Medicare Supplement Changes for 2010

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Introduction

- Medicare Improvements for Patients and Providers Act of 2008
  - "MIPPA"
  - Passed in July of last year
  - Driving force of key changes taking place for Medicare Supplement
- Direct Impact on Medicare Supplement
  - New Plans
- Indirect Impact on Medicare Supplement
  - MA Environment
- Other changes
- Beyond 2010?
  - Continued pressure on MA profits
  - Potential changes to refund filing requirements
  - Changes to Medicare Program Itself

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MIPPA Overview

- Passed in July 2008
- Medicare Supplement – Key section 104
  - Implementation of revised NAIC Model Law
    - States have until 9/24/2009 to adopt
    - Addresses new plan options required 6/1/2010 and later
    - Also addresses Genetic Information Nondiscrimination Act of 2008 (“GINA”)
  - Issuer must offer new plans “C” or “F” if not just offering “A”
- Medicare Advantage – Key sections 103, 162, 163, 166
  - Marketing practices
  - PFFS plans need to establish networks and have a quality of improvement program
  - MA Funding reductions
- Medicare Reimbursement – Key section 131
  - Pending cuts to physician payments blocked

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Reference chart of current Med Supp Standardization

Benefit	Plan A	Plan B	Plan C	Plan D	Plan E	Plan F *	Plan G	Plan H	Plan I	Plan J *	Plan K **	Plan L ***
Basic	X	X	X	X	X	X	X	X	X	X	X	X
Part A Deductible		X	X	X	X	X	X	X	X	X	X	X
Part B Deductible			X			X				X		
SNF Coinsurance			X	X	X	X	X	X	X	X	X	X
Part B Excess						100%	80%		100%	100%		
Foreign Travel Benefit			X	X	X	X	X	X	X	X		
At-Home Recovery Benefit				X			X		X	X		
Preventive Care					X					X		
Hospice											X	X
* - High Deductible version is also available												
** - Subject to 50% plan coinsurance and OOP Limit ($4,620 in 2009)												
*** - Subject to 75% plan coinsurance and OOP Limit ($2,310 in 2009)												

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New Medicare Supplement Plans for 2010

- Overview
  - Applicable to all policies with effective dates 6/1/2010 and later
  - Hospice coverage added
  - At-Home Recovery and Preventive removed
  - Some plans thought to be redundant and removed
  - Excess coverage now at 100% where applicable (Plans F and G)
  - Added two new lower cost plan options (M and N)
- How do the new “improved” plans compare to the current standardized versions?
  - Plans A,B,C, and F: Hospice Coverage added
    - Insignificant to overall claim costs
    - Consists of limited copay/coinsurance of outpatient drugs and inpatient respite care
  - Plan D
    - Hospice Coverage added
    - At-Home Recovery Benefit removed (not insignificant)
  - Plans E,H,I, and J: Gone
  - Plan G:
    - Cover 100% of Excess Physician
    - Remove At-Home Recovery
    - Add Hospice
  - Plans K and L: Unchanged

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New Medicare Supplement Plans for 2010

- New Plans M and N
  - Plan M
    - Just like Plan D except only 50% of Part A deductible is covered
  - Plan N
    - Just like Plan D except Part B benefits subject to copays
      - Office visit copay up to maximum of $20
      - Emergency room copay of up to $50 – waived if admitted
  - Lower cost option
  - How will these plans be received?
    - Lower premium would need to overcome higher cost sharing as well as low commission levels
    - Plans K, L, and High deductible plans have not had significant sales to date

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New Medicare Supplement Plans for 2010

- Replacement Offer
  - If a written offer to exchange policies is provided by issuer, the offer must comply with the following requirements:
    - Replacements from issue age rated policies need to recognize the policy reserve buildup
    - Rating class for the new policy shall be the class closest to that of the replaced policy
    - Issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the replaced policy…
    - However, issuer may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new policy not contained in the replaced policy
    - New policy shall be offered to all policyholders within a given plan, except where in violation of law.
  - Note that requirements only apply if replacement offer is made – not a requirement to make offer

- Rating Implications
  - Benefit differences
  - Regulatory restrictions
    - New plans are distinct policy forms from current policy forms
    - Required degree of relationship between new policy form rates and current policy form rates is subject to interpretation
    - Subject to actuarial justification
    - Stance will vary on a state by state basis

