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LINDA RUTHARDT
COMMISSIONER

Bulletin No. 95-02

To: All Medicare Supplement Insurers

From: Commissioner Linda Ruthardt

RE: P.L. 103-432--The Social Security Act Amendments of 1994
(Medicare Supplemental Technical Corrections)

Date: March 9, 1995

cc: All Health Maintenance Organizations Participating in the Market for Evidences of Coverage Issued Pursuant to a Risk or Cost Contract

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 to assist you with complying with the revised federal requirements. H.R. 5252 contains other provisions that may require changes to Massachusetts regulation 211 CMR 69.00 *et seq.*, which is entitled Medicare Supplement Insurance and Evidences of Coverage Issued Pursuant to a Risk or Cost Contract--To Facilitate the Implementation of M.G.L. c. 176K.

This bulletin summarizes some of the major components of H.R. 5252 that affect Medicare Supplement Insurance in Massachusetts, as well as the relationship between certain components and reform measures that have been implemented under 211 CMR 69.00.

Any questions regarding this bulletin should be referred to Kevin Beagan, Director of the Health Policy Unit, State Rating Bureau of the Division of Insurance at 617-521-7347.

1. Open Enrollment--*See* 42 U.S.C. Sec. 1395ss(s) and 211 CMR 69.10

OBRA 90

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) required the issuance of any Medicare supplement policy approved for use in Massachusetts to anyone who is age 65 or older for which an application is submitted within 6 months of when the applicant first enrolled in Medicare Part B. Individuals who qualified for Medicare prior to age 65 and enrolled in Medicare Part B before 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

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, H.R. 5252 does give these individuals a six-month open enrollment period upon attainment of age 65. Under these provisions, such 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 or 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 before reaching age 65, are given a one-time six-month open enrollment period beginning January 1, 1995 and ending on June 30, 1995. This one-time *federal* open enrollment period applies to any Medicare beneficiary who had Part B coverage before age 65 and turned 65 between November 5, 1991, and January 1, 1995.

Massachusetts Requirements

Massachusetts regulations provide under 211 CMR 69.03 and 69.10 that a person who is eligible for Medicare due to disability is an "eligible person" (except those who are eligible for Medicare only due to end stage renal disease if a Medicare Supplement insurer does not include them as "eligible persons) who becomes "initially eligible for [Medicare supplement or HMO Medicare plan] coverage" when that person enrolls in Medicare Part B, even if that person is under the age of 65 at the time of enrollment in Medicare Part B. As a result, such a person is entitled to a six-month open enrollment period in accordance with 211 CMR 69.10(4) upon enrollment in Medicare Part B or other events which trigger eligibility for coverage. Therefore, in Massachusetts, such a person does not have to wait until age 65 to have a six-month open enrollment period for Medicare supplement insurance.

Please note that a person who is eligible for Medicare due to disability (except those who are eligible for Medicare only due to end stage renal disease as noted above) will be able to benefit from the open enrollment period required by H.R. 5252 for Medicare Supplement insurance when that person

turns 65 as discussed above *in addition to* the Massachusetts open enrollment periods found in 211 CMR 69.10.

Those individuals who are eligible for Medicare only due to end stage renal disease and are not treated as "eligible persons" by the Medicare Supplement insurer, *once they turn 65*, will benefit from the open enrollment periods required by H.R. 5252, as well as any open enrollment period found in 211 CMR 69.10.

2. Loss Ratio Provisions--*See* 42 U.S.C. Sec. 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 calculation requirements. For policies issued prior to July 30, 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.

It should be noted that the loss ratio requirements for commercial insurance companies have remained consistent between the current regulation (211 CMR 69.00) and the previous regulation (211 CMR 68.00) but the requirements for Blue Cross and Blue Shield of Massachusetts, Inc. are different between the two regulations.

3. Duplication of Coverage--*See* 42 U.S.C. Sec. 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 that 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 developed model disclosure statements and submitted them to the Secretary of the U.S. Department of Health and Human Services (Secretary) for approval and publication. Policies that duplicate Medicare and are issued 60 days after publication and approval by the Secretary of the disclosure language that 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, the revised federal statute allows the sale of a Medicare supplement policy to a Qualified Medicare Beneficiary (QMB) if the policy provides benefits for outpatient prescription drugs. QMBs are persons at or below the federal poverty level who also meet certain other resource limits. In Massachusetts, therefore, carriers may now sell Medicare Supplement 2 under 211 CMR 69.00 to a QMB who applies for coverage to start on or after January 1, 1995. 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. Sec. 1395ss(d)(4)

OBRA 1990 prohibited issuers from mailing a duplicate copy of a Medicare supplement policy to a policyholder unless the policy had 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 that 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 that was suspended during a period of Medicaid eligibility.