

## **Title 210 – NEBRASKA DEPARTMENT OF INSURANCE**

### **Chapter 54 - REGULATION TO IMPLEMENT TRANSITIONAL REQUIREMENTS FOR THE CONVERSION OF MEDICARE SUPPLEMENT INSURANCE BENEFITS AND PREMIUMS TO CONFORM TO REPEAL OF MEDICARE CATASTROPHIC COVERAGE ACT**

001. Purpose. The purpose of this regulation is to assure the orderly implementation and conversion of Medicare supplement insurance benefits and premiums due to changes in the federal Medicare Program; to provide for the reasonable standardization of the coverage, terms and benefits of Medicare supplement policies or contracts; to facilitate public understanding of such policies or contracts; to eliminate provisions contained in such policies or contracts which may be misleading or confusing in connection with the purchase of such policies or contracts; to eliminate policy or contract provisions which may duplicate Medicare benefits; to provide for adjustment of required minimum benefits for Medicare supplement policies; to provide notice to former policyholders of offer to reinstitute coverage; to provide full disclosure of policy or contract benefits and benefit changes; and to provide for appropriate premium adjustments.

002. Authority. This regulation is issued pursuant to the authority vested in the Director under Neb.Rev.Stat., §44-101.01, the Unfair Insurance Trade Practices Act, §44-152~~21~~ et. seq., and the Medicare Supplement Insurance Minimum Standards Act, §44-3601 et. seq.

003. Applicability and scope. This regulation shall take precedence over other rules and requirements relating to Medicare supplement policies or contracts only to the extent necessary to assure that benefits are not duplicated and to adjust minimum required benefits to changes in Medicare benefits, that applicants receive adequate notice and disclosure of changes in Medicare supplement policies and contracts, that appropriate premium adjustments are made in a timely manner, and that premiums are reasonable in relation to benefits.

003.01 Except as otherwise provided in Section 005, this regulation shall apply to:

003.01A All Medicare supplement policies and contracts delivered, or issued for delivery, or which are otherwise subject to the jurisdiction of this state on or after the effective date hereof, and

003.01B All certificates issued under group Medicare supplement policies as provided in subsection 003.01A above.

## 004. Definitions.

004.01 For purposes of this regulation:

004.01A "Applicant" means:

004.01A(1) In the case of an individual Medicare supplement policy or contract, the person who seeks to contract for insurance benefits, and

004.01A(2) In the case of a group Medicare supplement policy or contract, the proposed certificateholder.

004.01B "Certificate" means any certificate issued under a group Medicare supplement policy.

004.01C "Medicare Supplement Policy" means a group or individual policy of sickness and accident insurance or any other contract which is advertised, marketed or designed primarily to provide health care benefits as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

## 005. Benefit conversion requirements.

005.01 Effective January 1, 1990, no Medicare supplement insurance policy, contract or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

005.02 Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

005.03 For Medicare supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be:

005.03A 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;

005.03B Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount.

005.03C Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital

inpatient reserve days;

005.03D Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

005.03E 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;

005.03F Coverage for the coinsurance 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 [\$75].

005.03G 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.

#### 005.04 General Requirements

005.04A No later than January 31, 1990, every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this State shall notify its policyholders, contract holders and certificateholders of modifications it has made to Medicare supplement insurance policies or contracts. Such notice shall be in the format contained in Appendix A.

005.04A(1) Such notice shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy or contract.

005.04A(2) The notice shall inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be effective.

005.04A(3) 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.

005.04A(4) Such notice shall not contain or be accompanied by any solicitation.

005.04B No modifications to an existing Medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this regulation except to the extent necessary to accomplish the purpose articulated in section 003 of this regulation.

## 006. Form and rate filing requirements.

006.01 As soon as practicable, but no longer than forty-five (45) days after the effective date of the Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this State shall file with the Department, in accordance with the applicable filing procedures of this State:

006.01A Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

006.01B Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare and to provide the benefits required by section 005. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

006.02 Upon satisfying the filing requirements of this State, every insurer, health care service plan or other entity providing Medicare supplement insurance in this State shall provide each covered person with any rider, endorsement or policy form necessary to make the adjustments outlined in section 005 above.

