

A. In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

B. Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

C. An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

Section 22. Reporting of Multiple Policies

A. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

(1) Policy and certificate number; and

(2) Date of issuance.

B. The items set forth above must be grouped by individual policyholder.

Drafting Note: Appendix B contains a reporting form for compliance with this section.

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

A. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.

B. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

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Drafting Note: Although NAIC is restricted from making revisions to its models that do not conform to the Omnibus Budget Reconciliation Act of 1990, states are encouraged to consider deletion of the words "for similar benefits" in Subsection A and the words "for benefits similar to those contained in the original policy or certificate" in Subsection B. States should eliminate Paragraphs (1) and (2) (applicable to preexisting conditions) of the replacement notice required by Section 16E.

Section 24. Prohibition Against Use of Genetic Information and Requests for Genetic Testing

This Section applies to all policies with policy years beginning on or after May 21, 2009.

A. An issuer of a Medicare supplement policy or certificate;

1. Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a pre-existing condition) on the basis of the genetic information with respect to such individual; and

2. Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

B. Nothing in Subsection A shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from

1. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

2. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy (in such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group).

C. An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

D. Subsection C shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection A.

E. For purposes of carrying out Subsection D, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

F. Notwithstanding Subsection C, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

(1) The request is made pursuant to research that complies with part 46 of title 45, Code of Federal Regulations, or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(2) The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that –

(a) Compliance with the request is voluntary; and

(b) Non-compliance will have no effect on enrollment status or premium or contribution amounts.

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(3) No genetic information collected or acquired under this subsection shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(4) The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(5) The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under this subsection.

G. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

H. An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

I. If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of Subsection H if such request, requirement, or purchase is not in violation of Subsection G.

J. For the purposes of this section only:

(1) "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer.

Drafting Note: Not all states currently regulate third-party administrators. However, the Genetic Information Nondiscrimination Act of 2008 requires that third-party administrators be included in the definition of an issuer of a Medicare supplement policy or certificate.

(2) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

(3) "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

(4) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(5) "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(6) "Underwriting purposes" means,

(a) Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy;

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(b) The computation of premium or contribution amounts under the policy;

(c) The application of any pre-existing condition exclusion under the policy; and

(d) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

Section 25. Separability

If any provision of this regulation or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

Section 26. Effective Date

This regulation 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, 595-603 (adopted).
1981 Proc. I 47, 51, 420, 422, 424, 466-447, 470-481 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652-654, 668-677 (amended and reprinted).
1988 Proc. II 5, 13, 568, 601, 604, 615-624 (amended and reprinted).
1989 Proc. I 14, 813-814, 836, 4-836.26 (amended at special plenary session September 1988).
1989 Proc. I 9, 25, 703, 753-754, 757-760 (appendices amended at regular plenary session).
1990 Proc. I 6, 27-28, 477, 574-576, 580-599 (amended and reprinted).
1990 Proc. II 7, 16, 599, 656, 657 (adopted reporting form).
1992 Proc. I 12, 16-75, 1084-1085 (amended at special plenary session in July 1991).
1995 Proc. 1st Quarter 7, 12, 501, 575, 586, 592-615 (amended and most of model reprinted).
1998 Proc. 1st Quarter 769, 772-799, 905 (amended).
1998 Proc. 3rd Quarter 15, 576, 697, 701, 702-717 (amended).
2000 Proc. 2nd Quarter 21-22, 162, 273, 275-288 (amended).
2001 Proc. 2nd Quarter 13, 14, 118, 171, 176, 181-187 (amended).
2004 Proc. 3rd Quarter 84, 679-681, 747, 748-866 (amended and reprinted).
2008 Proc. 3rd Quarter 3-114 to 3-116, 4-24 to 4-26 (amended and reprinted).
2010 Proc. 1st Quarter (technical corrections).
2014 1st Quarter (technical revisions).
2015 1st Quarter (technical revisions).
2016 1st Quarter (technical revisions).
2016 Proc. 2nd Quarter, Vol. I 113, 137-142, 325-456, 518 (amended).
2017 1st Quarter (technical revisions).
2018 1st Quarter (technical revisions).
2018 4th Quarter (technical revisions).
Fall 2019 (technical revisions).
Fall 2020 (technical revisions).

