TO: NAIC Members

FROM: Commissioner Sean Dilweg
Chair, Seniors Issues (B) Task Force

DATE: October 7, 2008

RE: Implementation Materials for Revisions to Medigap Model

On September 24, 2008 the NAIC Plenary adopted revisions to the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act. The revised NAIC model regulation includes major changes to Medigap plans and benefits first approved by the NAIC in March 2007 and authorized by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). In addition, the model revisions also contain changes required by the Genetic Information Nondiscrimination Act of 2008 (GINA).

States must adopt the NAIC model revisions in order to continue to regulate the Medigap market. MIPPA and GINA established strict deadlines for state adoption of these revisions. Therefore, I urge you to review the steps your state will need to take to adopt these revisions as soon as possible. States that require action by their state legislatures should be prepared to seek such approval in 2009. Other states must adopt the revisions required by GINA by July 1, 2009 and the revisions required by MIPPA by September 24, 2009.

To assist states in the implementation process, the Senior Issues (B) Task Force has developed the attached guidance document. The document includes answers to frequently asked questions, an analysis and summary of the model revisions, a chart of the new Medigap benefits and plans, and a timeline of key dates. In addition, Section II of the document includes a list of state regulators who are available to assist you in implementing these changes.

If you have any questions or require any additional information, you may also contact Jane Sung at the NAIC at (202) 471-3979 or jsung@naic.org.

Materials to Assist in Implementation of Recent Medigap Changes

October 7, 2008

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SECTION I. ANSWERS TO FREQUENTLY ASKED QUESTIONS:

Implementation and Dates:

1. Why is the NAIC Medigap model being revised?

The conference report of the Medicare, Prescription Drug, Improvement and Modernization Act of 2003 (MMA)[1] included language encouraging the NAIC to modernize the Medigap market. This prompted a review of Medigap plans and benefits, and in 2005 the NAIC formed a Subgroup to develop a modernization proposal. In March 2007, the NAIC Plenary approved this modernization proposal, in the form of revisions to the NAIC Medigap model. However, at that time states were unable to adopt these revisions in their states until further Congressional authority was enacted.

On July 15, 2008, this authority was granted by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)[2]. MIPPA also requires additional changes to the Medigap model. These changes are made throughout the model.

In addition, Congress enacted the Genetic Information Nondiscrimination Act of 2008 (GINA)[3] on May 21, 2008. This law also calls for changes to the NAIC Medigap model. These changes are contained in revised Section 24 of the model.

2. When were these revisions adopted by the NAIC?

The final revisions were adopted by the NAIC Plenary on September 24, 2008. These revisions included changes required by GINA as well as additional changes required by MIPPA, including changes to implement the March 2007 revisions.

3. Does the model as adopted by the NAIC in September 24, 2008 also show the model revisions approved in March 2007?

Yes.

4. Why do the model revisions refer to "2010 plans" and "1990 plans"?

"2010 plans" refer to the new, modernized policies effective June 1, 2010. In the definitions laid out in Sections 4 M-L, the model revisions clarify the distinction between policies enacted prior to the state effective dates of the Omnibus Budget Reconcilliation Act of 1990 (OBRA '90) revisions (these are known as "pre-standardized plans"), policies enacted after the state effective date of OBRA '90 revisions but before June 1, 2010 (these are known as "1990 plans"), and policies enacted on or after June 1, 2010 (the "2010 plans").

5. What are the key implementation dates that states must be aware of?

May 21, 2009	This is the effective date for Medigap issuers to comply with GINA requirements. However, states that do not enact the GINA changes by May 21, 2009 in their Medigap laws will not be considered out of compliance until July 1, 2009.
July 1, 2009	This is the deadline by which states must conform their statutes or regulations to the NAIC model law revisions for GINA requirements.
September 24, 2009	This is the deadline for states to adopt NAIC Medigap model changes as required / authorized by MIPPA (including the March 2007 NAIC Medigap model revisions).
June 1, 2010	This is the earliest effective date for 2010 standardized Medigap policies. 1990 standardized Medigap policies cannot carry an effective date that is on or after June 1, 2010.

[1] Public Law 108-173.
[2] Public Law 110-175.
[3] Public Law 110-233.

6. When do states need to make changes to their Medigap rules?

All of the changes to the Medigap model that comply with GINA are contained in (revised) Section 24 of the NAIC model. States have until July 1, 2009 to make these changes to their state laws or regulations.

Changes to the Medigap model that comply with MIPPA are contained throughout the NAIC model. States have until September 24, 2009, which is one year from the date the NAIC adopted the amended model, to conform their state laws or regulations.

