SB

43

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3811

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM January 28, 1981

SUBJECT: Filing Insurance Policy Forms - SB 43
(Work Order No. 12-0479)

TO: Senate Labor and Commerce Committee
ATTN: Linda Otey

FROM: Linn H. Asper
Legislative Counsel

You have asked if SB 43 as drafted, if enacted, will insure state compliance with P.L. 96-265 (42 U.S.C. Sec. 1395ss) and prevent federal intervention to regulate medicare supplemental insurance policies.

P.L. 96-265 creates a certification process for certain types of insurers, setting new standards for medicare supplemental insurance, including a requirement that such policies must be designed to pay out at least 75 percent of premiums collected in benefits. [42 U.S.C. Sec. 1395ss(c)(2)]. This is a federal requirement not directly related to state insurance laws, but if a state has not created requirements similar or identical to the federal requirements by July 1, 1982, the federal certification will come into play, superseding state regulation in this area. The State of Alaska favors state rather than federal regulation of the insurance industry in Alaska and thus wishes to obtain legislative authority to control premium-benefit ratios by enactment of SB 43.

The Division of Insurance has stated that the federal deadline of July 1, 1982 is misleading in that there is to be a federal survey of state laws existing on July 1st of this year which will be used to assess the need for federal intervention. The Division believes that changes in state law which become effective before July 1, 1982, but after July 1st of this year will not prevent the federal intervention which they seek to avoid. If the Division is correct, and I have no

reason to doubt them on this, then they do need authorizing legislation during this session to allow them to make regulations before July 1st of this year to avoid federal intervention.

It appears that SB 43 will give the Division of Insurance the authority it needs to avoid the threat of federal intervention as to medicaid supplemental insurance. It should be noted that the bill as written would allow regulation of premium-benefit ratios in all insurance policies written in the state, not just medicaid supplemental insurance. This broad authority may be desirable but it is not required by the new federal law. I also have some difficulty with the placement of the new law in AS 21.42.130, which has to do with insurance policy format, not substantive regulation of insurance rates. It might better be placed in AS 21.89 MISCELLANEOUS PROVISIONS, but its placement in AS 21.42.130 will not invalidate the law.

THIS IS REVISED IN CS TO DISABILITY INS.

To summarize, SB 43 will have the effect of supplanting federal certification procedures in the area of premium-benefit ratios in medicaid supplemental insurance, if enacted this session. It goes beyond medicaid supplemental insurance and, in fact, gives the Division of Insurance power to set premium-benefit ratios for all insurance policies.

LHA:jdn

THIS IS REVISED IN CS re DISABILITY INSURANCE.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

POUCH D
JUNEAU, ALASKA 99811
Phone: 465-2500

January 20, 1981

Honorable Bob Mulcahy
Chairman, Senate Labor and
Commerce Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Mulcahy:

RE: Position Paper SB 43

Thank you for your request for information on SB 43.

The recent passage of Public Law 96-265 in the Federal Congress has the effect of transferring a portion of the regulation of insurance to the Federal Government unless the various states establish certain equivalent programs and do so on an extremely short time frame.

The insurance industry has traditionally been regulated by the various states, individually. This approach was reinforced in 1945 with the passage of the McCarran-Ferguson Act (15 USCA 1011-1015). There has been a fairly steady attempt to bring such regulation under a federal agency, particularly by the Federal Trade Commission, which has been resisted by the states with equal fervor. The principal argument at the federal level has been that insurance is interstate commerce and should be regulated by a federal agency. The states, on the other hand, argue that the federal bureaucracy is either unable or unwilling to recognize and be responsive to local conditions and needs. Due to Alaska's population relative to the rest of the nation, this is an argument that has a good deal of substance. In fact, Alaska has already experienced a situation that accents the State's concerns and did so at the expense of Alaska's citizens to the tune of about $36,000, and that was in 1972 dollars.

Public Law 96-265 addresses changes in the Social Security Act and includes language dealing with medicare supplemental policies. It has two requirements termed "The Baucus Amendment" which impact State regulation of insurance. The first requirement concerns adoption of minimum standards of coverage for medicare supplemental policies. The Division of Insurance has sufficient statutory authority to establish the necessary standards based on an argument that it would be a misrepresentation to offer or sell a contract of insurance that purports to be a medicare supplemental policy unless it provides the adopted minimums. This can be accomplished by regulation and work on it has commenced.

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The second requirement of "The Baucus Amendment" is for cost/benefit ratio regulation. This is the area in need of a legislative solution. The Division of Insurance does not currently have rate regulatory authority over disability or accident/health kinds of insurance including medicare supplemental policies. It, in fact, wishes to avoid rate regulation of the kind now applied to property and casualty kinds of insurance as there would be a fiscal impact not commensurate with the results. However, it would be appropriate to determine a reasonable ratio of cost to benefit which could be regulated rather simply based on information supplied to the division annually, thus avoiding an elaborate and costly actuarial review process.

Under the federal legislation, the Secretary of Health, Education and Welfare is required to establish a certification program with respect to the various states that policies issued in those states meet certain standards, unless a state has established a program to regulate the minimum standards and cost/benefit relationship as previously noted. The secretary is to base his actions on a study to be completed by July 1, 1981, so we are faced with an exceptionally short time frame to act and avoid this federal intrusion.

The proposal modifies the reasons under which the Division of Insurance may base the refusal of a filing of a contract form, to include an inappropriate relationship between the benefit provided and the cost of the coverage. This responds to the federal action concerning medicare supplemental policies. It also addresses other kinds of insurance subject to filing under AS 21.42.

We are prepared to offer testimony and/or respond to questions when this issue is heard before your committee.

Very truly yours,

Charles R. Webber
Commissioner

CRW/jarE8

Coming: Help in finding a medigap policy that makes sense

Medigap plans meeting certain voluntary standards will get an okay from Uncle Sam starting next year.

MILLIONS of senior citizens are "victims of a colossal racket" that costs them one billion dollars a year: the sale of medigap health insurance policies that are "unneeded, duplicative, and therefore essentially worthless."

That charge isn't new. It was made two years ago by the staff of the House Select Committee on Aging and its chairman, Representative Claude Pepper (D.-Fla.). *Changing Times* has reported on the problem several times, most recently in "New Guides to Picking a Medigap Policy" (Feb. 1980).

What's new is that Congress has passed a law aimed at ending the medigap rip-off.

Medigap policies are private insurance plans that supplement medicare benefits. Since medicare pays less than 40% of the health-care costs of people 65 and older, there are plenty of gaps to fill. Medicaid plugs them for those who qualify, but for other senior citizens there is a real need for private insurance.

As you are aware if you've ever considered such a policy, it's tough to judge how much protection is offered and just how the coverage would mesh with medicare benefits. Investigations have shown that the medigap business is fertile ground for unscrupulous agents pushing policies of little or no value. The Committee on Aging figures that a fourth of the four billion dollars spent annually for medigap insurance is wasted.

The new law should make choosing a supplemental policy easier and safer. It calls for a voluntary federal certification program to begin in the summer of 1982. Only plans that meet minimum standards will be awarded the government's seal of approval:

- The policy must supplement both part A and part B of medicare.
- It must be written in easy-to-understand language.
- It cannot exclude coverage of a preexisting health condition for more than six months.
- It has to permit cancellation within 30 days without financial loss.
- It must offer reasonable economic benefit in relation to the premium charged.

The question of what is a reasonable economic benefit will be answered in part by the policy's loss ratio—the percentage of premium income returned to policyholders in benefits. The higher the loss ratio, the smaller the portion of each premium dollar that goes for profits, agents' commissions and other expenses. The federal standards set 75% as the minimum loss ratio for group medigap policies; for individual policies the minimum ratio will be 60%.

Clearly, some medigap policies now sold cannot pass the test. The Committee on Aging reports, for example, that some individual policies pay out less than 30 cents of each premium dollar in benefits. In contrast, Blue Cross/Blue Shield group plans—which account for about half of the nearly 20,000,000 policies purchased each year to supplement medicare—average a loss ratio of about 90%.

Because the federal program will be voluntary, insurance companies won't be required to submit their medigap plans for government scrutiny. Plans that don't meet the minimum standards won't be banned, but it is expected that the potential marketing advantage of winning the government's okay will encourage companies to seek certification, and that passing the federal test will become a benchmark for medigap policies. (In states that impose equal or higher standards than those in the federal law, the state's requirements will apply.) The Department of Health and Human Services (HHS) will design an emblem for display on federally approved policies.

In addition to establishing the certification program, the new law takes aim at medigap abuses by making it a federal crime for agents to use certain sales practices. It will be illegal, for example, to knowingly sell a policy that duplicates coverage an individual already has from medicare or another private policy. It will also be a crime to claim falsely that a policy has been okayed by the government or for a company to offer a mail-order medigap policy in a state unless the policy has been approved by the state's insurance office.

You still have to compare

Federal certification won't mean all insurance plans will be identical. Approved policies will undoubtedly differ on specific coverages offered and premiums charged. As with any other insurance, you'll have to compare carefully to get the medigap policy that best fits your needs.

There's help coming in that area, too. HHS is setting up a nationwide counseling service to help people evaluate medigap policies. Although counselors won't recommend individual policies, they will analyze plans and help buyers compare policies on such points as whether coverage duplicates medicare, which gaps are filled and which aren't, and exactly what benefits are offered.

Although HHS is uncertain when this service will be widely available, your local social security office or an area senior citizens organization may be able to tell you whether it will be offered in your area.

You can compare medigap policies yourself by getting copies of the HHS "Medicare/Private Insurance Checklist." This four-page work sheet gives the limits of medicare coverage and gives you space to chart the terms and benefits of supplemental policies you are considering. You can get copies of the checklist free from the office that handles your medicare. □

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

POUCH D
JUNEAU, ALASKA 99811
Phone: 465-2500

February 10, 1981

Honorable Bob Mulcahy, Chairman
Senate Labor and Commerce Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Mulcahy:

Re: Senate Bill 43

On Monday, February 9, 1981, Don Koch of this department appeared before your committee in support of SB 43. A representative of the Health Insurance Association of America (HIAA) also appeared and presented that association's views on SB 43 which were partly in conflict with Mr. Koch's testimony and position. Your committee suggested that it would be appropriate for this department and HIAA to attempt a compromise solution to conflicts.