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Indirect Changes – Medicare Advantage Environment

- Tightened marketing and sales practices
- PFFS plans will need to set up networks and quality improvement program
- Reduction in reimbursement levels

Other Changes

- Innovative Benefits
- Genetic Information Nondiscrimination Act of 2008 (“GINA”)

Innovative Benefits

- Model regulation includes some revised clarifying language and refers to additional guidance in the compliance manual
  - Old language "… **may** include benefits that are appropriate to Medicare Supplement insurance…"
  - New language "… **shall** include **only** benefits that are appropriate to Medicare Supplement insurance…"
  - Additional sentence added: "New or Innovative benefits shall not be used to change or reduce benefits including a change in any cost-sharing provision, in any standardized plan."

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Innovative Benefits – Updated Draft Compliance Manual

- Added section on Innovative Benefit Issues
- Provides Examples
  - Includes: Hearing Services, Vision Services, Dental Services, Preventive Care Services
  - Excludes: Discounts for eye glasses/frames or hearing aides, health club memberships, other types of ancillary services/programs, or alternative cost-sharing provisions
- Filings and Approvals
- Adding to existing benefit designs
  - Cost/premium should be disclosed separately
  - Disclosure if no coverage w/o innovative benefits
  - Considered part of policy with respect to open enrollment and guarantee issue provisions
  - Only one policy with innovative benefits per plan/type combination is allowed
- Premiums, Premium Changes, and Claims Experience
  - Consistency with rating basis of attached policy
  - Consistency of experience reporting with basis of premium changes
  - Refund calculations should include innovative benefits with base plan

Innovative Benefits – Updated Draft Compliance Manual (continued)

- Market Place Availability
  - States should report new or innovative benefit (NIB) approvals to the NAIC Senior Issues (B) Task Force
  - Task Force will maintain record of all NIB approved
  - Task Force will periodically review approvals and determine whether any warrant inclusion of Standard benefit plan designs
  - Each state should consider publishing all NIB approved

Genetic Information Nondiscrimination Act of 2008 ("GINA")

- Timeline
  - Enacted legislation on 5/21/2008
  - Provisions effective for policy years beginning on or after 5/21/2009
  - States must adopt provisions no later than 7/1/2009
- Prohibits issuers from denying or conditioning the issuance or effectiveness of a policy (including pre-x exclusions) based on an individual's genetic information
- Generally prohibits issuers from requesting or requiring a genetic test, with two exceptions:
  - Determine payment
  - May request (but not require) solely for research purposes
- Definitively prohibits issuers from requesting, requiring, or purchasing genetic information for underwriting purposes
  - Unless genetic information is obtained incidental to the request, requirement, or purchase of other information provided it is not used for underwriting purposes
- Genetic Information defined as information about individual's genetic test or tests of family members and the manifestation of a disease or disorder in family members (i.e. family history)
  - Also includes an individual's request for, or receipt of, genetic services, or participation in clinical research that includes genetic services, but does not include information about the sex or age of any individual

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What to look out for beyond 2010

- Continued Pressure on Medicare Advantage Programs
- Refund Formula
  - Pooling Issues
  - Formula/Methodology
- Changes to Medicare Program itself
  - Under 65 buy-in?
  - Benefit reductions/changes?

Refund Formula

- Pooling
  - Current Draft version of Compliance Manual says 1990 Plans must be pooled with 2010 Plans of same letter
  - AAA Medicare Supplement Working Group has commented that pooling not necessarily ideal in all situations, particularly between different rating characteristics, and possibly between states and issue period generations
- Formula/Methodology
  - AAA Medicare Supplement Work Group has been asked to recommend updates to refund formula
  - Consideration of rating structure
  - Appropriateness of 3rd Year loss ratio requirement and applicability of active life reserves
  - Tolerance Formula

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Changes to the Medicare Program Itself

- Under Age 65 Buy-in?
  - A possible idea that has been floating around
  - How would this affect open enrollment?
  - Would this expand the Medicare Supplement market?
    - If so, how would the overall morbidity level of the market change?
- Benefit Reductions/Changes?
  - Is the day of reckoning finally approaching?
  - Will benefit reductions be picked up by Med Supp or passed on to the beneficiaries?
  - Will Medicare Supplement standardization need to continuously evolve?
    - Modernization in 2010 may just be an interim step
    - Probably won't go another 19 years before the next set of changes

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Questions/Comments

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