Therefore, if a state needs to make changes to its state laws or regulations, it should consider making both sets of changes simultaneously, by July 1, 2009 in order to meet the earlier deadline set by GINA.

7. What happens if a state does not adopt the changes?

Then the state will be considered out of compliance with federal requirements, and the state will not be able to regulate Medigap plans. CMS would regulate Medigap business in place of the state.

8. What if a state legislature does not meet in 2009?

According to NAIC research, all state legislatures meet in 2009.

9. May a state implement an effective date for GINA requirements for issuers earlier than May 21, 2009? May a state implement an effective date for the new modernization plans / benefits that is earlier than June 1, 2010?

No, in general these dates are set by federal statute.

While the GINA requirements are effective for Medigap issuers on May 21, 2009, states have until July 1, 2009 to promulgate these changes to their Medigap rules in order to enforce them.

With respect to the modernization changes for benefits and benefit plan designs, federal law (MIPPA) is very specific that 2010 standardized plans cannot have effective dates prior to June 1, 2010.

10. Why is there such a big gap of time between state adoption of the new NAIC model regulation (required by September 24, 2009), and the June 1, 2010 effective date for 2010 standardized Medigap plans?

These dates are established by federal law (MIPPA) on the theory that both states and companies will likely need the time to allow Medicare supplement issuers to file and get their 2010 Medicare supplement policy forms and rates filed and approved. Since these changes affect every Medigap plan except for Plans K and L, all Medigap carriers will have to submit new filings (including certificates, rates, advertisements, etc) during this time period in order to offer the new 2010 standardized plans prior to June 1, 2010 and to allow such plans to have an effective date on or after June 1, 2010.

11. What is required of waived states?

The GINA requirements apply to all states including waived states.

Since waived states are waived for standardization requirements contained in the federal law, it is up to the individual waived state how it will handle the benefit and benefit plan design changes in the updated NAIC Medicare supplement model. To avoid potential misunderstanding across state lines, if a waived state chooses to adopt changes to its Medigap benefit and benefit plan design consistent with the revised NAIC model regulation, the state is encouraged to make its changes applicable to policies with an effective date on or after June 1, 2010.

Modernization Changes to the Medigap model:

12. How do these "modernization" changes alter the lineup of Medigap plans?

Currently there are 17 different standardized Medigap plans in force (Plans A-L, High Deductible Plan F and High Deductible Plan J).

After the modernization revisions are implemented, there will be 11 plans available (Plans A-D, Plan F, High Deductible Plan F, Plan G, and Plans K-N). Note that the NAIC considered revising the plan letter designations to avoid missing letters, however it was felt that the marketplace was already familiar with the existing plans and therefore, changing existing plan letter designations would be more confusing.

13. What plans are eliminated and why?

Plan H, Plan I, Plan J, and High-Deductible Plan J are eliminated. Prescription drug benefits were removed from these plans by MMA. Now that redesign has also eliminated Medigap Preventive Care and At-Home Recovery benefits, these plans have become unnecessary and duplicative of other plans.

Plan E is also being eliminated. Once other benefit changes were made (in particular the replacement of the 80% Part B Excess Charge benefit with a 100% Part B Excess Charge benefit) this plan became unnecessary and duplicative of another plan.

14. What new plans are created and why?

New Plan M and new Plan N are created. These plans are designed to give beneficiaries new options for higher beneficiary cost-sharing with a lower premium.

Plan M includes 50% coverage of the Part A deductible and no coverage of the Part B deductible.

Plan N includes full 100% coverage of the Part A deductible but no coverage for the Part B deductible. In addition, coverage for the Part B coinsurance (as part of the Basic benefits) is subject to a new copay structure. The copay is up to $20 for office visits and up to $50 for emergency room visits.

15. Why does the model contain a "Section 8.1" and a "Section 9.1"?

This structure was selected so that as few changes to the model could be made as possible. Section 8 and Section 9 will remain in the model so that states can continue to reference these sections for 1990 Standardized policies effective in their states.

16. Why is the Medigap Preventive Care Benefit being eliminated?

This was an underutilized and outdated benefit given the enhanced benefits that are now available for preventive care under Medicare Part B that are not subject to Medicare's deductible and co-payment requirements.

17. Why is the Medigap At-Home Recovery being eliminated?

The At-Home Recovery benefit was an underutilized and outdated benefit given the limited availability of the benefit in the old plans. It no longer provides a significant benefit.

18. What is the change with the Hospice benefit?

The Hospice benefit is being added as a Basic (core) benefit, which will ensure that hospice coverage is available to all beneficiaries. (Note that Plans K and L already include hospice coverage.) The new Hospice benefit covers cost sharing for all Part A eligible hospice and respite care expenses.