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APPENDIX A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of_____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Years' Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a–1b		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		
4.	Refunds Last Year (Excluding Interest)		
5.	Previous Since Inception (Excluding Interest)		
6.	Refunds Since Inception (Excluding Interest)		
7.	Benchmark Ratio Since Inception (*see worksheet for Ratio 1*)		
8.	Experienced Ratio Since Inception (*Ratio 2*) Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a)–Refunds Since Inception (line 6)		
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		
10.	Tolerance Permitted (obtained from credibility table)		

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 -9,999	5.0%
2,500 -4,999	7.5%
1,000 -2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
3 Includes Modal Loadings and Fees Charged
4 Excludes Active Life Reserves
5 This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

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MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of_____ Company Name _____
NAIC Group Code_____ NAIC Company Code _____
Address _____ Person Completing Exhibit _____
Title _____ Telephone Number_____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6)] x Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a)–Refunds Since Inception (line 6) –[Adjusted Incurred Claims (line 12)/Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title - Please Type

_____
Date

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REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code_____
Address _____ Person Completing Exhibit _____
Title_____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

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REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR_____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code_____
Address _____ Person Completing Exhibit _____
Title_____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b)x(c)	Cumulative Loss Ratio	(d)x(e)	Factor	(b)x(g)	Cumulative Loss Ratio	(h)x(i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

1 Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans

3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

6 To include the earned premium for all years prior to as well as the 15th year prior to the current year.

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APPENDIX B

**FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES**

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

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APPENDIX C

DISCLOSURE STATEMENTS

Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882 (d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

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Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

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This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

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Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

Important Notice to Persons on Medicare

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Hospice care
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

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This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items & services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- The benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

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√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

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Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.
This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.
Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

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[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.
Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

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This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items & services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

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IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient prescription drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or your state [health] insurance [assistance] program [SHIP].

Drafting Note: Insurers insert reference to: outpatient prescription drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

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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.

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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 (1992/2017).	BULLETIN 9-1-2009 (2009).
Alaska	ALASKA ADMIN. CODE tit. 3, §§ 28.410 to 28.510 (1982/2019) (portions of model).	BULLETIN 2019-6 (2019).
American Samoa	NO CURRENT ACTIVITY	
Arizona	ARIZ. ADMIN. CODE §§ R20-6-1101 (2009/2019).	
Arkansas	054-00-27 ARK. CODE R. §§ 1 to 27 (1981/2018).	
California	CAL. HEALTH & SAFETY CODE §§ 1358 to 1358.24 (1992/2019) (HMOs); CAL. INS. CODE §§ 10192.1 to 10192.24 (1981/2019).	CAL. CODE REGS. tit. 10, §§ 2220.50 to 2220.58 (1983/2000).
Colorado	3 COLO. CODE REGS. § 702-4:4-3-1 (1992/2018).	BULLETIN B-4.23 (2008); BULLETIN B-4.33 (2010).
Connecticut	CONN. AGENCIES REGS. §§ 38a-495a-1 to 38a-495a-21 (1992/2019).	CONN. AGENCIES REGS §§ 38a-474-1 to 38a-474-4 (1995/2012) (review of rates).
Delaware	18 DEL. CODE REGS. § 1501 (1990/2019).	
District of Columbia		D.C. MUN. REGS. tit. 26, §§ 22.2200 to 22.2299 (1993/2012) (previous version of model).

