Regulatory Analysis Form

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REVIEW COMMISSION

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IRRC Number: 2000

(1) Agency

Insurance Department

(2) I.D. Number (Governor's Office Use)

11-193

(3) Short Title

Medicare Supplement Insurance Minimum Standards

(4) PA Code Cite

31 Pa. Code, Chapter 89, §§89.777, 89.890 and Appendix E

(5) Agency Contacts & Telephone Numbers

Primary Contact: Peter J. Salvatore, Regulatory Coordinator, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429
Secondary Contact:

(6) Type of Rulemaking (check one)

- ☐ Proposed Rulemaking
- ☒ Final Order Adopting Regulation
- ☐ Final Order, Proposed Rulemaking Omitted

(7) Is a 120-Day Emergency Certification Attached?

- ☒ No
- ☐ Yes: By the Attorney General
- ☐ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.

The Insurance Department is modifying Subchapter K to allow for the sale of "Medicare Select" products (previously a federal pilot program) which is intended to expand the health care choices of Medicare eligible insureds. Generally, Medicare Select will allow consumers to purchase Medicare Select products for lower premiums than standard Medicare supplement policies. The major difference between standard Medicare supplement policies and Medicare Select policies is that each Medicare Select issuer will have a network of specific hospitals, and possibly specific doctors, that must be utilized in order to receive full benefits, except in the case of an emergency. The addition of Medicare Select products in Pennsylvania will allow consumers an additional choice in selecting a Medicare supplement product and will bring a nationally marketed product to the Commonwealth.

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

The Department proposes the amendments to 31 Pa. Code under the authority of sections 206, 506, 1501 and 1502 of the Administrative Code of 1929 (71 P.S. §§ 66, 186, 411, and 412).

(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

No.

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

The Insurance Department amends Chapter 89, §§89.777, 89.890 and Appendix E to be consistent with the authorizing statute. Moreover, it is in the public interest to amend the confusing regulatory requirements and give the public more choice when selecting Medicare Supplement Insurance.

(12) State the public health, safety, environmental or general welfare risks associated with nonregulation.

There are no public health, safety, environment or general welfare risks associated with this rulemaking.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

The general public will benefit from the regulation to the extent that it will be consistent with the statute and will give the public more options.

(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

There will be no adverse effects on any party as a result of the amendment of this regulation.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

The regulation applies to all insurers offering Medicare Supplement Insurance and who are licensed to do business in the Commonwealth, who choose to offer Medicare Select policies.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

Comments regarding the amendment of this regulation were solicited from the various trade associations representing the insurance industry. No comments were received prior to or during the 30-day public comment period. The Independent Regulatory Review Commission did comment on the regulation during its review period.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures which may be required.

The amendment of the regulation will have minimal additional costs, in filing for the approval of forms, for insurance companies.

(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures which may be required.

There are no costs or savings to local governments associated with this rulemaking.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures which may be required.

There are no costs or savings associated to state government associated with this rulemaking.

Regulatory Analysis Form

(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years. N/A

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	$	$	$	$	$	$
Regulated Community						
Local Government						
State Government						
Total Savings						
COSTS:						
Regulated Community						
Local Government						
State Government						
Total Costs						
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(20a) Explain how the cost estimates listed above were derived.

N/A.

(20b) Provide the past three year expenditure history for programs affected by the regulation.
N/A.

Program	FY –3	FY -2	FY -1	Current FY

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

No costs or adverse effects are anticipated as a result of this regulation.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

Amending Chapter 89, §§89.777, 89.890 and Appendix E is the most efficient method to achieve consistency with the authorizing statute. No other alternatives were considered.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

No other regulatory schemes were considered. The amendment of the regulation is the most efficient method of updating the regulatory requirements.

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

No.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

The rulemaking will not put Pennsylvania at a competitive disadvantage with other states. It merely provides for consistency with the statute. The addition of Medicare Select products in Pennsylvania will allow consumers an additional choice in selecting a Medicare supplement product and will bring a nationally marketed product to the Commonwealth.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

No.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

No public hearings or informational meetings are anticipated.

(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports which will be required as a result of implementation, if available.