19. Are there any changes being made to New or Innovative Benefits?

Section 9.1 of the revised model includes some changes concerning approval of new or innovative benefits. (See Section 9.1F.) The new language clarifies that approval of new or innovative benefits cannot adversely impact the

goal of Medicare supplement simplification, and these benefits should not be used to change or reduce coverage for Parts A and B deductibles, co-payments or coinsurance and benefits in any standardized plan.

In addition, the NAIC Accident and Health Working Group is reviewing language developed by the Senior Issues Task Force concerning these new or innovative benefits in the NAIC Medicare Supplement Compliance Manual. The drafting note following Section 9.1F recommends that states consider making publicly available all approved new or innovative benefits, and requests that states report the approval of these benefits to the NAIC Senior Issues Task Force who will maintain a record of these benefits for use by regulators and others. The Task Force intends to periodically review these approved benefits and consider whether to recommend that they be made part of standard benefit plan designs.

20. What is the effect of these changes on Medicare Select?

The changes made to benefits and plan designs apply to Medicare Select plans as well as non-Select plans. All plans, including Plans M and N, can also be offered as Select plans.

Required Offerings:

21. What is the new requirement regarding Plans C or F?

For 1990 standardized policies with effective dates prior to June 1, 2010, the law already requires that carriers wishing to offer any Medicare supplement plan in a state must offer at least Plan A.

MIPPA expands this requirement for 2010 standardized policies, effective on or after June 1, 2010. If a carrier wishes to offer any plan(s) in addition to Plan A, then they must also offer either Plan C or Plan F.

22. Can carriers still continue to offer only Plan A?

Yes.

23. Must companies offer both Plan C and Plan F?

No. If a carrier wants to offer more than just Plan A, then it must also offer either Plan C or Plan F. It does not have to offer both Plan C and Plan F.

24. Does offering only Plan A and High Deductible F comply with this requirement?

No. High Deductible Plan F does not meet this requirement. The carrier must offer Plan C or Plan F without a high deductible if it offers more than just Plan A.

Transition Issues:

25. Do insured beneficiaries with pre-standardized and 1990 standardized Medigap plans have to make a change?

No.

26. What if a beneficiary in an existing Medigap policy would like to get a new 2010 standardized policy?

Section 8 of the revised model provides transition standards which allow (but does not require) companies to offer existing policyholders the opportunity to exchange their current policy for a new policy without medical underwriting.

The opportunity to get a modernized 2010 standardized policy without underwriting depends on whether the company chooses to not underwrite its existing policyholders into a 2010 standardized policy.

If a company chooses not to make such an offer available, existing policyholders who want 2010 standardized policies can still choose to apply for a new policy. However, their applications would be subject to medical underwriting (unless an open enrollment or guarantee issue situation is involved).

27. When can companies begin marketing the new 2010 standardized plans and benefits?

As soon as states adopt the revised model and companies get their 2010 policy forms, rates and, if necessary, advertising approved by the state insurance department. But even though these plans may be marketed prior to June 1, 2010, they cannot have an effective date prior to June 1, 2010.

28. If a policy is applied for prior to June 1, 2010, what coverage should a person receive?

It depends on the effective date of the policy. 2010 standardized policies cannot have effective dates prior to June 1, 2010. Conversely, 1990 standardized policies cannot have effective dates on or after June 1, 2010.

Miscellaneous:

29. What is the intention of MIPPA Section 104(c) and the new drafting note following the definition of "Medicare Supplement policy" in Section 4(L) of the revised model?

MIPPA included language for plans that are designed to primarily supplement Medicare Advantage plans, requiring these plans to comply with Medicare supplement requirements. A state can prohibit the sale of plans designed to supplement Medicare Advantage plans if the plans are inconsistent with Medicare supplement standardization.

30. Will the NAIC Medicare Supplement Compliance Manual be updated to reflect all of these new changes?

Yes, the NAIC Accident and Health Working Group is currently reviewing changes that need to be made to the Compliance Manual.

31. Will the 2010 "Guide to Health Insurance for People with Medicare" (published jointly by CMS and the NAIC) include these new changes?

Yes, the 2010 Guide (which is expected to be available October 2009) will have information about both the 1990 plans and the 2010 plans.