With the assistance of Mr. Mike Thomas, HIAA's representative, we have worked out a resolution of our differences and ask that you offer the enclosed revision as a substitute to SB 43. It accomplishes the desires of this department in a manner acceptable to HIAA. We sincerely appreciate the reception that you and your committee have given this proposal.

Sincerely,

Charles R. Webber
Commissioner

CRW/val21G7
Enclosure

08-H2LH

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February 10, 1981

The Honorable Robert Mulcahy
Chair, Senate Commerce & Labor Committee
Alaska State Senate
Pouch "V", Mail Stop 3100
Juneau, Alaska 99811

Re: Senate Bill 43

Dear Senator Mulcahy:

I have reviewed Commissioner Webber's letter of February 10, 1981, and the enclosed proposal for a committee substitute. The proposed language will, we believe, adequately and appropriately deal with the director's concerns, and we urge its adoption.

Thank you for your consideration on this bill.

Very truly yours,

ROBERTSON, MONAGLE, EASTAUGH & BRADLEY

M. T. Thomas

MTT/dh

Federal Register

Wednesday
January 21, 1981

Part V

Department of Health and Human Services

Health Care Financing Administration

Medicare Program; Medigap—Certification of Medicare Supplemental Health Insurance Policies

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Part 403

Medicare program; Medigap—Certification of Medicare Supplemental Health Insurance Policies

AGENCY: Health Care Financing Administration (HCFA), HHS.

ACTION: Proposed Rule.

SUMMARY: This proposal would establish a program of certification, by the Secretary, of Medicare supplemental health insurance policies (so-called Medigap policies) voluntarily submitted by insurers for review. It would implement, in part, section 507 of the Social Security Disability Amendments of 1980. HCFA will administer the certification program.

The voluntary certification program would go into effect July 1, 1982, and would apply only to policies issued in those States that do not have in effect a program for regulating Medigap policies equal to or more stringent than the one to be described in these regulations. A Supplemental Health Insurance Panel, consisting of the Secretary or a designee and four State Commissioners or Superintendents of Insurance appointed by the President, will determine the adequacy of a State's program in relation to the standards contained in the regulations.

These regulations would: (1) set standards for policies voluntarily submitted to HCFA for certification, (2) establish procedures for the certification program, and (3) promulgate the statutory requirements that the Supplemental Health Insurance Panel would use to approve State regulatory programs.

DATE: To assure consideration, comments should be received by: March 23, 1981.

ADDRESS: Address comments in writing to: Administrator, Health Care Financing Administration, Department of Health and Human Services, P.O. Box 17073, Baltimore, Maryland 21235. If you prefer, you may deliver your comments to Room 309–G Hubert H. Humphrey Building, 200 Independence Ave., S.W., Washington, D.C., or to Room 789, East High Rise Building, 6401 Security Boulevard, Baltimore, Maryland.

Please refer to BPP–91–P. Agencies and organizations are requested to submit comments in duplicate. Comments will be available for public inspection, beginning approximately two weeks after publication, in Room 309–G of the Department's office at 200 Independence Ave., S.W., Washington, D.C. 20201 on Monday through Friday of each week from 8:30 to 5:00 p.m. (202–245–7890).

FOR FURTHER INFORMATION CONTACT: Thomas Hoyer, 301–594–9690.

SUPPLEMENTARY INFORMATION: Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments and will respond to them in the preamble to that rule.

Medicare Program

Medicare is a Federal health insurance program, provided for under title XVIII of the Social Security Act, for people 65 and older and some people under 65 who are disabled. The Medicare program consists of two parts, a Hospital Insurance Program (Part A) and a Supplementary Medical Insurance Program (Part B).

Part A, Hospital Insurance, covers hospital, skilled nursing facility (SNF) and home health care, as well as certain therapy services. It is oriented towards acute care, and its coverage provisions are based on the concept of a benefit period or "spell of illness", a period that begins when an individual receives inpatient hospital or SNF services and ends when that individual has been out of the hospital or SNF for 60 consecutive days. In each benefit period, individuals are entitled to up to 90 days of inpatient hospital care, up to 100 days of post-hospital SNF care, and up to 100 post hospital home health visits. If the full 90 days of hospital benefits are exhausted during a spell of illness, a beneficiary may draw on 60 additional lifetime reserve days.

Part B, the Supplementary Medical Insurance Program, provides coverage for physicians' services, medical and other health services (a wide range of services including diagnostic tests and X-rays, outpatient hospital services, durable medical equipment, ambulance service, prosthetic devices, physical therapy, etc.), and up to 100 home health visits per year.

Both parts of Medicare contain cost sharing provisions, that is, deductible and coinsurance. The law requires that, under Part A, the inpatient hospital deductibles and hospital and SNF coinsurance amounts be adjusted annually to reflect the rising costs of health care (Section 1813(b)(2) of the Act). Under Part A, there is currently an annual hospital deductible of $180, a daily co-payment of $45 for the 61st through the 90th day of care, and $90 a day for each lifetime reserve day. In a SNF, there is a $22.50 co-payment for care from the 21st through the 100th day.

Under Part B, medical insurance generally pays 80 percent of "reasonable charges", and the beneficiary pays 20 percent coinsurance. (Under Title XVIII, the "reasonable charge" is the amount of the actual charge of a physician or supplier that can be recognized for payment under Medicare.) Since actual charges generally exceed the "reasonable charges", beneficiaries are also responsible for the difference, unless the physician or supplier accepts "assignment" of a beneficiary's claim. In addition, the beneficiary must pay an annual $60 deductible.

There are a number of items and services that are not covered under either of Medicare's two insurance programs. These items and services include: custodial nursing home care, custodial home care, most prescription drugs, dental care, eyeglasses and eye examinations, immunizations, most foot care, and homemaker services. Beneficiaries must pay the full cost of these services out-of-pocket or obtain additional insurance protection to pay the costs.

Medicare Supplemental Health Insurance Policies—Nature and Problems

The Medicare program was never designed to cover the total cost of providing medical care for its beneficiaries. It has been estimated that Medicare paid for about 44 percent of all health care costs for its beneficiaries in 1976. The remaining 56 percent included the cost of noncovered services and cost-sharing provisions of the Medicare program. Since the enactment of the Medicare program, various insurance organizations, both profit and nonprofit, have developed and marketed health insurance policies aimed at paying health care expenses not covered by the Medicare program. In 1978, about 15 million of the 23 million Medicare beneficiaries spent $4 billion for approximately 19 million policies to supplement Medicare. These policies are commonly referred to as "Medigap" policies and principally include Medicare supplement policies, Indemnity policies and specified disease policies.

Medicare supplement policies are designed to fill specific gaps in the Medicare benefit structure. These policies typically offer coverage of some or all of Medicare's deductible and coinsurance amounts and sometimes include coverage of services not covered under Medicare. There are many varieties of supplement policies with premiums and benefit structures

designed to meet the needs of people with a variety of incomes. A characteristic of most of these policies, however, is that they base their payments on Medicare's coverage and reimbursement structures. They seldom pay more than the 20 percent coinsurance amount of the "reasonable charge" recognized by Medicare. They rarely pay any of the difference between the "reasonable charge" and the actual amount that a physician or supplier of services might charge. Furthermore, they frequently do not cover a broader range of services than are covered under Medicare. The premiums for these policies are usually adjusted annually to compensate for increases in Medicare's deductible and coinsurance amounts.

Indemnity policies usually have fixed premiums and pay a predetermined amount of money when certain conditions are present or certain health care services are furnished. An indemnity policy, for example, might pay a fixed amount for each day of hospital or nursing home care, for each medical or surgical procedure required, or for a given diagnosis. The amount of benefits is usually predetermined and is not tied to the beneficiary's actual health care expenses. Indemnity benefits are usually payable without regard to other coverage.

Specified disease policies, popularly known as "dread disease policies", will pay certain specified amounts once a positive diagnosis (e.g., cancer) has been medically confirmed. As with indemnity policies, the benefits paid under specified disease policies are often fixed and are not usually tied to the beneficiary's actual expenses.

In May, 1972, the Senate Judiciary Committee, Subcommittee on Anti-Trust and Monopoly, held hearings related to the sale of Medigap policies. Since then more than a dozen other investigations and studies by congressional committees, the Federal Trade Commission, the news media, and various other individuals and agencies have revealed and confirmed certain problems with Medigap insurance. Some of the problems relate to the nature of the policies, and some of them relate to the manner in which they are sold:

1. There is such a wide variety of Medigap policies that it is difficult, if not impossible, for a beneficiary to compare them and effectively assess their relative benefits and costs.

2. The policies themselves are often written in complicated language that obscures the extent of their coverage or the nature of their exclusions. For example, many policies contain clauses which limit or exclude payment for services received in connection with medical conditions which were known to exist at the time the policy was sold. These pre-existing condition clauses can negate coverge described in other portions of the policy.

3. Medicare beneficiaries often misunderstand the coverage available under Medicare. This, when coupled with misunderstanding of coverage of the supplemental policies, may lead individuals to purchase coverage that duplicates Medicare coverage or coverage that exists under another supplemental policy, while at the same time leaving significant gaps in coverage.

4. It is also virtually impossible for Medicare beneficiaries to determine the value of the policy's benefits in relationship to the premiums paid. This relationship, known as the loss ratio, is a way of determining how much of the aggregate premium income from a policy an insurance organization spends on aggregate benefits. Many group policies return 80 to 90 cents, or more, on the premium dollar, while some individual policies return less than 25 cents. In general, Medigap policies as a class often return less money in benefits than most other health insurance policies. ("Medigap: State Responses to Problems with Health Insurance for the Elderly", T. Van Ellet; Intergovernmental Health Policy Project, The George Washington University, Washington, D.C.; October 30, 1979 (hereafter, "Medigap" by Van Ellet), p. 10.)

5. Financial incentives, including very large sales commissions, have led some insurance agents to persuade policyholders to terminate a good policy in order to subscribe to a new one. The practice is costly to the beneficiaries and often leaves them without protection for a period of time because the new policy usually has a waiting period for pre-existing conditions. In other cases, a beneficiary is persuaded to purchase additional insurance policies to increase coverage when, in fact, the additional policy duplicates rather than supplements existing protection.