006.03 Any premium adjustments shall produce an expected loss ratio under such policy or contract as will conform with minimum loss ratio standards for Medicare supplement policies and shall result in an expected loss ratio at least as great as that originally anticipated by the insurer, health care service plan or

other entity for such Medicare supplement insurance policies or contracts. Premium adjustments may be calculated for the period commencing with Medicare benefit changes.

006.04 Require that such filing made pursuant to State laws and rules be accompanied by the certification of an officer of the filing entity that the filing complies with all the requirements of the Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of the Medicare Catastrophic Coverage Act (Transition Rule), and that any portion of the filing found by the Director not to comply with any requirement of the Transition Rule will be modified by the filing entity as ordered by the Director to comply with the Transition Rule. The filing entity must further certify that any such modification ordered by the Director will be made effective as of the effective implementation date of the filing to which the original certification applies and that the entity will promptly notify affected insureds of the modification.

006.04.01A Upon receipt of a Medicare supplement insurance filing made solely for the purpose of implementing adjustments to Medicare supplement insurance necessary to provide a transition of benefits and premiums to conform to repeal of the Medicare Catastrophic Act and to the requirements of the Transition Rule, the Director deems approved for immediate use such filed adjustments as to comply with all requirements of the Transition Rule.

006.04.01B Upon completion of review of the filings received pursuant to these accelerated policy adjustment procedures, the Director shall order such modifications as are necessary to bring the filing into compliance with the Transition Rule. The review shall be conducted in accordance with the time period provided by the applicable laws and rules of the State.

## 007. Offer of reinstatement of coverage.

007.01 Except as provided in ~~sub~~section 007.02, in the case of an individual who had in effect, as of December 31, 1988, a Medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificateholder) and the individual terminated coverage under such policy before the date of the enactment of the repeal of the Medicare Catastrophic Coverage Act of 1988, the insurer shall:

007.01A Provide written notice no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate-holder (at the most recent available address) of the offer

described below; and

007.01B Offer the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstatement of coverage (with coverage effective as of January 1, 1990), under the terms which:

007.01B(1) Does not provide for any waiting period with respect to treatment of pre-existing conditions;

007.01B(2) Provides for coverage which is substantially equivalent to coverage in effect before the date of such termination; and

007.01B(3) Provides for classification of premiums on which terms are at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage never terminated.

007.02 An insurer is not required to make the offer under subsection 007.01B in the case of an individual who is a policyholder or certificateholder in another Medicare supplemental policy as of January 1, 1990 if the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.

## 008. Requirements for new policies and certificates.

008.01 Effective January 1, 1990, no Medicare supplement insurance policy, contract or certificate shall be delivered or issued for delivery in this State which provides benefits which duplicate benefits provided by Medicare. No such policy, contract or certificate shall provide less benefits than those required under the existing Medicare Supplement Insurance Minimum Standards Act or Regulation except where duplication of Medicare benefits would result and except as required by these transition provisions.

### 008.02 General Requirements

008.02A Within ninety (90) days of the effective date of this regulation, every insurer, health care service plan or other entity required to file its policies or contracts with this State shall file new Medicare supplement insurance policies or contracts which eliminate any duplication of Medicare supplement benefits with benefits provided by Medicare, which adjust minimum required

benefits to changes in Medicare benefits and which provides a clear description of the policy or contract benefit.

008.02B The filing required under subsection 006.01A shall provide for loss ratios which are in compliance with all minimum standards.

008.02C Every applicant for a Medicare supplement insurance policy, contract or certificate shall be provided with an outline of coverage which simplifies and accurately describes benefits provided by Medicare and policy or contract benefits along with benefit limitations.

009. Filing requirements for advertising. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this State shall provide a copy of any advertisement intended for use in this State, whether through written, radio or television medium to the Director of this state for review or approval by the Director to the extent it may be required under state law. Such advertisement shall comply with all applicable laws of this State.