SECTION II. STATE CONTACTS:

The following state regulators participated in the development of the Medigap model revisions and are available to assist other state regulators:

Guenther Ruch
Wisconsin
(608) 266-0295
guenther.ruch@wisconsin.gov

Mary Beth Senkewicz
Florida
850-413-5104
MaryBeth.Senkewicz@floir.com

John Rink
Nebraska
402-471-2850
John.Rink@nebraska.gov

Sarah Allen
New York
(518) 486-7815
sallen@ins.state.ny.us

Bill McAndrew
Illinois
217-782-4254
Bill.McAndrew@illinois.gov

SECTION III. SECTION-BY-SECTION ANALYSIS OF MODEL CHANGES

A description of significant changes to each section of the model are provided below. This document describes revisions adopted by the NAIC on September 24, 2008, which include the revisions approved by the NAIC on March 11, 2007.

Note that revisions that are purely cosmetic or stylistic, including minor changes to cross-references or inclusion of effective dates, have not been included in this document.

Section 1: Purpose

No changes were made.

Section 2: Authority

No changes were made.

Section 3: Applicability and Scope

No changes were made.

Section 4: Definitions

A drafting note was added following L. This note references Section 104(c) of the Medicare Improvements of Patients and Providers Act of 2008 (MIPPA), which clarifies that policies intended to supplement Medicare Advantage plans are required to comply with Medicare supplement requirements. Therefore, state regulators may prohibit such plans that do not comply with Medicare supplement standardization.

M. A definition was added for "pre-standardized" plans, to refer to policies issued prior to the state effective date for revisions conforming to the Omnibus Budget Reconcilliation Act of 1990 (OBRA '90).

N. A definition was added for "1990 standardized" plans, to refer to policies issued on or after the state effective date for revisions conforming to OBRA '90 but prior to June 1, 2010.

O. A definition was added for "2010 standardized" plans, to refer to policies issued on or after June 1, 2010.

Section 5. Policy Definitions and Terms

No changes were made.

Section 6. Policy Provisions

No significant changes were made. Only changes to cross-references or stylistic changes have been made.

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]

This section continues to be retained for transitional purposes, and governs "pre-standardized" policies or certificates.

A(3). A reference to "copayment" or "coinsurance" was added. This update was made to mirror the new language in Section 8 and Section 8.1.

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

This section is retained for transitional purposes, and governs "1990 standardized" policies or certificates.

A(3). A reference to "copayment" or "coinsurance" was added. This update was made to mirror the new language in Section 7 and Section 8.1.

A(8). These are transition standards which permit companies to offer existing policyholders the opportunity to exchange their current policy for a new policy without medical underwriting. The company has the choice whether or not to make such a transition available. If the company chooses not to make such a transition available, existing policyholders may still apply for a new policy, subject to medical underwriting, if they so choose.

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

This new section includes standards for all modernized 2010 Standardized policies effective on or after June 1, 2010. This section is intended to be similar to Section 8, which governs 1990 Standardized policies and has been placed next to Section 8 for ease of reference.

B(6). This section describes the new hospice benefit, which was created to be part of the Basic (Core) benefits.

C. In contrast to the Standards for the 1990 Standardized Additional Benefits, there are no standards for the following benefits which have been eliminated or (in the case of the prescription drug benefits) are no longer applicable:

- 80% coverage of the Part B Excess Charge
- Basic Outpatient Prescription Drug Benefit
- Extended Outpatient Prescription Drug Benefit
- Preventive Medical Care Benefit
- At-Home Recovery Benefit

The descriptions of Plans K and L have been placed in Section 9.1, rather than Section 8.1.

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

This section is retained for transitional purposes, and governs "1990 standardized" policies or certificates. No significant changes were made.

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

This new section includes standards for all modernized 2010 Standardized policies effective on or after June 1, 2010. This section is intended to be similar to Section 9, which governs 1990 Standardized policies and has been placed next to Section 9 for ease of reference.

A(2). This language is intended to promulgate a new requirement in MIPPA. Medigap rules already require that carriers wishing to offer any Medicare supplement plan in a state must offer at least Plan A. MIPPA expands this requirement so that if a carrier wishes to offer any plan(s) in addition to Plan A, then they must also offer either Plan C or Plan F. This requirement is also reflected in a drafting note at the end of Section 9.1.

E. The make-up of Plans D and G have changed. The make-up for new Plans M and N have also been added. In addition, there are no standards for the make-up of Plans E, H, I, and J as those plans have been eliminated.

E(8) and (9). The full descriptions of the benefits contained in Plans K and L have been added to this section (rather than in Section 8.1). This is a change from the format of Sections 8 and 9 for 1990 standardized policies.

F. The language describing new or innovative benefits has been updated slightly from the version in Section 9. In addition to stylistic changes, this section deletes reference to prescription drug benefits, and also

includes stronger language to reinforce the fact that these benefits should not impact the goal of Medigap simplification and should not be used to change or reduce benefits in any standardized plan.