The amendment of the regulation imposes some additional paperwork requirements on the Department, insurers or the general public. The insurance industry must submit forms for approval to the Department who must review the forms and reports on grievances filed with the carrier.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

The rulemaking will have no effect on special needs of affected parties.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

The rulemaking will take effect upon approval of the final form regulation by the legislative standing committees, the Independent Regulatory Review Commission, the Office of the Attorney General and upon final publication in the *Pennsylvania Bulletin.*

(31) Provide the schedule for continual review of the regulation.

The Department reviews each of its regulations for continued effectiveness on a triennial basis.

CDL-1

FACE SHEET FOR FILING DOCUMENTS WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

#2000

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality. Attorney General	Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:	Copy below is hereby approved as to form and legality. Executive or Independent Agencies
By _____ (Deputy Attorney General)	Insurance Department (AGENCY)	BY: _____
_____ Date of Approval	DOCUMENT/FISCAL NOTE NO. 11-193	2/28/00 DATE OF APPROVAL
	DATE OF ADOPTION: _____	(DEPUTY GENERAL COUNSEL) (~~CHIEF COUNSEL, INDEPENDENT AGENCY~~) (STRIKE INAPPLICABLE TITLE)
→ Check if applicable. Copy not approved. Objections attached.	BY: M. Diane Koken M. Diane Koken Insurance Commissioner	→ Check if applicable. No Attorney General approval or objection within 30 days after submission.
	TITLE: _____ (EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)	

NOTICE OF FINAL RULEMAKING

INSURANCE DEPARTMENT

31 Pa. Code, Chapter 89
Sections 89.777, 89.890 and Appendix E

Medicare Supplement Insurance Minimum Standards

PREAMBLE

By this notice the Insurance Department (the Department) hereby proposes to amend 31 Pa. Code, Chapter 89, Subchapter K, Medicare Supplement Insurance Minimum Standards, §§ 89.777, 89.790 and Appendix E, to read as set forth in Annex A. The Department proposes the amendments to 31 Pa. Code under the authority of sections 206, 506, 1501 and 1502 of the Administrative Code of 1929 (71 P.S. §§ 66, 186, 411, and 412).

Purpose

Chapter 89, Subchapter K, was initially promulgated to establish certain minimum standards for Medicare Supplement Insurance. The Insurance Department seeks to modify Subchapter K to allow for the sale of "Medicare Select" products (previously a federal pilot program) which is intended to expand the health care choices of Medicare eligible insureds. Generally, Medicare Select will allow consumers to purchase Medicare Select products for lower premiums than standard Medicare supplement policies. The major difference between standard Medicare supplement policies and Medicare Select policies is that each Medicare Select issuer will have a network of specific hospitals, and possibly specific doctors, that must be utilized in order to receive full benefits, except in the case of an emergency. It is similar in concept to preferred provider organizations (PPOs) for accident and health insurance. However, Medicare Select policies are not PPO policies and are not subject to Section 630 of the Insurance Company Law (40 P.S. § 764a). In addition, because Medicare Select policies do not meet the definition of "managed care plans" in Act 68 of 1998 (40 P.S. §§ 991.2101 - 991.2193), the provisions of that act, including those relating to complaints and grievances, do not apply to Medicare Select policies. Pennsylvania is one of the few remaining states that has not authorized the sale of the Medicare Select product. The Department believes this puts consumers and issuers at a competitive disadvantage in comparison with neighboring states. The Department has received numerous inquiries and letters of support for Medicare Select from consumers, the insurance industry and providers alike. The Department has also clarified and revised language to improve the readability and understandability of the regulations.

Comments and Response

Notice of proposed rulemaking was published at 29 Pa.B. 650 (February 6, 1999) as a proposed rulemaking with a 30-day public comment period. No comments were received from the public or the insurance industry.

On April 8, 1999, the Independent Regulatory Review Commission (IRRC) responded with comments.

IRRC noted that the regulation was not clear regarding what constitutes a complaint, how complaints are to be distinguished from grievances, and the procedures

an insurer must follow when a complaint is received. IRRC also commented that the definition of "complaint" in section 89.777a(c)(1) does not provide a clear distinction between a complaint and a grievance.

Complaints are more general and less formal than grievances. Grievances are more formal and focused on the administration, claims practices or provision of services of a Medicare Select issuer or its network providers. The Department believes that both complaints and grievances need to be included in the regulation. Based on its review of this comment, the Department revised the definition to clarify that a complaint can be expressed "orally or in writing" and can be filed by an individual "insured under a Medicare Select policy or certificate."

