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Impact of the Medicare Prescription Drug, Improvement and Modernization Act on Medicare Supplement Insurance Plans

by Dennis Hare

President Bush signed the Medicare Prescription Drug, Improvement and Modernization Act (MMA) on Dec. 8, 2003. Among the many requirements of MMA was the addition of prescription drug benefits in the new Medicare Part D. Provision of drug benefits via Medicare required the NAIC to make several changes to the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, i.e. Model Regulation, in order to conform to the federal law. These changes had a direct impact on certain Medicare supplement, or Medigap, products. On Sept. 8, 2004 the NAIC adopted amendments to the Medicare Supplement Model Regulation in response to the requirements of MMA.

The amendments to the Medicare Supplement Model Regulation that implement the following four requirements of MMA are described below in more detail:

1. Add two new plans (called K and L) to the standard Medigap plans A through J;
2. Prohibit the sale of outpatient prescription drug coverage in Medigap plans after Dec. 31, 2005 (i.e., when Part D comes into effect);
3. Revise Medigap plans to eliminate outpatient prescription drug coverage for those who enroll in Medicare Part D;
4. Make any other changes to the model regulation that might be required as a result of the legislation.

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New Plans K and L

Medigap plans K and L have been added to the Model Regulation in response to the MMA requirement that two new standardized Medigap benefit packages be developed. These federally prescribed benefit packages generally increase the cost sharing by the insured over that of plans A through J.

Coverage under Plan K includes 50 percent of the cost sharing otherwise applicable under Medicare Parts A and B, except there is no coverage for the Part B deductible and any cost sharing otherwise applicable for preventive benefits is covered at 100 percent. All hospital inpatient coinsurance and 365 extra lifetime days of coverage of inpatient hospital services are covered as in the current core benefit package. After the individual has reached the annual out-of-pocket limit, all cost sharing under Medicare Parts A and B is covered at 100 percent for the balance of the calendar year. The annual out-of-pocket limit is $4,000 for 2006, and is indexed for inflation in future years.

Benefits under Plan L are identical to Plan K except that 75 percent, rather than 50 percent, of cost sharing for Parts A and B is covered until the annual out-of-pocket limit is reached, and the initial out-of-pocket maximum in 2006 is $2,000 rather than $4,000.

The outlines of coverage illustrated in the Model Regulation have been revised to reflect these two new plans.

Ban on Future Sale of Outpatient Prescription Drug Coverage

After Dec. 31, 2005, companies are no longer allowed to issue Medigap plans that provide outpatient prescription drug coverage. Beginning Jan. 1, 2006, companies will only be allowed to issue plans H, I and J or related plans in waiver states if they have been modified to eliminate prescription drug benefits and the premiums have been adjusted accordingly.

Plan Revisions for Policies With Drug Coverage

On Jan. 1, 2006 the rules for renewal of Medigap policies providing outpatient prescription drug coverage change. Renewal options for standardized and pre-standardized plans with drug benefits that were sold prior to Jan. 1, 2006 depend upon whether the insured has elected to enroll in Medicare Part D.

If the insured does not enroll in Part D, the policy can be renewed at the option of the insured without any modification. However, there are two options available to insureds if they elect to enroll in Part D during the initial enrollment period that ends May 15, 2006. The insured may choose to continue their current policy, but the insurer must

eliminate the drug benefits and appropriately adjust the premium, or the insured may cancel their current policy and purchase under a guaranteed issue provision a new standardized plan A, B, C, F, K or L offered for sale by their current insurer. This guaranteed issue offer begins on the date the individual receives notice from the carrier during the 60-day period immediately preceding the initial Part D enrollment period and ends 63 days after the effective date of the insured's coverage under Part D. If the insured elects to enroll in Part D after the initial enrollment period, they may continue their current policy without drug benefits, but they do not have the guaranteed issue option to switch to another plan offered by the insurer.

To assist insurers with the premium modification for these plans, the NAIC Accident and Health Working Group of the Life and Health Actuarial Task Force is currently working on a set of principles to guide carriers when Medigap plans are modified to remove drug benefits. Proposed language for these principles is expected to be finished in the first quarter of 2005, and amendments to the Model Regulation or the NAIC Medicare Supplement Insurance Model Regulation Compliance Manual will follow.

The Working Group previously considered whether changes to the premium refund provision of the Model Regulation are necessitated by MMA. A single change was made to the benchmark loss ratio formula used in the premium refund calculation. The relatively minor change expands the formula to include use of earned premiums for the lifetime of the policy rather than stopping after the first 15 years as required in the previous formula. During discussions of other possible changes the Working Group agreed that for purposes of the premium refund calculation, plans where drug coverage has been eliminated should be combined with like plans that continue to provide outpatient prescription drug coverage.

Another amendment requires an issuer to file any riders or amendments to the policy or certificate forms used to delete outpatient prescription drug benefits only with the commissioner in the state in which the policy or certificate was issued.

The discontinuance of outpatient prescription drug benefits is reflected in the revised outlines of coverage illustrated in the Model Regulation.

Other Changes to the Model Regulation

All Medigap carriers are required to provide notification regarding the insured's options and rights to each individual insured with a Medigap plan that covers outpatient prescription drugs during the 60-day period immediately preceding the initial Part D enrollment period. Generally, the initial enrollment period for Part D is the same as the initial enrollment period established for Part B. However, for those individuals already eligible to enroll in Part D as of November 15, 2005, the initial enrollment period for Part D begins on November 15, 2005. The Secretary of Health and Human Services is working in consultation with the NAIC to develop the required notification.

Certain provisions of the Model Regulation require reinstitution of previous Medigap coverage that was suspended at the option of the policyholder for specified reasons. Clarification was added to the Model Regulation stating that if the suspended Medigap policy provided coverage for outpatient prescription drugs and the insured enrolled in Medicare Part D while their policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to the coverage before the date of the suspension.

The required eligibility questions included on the Medigap application and the text of the notice to the applicant regarding replacement of Medicare supplement insurance have been revised to improve clarity and understanding.

The changes to the Medicare Supplement Model Regulation that were adopted by the NAIC reflect only the unambiguous provisions of MMA that directly relate to Medigap plans, with some minor exceptions for clarification purposes. This article has highlighted the majority of the amendments to the Model Regulation, but is not an exhaustive description. To review all changes to the Medicare Supplement Model Regulation visit *www.NAIC.org* to obtain a copy of the adopted version of the model. In addition to the changes specified in MMA, the NAIC was directed to evaluate the benefits provided by the standardized plans and recommend whether the number of plans available should be reduced. The NAIC Senior Issues Task Force has begun discussing this charge, but at this time it is difficult to predict what recommendation might be made.