The drafting note following Section F also references changes that are being considered for the Medicare Supplement Compliance Manual. These suggestions are intended to increase awareness of approval of new or innovative benefits in the states, and also create a process whereby successful new or innovative benefits may eventually be considered for inclusion in standardized plan designs.

Section 10. Medicare Select Policies and Certificates

No changes were made.

Section 11. Open Enrollment

No changes were made.

Section 12. Guaranteed Issue for Eligible Persons

No significant changes were made.

Section 13. Standards for Claims Payment

No changes were made.

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

No significant changes were made.

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

A drafting note has been added concerning the filing of 2010 policy forms.

Section 16. Permitted Compensation Arrangements

No changes were made.

Section 17. Required Disclosure Provisions

The benefit chart following this section was updated to reflect the new 2010 standardized plan designs and benefits. The chart for 1990 standardized plans has been deleted. The disclosures and detailed plan charts have also been updated to reflect the new 2010 standardized plan designs and benefits. (Please note that the numbers in brackets are indexed annually and must be updated).

Section 18. Requirements for Application Forms and Replacement Coverage

No changes were made.

Section 19. Filing Requirements for Advertising

No changes were made.

Section 20. Standards for Marketing

No changes were made.

Section 21. Appropriateness of Recommended Purchase and Excessive Insurance

No changes were made.

Section 22. Reporting of Multiple Policies

No changes were made.

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

No changes were made.

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

This Section was added to conform to the Genetic Information Nondiscrimination Act of 2008 (GINA).

J. The definitions included here are for the purposes of Section 24 only.

Section 25. Separability

The old Section 24 was renumbered as Section 25.

Section 26. Effective Date

The old Section 25 was renumbered as Section 26.

SECTION IV. NEW CHART

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

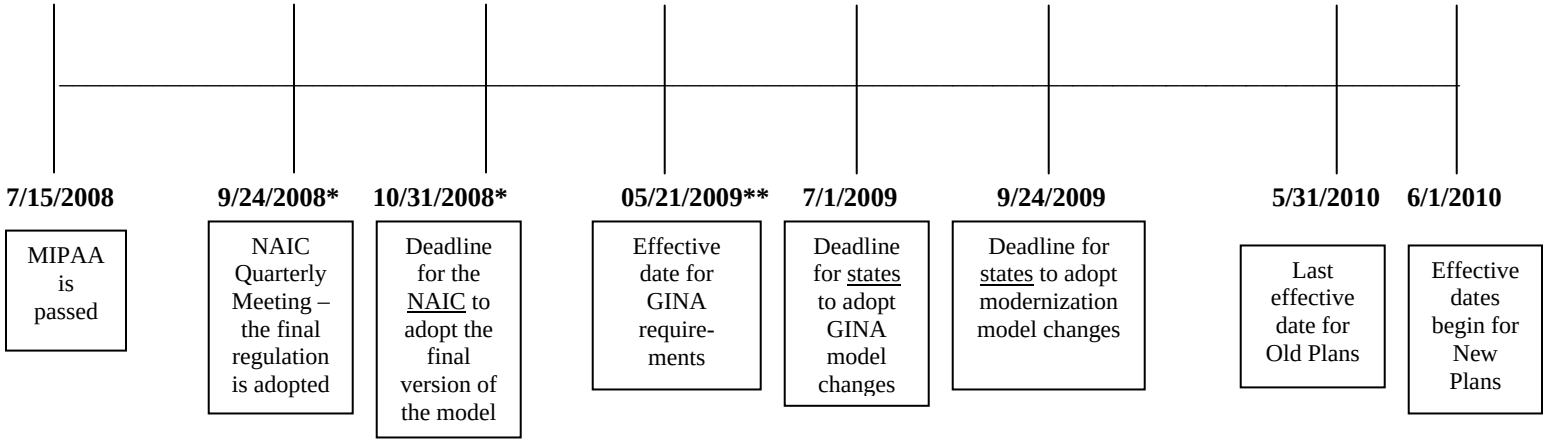
A	B	C	D	F	F*	G
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance
		Skilled Nursing Facility Coinsurance	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 $[4440]; paid at 100% after limit reached	Out-of-pocket limit $[2220]; 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 [$1900] deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed [$1900]. 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.

SECTION V. TIMELINE

NAIC Model Regulation Timeline



*****States may begin to adopt the model regulation as soon it is adopted by the NAIC. The Medigap filing process can begin in a state as soon as the state adopts the model regulation.

**States that do not enact GINA changes by this date will not be considered out of compliance until July 1, 2009.