IRRC commented that paragraph (f)(3) requires a Medicare Select issuer to provide a description of the grievance procedure. They questioned why there was not a similar requirement for complaints.

The Department agrees and a new paragraph (f)(4) has been added requiring that Medicare Select issuers provide a description of the complaint procedure to be utilized.

IRRC further commented that the scope of paragraph (f)(7), which required a proposed plan to contain "other information requested by the Commissioner", was too broad and should be narrowed to information pertinent to the plan of operation.

The Department agrees and paragraph (f)(7) has been renumbered as (f)(8) and revised to include that the other information requested by the Commissioner shall be "pertinent to the plan of operation".

IRRC commented that the requirements for hearing complaints and resolving written grievances in paragraphs (l)(1) – (6) should apply to both complaints and grievances.

The Department agrees and paragraphs (l)(1) – (5) have been revised to include these requirements for both complaints and grievances. Paragraph (l)(6) has not been revised to include complaints. Because complaints are a less formal process than grievances and can be expressed orally, the Department believes it would be an unnecessary regulatory burden to require issuers to track and formally report on complaints to the Department. The Department has the authority under the examination law to review insurers' files. Examinations can be performed at anytime to determine if an insurer is properly classifying complaints and grievances should the Department determine that an examination is necessary.

IRRC further commented regarding subsection (l) that the Department should require issuers to explain how an individual may initiate a complaint or grievance.

The Department believes that this issue is addressed by the proposed language in paragraph (l)(2).

IRRC further commented on the timeframes for consideration of and notification to concerned parties in paragraphs (l)(3) – (5). They were concerned that these subsections do not provide clear guidance for when the actions are expected to occur.

Medicare Select is a Medicare supplement product that pays after Medicare pays based on Medicare's benefit determination and the use of participating Medicare Select providers. Timeframes for the consideration of complaints and grievances have been added. The timeframes for action by the issuer do not start until after a benefit determination has been made by Medicare. The Department has clarified this in paragraphs (l)(3)-(5).

Persons Regulated

This regulation applies to all insurance companies who issue Medicare Supplement products in the Commonwealth and who choose to offer Medicare Select policies.

Fiscal Impact

The Insurance Department currently has the capacity to review the new Medicare Select filings in the course of normal business and should experience minimal or no cost increases in reviewing these new products.

The insurance industry will incur minimal additional costs in filing for the approval of the new forms, if they chose to offer Medicare Select products. Most issuers should be able to submit forms either identical, or very similar to, variations approved in other states because this regulation is adopting the NAIC model language.

Consumers could experience additional savings based on greater product availability.

Paperwork

Adoption of these regulations will require additional paperwork in the product development area only if issuers chose to market Medicare Select products. Paperwork requirements should not be burdensome for the Department because the new Medicare Select products can be reviewed during the normal course of business.

Effectiveness/Sunshine Date

The proposed regulation will become effective upon final adoption and publication in the *Pennsylvania Bulletin* as final rulemaking. No sunset date has been assigned.

Contact Person

Questions or comments regarding this final form rulemaking may be addressed to Peter J. Salvatore, Regulatory Coordinator, Pennsylvania Insurance Department, 1326 Strawberry Square, Harrisburg, Pennsylvania 17120, telephone number (717) 787-4429. Questions and comments may also be e-mailed to psalvato@ins.state.pa.us or faxed to (717) 772-1969.

Regulatory Review

Under Section 5(a) of the Regulatory Review Act (71 P.S. §745.5(a)) the agency submitted a copy of this regulation on January 27, 1999 to the Independent Regulatory Review Commission and to the Chairpersons of the Senate Committee on Banking and Insurance and the House Insurance Committee. In addition to the submitted regulation, the agency has provided the Commission and the Committees with a copy of a detailed Regulatory Analysis Form prepared by the agency in compliance with Executive Order 1996-1, "Regulatory Review and Promulgation." In compliance with section 5(c) of the Regulatory Review Act (71 P.S. §745.5(c)), the Department also provided IRRC and the Committees with copies of the comments received. A copy of that material is available to the public upon request.