6. Elderly beneficiaries tend to rely on insurance agents for information about the Medicare program and the coverage available under the Medigap policies they are offered, and they are particularly vulnerable to misrepresentation and other abuses. Evidence of fraud, forgery, and intimidation has also been uncovered.

Regulation of Medigap Policies

The McCarran-Ferguson Act of 1945 (15 U.S.C. 1011 et seq.) permitted individual States to regulate the insurance business, and the States have been traditionally responsible for regulating Medigap policies. States have general laws which affect the entire field of insurance, and a number of States have enacted, or have final approval pending of, laws and regulations specific to Medicare supplemental insurance. Despite the current level of activity among the States, however, studies have shown that the scope of regulation varies from State to State and that enforcement of existing regulations is also uneven. (See "Medigap" by Van Ellet.)

There have been several significant initiatives in recent years to address the problems associated with Medigap policies. The National Association of Insurance Commissioners (NAIC), an association of the chief insurance regulatory officials of the 50 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands, has played a major role in the effort. The NAIC, in collaboration with HCFA, developed a "Guide to Health Insurance for People with Medicare". Over 6 million copies of the pamphlet have thus far been distributed through social security offices, insurance companies, State insurance departments, and senior citizen interest groups. More important, however, the NAIC also amended its model standards for individual accident and sickness insurance policies so they can be used by States specifically to regulate Medigap policies. The amended model, adopted by the NAIC on June 6, 1979, contains minimum standards that Medigap policies would be required to meet (Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act, as it applies to Medicare Supplemental policies; "NAIC Model Standards"). Standards address such issues as minimum coverage requirements, limits on exclusions of coverage because of pre-existing conditions, disclosure requirements, and refund requirements.

As a result of the abuses associated with Medigap policies, Congress enacted section 507 of Pub. L. 96-265 (the Social Security Disability Amendments of 1980). That section of the law established a voluntary certification program for Medicare supplemental health insurance policies (section 1882 of the Social Security Act (42 U.S.C. 1395ss)). The intent of the legislation is to establish a program that enables Medicare beneficiaries to identify Medigap policies for purchase that are represented accurately both by sales agents and promotional literature, do not duplicate Medicare or other health insurance coverage, and provide fairly priced minimum protection against

health care expenses that are not paid for by Medicare.

In the debate that preceded enactment of Pub. L. 96-265, and in the law itself, Congress recognized the progress already made by the States in the area of Medigap regulation. Further, it recognized and accepted the traditional role of the States in regulating insurance. Its intention in developing Medigap legislation was to provide the States and insurance companies with an incentive to speed up their activities to improve the regulation and quality of Medigap policies. At the same time, Congress established an alternative mechanism of certification that could be implemented at the national level for policies issued in States that choose not to establish minimum regulatory programs by July 1, 1982.

While the law relies on improve State and Federal regulation of Medigap policies as a major means of identifying and curbing abuses in the sale of Medigap policies, it also places strong reliance on consumer education as a force in improving the general quality Medigap policy offerings. The presumption is that beneficiaries, assisted by information provided by HHS, the States, insurance companies and other sources, will become better informed, more aggressive purchasers of Medigap insurance and that insurance organizations will therefore improve the quality of the policies they offer for sale in order to retain their competitive position in the market.

The basic provisions of the Medigap legislation addressed in these regulations are as follows:

1. The statute mandates that the Secretary of HHS establish a program of review and certification of Medigap policies that meet or exceed requirements specified in the statute and regulations. The Secretary's program is voluntary in that it provides for review of only those policies that are voluntarily submitted by insurers (section 1882(a) of the Act). It goes into effect July 1, 1982. (The Secretary has determined that HCFA will administer the voluntary program.)

2. Medigap policies must meet the NAIC Model Standards in order to be certified in the Secretary's program. (A summary of the NAIC Model Standards applicable to Medigap policies is presented below.) However, Congress structured the voluntary program so that it would apply the NAIC Model Standards to group policies as well as individual policies and also established minimum loss ratio requirements for each category of policy (section 1882(c) of the Act).

The NAIC has standards applicable to a variety of policies, including Medicare supplement policies, indemnity policies, and specified disease policies. However, it is important to note that the NAIC Model Standards that Congress incorporated by reference into P.L. 96-265 specifically address only "Medicare supplement policies". Consequently, the focus of the voluntary certification program is on those policies and does not address the certification of, or minimum standards for, "specified disease policies" or "indemnity policies".

3. The Secretary's voluntary certification program will apply only in those States that have not implemented, under State law, a regulatory program that applies standards equal to or more stringent than the NAIC Model Standards and the loss ratio requirements as specified in the statute (section 1882 (b) and (i) of the Act). Regarding the NAIC standards and loss ratio requirements, Congress clearly did not intend to encourage States to limit their regulatory programs to the minimum level specified in the law. On the contrary, the intent of Congress was to encourage States to implement regulatory programs that they determine are appropriate to their needs and to assure States that those programs meeting or exceeding specified minimum standards would be approved by a panel, as specified below. (See Conference Committee Report on Social Security Disability Amendments of 1980, H.R. 3236, Report No. 96-944, pp. 76-77.)

4. The statute also provides for a Supplemental Health Insurance Panel that will determine whether or not State regulatory programs for Medigap policies meet the requirements of the law. The Panel will consist of the Secretary or a designee, who will serve as chairperson, and four State Commissioners or Superintendents of Insurance, to be appointed by the President (section 1882(b) of the Act).

5. The Secretary will authorize the use of an emblem by an insurer to indicate that a policy has been certified as meeting the standards of the voluntary certification program (section 1882(a) of the Act).

The statute contains provisions other than those addressed in these regulations. These include Federal criminal penalties designed to assist States and the Federal government in dealing with abuses identified in the various studies and investigations of Medigap policies (section 1882(d) of the Act). These penalties basically apply to cases in which false statements or misrepresentations are made about a policy's certification or about the extent and nature of the policy's coverage for the purpose of obtaining certification. They also apply to cases of misrepresentation by an insurance agent as an employee or agent of the Federal government (e.g., of the Medicare program) and to cases in which an individual sells a policy that is known to be duplicative of Medicare coverage or other health insurance the individual has. There is also a penalty governing the use of the mails for the delivery of advertisement of Medicare supplemental health insurance policies that have not been approved for sale in a State.

Section 1832(f) of the Act requires the Secretary to undertake a comprehensive study of the comparative effectiveness of various State regulatory approaches in (a) limiting marketing and agent abuse, (b) assuring the dissemination of information to Medicare beneficiaries (and to other consumers) that is necessary for informed purchase of Medigap policies, (c) promoting policies that provide reasonable economic benefits for the insured, (d) reducing the purchase of unnecessary duplicative coverage, (e) improving price competition, and (f) establishing effective State regulatory programs.

At the same time, the Secretary's study must address the need for standards for, or certification of, health insurance policies other than Medicare supplemental health insurance policies sold to Medicare beneficiaries. In order to carry out this study, HCFA needs to collect information concerning policy provisions, premium cost, premium volume and number of policyholders per policy on a State by State basis, loss ratio per policy, consumer knowledge of Medicare and other private health insurance coverage, and consumer purchasing behavior. This study would be used to collect baseline data for the later evaluation of the impact of the Federal voluntary certification program. Suggestions on how to obtain this information would be appreciated. Ideas on how to identify all health insurance products and the companies that sell them to Medicare beneficiaries, and ideas on comparing insurance policies, e.g., a scoring system, and establishing some method for comparing loss ratios would also be welcome.

The Secretary is also required to submit to Congress, no later than July 1, 1982, and at least every two years thereafter, a report evaluating the effectiveness of the certification procedures and the criminal penalties established under the law (section 1882(f) (2) of the Act). The report must include an analysis of the impact that

the certification program and the penalties have on the types, market share, value, and cost of policies certified by the Secretary. The report will also address whether the certification program and the criminal penalties should be continued or changed. We invite suggestions and comments regarding the potential sources of information for the report, the types of information that would be most appropriate, and the organizations or individuals that should be consulted.

Finally, section 1882(e) requires that the Secretary furnish all Medicare beneficiaries information that will enable them to make informed purchases of Medigap policies. Prior to the enactment of this provision, HCFA's Office of Beneficiary Service began distributing informational materials and conducting training classes for, and distributing training materials to, individuals who have contact with Medicare beneficiaries on the State and local levels. Those individuals will be in a position to inform beneficiaries of the problems inherent in the selection of Medigap insurance and of the certification program.

Provisions of the Regulations

State Regulation of Health Insurance Policies

Congress specifically stated that nothing in the statute should be construed so as to affect the right of any State to regulate Medicare supplemental health insurance policies that are marketed within its borders (section 1882(i) of the Act). This same provision would be contained in the regulations. In practice, for example, a policy certified in one State, either by that State or under the voluntary program, could be barred from sale in a second State, if the policy fails to meet the more stringent requirements of the second State.

Medicare Supplemental Health Insurance Policy

These regulations would define a Medicare supplemental health insurance policy, in accordance with section 1882(g) (1) of the Act, as a health insurance policy or other health benefit plan that a private entity offers to a Medicare beneficiary to supplement Medicare. Under the definition, the policy would provide payment for expenses that are not reimbursed under the Medicare program because of deductibles, coinsurance, noncoverage, or other limitations.

The term "Medicare supplemental health insurance policy" (Medigap policy) would include individual as well as group policies. In accordance with section 1882(c) of the Act, policies issued as a result of solicitation of individuals through the mail or by mass media advertising (including both print and broadcasting advertising) would be considered individual policies. The term "policy" would include a certificate issued under a policy (section 1882(g)(1) of the Act). However, in accordance with section 1882(g) of the Act, group health insurance policies of employers and labor organizations would not come under the provisions of these regulations. These policies were exempted for a number of reasons: they are usually sold without regard to age; they are not often sold specifically to supplement Medicare; and abuses commonly associated with Medigap policies have not generally been found to occur with respect to them. In fact, many of these policies have proven to be the best Medicare supplement available to retired workers.