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

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
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 (1992/2011) (previous version of model).
Guam	NO CURRENT ACTIVITY	
Hawaii	HAW. CODE R. §§ 16-12-1 to 16-12-12 (1982/2019).	
Idaho	IDAHO ADMIN. CODE r. 18.01.54.000 to 18.01.54.032 (1992/2019).	
Illinois	ILL. ADMIN. CODE tit. 50, §§ 2008.10 to 2008.110 (1983/2019).	BULLETIN 2011-15 (2011).
Indiana	760 IND. ADMIN. CODE 3-1-1 to 3-20-1 (2007/2019).	
Iowa	IOWA ADMIN. CODE r. 191-37.1 to 191-37.51; Apps. A to F. (1992/2019).	
Kansas	KAN. ADMIN. REGS. § 40-4-35 (1982/2017).	
Kentucky	806 KY. ADMIN. REGS. 17:570 (2018).	Advisory Opinion 2014-4 (2014).
Louisiana	LA. ADMIN. CODE tit. 37, § XIII.501 to XIII.599 (Regulation 33) (1992/2018).	
Maine	02-031-275 ME. CODE R. §§ 1 to 26; Apps. A to C (1992/2018).	
Maryland	MD. CODE REGS. §§ 31.10.06.01 to 31.10.06.31 (1992/2019).	
Massachusetts		211 MASS. CODE REGS. 71.01 to 71.24 (1996/2019).
Michigan	MICH. COMP. LAWS §§ 500.3801 to 500.3861 (1992/2018).	
Minnesota		MINN. STAT. §§ 62A.31 to 62A.44 (1981/2019); BULLETIN 2009-1 (2009).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Mississippi	19 MISS CODE R. Pt. 3, §§ 10.01 to 10.29 (2009/2019).	
Missouri	MO. CODE REGS. ANN. tit. 20, § 400-3.650 (1992/2019).	
Montana	MONT. ADMIN. R. §§ 6.6.503 to 6.6.527 (1982/2018).	MONT. ADMIN. R. §§ 6.6.601 to 6.6.614 (1996/2017).
Nebraska	210 NEB. ADMIN. CODE §§ 36-001 to 36-002 (1992/2018) (adopts model by reference).	
Nevada	LCB File No. R041-17 (2019).	NEV. ADMIN. CODE §§ 687B.200 to 687B.330 (1989/2009) (previous version of model); BULLETIN 92-002 (1992).
New Hampshire	N.H. CODE ADMIN. R. ANN. INS. §§ 1905.01 to 1905.27; Apps. A to C (1992/2018).	N.H. CODE ADMIN. R. ANN. INS. § 1902.06 (2016); N.H. CODE ADMIN. R. ANN. INS. § 1903.04 (2006); BULLETIN 06-039-AB (2006).
New Jersey		N.J. ADMIN. CODE §§ 11:4-23.1 to 11:4-23.24 (1991/2009) (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 (2019).	N.M. CODE R. §§ 13.10.24 (2009).
New York		N.Y. COMP. CODES R. & REGS. tit. 11, §§ 52.11 to 52.95 (1982/2019) (previous version of model).
North Carolina	11 N.C. ADMIN. CODE 12.0843 (2005) (incorporates model by reference).	N.C. GEN. STAT. § 58-3-215 (2009).
North Dakota		N.D. ADMIN. CODE §§ 45-06-01.1-01 to 45-06-01.1-22; Apps. A to C (1994/2009) (previous version of model).
Northern Marianas	NO CURRENT ACTIVITY	
Ohio	OHIO ADMIN. CODE 3901-8-08 (2018).	

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

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Oklahoma	OKLA. ADMIN. CODE §§ 365:10-5-120 to 365:10-5-143 (1993/2019).	
Oregon	OR. ADMIN. R. 836-052-0103 to 836-052-0194 (1982/2018).	
Pennsylvania	31 PA. CODE §§ 89.770 to 89.791 (1990/2018).	
Puerto Rico		P.R. REGS. § 7747 (Rule L) (1982/2009) (previous version of model).
Rhode Island	230 R.I. CODE R. §§ 20-30-7.1 to 20-30-7.28 (2018).	
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 (1982/2018).	BULLETIN 90-2 (1990).
Tennessee	TENN. COMP. R. & REGS. 0780-1-58 (1992/2019).	BULLETIN 7-29-2013 (2013).
Texas	28 TEX. ADMIN. CODE §§ 3.3301 to 3.3326 (1982/2018).	
Utah	UTAH ADMIN. CODE R590-146 (1996/2019).	UTAH ADMIN. CODE R590-85 (1989/2006).
Vermont	VT. ADMIN. CODE §§ 4-5-14:1 to 4-5-14:26 (H-2009-04) (2019).	
Virgin Islands		V.I. REG. §§ 1453-1 to 1453-25 (1990/2007) (previous version of model).
Virginia	14 VA. ADMIN. CODE §§ 5-170-10 to 5-170-220; Apps. A to D (1992/2018).	
Washington	WASH. ADMIN. CODE 284-66-010 to 284-66-400 (1990/2019).	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
West Virginia		W. VA. CODE R. §§ 114-24-1 to 114-24-22; Apps. A to G (1981/2010) (previous version of model).
Wisconsin	WIS. ADMIN. CODE INS. § 3.39 (1989/2019) (emergency rule amended regulation).	BULLETIN 10-17-2006.
Wyoming		35 WYO. CODE R. §§ 1 to 26; Apps. A to C (1980/2009) (previous version of model).

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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**.

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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**.

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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.**

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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

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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**.

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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.

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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.**

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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**.

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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**.

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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**.

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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**.

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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**.

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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

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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

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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.

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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**.

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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.**

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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**.

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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**.

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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**.

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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**.

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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**.

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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**.

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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.**

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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.**

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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**.

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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

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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**.

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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

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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.**

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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.

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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).

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