This final form regulation was (deemed) approved by the Senate Committee on Banking and Insurance on _____ and (deemed) approved by the House Insurance Committee on _____in accordance with section 5a(d) of the Regulatory Review Act (71 P.S. §745.5a(d)). IRRC met on _____ and (deemed) approved the regulation in accordance with section 5a(e) of the Regulatory Review Act (71 P.S. §745.5a(e)).

Findings

The Insurance Commissioner finds that:

(1) Public notice of intention to adopt this rulemaking as amended by this order has been given under sections 201 and 202 of the act of July 31, 1968, (P.L. 769, No. 240) (45 P.S. §§1201 and 1202) and the regulations thereunder, 1 Pa. Code §§7.1 and 7.2.

(2) The adoption of this rulemaking in the manner provided for in this order is necessary and appropriate for the administration and enforcement of the authorizing statutes.

Order

The Insurance Commissioner, acting under the authorizing statutes, orders that:

(a) The regulations of the Insurance Department, 31 Pa. Code, Chapter 89 is amended to read as set forth in Annex A.

(b) The Commissioner shall submit this order and Annex A to the Office of General Counsel and Office of Attorney General for approval as to form and legality as required by law.

(c) The Commissioner shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(d) The regulations adopted by this order shall take effect publication in the *Pennsylvania Bulletin.*

M. Diane Koken
Insurance Commissioner

CONTINUATION SHEET FOR FILING DOCUMENTS
WITH THE LEGISLATIVE REFERENCE BUREAU
Pursuant to Commonwealth Documents Law

ANNEX A

TITLE 31.—INSURANCE. PART IV.—LIFE INSURANCE. CHAPTER 89 - APPROVAL OF LIFE, ACCIDENT, AND HEALTH INSURANCE. Subchapter K. Medicare Supplement Insurance Minimum Standards

Section 89.777a Medicare Select policies and certificates.

* * * * *

Section 89.790 Guaranteed issue for eligible persons.

Appendix E Medicare Supplement Refund Calculation Forms; Reporting Forms for Calculation of Benchmark Ratio.

* * * * *

31 § 89.777a. Medicare Select policies and certificates.

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

(b) A policy or certificate may not be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(c) For the purposes of this section the following words and terms shall have the following meanings, unless the context clearly indicates otherwise:

(1) *Complaint* - Dissatisfaction expressed ORALLY OR IN WRITING by an individual INSURED UNDER A MEDICARE SELECT POLICY OR CERTIFICATE concerning a Medicare Select issuer or its network providers.

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

(3) *Medicare Select issuer* - An issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(4) *Medicare Select policy* or *Medicare Select certificate* - A Medicare supplement policy or certificate, respectively, that contains restricted network provisions.

(5) *Network provider* - 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* - A provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(7) *Service area* - The geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

(d) 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 (42 U.S.C.A. § 1395b-2) if the Commissioner finds that the issuer has satisfied the requirements of this section.

(e) 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.

(f) 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:

(i) 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 the usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

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

(A) Deliver adequately all services that are subject to a restricted network provision.

(B) Make appropriate referrals.

(iii) There are written agreements with network providers describing both parties' specific responsibilities.

(iv)Emergency care is available 24 hours per day and 7 days per week.

(v) 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 COMPLAINT PROCEDURE TO BE UTILIZED.

~~(4)~~(5) A description of the quality assurance program, including the following:

(i) The formal organizational structure.

(ii) The written criteria for selection, retention and removal of network providers.

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

~~(5)~~(6) A list and description, by specialty, of the network providers.

~~(6)~~(7) Copies of the written information proposed to be used by the issuer to comply with subsection (j).

~~(7)~~(8) Other information PERTINENT TO THE PLAN OF OPERATION requested by the Commissioner.

(g) A Medicare Select issuer shall file:

(1) 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 30 days unless specifically disapproved.

(2) An updated list of network providers with the Commissioner at least quarterly, if changes occur.

(h) A Medicare Select policy or certificate may not restrict payment for covered services provided by nonnetwork providers if the following apply:

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

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

(i) 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.

(j) 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 ~~other~~:

(i) Medicare supplement policies or certificates offered by the issuer.

(ii) 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.

(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 another 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.

(k) 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 (j) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(l) 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 COMPLAINT AND 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 COMPLAINT OR grievance may be registered with the issuer.