Congress also intended that group health insurance policies of trade, professional, and occupational associations be exempted (Conference Committee Report on H.R. 3236, Report No. 96-944, p. 77). A policy would be exempt, however, only if the association—

1. Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;

2. Has been maintained in good faith for a purpose other than the obtaining of insurance; and

3. Has been in existence at least two years before the date of its initial offering of a Medigap policy to its members.

General Requirements

In order to be certified under the voluntary or a State program, a policy must meet standards specified in section 1882(c) of the Act. It would have to meet the NAIC standards and the loss ratio standards, as provided for below. These standards would have to be met or exceeded either in a single policy or, in the case of policies of nonprofit hospital and medical service associations, in two or more policies issued in conjunction with one another.

NAIC Model Standards

Medigap policies must meet the NAIC model standards in order to be certified in either the voluntary program or an approved State program. (See section 1882(c)(1) of the Act.) These proposed regulations, however, would differ from the NAIC standards in specified instances:

1. The NAIC standards address only individual policies. However, the statute clearly addresses both individual and group policies, thereby establishing that Congress intended both individual and group policies to meet requirements prescribed by the NAIC standards (including the standards relating to minimum benefit provisions, pre-existing condition limitations, full disclosure, and cancellation clauses).

2. The NAIC standards define a Medigap policy as one offered to an individual eligible for Medicare by reason of age. The statute, however, defines a Medicare supplemental health insurance policy as one offered to an individual entitled to Medicare, without regard to age (section 1882(g) of the Act). Therefore, in these regulations, a certified Medigap policy for any Medicare beneficiary would be required to comply with the standards prescribed by the statute.

3. The NAIC standards provide optional loss ratio guidelines for individual policies only. These regulations would mandate the loss ratio standards for individual and group policies contained in the statute (section 1882(c) of the Act), as discussed below.

Loss Ratios

The proposed regulations would require that Medicare supplemental policies meet the loss ratio standards mandated in section 1882(c) of the Act. Policies would be expected to return to policyholders in the form of aggregate benefits provided under the policy at least 75 percent of the aggregate amount of premiums in the case of group policies and 60 percent in the case of individual policies. These regulations would specify the formula for determining loss ratios and the components and assumptions used in applying that formula. In addition, under the voluntary certification program insurers would be required to submit supporting information to HCFA that identifies the data incorporated into that formula. We believe that such specificity is necessary in the regulations to assure that policies meet the loss ratio standards of the law and that loss ratio calculations are done "in accordance with accepted actuarial principles and practices", as mandated in section 1882(c)(2) of the Act. Accordingly, insurers would be required to submit the following, together with the policy and the loss ratio computation:

1. The scale of premiums for the loss ratio calculation period.

2. A description of all assumptions made in the development of the loss ratio,

3. The formula used to calculate gross premiums.

4. The expected level of earned premiums in the loss ratio calculation period.

5. The expected level of incurred claims in the loss ratio calculation period.

We would also require that a qualified actuary sign an actuarial certification, a declaration that the expected loss ratio for a given policy is based on actuarial assumptions that are appropriate and reasonable, taking into account actual policy experience, if any, and reasonable expectations. For purposes of these regulations, a "qualified actuary" would mean a member in good standing of the American Academy of Actuaries, or a person who has otherwise demonstrated his or her actuarial competence to the satisfaction of the Commissioner or Superintendent of Insurance of the domiciliary State of the insurer.

Note.—These regulations address only the specifications of the loss ratio calculation and supporting information that would be required when the insurer submits a policy to HCFA in order to obtain initial certification. For a certified policy to maintain its certification, the insurer must submit material, including an updated loss ratio, at least on an annual basis to HCFA. The law clearly envisions that the Secretary's evaluation of that material would extend to the actual experience of the policy in previous years. Therefore, for purposes of those subsequent submittals, HCFA would require both a loss ratio that addresses anticipated experience and data on actual claims and premiums for that policy. We intend to publish proposed regulations, at a later date, regarding the specific data that HCFA would require.

In dealing with the issue of loss ratio specifications, HCFA has recognized that it is necessary to establish the formula for loss ratio calculations and to define carefully its direct and indirect components. The definitions have been included because of HCFA's recognition that "accepted actuarial principles and practices" permit a wide range of discretion to the actuary in selecting among the techniques and data at his or her disposal.

The loss ratio formula has been stated specifically in the regulations as a simple ratio of benefits to premiums. In the ratio, "benefits" would be computed by adding the present value, on the initial calculation date, of expected incurred benefits in the loss ratio calculation period to the present value, on the initial calculation date, of the total policy reserve at the last day of the loss ratio calculation period. The total policy reserve on the initial calculation date would then be subtracted. "Premiums" would be composed of the present value, on the initial calculation date, of expected earned premiums for the loss ratio calculation period. For purposes of the formula, "present values" could be an aggregate, computed by the insurer for a period not to exceed 12 consecutive months, of expected earned premiums and incurred benefits.

In developing definitions of the various direct and indirect loss ratio components, HCFA recognizes, as indicated above, that "accepted actuarial principles and practices" encompass a range of choices that are made by the actuary on the basis of his or her professional judgment as to appropriate data and techniques available. To avoid widely varying professional interpretations, HCFA has provided definitions for the components. These definitions specify the actuarial concepts that HCFA, on the basis of its consultations with actuaries internally and in the insurance industry, believes are appropriate for developing loss ratios for purposes of these regulations.

In addition to the formula and definitions discussed above, it will also be necessary for HCFA to specify other requirements relating to types of computations, assumptions, and data to be considered in developing loss ratios for purposes of these regulations. HCFA believes that these specifications will be necessary to assist actuaries in the development of loss ratios that are consistent will the intent of the law and regulations. These further issues are discussed in the next section of this preamble, which invites comments specifically on a number of the issues now under development.

We believe that the approach to loss ratio requirements taken in these regulations will assure that the requirements of the law are met, will provide for consistent application of the loss ratio threshold standards to all policies submitted for review, and enable comparison among policies on the basis of loss ratios. Once the system is fully articulated and in place, HCFA believes that different actuaries, considering the same Medigap policy and taking into account the principles and concepts described in these regulations, would be able independently to achieve comparable loss ratios.

Solicitation of Comments Specific to Loss Ratios

As we have noted above, some of the specifications for loss ratio determinations are not yet complete. HCFA is studying the practices of various States and is consulting insurance and actuarial groups and other professionals in the field to develop these specifications. We intend to take into consideration the data acquired in that study and through those consultations, and also the comments to this proposed rule, when we prepare the final rule. In addition, we will provide for a further comment period for the loss ratio specifications in the final regulations. We invite comments on all aspects of the loss ratio proposal; however, we are especially interested in comments on the following:

1. In determining premiums and benefits, the insurer must provide for various factors, as appropriate. Two of those are: (a) the expected future change in the distribution by age and sex of the insured group; and (b) the expected wearing off of the impact, in the early period(s) after a policy is issued, of the process the company used to select the insured and of clauses that temporarily exclude pre-existing conditions from coverage. These factors will influence claims. For example, the company that screens and selects the insured (excluding, for example, those with certain health conditions) will have fewer claims to pay in the early years of a policy than the company that guarantees acceptance to all applicants. (The insured in the former instance will most likely be healthier, at lower risk.) We believe that the insuring organization, in calculating the benefits of a policy, should provide for the impact of these factors on claims beyond the loss ratio calculation period.

2. Assumptions regarding a variety of factors, such as lapse of policies, interest, mortality, and morbidity, are integral components of a loss ratio formula. We will address them in final regulations, but we invite comments and suggestions now for our consideration.

3. These proposed regulations would require the insurer to submit supporting data for loss ratios (e.g., scale of gross premiums, a description of assumptions, formula used to calculate gross premiums, and expected level of earned premiums and incurred claims). We invite comments on that supporting data and recommendations regarding other or additional data that would be appropriate.

The Supplemental Health Insurance Panel

Establishment of the Supplemental Health Insurance Panel is authorized by section 1882(b) of the Act. The Panel will consist of the Secretary or a designee, who serves as chairperson, and four State Commissioners or Superintendents of Insurance appointed by the President. HCFA published a notice in the Federal Register on August 5, 1980 (45 FR 51923) inviting interested

parties to recommend, by September 4, 1980, State Commissioners and Superintendents of Insurance to serve on the Panel. The President is required by section 1882(b)(2) of the Act to make appointments to the Panel no later than December 31, 1980.

The principal function of the Panel is to assess State regulatory programs for Medigap policies and to determine if those programs meet minimum requirements. If the Panel approves a program as meeting the requirements of the law, that State has an "approved program". The decisions of the Panel are binding on HCFA; that is, HCFA can implement the voluntary program only in those States that do not have approved programs. The Secretary shall report to Congress, no later than January 1, 1982, the Panel's initial determinations as to which States cannot be expected to have implemented an approved program by July 1, 1982. (See section 1882(i)(2)(B) of the Act and Conference Committee Report on H.R. 3236, Report No. 96-944, p. 76.) Finally, the Panel could maintain oversight to assure that States satisfactorily implement their regulatory programs once the Panel has approved them.

The Panel is an independent component within HHS and will be responsible for establishing and implementing its own operating procedures. While those procedures are beyond the scope of these regulations, we are taking this opportunity to identify some of the questions and issues that will be before the Panel, and we invite comments and suggestions.

1. What criteria should the Panel use to determine whether or not a State has established and implemented a satisfactory program for the regulation of Medigap policies?

2. Determinations of the Panel are binding on States and on HCFA. Should the Panel establish procedures so that States might seek review of its determinations before they become effective? If so, what should they be?

3. How should the Panel communicate its determinations to affected parties, principally the State Commissioners and Superintendents of Insurance and the insurance industry? Should notices in the Federal Register be used for this purpose? What other means could be used?

Emblem

Section 1882(a) of the Act provides for an emblem, a graphic symbol the Secretary uses to indicate that a policy has been certified as meeting the requirements of the voluntary certification program. We would authorize the insurer to imprint the emblem on certified policies. (However, where a State prohibits the display of such symbols, insurers could not use the emblem.) We are currently in the process of designing the emblem.

We will also empower States with approved programs for regulating Medigap policies to authorize insurers to use the emblem on policies issued in their States.