010. Buyer's guide. No insurer, health care service plan or other entity shall make use of or otherwise disseminate any Buyer's Guide or informational brochure which does not accurately outline current Medicare benefits and which has not been adopted by the Director.

011. ~~Separability~~ Severability. If any provision of this regulation or the application thereof to any person or circumstances 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.

012. Effective date. This regulation shall become operative on January 1, 1990.

## APPENDIX A

[COMPANY NAME]

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE

SUPPLEMENT INSURANCE -- 1990

THE FOLLOWING CHART BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

[A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.]

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
			Effective	January 1
			Your	1989 Your
		Effective	1988	Coverage
		January 1, 1989	Coverage	Will Pay
	Medicare Now	Medicare Will	Per	Per
	Pays Per Benefit	Pay Per Calendar	Benefit	Calendar
	Period	Year	Period	Year

MEDICARE PART A

SERVICES AND

SUPPLIES

Inpatient	Unlimited number of	All but \$592 for
Hospital	Hospital days after	First 60
Services	\$560 deductible	days/benefit period



Semi-Private	All but \$148 a day
Room & Board	for 61st - 90 <sup>th</sup> days/benefit period
Misc. Hospital	All but \$296 a day
Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	for 91st - 150 <sup>th</sup> days (if individual chooses to use 60 Nonrenewable lifetime reserve days)

YOUR MEDICARE

MEDICARE BENEFITS

SUPPLEMENT

SERVICES

COVERAGE

BLOOD	Pays all costs except payment of deductible(equal to costs for first 3 pints) each calendar year. Part A blood deductible period reduced to	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period.
-------	---	--

the extent paid

under Part B

SKILLED  
NURSING

There is no prior  
confinement  
requirement for  
this benefit

100% of costs for  
1st 20 days (after  
a 3 day prior  
hospital  
confinement)/  
benefit period

FACILITY CARE

First 8 days--All  
but \$25.50 a day  
  
9th through 150th  
day -- 100% of  
costs period

All but \$74.00 a  
day for 21st - 100<sup>th</sup>  
days/benefit period

Beyond 150 days --  
Nothing

Beyond 100 days --  
Nothing/benefit

MEDICARE PART  
B

80% of allowable  
charges (after \$75  
deductible)

80% of allowable  
charges (after \$75  
deductible/calendar  
year)

SERVICES AND  
SUPPLIES

PRESCRIPTION	Inpatient	Inpatient
DRUGS	prescription drugs.	prescription drugs.
	80% of allowable	80% of allowable
	charges for	charges for
	immunosuppressive	immunosuppressive
	drugs during the	drugs during the
	first year following	first year following
	a covered	a covered
	transplant	transplant
	(after \$75	(after \$75
	deductible	deductible
	calendar year)	calendar year)

YOUR MEDICARE

MEDICARE BENEFITS

SUPPLEMENT

SERVICES

COVERAGE

BLOOD	80% of all costs	80% of all costs
	except non-	except
	replacement fees	nonreplacement
	(blood deductible)	fees
	(blood deductible)	(blood deductible)
	for first 3 pints	for first 3 pints
	after \$75	after \$75
	deductible	deductible
	calendar year	calendar year

[ANY OTHER POLICY BENEFITS NOT MENTIONED IN THIS CHART SHOULD BE ADDED TO THE CHART IN THE ORDER PRESCRIBED BY THE OUTLINE OF COVERAGE BENEFITS. IF THERE ARE CORRESPONDING MEDICARE BENEFITS, THEY SHOULD BE SHOWN.]

[Describe any coverage provisions changing due to Medicare modifications.]

[Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY [COMPANY] ONLY BRIEFLY DESCRIBE SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT [Policy] CONTACT:

[COMPANY OR FOR AN INDIVIDUAL POLICY -- NAME OF AGENT]

[ADDRESS/PHONE NUMBER]