

STATE OF NEBRASKA

DEPARTMENT OF INSURANCE

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E. Benjamin Nelson
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BULLETIN

SUBJECT: P.L. 103-432 -- THE SOCIAL SECURITY ACT AMENDMENTS OF 1994
(MEDICARE SUPPLEMENT TECHNICAL CORRECTIONS)

The Social Security Act Amendments of 1994 -- P.L. 103-432 (H.R. 5252) makes several amendments to the federal requirements relating to Medicare supplement insurance. Several of these changes are effective October 31, 1994, the date of enactment of H.R. 5252. The purpose of this bulletin is to notify you of these changes in an effort to assist you with complying with the revised federal requirements. H.R. 5252 contains other provisions that will require changes to Chapter 36 of the Nebraska Department of Insurance Regulations entitled, "Regulation to Implement the Medicare Supplement Insurance Minimum Standards Act," and may require amendments to Neb.Rev.Stat. §44-3601 et seq., Medicare Supplement Insurance Minimum Standards Act. This bulletin summarizes some of the major components of H.R. 5252 that affect Medicare supplement insurance.

1. Open Enrollment - See 42 U.S.C §1395ss(s)

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) required the issuance of any Medicare supplement policy approved for use in this state to anyone who is age 65 or older for which an application is submitted within six months of when the applicant first enrolls in Medicare Part B. Individuals who qualified for Medicare prior to age 65 and enrolled in Medicare Part B prior to age 65 by reason of disability or end stage renal disease were previously not covered by the OBRA 1990 open enrollment because they were not "first" enrolling in Medicare Part B at age 65.

H.R. 5252 does not extend open enrollment to persons under age 65 who are eligible for Medicare due to disability or end stage renal disease, however, it does give these individuals a six-month open enrollment period upon attainment of age 65. Under these provisions, persons are eligible for a six-month open enrollment period as of the first day they are both 65 years of age or older and enrolled in Medicare Part B. During the open enrollment period, issuers may not deny or condition the issuance of effectiveness of a Medicare supplement policy, or discriminate in the pricing of the policy, because of health status, claims experience, receipt of health care, or medical condition.

Additionally, all Medicare beneficiaries who turned 65 between November 5, 1991, and January 1, 1995, and who were not eligible for the OBRA 1990 open enrollment because they were enrolled in Medicare Part B prior to reaching age 65, are given a one-time six-month open enrollment period beginning January 1, 1995. This one-time federal open enrollment period applies to any Medicare beneficiary who had part B coverage prior to age 65 and turned 65 between November 5, 1991, and January 1, 1995.

2. Loss Ratio Provisions - See 42 U.S.C. §1395ss(r)

Under OBRA 1990, any policy issued after November 5, 1991, was required to obtain a 65% loss ratio for individual policies and a 75% loss ratio for group policies and to return to policyholders premium amounts collected in excess of these standards. Compliance with these requirements is verified through an annual filing of a worksheet showing the experience of those policy forms. However, the effective date of the state requirement was not the same as that of the federal requirement. H.R. 5252 resolves the difference between the federal effective date and the state effective date on refund calculations and also subjects all Medicare supplement policies to the same loss ratio and refund calculation requirements. However, for policies issued prior to June 1, 1992, the requirement for the 65% loss ratio requirement for individual policies and 75% loss ratio requirement for group policies and refund or credit against future premium payments apply only to the experience occurring after the revised standards are promulgated to implement H.R. 5252.

3. Duplication of Coverage - See 42 U.S.C. §1395ss(d)

With the enactment of OBRA 1990, it has generally been a violation of federal law to sell or issue a health insurance policy to a Medicare beneficiary with knowledge that the policy duplicates health benefits (Medicare, Medicaid, or private health coverage) to which the individual is otherwise entitled. It is also unlawful for a company to sell a duplicate Medicare supplement policy to a Medicare beneficiary.

The revised federal law continues the prohibition against selling duplicate Medicare supplement policies. However, policies which duplicate Medicare will be exempt from the prohibition if they pay benefits directly to the beneficiary without regard to other coverage and the application for insurance contains a clear statement disclosing the extent to which the policies duplicate Medicare. The NAIC has until January 29, 1995, to develop model disclosure statements and submit them to the Secretary of the U.S. Department of Health and Human

Services (Secretary) for approval and publication. Policies issued 60 days after publication and approval by the Secretary of the disclosure language which duplicate Medicare must include the approved disclosure statement on the application.

The current prohibition of sales of Medicare supplement policies to Medicaid beneficiaries has not changed. However, in addition to the existing exception for situations in which Medicaid pays the premium, the revised federal statute allows the sale of a Medicare supplement policy to a Qualified Medicare Beneficiary (QMB), as defined in 42 U.S.C. §1396(p)(1), if the policy provides benefits for prescription drugs. This allows carriers to sell Medicare supplement standard plans H, I, and J to QMBs. QMBs are persons at or below the federal poverty level who also meet certain other resource limits. Additionally, companies may sell a Medicare supplement policy to a Specified Low-Income Medicare Beneficiary (SLMB). SLMBs are persons at or below 120% of the federal poverty level meeting certain resource limits. Medicaid pays only the Part B premium for SLMBs and covers none of the other cost sharing amounts under Medicare.

4. Mailing of Policies - See 42 U.S.C. §1395ss(d)(4)

OBRA 1990 prohibited issuers from mailing a duplicate copy of a Medicare supplement policy to a policyholder unless the policy has been approved in the state in which the policyholder permanently resides or the policy would terminate within 12 months of being mailed. This affected persons who had misplaced their policy or certificate and had moved to a state where it had not been filed.

H.R. 5252 permits mailing a duplicate policy which has not been filed in the policyholder's home state under any of the following circumstances (1) The policy is guaranteed renewable; (2) It is a conversion to individual coverage required because the master group policy terminated or the certificateholder has left the group; (3) A whole group policy is being replaced; or (4) The individual is reinstating coverage which was suspended during a period of Medicaid eligibility.


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