As a safeguard to beneficiaries, we would require that an insurer could use the emblem only if the insurer agrees to inform the policyholder in writing within 60 days after his or her policy loses its certification.

States With Approved Regulatory Programs

HCFA would not review or certify policies issued in a State with an approved program for the regulation of Medigap policies. Those policies are presmued to meet the standards of the law and would be deemed certified. For a State to have an "approved program", the Panel must determine that the State has established, under State law, a regulatory program that applies standards equal to or more stringent than the NAIC standards and loss ratio requirements, specified in section 1882(c) of the Act, to each Medicare supplemental health insurance policy issued in that State. (See section 1882(b) of the Act.) For purposes of these regulations, "policy issued in that State" would mean—.

1. A group policy, if the holder of the master policy resides in that State; and

2. An individual policy, if a holder of that policy resides in that State. (See section 1882(g)(2)(c) of the Act.)

The Voluntary Certification Program

The Secretary has determined that HCFA will administer the voluntary certification program. Under these regulations, the procedures of that program would be as follows:

1. We would review policies that insurers voluntarily submit. However, we would review and certify only those policies issued in a State that does not have approved regulatory program for all Medicare supplemental health insurance policies issued in that State.

2. The insurer would be required to submit the following material to HCFA for review:

a. A copy of the policy and an outline of the policy's coverage, in the form prescribed by the NAIC model standards.

b. A statement that the information submitted for certification is accurate and complete and does not misrepresent any material fact. We would require that the president of the insurance company, or a designee, sign this statement. We believe that this requirement is necessary to assure that the material is accurate and that it has been submitted by an authorized representative of the insuring organization.

c. An actuarial certification, as specified in the regulations.

d. A statement that the policy meets the requirements of the State in which the policy is issued and of the States in which the policy will be marketed as a certified policy.

e. A list of the States in which the insurer is authorized to market the policy.

f. A statement that the insurer agrees to inform the policyholder in writing if HCFA decertifies that policy.

3. We would certify policies that meet or exceed the NAIC standards and loss ratio requirements specified in regulations.

4. We would certify a policy only if the insurer agrees to notify the policyholder in writing within 60 days of decertification, if the policy was identified as a "certified policy" at the time of sale and later decertified.

5. We would continue to recognize the State's role in regulating insurance policies marketed within its borders. Therefore, we would not certify a policy for sale in a State unless it meets both the requirements of these regulations and requirements of the State in which it is issued and of the States in which the policy will be marketed as a certified policy.

6. A policy that continues to meet the standards would retain its certification if the insurer files with HCFA, no later than June 30 of each year, updated versions of the documents listed in item 2 above. Submittal by this date is required by the statute (Section 1882 (a)).

Insurers would be encouraged to file the above material as early as possible, between January 1 and June 30, to facilitate annual review. The first annual submission of material for a newly certified policy would be due no later than June 30 of the calendar year following HCFA's certification of that policy.

Although the statute mandates that the insurer file material annually, no later than June 30, the insurer could be required in some cases to submit the material before that date. To obtain certification of a policy, the insurer must calculate a loss ratio for an identified period, called the "loss ratio calculation period". For the policy to retain its certification beyond the last date of that period, the insurer would have to submit a complete packet of material, including an updated loss ratio determination.

Accordingly, the regulations would require that the insurer submit the necessary documents no later than June 30 or the last date of the loss ratio calculation period, whichever occurs earlier.

7. We would decertify a policy if the policy fails to meet the standards specified in regulations or if the insurer fails to file material, as specified above.

8. We would authorize insurers to imprint the Secretary's emblem on certified policies. We would also monitor insurers to assure that they notify policyholders when a policy bearing the emblem loses its certification.

9. We would inform each State of all policies certified or decertified under the voluntary program.

Appeal of HCFA Determinations

These regulations would provide opportunity for an administrative review, if HCFA determines not to certify, or to decertify, a policy under the voluntary program.

1. *Notice to the insurer.* If HCFA determines not to certify, or to decertify, a policy, HCFA would send a notice informing the insurer of the following:

a. The reasons for the determination.

b. That the insurer has 30 days from the date of the notice to appeal, in writing, HCFA's determination and to submit additional information to HCFA for review.

c. That if the insurer appeals, HCFA will conduct an administrative review, as provided for below.

d. That in a case involving decertification, the decertification will go into effect in 30 days from the date of the notice, unless the insurer appeals. Should the insurer appeal, the policy would retain its certification, pending the results of the administrative review.

2. *Administrative review.*

a. A HCFA official, not involved in the original determination, would conduct an independent review of the material, including any additional information the insurer provides.

b. The administrative review would be initiated within 90 days of the date of the initial notice to the insurer of the decision to decertify, or not to certify, a policy.

c. Within 15 days of completion of the review, HCFA would inform the insurer of the results of that review, with an explanation of the final determination. In a decertification case a final decision to decertify would go into effect 15 days after the date of the notice to the insurer of the final determination.

We believe that these procedures afford a reasonable opportunity for the insurers to contest an adverse determination on certification, without undue administrative burden either on HCFA or the insurer.

Transfer of Policies From a State Program to the Voluntary Program

These regulations would provide for the orderly transfer of Medigap policies deemed certified under an approved State program to the voluntary program, if the Panel determines that the State no longer has an approved program. If the Panel determines that a State ceases to have an approved regulatory program for Medigap policies, all policies issued in that State immediately lose their deemed certification and automatically come under the aegis of the voluntary program. Policies that have certification status from the State on the day that the determination of the Panel is effective would be presumed to meet the requirements of, and would be certified under, the HCFA progam until the earlier of the following:

1. Six months after the effective date of the Panel's determination.

2. The expiration date of the certification received under the State program.

If the insurer wishes to have a policy retain its certification beyond the date specified above, the insurer would be required to submit the policy to HCFA for review and certification. The insurer is encouraged to submit the policy as soon as possible to enable HCFA to review the material and make a determination while the policy still retains its certification.

These regulations would not address the transition that would occur when policies certified under the HCFA program become subject to an approved State regulatory program. When the Panel determines the State has an approved program, all Medigap policies issued in that State come under the authority of that State's program. We anticipate that the State would provide for the orderly transfer of policies from HCFA's certification progrm to its own regulatory program to avoid unnecessary difficulties for beneficiaries as well as insurers. We recommend that States begin to develop procedures for the transfer of policies from the HCFA program to their own programs.

Effective Dates

Final regulations would be effective 60 days after publication, except for the following:

1. The effective date of certification of a policy would be July 1, 1982 or later. That is also the first date that a certified policy could bear the emblem (section 1882(i) of the Act). The effective date for the use of the emblem is based on Congressional concern that insurers not be given an unfair competitive advantage in its use, specifically insurers with policies in force that already meet or exceed the standards specified in the statute. Congress intended to give insurers adequate lead time to review their policies and to make changes, as appropriate, in order to be certified under the voluntary program or to meet the requirements of an approved State program. In addition, States that wish to establish approved programs would have time to review and amend State laws and regulations. Finally, this also affords reasonable time for the Panel to assess State programs, so that HCFA would know those States in which the voluntary program would be operative.

2. HCFA cannot begin to certify policies until the Panel's determinations, as to which States have established programs that meet the requirements of the statute, become effective. Section 1882(i) of the Act specifies that the Panel's initial determinations must be submitted to Congress no later than January 1, 1982 and that they become effective 60 days later. In counting those 60 days, "days on which either House is not in session because of an adjournment sine die or an adjournment of more than three days to a day certain are excluded in the computation." (See section 1882(i)(2)(B) of the Act.)

In order to facilitate the start of the voluntary program and to enable companies to display the emblem on approved policies on July 1, 1982, HCFA would begin reviewing policies issued in States found not to have satisfactory programs as soon as the initial determinations of the Panel are sent to Congress. HCFA's certification of those policies, however, would not become effective before July 1, 1982. Moreover, if the Panel should reverse an earlier negative determination, by approving the State's regulatory program, any policy that HCFA reviewed, and that is issued in that State, would immediately come under the State program.

The Department is required to submit section 403.245 of the regulations to the Office of Management and Budget (OMB) for review and approval. This section deals with the submission of information by an insuring organization in order to obtain and maintain certification under the voluntary program. The Department will submit this section to OMB.

Economic Impact

The Department has analyzed the economic impact of these proposals and does not believe that they are "major" within the meaning of Executive Order

12044. For example, these proposals would not create a cost impact of $100 million or more within the next five years.

Direct administrative costs to beneficiaries, the insurance industry, States, and Federal government are unlikely to exceed several million dollars annually, compared to current costs approaching $4 billion annually for Medigap policies and approximately $122 million for State insurance regulation (covering all insurance, not just Medigap). The insurance companies would not be required to submit data to HCFA which they would not ordinarily have prepared either for internal use or State review; or both. However, some States do not now review policy content in detail; and these proposals may have consequential impact in insurance commissions in those States. Also, although we have sought to minimize administrative burdens, further improvements may be possible. We request comments on any aspect of administrative requirements in these proposals for which burden could be reduced further.

The proposed rule would create improved information for consumers. Nothing in the proposal imposes entry restrictions, licensing restrictions, or other forms of "command and control" government regulation. In addition, certification is voluntary. Accordingly, we do not believe that these proposals have direct regulatory impact on the insurance industry. Clearly, however, they will result in a market response over time as newly informed consumers purchase better policies and the insurance industry adjusts its policies to meet consumer expectations. We have no quantitative basis for projecting these responses at this time, but expect them to involve an increased proportion of the $4 billion spent to Medigap policies to be returned to consumers in the form of benefits, with offsetting reductions in administrative cost such as selling expenses. There should be no adverse impact, except insofar as companies unable or unwilling to adjust to a more competitive market lose market share. The study required by law by 1982 will address this issue, but we welcome comments at this time.

NAIC Model Standards

For the reader's information, we present here a summary of the basic requirements of the NAIC model standards, as applicable to Medigap policies. Complete copies of the text may be obtained from The National Association of Insurance Commissioners 350 Bishops Way, Brookfield, Wisconsin 53004; Attention: Dana Horenberger, Publications Coordinator.