(3) ~~Grievances~~ COMPLAINTS AND GRIEVANCES shall be considered ~~in a timely manner and~~ WITHIN 45 DAYS. IF A BENEFIT DETERMINATION BY MEDICARE IS NECESSARY, THE 45 DAY REVIEW PERIOD SHALL NOT BEGIN UNTIL AFTER THE MEDICARE DETERMINATION HAS BEEN MADE. THE COMPLAINT OR GRIEVANCE shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a COMPLAINT OR grievance is found to be valid, corrective action shall be taken ~~promptly~~ WITHIN 45 DAYS.

(5) The concerned parties shall be notified about the results of a COMPLAINT OR grievance WITHIN 45 DAYS OF THE DECISION.

(6) The issuer shall report by 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 the grievances.

(m) 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.

(n) For purposes of this section the following apply:

(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 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 prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(o) Medicare Select policies and certificates shall provide for continuation of coverage in the event the ~~HHS~~ UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES Secretary determines that Medicare Select policies and certificates issued under 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 prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

(p) 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.

* * * * *

31 § 89.790 Guaranteed issue for eligible persons.

* * * * *

(b) Eligible Persons

An eligible person is an individual described in paragraphs (1)-(6):

* * * * *

(6) The individual, upon first becoming eligible for benefits under Part A [or] and enrolled in Part B, if eligible, of Medicare [at age 65 or older], enrolls in a Medicare+Choice plan under Part C of Medicare, and disenrolls from the plan within 12 months after the effective date of enrollment.

* * * * *

Appendix E

MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____

For the State of _____

Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Person Completing This Exhibit _____

Title _____ Telephone Number _____

		(a) Earned Premium[3]	*(b) Incurred Claims[4]*
1	Current Year's 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 Years' Experience)	_____	_____
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)	_____	

Ratio 2 = $\frac{\text{Total Actual Incurred Claims (line 3, col b)}}{\text{Total Earned Premium (line 3, col a) - Refunds Since Inception (line 6)}}$ [= Ratio 2]

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 REFUND CALCULATION FORM FOR CALENDAR YEAR_____TYPE1_____SMSBP2_____

_____ For the State of _____

Company Name _____ NAIC Group Code _____NAIC Company Code _____]

11 Adjustment to Incurred Claims for Credibility (Ratio 3) _____

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) (line 7)}

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 and/or credit against premium to be used must be attached to this form.

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.

[MEDICARE SUPPLEMENT REFUND CALCULATION FORM FOR CALENDAR YEAR____TYPE1_____SMSBP2_____

____ For the State of _____

Company Name _____ NAIC Group Code _____NAIC Company Code _____]

[1] Individual [and], Group, Individual Medicare Select, and Group Medicare Select only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan—Use "P" for prestandardized plans.

[3] Includes modal [model] 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."

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

_____
Date

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 _____

Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a)[3]	(b)[4] Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o)[5] PolicyYear 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		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(l):		(m):		(n):		

Benchmark ratio since inception (Ratio 1): (l + n)/(k + m):

1 Individual [and], Group, Individual Medicare Select, and Group Medicare Select only.

2 "SMSBP" = Standardized Medicare Supplement Benefit Plan—Use "P" for prestandardized 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, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown for informational purposes only.

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 _____

Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a)[3]	(b)[4] Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o)[5] PolicyYear 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		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		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark ratio since inception (Ratio 1): (l + n)/(k + m):

[1] Individual [and], Group, Individual Medicare Select, and Group Medicare Select only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan—Use "P" for prestandardized 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, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown for informational purposes only.

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER:	11-193
SUBJECT:	MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS
AGENCY:	DEPARTMENT OF INSURANCE

TYPE OF REGULATION

Proposed Regulation

X Final Regulation

Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

Delivery of Tolled Regulation
a. With Revisions b. Without Revisions

RECEIVED
2000 MAR -8 PM 1:38
INDEPENDENT REGULATORY
REVIEW COMMISSION

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
3-8-00	Sheila Eckhart	HOUSE COMMITTEE ON INSURANCE
3/8/00	Denise Taylor	SENATE COMMITTEE ON BANKING AND INSURANCE
3/8/00	J. Schmidt	INDEPENDENT REGULATORY REVIEW COMMISSION
		ATTORNEY GENERAL
		LEGISLATIVE REFERENCE BUREAU

March 7, 2000