RULE AND REGULATION 46
TRANSITIONAL REQUIREMENTS
FOR THE CONVERSION OF MEDICARE SUPPLEMENT
INSURANCE BENEFITS AND PREMIUMS TO CONFORM
TO REPEAL OF MEDICARE CATASTROPHIC COVERAGE ACT

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Section 1. 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.

Section 2. Authority

This Regulation is issued pursuant to the authority vested in the Commissioner under Ark. Code Ann. Sections 23-61-108, and 25-15-202, et seq.

Section 3. Applicability and Scope

This Regulation shall take precedence over other rules and requirements relating to Medicare supplement policies or contracts: to the extent necessary to assure that benefits are not duplicated; to adjust minimum required benefits to changes in Medicare benefits; to assure that applicants receive adequate

notice and disclosure of changes in Medicare supplement policies and contracts; to assure that appropriate premium adjustments are made in a timely manner, and that premiums are reasonable in relation to benefits.

Except as provided in Section 5, this Regulation shall apply to:

(A) 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

(B) All certificates issued under group Medicare supplement policies as provided in (A) above.

Section 4. Definitions

For purposes of this Regulation:

(A) " Applicant" means:

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

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

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

(C) "Medicare Supplement Policy" means a group or individual policy of disability 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.

Section 5. Benefit Conversion Requirements

(A) 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.

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

(C) 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:

(1) 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;

(2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(5) 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;

(6) 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]; and

(7) 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.

(D) General Requirements

(1) 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 a format prescribed by the Commissioner as adopted by the NAIC and which is attached as Appendix A to this Rule, and:

(a) 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.

(b) The notice shall inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be effective;

(c) 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; and

(d) Such notice shall not contain or be accompanied by any solicitation.

(2) 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 purposes articulated in Section 1 of this Regulation.

Section 6. Form and Rate Filing Requirements

(A) 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:

(1) 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.

(2) 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 5. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

(B) Upon satisfying the filing and approval 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 5 above.

(C) 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.

Section 7. Offer of Reinstitution of Coverage

(A) Except as provided in Subsection B of this Section, 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:

(1) Provide written notice no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificateholder (at the most recent available address) of the offer described below, and

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

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

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

(c) 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 certificate-holder had the coverage never terminated.

(B) An insurer is not required to make the offer under Paragraph (2) above 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.

Section 8. Requirements for New Policies and Certificates

A. 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 fewer benefits than those required under the existing Medicare Supplement Insurance Minimum Standards Model Act or Regulation except where duplication of Medicare benefits would result and except as required by these transition provisions.

B. General Requirements

(1) 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 provide a clear description of the policy or contract benefit.

(2) The filing required under Section 6(A)(1) shall provide for loss ratios which are in compliance with all minimum standards.

(3) 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.

Section 9. 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 Commissioner of Insurance of this State for review or approval by the Commissioner to the extent it may be required under Arkansas Rule and Regulation 41. Such advertisement shall comply with all applicable laws of this State.

Section 10. 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 Commissioner.

Section 11. Separability

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.

Section 12. Effective Date

The effective date of this Regulation is March 1, 1990.

Ron Taylor

RON TAYLOR
INSURANCE COMMISSIONER

2-13-90

DATE

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990 Your Coverage Will Pay
	9th through 150th day - 100% of cost Beyond 150 days - Nothing	Beyond 100 days - Nothing/benefit period		
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after $75 deductible)	80% of allowable charges (after $75 deductible/ calendar year)		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immuno-suppressive drugs during the first year following a covered transplant (after $75 deductible/ calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after $75 deductible/calendar year)		
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after $75 deductible/calendar year	80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after $75 deductible/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. 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 DESCRIBES 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]