1. *General Provisions:*

a. "Medicare Supplement Coverage" means a policy of accident and sickness insurance (1) that is designed primarily to supplement Medicare, or is advertised, marketed or otherwise purported to be a supplement to Medicare, and (2) that meets the requirements of these standards.

b. The terms "Medicare Supplement", "Medigap", and words of similar import must not be used to characterize a policy, unless the policy is issued in compliance with these standards.

c. A policy issued as a "Medicare Supplement Coverage" must not include limitations or exclusions that are more restrictive than those of Medicare for any type of care covered under the policy.

Note.—The drafters of the NAIC Model Standards intended that nonprofit hospital and medical service associations be subject to these standards. In States where such hospital and medical service associations are prohibited from issuing single subscriber contracts that include all of the benefits required by these standards, the issuing entity must meet the following requirements: Subscriber contracts (1) must include as much of those benefits as are permitted, and (2) must be issued in conjunction with another contract that includes at least the remainder of the minimum benefits required. In that event, the combination of contracts will be considered to meet these standards.

2. *General Coverage provisions:* These are minimum standards and do not preclude policies from including additional benefits.

a. "Medicare benefit period" means the unit of time used in the Medicare program to measure use of services and availability of benefits under Part A, Medicare hospital insurance.

b. "Medicare eligible expenses" means health care expenses of the kinds covered by Medicare, to the extent that these expenses are recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity, as are applicable to Medicare claims.

c. Except as provided for in paragraphs d and e of this section, policies must not contain waivers to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions.

d. Pre-existing condition limitations must not exclude coverage, for more than 6 months after the effective date of coverage under the policy, of a condition for which medical advice was given by or treatment was recommended by or received from, a physician within 6 months before the effective date of the coverage.

e. Coverage must not be subject to any exclusions, limitations, or reductions that are inconsistent with the exclusions, limitations or reductions permissible under Medicare. A policy may, however, stipulate that coverage is not provided for any expenses to the extent of any benefit available to the insured person under Medicare.

f. Coverage must not indemnify against expenses resulting from sickness on a different basis from losses resulting from accidents.

g. Coverage must provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be changed to correspond with such changes.

3. *Minimum Benefit Provisions:* Medicare supplemental coverage must provide at least the following:

a. 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.

b. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime inpatient reserve days.

c. Upon exhaustion of all Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90 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.

d. Coverage of 20 percent of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

4. *Disclosure Provisions:*

a. All policies, except single premium nonrenewable policies and those resulting from direct response solicitation, must have a refund notice prominently printed on, or attached to, the first page of the policy. That notice must state that the policyholder has the right to return the policy within ten days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason. With respect to policies issued as a result of a direct response

solicitation (that is, issued as result of solicitation through the news media or the mail), the policy must have a notice prominently printed on, or attached to, the first page of the policy stating in substance that the policyholder has the right to return the policy within 30 days of its delivery and to have the premium refunded if, after examination of the policy, the policyholder is not satisfied for any reason.

b. All insurers must provide an appropriate outline of coverage for a Medicare supplement policy. The insurers must deliver the outline to the applicant at the time application is made, and, except for a direct response policy, the insurer must obtain verification of receipt of that outline. The items included in the outline must appear in the sequence prescribed below. (The coverage outline that follows is taken verbatim from the NAIC Model Standards.)

(Company Name) Medicare Supplement Coverage Outline of Coverage

(1) Read Your Policy Carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you Read Your Policy Carefully!

(2) Medicare Supplement Coverage—Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to other limitations which may be set forth in the policy. The policy does not provide benefits for Custodial Care such as helping in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).

(3) (a) (for agents:) Neither (insert company's name) nor its agents are connected with Medicare.

(b) (for direct response:) (insert company's name) is not connected with Medicare.

(4) (A brief summary of the major benefit gaps in Medicare Parts A and B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare Supplement Coverage in the following order:)

Service	Benefit	Medicare pays	This policy pays	you pay
Hospitalization:				
Semiprivate room and board general nursing and miscellaneous hospital services and supplies.	First 60 days	All but $(180)	$	$
	61st to 90th day	All but $(45) a day		
Includes meals, special care units, drugs, lab tests, diagnostic X-rays, medical supplies, operating and recovery room, anesthesia and rehabilitation services.	91st to 150 day	All but $(90) a day		
	Beyond 150 days	Nothing		
Posthospital skilled nursing care: In a facility approved by Medicare, you must have been in a hospital for at least 3 days and enter the facility within 14 days after hospital discharge.	First 20 days	100% of costs		
	Additional 80 days	All but $(22.50) a day		
	Beyond 100 days	Nothing		
Medical expense	Physician's services, inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance.	80% of reasonable charge (after $(60) deductible.		

(5) (A statement that the policy does or does not cover the following):

(a) Private duty nursing.

(b) Skilled nursing home care costs (beyond what is covered by Medicare).

(c) Custodial nursing home care costs.

(d) Intermediate nursing home care costs.

(e) Home health care (above number of visits covered by Medicare).

(f) Physician charges (above Medicare's reasonable charge).

(g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay).

(h) Care received outside of U.S.A.

(i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.

(6) (A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (4) above, including conspicuous statements:)

(a) (That the chart summarizing Medicare benefits only briefly describes such benefits.)

(b) (That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.)

(7) (A description of policy provisions respecting renewability or continuation of coverage, including any reservation of right to change premium.)

(8) (The amount of premium for this policy.)

42 CFR Chapter IV, Subchapter A, is amended by adding a new Part 403 and Subpart B to read as follows:

PART 403—SPECIAL PROGRAMS AND PROJECTS

* * * * *

Subpart B—Certification of Medicare Supplemental Health Insurance Policies

Sec.

Authority: Sections 1102, 1871, and 1882 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395ss).

§ 403.200 Basis and scope.

This subpart implements, in part, section 1882 of the Social Security Act, which provides for voluntary certification, by the Secretary of Health and Human Services, of Medicare supplemental health insurance policies. The intent of the legislation is to establish a program that enables Medicare beneficiaries to identify Medicare supplemental health insurance policies that do not duplicate Medicare coverage and that provide adequate, fairly priced protection against health care expenses that are not covered by Medicare. This subpart sets forth the standards and procedures HCFA will use to implement the certification program.

General Provisions

§ 403.208 State regulation of insurance policies.

The provisions of this subpart do not affect the right of a State to regulate policies marketed in that State.

§ 403.212 Medicare supplemental health insurance policy.

(a) Except as specified in paragraph (c) of this section, "Medicare supplemental health insurance policy" (policy) means a health insurance policy or other health benefit plan—

(1) That a private entity offers to a Medicare beneficiary; and

(2) That provides payment for expenses incurred for services and items that are not reimbursed under the Medicare program because of deductibles, coinsurance, or other limitations under Medicare.

(b) Medicare supplemental health insurance policy includes the following:

(1) An individual policy. For purposes of this section, "individual policy" includes any policy issued as a result of solicitation of individuals—

(i) Through the mail; or

(ii) By mass media advertising.

(2) A group policy.

(3) A certificate issued under a policy.

(c) Medicare supplemental health insurance policy does not include any of the following health insurance policies or health benefit plans:

(1) A policy or plan of one or more employers for employees, former employees, or any combination thereof.

(2) A policy or plan of one or more labor organizations for members, former members, or any combination thereof.

(3) A policy or plan of the trustees of a fund established by one or more labor organizations, one or more employers, or any combination, for any one or combination of the following:

(i) Employees.

(ii) Former employees.

(iii) Members.

(iv) Former members.

(4) A policy or plan of a professional trade or occupational association, if the association—

(i) Is composed of individuals all of whom are actively engaged in the same profession, trade, or occupation;

(ii) Has been maintained in good faith for a purpose other than obtaining insurance; and

(iii) Has been in existence for at least two years before the date of its initial offering of a Medicare supplemental health insurance policy to its members.

§ 403.215 General standards for certified medicare supplemental health insurance policies.

(a) A policy that meets the requirements of this subpart will be either—

(1) Deemed certified in a State with an approved regulatory program, as provided for in § 403.242; or

(2) Certified under the voluntary certification program, as provided for in § 403.248.

(b) To be certified under paragraph (a) of this section, a policy must meet—

(1) The NAIC model standards of § 403.218;

(2) The loss ratio standards of § 403.221; and

(3) For purposes of paragraph (a)(2), any State requirements applicable to a policy—

(i) Issued in that State; or

(ii) Marketed in that State as a certified policy.

(c) The standards specified in §§ 403.218 and 403.221—

(1) May be met in two or more policies issued in conjuction with one another in the case of—

(i) A nonprofit hospital association; and

(ii) A medical service association; and

(2) Must be met in a single policy in all other cases.

§ 403.218 NAIC model standards.

(a) "NAIC model standards" means the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act, as amended and adopted by NAIC on June 6, 1979, as it applies to Medicare supplemental policies.

(b) The policy must meet or exceed the NAIC model standards, except that—

(1) The policy must meet the NAIC model standards, regardless of the Medicare beneficiary's age; and

(2) The policy must meet the loss ratio standards specified in §403.221.

§ 403.221 Loss ratio standards.

(a) The policy must be expected to return to the policyholders, in the form of aggregate benefits provided under the policy—

(1) At least 75 percent of the aggregate amount of premiums in the case of group policies; and

(2) At least 60 percent of the aggregate amount of premiums in the case of individual policies.

(b) The insuring organization must calculate loss ratios according to the provisions of §§ 403.224 and 403.225.

§ 403.224 Calculation of expected loss ratios: General provisions.

(a) *Basic formula.*

(1) The expected loss ratio is calculated by determining the ratio of benefits to premiums.

(2) To calculate the amount of "benefits"—

(i) Add the present values on the initial calculation date of—

(A) Expected incurred benefits in the loss ratio calculation period, to—

(B) The total policy reserve at the last day of the loss ratio calculation period; and

(ii) Subtract the total policy reserve on the initial calculation date from the sum of these values.

(3) To calculate the amount of "premiums", calculate the present value on the initial calculation date of expected earned premiums for the loss ratio calculation period.

(b) *Provisions for calculating "benefits".*

(1) "Total policy reserve" means the sum of—

(i) Additional reserve; and

(ii) The reserve for future contingent benefits.

(2) "Additional reserve" means the amount calculated on a net level reserve basis, using appropriate values to account for lapse, mortality, morbidity, and interest, that on the valuation date represents—

(i) The present value of expected incurred benefits over the loss ratio calculation period; less—

(ii) The present value of expected net premiums over the loss ratio calculation period.

(3) "Net premium" means the level portion of the gross premium used in calculating the additional reserve. On the day the policy is issued, the present value of the series of those portions equals the present value of the expected

incurred claims over the period that the gross premiums are computed to provide coverage.

(4) "Reserve for future contingent benefits" means the amounts, not elsewhere included, that provide for the extension of benefits after insurance coverage terminates. These benefits—

(i) Are predicated on a health condition existing on the date coverage ends;

(ii) Accrue after the date coverage ends; and

(iii) Are payable after the valuation date.

(c) *Provisions for calculating "premiums".*

(1) "Earned premium for a given period means—

(i) Written premiums for the period; plus—

(ii) The total premium reserve at the beginning of the period; less—

(iii) The total premium reserve at the end of the period.

(2) "Written premiums in a given period" means—

(i) Premiums collected in that period; plus—

(ii) Premiums due and uncollected at the end of that period; less—

(iii) Premiums due and uncollected at the beginning of that period.

(3) "Total premium reserve" means the sum of—

(i) The unearned premium reserve;

(ii) The advance premium reserve; and

(iii) The reserve for rate credits.

(4) "Unearned premium reserve" means the portion of gross premiums due that provide for days of insurance coverage after the valuation date.

(5) "Advance premium reserve" means premiums received by the insuring organization that are due after the valuation date.

(6) "Reserve for rate credits" means rate credits on a group policy that—

(i) Accrue by the valuation date of the policy; and

(ii) Are paid or credited after the valuation date.

§ 403.225 Calculation of expected loss ratios: Date and time frame provisions.

(a) "Application date" means the day the insuring organization sends the policy to HCFA for review.

(b) "Initial calculation date" means the first date of the period that the insuring organization uses to calculate the policy's expected loss ratio.

(1) The initial calculation date may be before, the same as, or after the application date; except—

(2) The initial calculation date must not be earlier than January 1 of the calendar year of the application date.

(c) "Loss ratio calculation period" means the period beginning with the initial calculation date and ending with the last day of the period for which the insuring organization calculates the policy's scale of premiums.

(d) To calculate "present values", the insuring organization may use approximations that aggregate, for a period not to exceed 12 months—

(1) Expected earned premiums, and

(2) Expected incurred benefits.

§ 403.227 Actuarial certification.

(a) For purposes of certification requests submitted under § 403.245(b), "actuarial certification" means a signed declaration in which a qualified actuary states that the assumptions used in calculating the expected loss ratio are appropriate and reasonable, taking into account actual policy experience, if any, and reasonable expectations.

(b) "Qualified actuary" means—

(1) A member in good standing of the American Academy of Actuaries; or

(2) A person who has otherwise demonstrated his or her actuarial competence to the satisfaction of the Commissioner or Superintendent of Insurance of the domiciliary State of the insuring organization.

§ 403.230 Supplemental health insurance panel.

(a) *Membership.* The Supplemental Health Insurance Panel (Panel) consists of—

(1) The Secretary or a designee, who serves as chairperson, and

(3) Four State Commissioners of Superintendents or Insurance appointed by the President.

(b) *Functions.*

(1) The Panel determines whether or not a State regulatory program for Medicare supplemental health insurance policies meets and continues to meet minimum requirements, as specified under § 403.240.

(2) The Secretary, as chairperson of the Panel, informs the State Commissioners and Superintendents of Insurance of all determinations made under paragraph (b)(1) of this section.

§ 403.234 Emblem.

(a) The emblem is a graphic symbol, approved by HHS, that indicates that a policy meets the certification requirements of this subpart.

(b) Unless prohibited by the State in which the policy is marketed, the insuring organization may display the emblem on policies certified under the voluntary certification program.

(c) If a policy is issued in a State with an approved regulatory program, the State in which the policy is marketed may authorize the insuring organization to display the emblem on that policy.

(d) In the case of a policy displaying the emblem, the insuring organization must notify each holder of the policy within 60 days in writing, if—

(1) HCFA decertifies the policy, as specified in §§ 403.255, 403.258(b)(3), and 403.260(b)(5) and (c)(4); or

(2) The State with an approved regulatory program determines that the policy ceases to meet State requirements.

State Regulatory Programs

§ 403.240 State with an approved regulatory program.

(a) A State has an approved regulatory program if the Panel determines that the State has in effect under State law a regulatory program that provides for the application of standards, with respect to each Medicare supplemental health insurance policy issued in that State, that are equal to or more stringent than those specified in § 403.215.

(b) "Policy issued in that State" means—

(1) A group policy, if the holder of the master policy resides in that State; and

(2) An individual policy, if a holder of that policy resides in that State.

§ 403.242 Certification of policies.

If a State has an approved regulatory program, a policy issued in that State is deemed certified.

Voluntary Certification Program

§ 403.245 Requirements for obtaining certification.

(a) A policy must meet the standards specified in § 403.215 to be certified by HCFA.

(b) An insuring organization requesting certification of a policy must submit the following to HCFA for review:

(1) A copy of the policy.

(2) A copy of the outline of coverage, in the form prescribed by the NAIC model standards.

(3) A statement that the policy meets the requirements specified in paragraph (a) of this section.

(4) A copy of the calculations for the expected loss ratio.

(5) Supporting data used in calculating the expected loss ratio. That data must include—

(i) The scale of premiums for the loss ratio calculation period;

(ii) A description of all assumptions;

(iii) The formula used to calculate gross premiums;

(iv) The expected level of earned premiums in the loss ratio calculation period; and

(v) The expected level of incurred claims in the loss ratio calculation period.

(6) An actuarial certification, as specified in § 403.227, of the loss ratio computations.

(7) A list of States in which the insuring organization is authorized to market the policy.

(8) A statement that the insuring organization will notify the policyholders in writing within 60 days of decertification, if the policy is identified as a certified policy at the time of sale and later decertified.

(9) A signed statement in which the president of the insuring organization, or a designee, attests that the information submitted to HCFA for review is accurate and complete and does not misrepresent any material fact.

§ 403.248 Review and certification of policies.

(a) HCFA will review policies that the insuring organization voluntarily submits, except that HCFA will not review a policy issued in a State with an approved regulatory program under § 403.240.

(b) If the requirements specified in § 403.245 are met, HCFA will—

(1) Certify the policy; and

(2) Authorize the insuring organization to imprint the emblem on the policy, as provided for in § 403.234.

(c) HCFA will inform all State Commissioners and Superintendents of Insurance of Policies that it certifies.

§ 403.251 Submittal of material to retain certification.

(a) HCFA certification for policies that continue to meet the standards will remain in effect, if the insuring organization files the material specified in § 403.245(b) no later than the date specified in paragraph (b) or (c) of this section.

(b) Except as specified in paragraph (c) of this section, the insuring organization must file the material with HCFA no later than June 30 of each year. The first time the insuring organization must file the material is no later than June 30 of the calendar year that follows the year in which HCFA—

(1) Certifies a new policy; or

(2) Certifies a policy that has been decertified, as provided in § 403.255.

(c) If the loss ratio calculation period, used to calculate the expected loss ratio for the last actuarial certification submitted to HCFA, ends before the June 30 date of paragraph (b) of this section, the insuring organization must file the material with HCFA no later than the last day of that rate calculation period.

§ 403.255 Decertification of policies.

(a) HCFA will decertify a policy, if—

(1) The policy fails to meet the requirements specified in § 403.245(a); or

(2) The insuring organization fails to meet the requirements for submittal of material specified in § 403.251.

(b) If HCFA decertifies a policy, HCFA will inform the insuring organization and all State Commissioners and Superintendents of Insurance of its determination.

(c) HCFA will monitor the insuring organization to assure that the insuring organization notifies each policyholder in writing when his or her policy is decertified.

§ 403.258 Termination of a State program: Transfer of policies.

(a) When the Panel determines that a State no longer has an approved regulatory program, policies issued in that State are transferred to the jurisdiction of the voluntary certification program.

(b) If the policy was certified under a State regulatory program, but is transferred to the voluntary program, the following provisions apply:

(1) HCFA will waive the requirements specified in § 403.245(b) for submittal of certain information by the insuring organization to obtain initial certification.

(2) HCFA will certify the policy. That certification will be in effect—

(i) Until the expiration date of the certification the policy received under the State program; but

(ii) Not for more than 6 months.

(3) If the insuring organization wishes certification to continue beyond the date specified in paragraph (b) (2) of this section, the insuring organization must submit the material specified lin § 403.245(b) before that date.

(i) If HCFA certifies the policy on or before the date specified in paragraph (b) (2), the new certification will become effective on the date the determination is made.

(ii) If HCFA does not certify the policy on or before the date specified in paragraph (b) (2) of this section, that policy is decertified.

§ 403.260 Administrative review of HCFA determinations.

(a) This section provides for administrative review of a HCFA determination—

(1) Not to certify a policy; or

(2) To decertify a policy.

(b) HCFA will send a notice to the insuring organization containing the following information:

(1) That HCFA has made a determination—

(i) Not to certify a policy; or

(ii) To decertify a policy.

(2) The reasons for the determination.

(3) That the insuring organization has 30 days from the date of the notice to—

(i) Request, in writing, an administrative review of the HCFA determination; and

(ii) Submit additional information to HCFA for review.

(4) That, if the insuring organization requests an administrative review, HCFA will conduct the review, as provided for in paragraph (c) of this section.

(5) That, in a case involving decertification, the decertification will go into effect 30 days from the date of the notice, unless the insuring organization requests an administrative review. If the insuring organization requests an administrative review, the policy retains its certification until HCFA makes a final determination.

(c) If the insuring organization requests an administrative review, HCFA will conduct the review as follows:

(1) A HCFA official, not involved in the initial HCFA determination, will initiate an administrative review within 90 days of the date of the notice provided for in paragraph (c) of this section.

(2) The official will consider—

(i) The original material submitted to HCFA for review, as specified in §§ 403.245(b) or 403.251; and

(ii) Any additional information, that the insuring organization submits to HCFA.

(3) Within 15 days after the administrative review is completed, HCFA will inform the insuring organization in writing of the final decision, with an explanation of the final decision.

(4) If the final decision is to decertify a policy, the decertification will go into effect 15 days after the date of HCFA's notice to inform the insuring organization of the final decision.

(Secs. 1102, 1871, and 1882 of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395ss))

(Catalog of Federal Domestic Assistance Program No. 13.773, Medicare—Hospital Insurance Program; No. 13.774, Medicare—Supplementary Medical Insurance Program)

Dated: November 5, 1980.

Howard Newman,

Administrator, Health Care Financing Administration.

Approved: January 9, 1981.

Patricia Roberts Harris,

Secretary.

[FR Doc. 81-1775 Filed 1-19-81; 8:45 am]

BILLING CODE 4110-35-M

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SB 43
Title An Act relating to insurance policy form filings
Requested by Governor Date Dec. 10, 1980

II. FISCAL DETAIL
Agency Affected Division of Insurance
Program Category Affected Public Protection
BRU, Program, or Subprogram(s) Affected Division of Insurance
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES	0	0				
200 TRAVEL	0	0				
300 CONTRACTUAL	0	0				
400 COMMODITIES	0	0				
500 EQUIPMENT	0	0				
600 LAND & STRUCTURES	0	0				
700 GRANTS, CLAIMS, ETC.	0	0				
TOTAL	0	0				

FUNDING (Thousands of Dollars)

GENERAL FUND	0	0				
FEDERAL FUNDS	0	0				
OTHER (Specify Fund Source)	0	0				

POSITIONS

FULL TIME	0	0				
PART TIME	0	0				
TEMPORARY	0	0				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

IV. DATE Dec. 10, 1980 PREPARED BY John George, Div. of Insurance
AGENCY Commerce and Economic Development
Original: Legislative Finance PHONE 2515

January 12, 1981

President of the Senate
Alaska State Legislature
Pouch V
Juneau, AK 99811

Dear Mr. President:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill which amends AS 21.42.130 by allowing the director of insurance to disapprove a form filed under AS 21.42.120 when the insurance benefits do not bear a reasonable relationship to the premiums charged. Regulations establishing appropriate cost/benefit ratios will be adopted to provide guidelines for the exercise of this power.

This amendment is a response to Public Law 96-265 which empowered the federal government to certify programs for medicare supplemental policies in states that fail to establish equivalent programs of certification. This bill will provide a mechanism for the director of insurance to certify supplemental medicare policies and avoid federal regulation of this area.

Sincerely,

S/JSH

Jay S. Hammond
Governor

to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. Forms for use in property, marine (other than wet marine and transportation coverages), casualty and surety insurance coverages the filing required by this section may be made by rating organizations on behalf of its members and subscribers; but this provision does not prohibit a member or subscriber from filing the forms on its own behalf.

(b) Each filing shall be made not less than 30 days in advance of delivery. At the expiration of the 30 days the form filed shall be considered approved unless before the 30-day period it has been affirmatively approved or disapproved by order of the director. Approval of the form by the director constitutes a waiver of the unexpired portion of the waiting period. The director may extend by not more than an additional 30 days the period within which he may affirmatively approve or disapprove the form, by giving notice of the extension before expiration of the initial 30-day period. At the expiration of the extended period, and in the absence of a prior affirmative approval or disapproval, the form shall be considered approved. The director may at any time, after notice and for cause shown, withdraw the approval.

(c) An order of the director disapproving the form or withdrawing a previous approval shall state the grounds and the particulars in such detail as reasonably to inform the insurer thereof.

(d) The director may, by order, exempt from the requirements of this section for as long as he considers proper an insurance document or form or type thereof as specified in the order, to which, in his opinion, this section may not practicably be applied, or the filing and approval of which are, in his opinion, not desirable or necessary for the protection of the public.

(e) This section applies also to a form used by domestic insurers for delivery in a jurisdiction outside this state, if the insurance supervisory official of the jurisdiction informs the director that the form is not subject to approval or disapproval by the official, and upon the director's order requiring the form to be submitted to him for the purpose. The applicable same standards shall apply to these forms as apply to forms for domestic use. (§ 1 ch 120 SLA 1966)

Sec. 21.42.130. Grounds for disapproval. The director shall disapprove a form filed under § 120 of this chapter or withdraw a previous approval thereof, only if the form

(1) is in any respect in violation of or does not comply with this title;

(2) contains or incorporates by reference, where incorporation is permissible, an inconsistent, ambiguous, or misleading clause,

or exception and condition which deceptively affects the risk purported to be assumed in the general coverage of the contract;

(3) has a title, heading, or other indication of its provisions which is misleading;

(4) is printed or otherwise reproduced in a manner which renders a provision of the form substantially illegible. (§ 1 ch 120 SLA 1966)

Sec. 21.42.140. Standard provisions. (a) Insurance contracts shall contain the standard or uniform provisions which are required by the applicable provisions of this title pertaining to contracts of particular kinds of insurance. The director may waive the required use of a particular provision in a particular insurance policy form if

(1) he finds the provision unnecessary for the protection of the insured and inconsistent with the purposes of the policy; and

(2) the policy is otherwise approved by him.

(b) No policy may contain a provision inconsistent with a standard or uniform provision used or required to be used, but the director may approve a substitute provision which is, in his opinion, not less favorable in any particular to the insured or beneficiary than the provisions otherwise required.

(c) In lieu of the provisions required by this title for contracts for particular kinds of insurance, substantially similar provisions required by the law of the domicile of a foreign or alien insurer may be used when approved by the director.

(d) A provision required by this title to be contained in a policy cannot be waived by agreement between the insurer and another person. (§ 1 ch 120 SLA 1966)

Am. Jur., ALR and C.J.S. references.—29 Am. Jur., Insurance, §§ 186 to 188.

Departure from standard policy as affecting enforcibility of policy provision against insurer, 113 ALR 773.

44 C.J.S. Insurance §§ 249 to 261.

Sec. 21.42.150. Policy must contain entire contract. The policy, when issued, shall contain the entire contract between the parties, and neither the insurer nor its agent or representative, nor a person insured by the policy, may make an agreement as to the insurance which is not expressed in the policy. This section does not prohibit the modification of a policy, after issuance, by written rider or endorsement issued by the insurer. (§ 1 ch 120 SLA 1966)

Sec. 21.42.160. Contents of policies in general. (a) Each policy shall specify

(1) the names of the parties of the contract;

(2) the subject of the insurance;

(3) the risks insured against;

(4) the society has a board of directors charged with the responsibility for managing its affairs in the interim between meetings of its supreme legislative or governing body, subject to control by the body and having powers and duties delegated to it in the constitution or laws of the society;

(5) the board of directors is elected by the supreme legislative or governing body, except in case of filling a vacancy in the interim between meetings of the body;

(6) the officers are elected either by the supreme legislative or governing body or by the board of directors; and

(7) the members, officers, representatives or delegates may not vote by proxy. (§ 1 ch 120 SLA 1966)

Sec. 21.84.590. Other provisions applicable. In addition to the provisions contained in this chapter, other chapters and provisions of this title shall apply to fraternal benefit societies, to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications thereof, as follows:

(1) AS 21.03
(2) AS 21.06, with the exception of AS 21.06.250
(3) The following sections of AS 21.09:
  (A) AS 21.09.050
  (B) AS 21.09.100
(4) AS 21.33.010
(5) AS 21.36
(6) AS 21.42.290
(7) AS 21.69.370
(8) AS 21.69.640
(9) AS 21.78. (§ 1 ch 120 SLA 1966)

Chapter 87. Hospital and Medical Service Corporations.

Chapter 89. Miscellaneous Provisions.

Sec. 21.89.020. Required motor vehicle coverage. (a) An automobile liability policy which insures an owner or operator of a motor vehicle against loss resulting from his liability for bodily injury or death, or for property injury or destruction, or both, which is sold in this state after January 1, 1969, by an insurance carrier authorized to transact business in this state, shall contain limits in at least the amount prescribed for a motor vehicle liability policy in AS 28.20.440(b)(2), and meet the requirements of AS 28.20.440(b)(3) unless waived as provided in that paragraph.

(b) This section may not be construed to apply only to automobile liability policies obtained to satisfy a requirement of AS 28.20. (§ 1 ch 105 SLA 1968)

Cross reference. — As to motor vehicle liability policy, see AS 28.20.440.

Legislative committee report. — For legislative committee report on ch. 105, SLA 1968 (HB 236), see House Journal (1967), p. 370.

This section does not require stacking in the single policy context. This conclusion follows from the fact that uninsured motorists insurance may be waived in Alaska. Curran v. Fireman's Fund Ins. Co., 393 F. Supp. 712 (D. Alas. 1975).

Insured was allowed to "stack" the uninsured motorists coverage provided him in a single multivehicle policy where the insured, under the interpretation of the contract propounded by the insurer, would receive absolutely no additional coverage for his premium dollars paid for uninsured motorists coverage on the vehicles other than the one involved in the accident and where the only possible interpretation of the contract was that the uninsured motorists premiums paid in connection with the other vehicles were meant to increase the amount of coverage, the limits of liability clause notwithstanding. Curran v. Fireman's Fund Ins. Co., 393 F. Supp. 712 (D. Alas. 1975).

A policy provision which "waived" uninsured motorist coverage in the event the insured has other available insurance does not directly contravene this section. Werley v. United Servs. Auto. Ass'n, Sup. Ct. Op. No. 799 (File Nos. 1454, 1455), 498 P.2d 112 (1972).

Sec. 21.89.030. Payment. No insurance company doing business in this state may pay a judgment or settlement of a claim in this state for a loss incurred in this state with an instrument other than a negotiable bank check payable on demand and bearing even date with the date of writing. (§ 1 ch 172 SLA 1968)

Revisor's note. — Both chapters 105 and 172, SLA 1968, added a new section designated 21.89.020. This section has been renumbered.

Legislative committee report. — For legislative committee report on ch. 172 SLA 1968 (CSHB 365), see House Journal (1968), p. 246.