§ 1358.13. Compliance with federal statutes

(a) An issuer shall comply with Section 1882(c)(3) of the federal Social Security Act (as enacted by Section 4081(b)(2)(C) of the federal Omnibus Budget Reconciliation Act of 1987 (OBRA), Public Law 100-203) by doing all of the following:

(1) Accepting a notice from a Medicare Administrative Contractor, formerly known as a fiscal intermediary or carrier, on dually assigned claims

submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice.

(2) Notifying the participating physician or supplier and the beneficiary of the payment determination.

(3) Paying the participating physician or supplier directly.

(4) Furnishing, at the time of enrollment, each enrollee with a card listing the contract name, number, and a central mailing address to which notices respecting coverage from a Medicare Administrative Contractor may be sent.

(5) Paying user fees established under Section 1395u(h)(3)(B) of Title 42 of the United States Code, for claim notices that are transmitted electronically or otherwise.

(6) Providing to the secretary, at least annually, a central mailing address to which all claims may be sent by Medicare Administrative Contractors.

(b) Compliance with the requirements set forth in subdivision (a) shall be certified on the Medicare supplement insurance experience reporting form provided by the director.

HISTORY:
Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2009 ch 10 § 9 (AB 1543), effective July 2, 2009.

§ 1358.14. Loss ratio standards; Refund or credit calculations; Prepaid or periodic charges and supporting documentation; Public hearings

(a)(1)(A) With respect to loss ratio standards, a Medicare supplement contract shall not be advertised, solicited, or issued for delivery unless the contract can be expected, as estimated for the entire period for which prepaid or periodic charges are computed to provide coverage, to return to subscribers and enrollees in the form of aggregate benefits under the contract, not including anticipated refunds or credits provided under the contract, at least 75 percent of the aggregate amount of charges earned in the case of group contracts, or at least 65 percent of the aggregate amount of charges earned in the case of individual contracts, on the basis of incurred claims or costs of health care services experience and earned prepaid or periodic charges for that period and in accordance with accepted actuarial principles and practices.

(B) Loss ratio standards shall be calculated on the basis of incurred health care expenses where coverage is provided by a health care service plan on a service rather than reimbursement basis, and earned prepaid or periodic charges shall be calculated for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health care service plan shall not include any of the following:

(i) Home office and overhead costs.

(ii) Advertising costs.

(iii) Commissions and other acquisition costs.

(iv) Taxes.

(v) Capital costs.

(vi) Administrative costs.

(vii) Claims processing costs.

(2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to prepaid or periodic charges comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(3) For purposes of applying paragraph (1) of subdivision (a) and paragraph (3) of subdivision (d) of Section 1358.15 only, contracts issued as a result of solicitations of individuals through the mail or by mass media advertising, including both print and broadcast advertising, shall be deemed to be individual contracts.

(b)(1) With respect to refund or credit calculations, an issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form required by the director (NAIC Appendix A) for each type of coverage in a standard Medicare supplement benefit plan.

(2) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type of contract offered by the issuer. For purposes of the refund or credit calculation, experience on contracts issued within the reporting year shall be excluded.

(3) For the purposes of this section, with respect to contracts advertised, solicited, or issued for delivery prior to January 1, 2001, the issuer shall make the refund or credit calculation separately for all individual contracts, including all group contracts subject to an individual loss ratio standard when issued, combined and all other group contracts combined for experience after January 1, 2001. The first report pursuant to paragraph (1) shall be due by May 31, 2003.

(4) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds ten dollars ($10). The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against prepaid or periodic charges due shall be made by September 30 following the experience year upon which the refund or credit is based.

(c) An issuer of Medicare supplement contracts shall file annually its prepaid or periodic charges and supporting documentation including ratios of incurred losses to earned prepaid or periodic charges by contract duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which charges are computed. The demonstration shall exclude active life reserves. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for contracts in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement contracts shall file with the director, in accordance with applicable filing procedures, all of the following:

(1)(A) Appropriate prepaid or periodic charge adjustments necessary to produce loss ratios as anticipated for the current charge for the applicable contracts. The supporting documents necessary to justify the adjustment shall accompany the filing.

(B) An issuer shall make prepaid or periodic charge adjustments necessary to produce an expected loss ratio under the contract to conform to minimum loss ratio standards for Medicare supplement contracts and that are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current charges by the issuer for the Medicare supplement contracts. No charge adjustment that would modify the loss ratio experience under the contract other than the adjustments described in this section shall be made with respect to a contract at any time other than upon its renewal date or anniversary date.

(C) If an issuer fails to make prepaid or periodic charge adjustments acceptable to the director, the director may order charge adjustments, refunds, or credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate contract amendments needed to accomplish the Medicare supplement contract modifications necessary to eliminate benefit duplications with Medicare. The contract amendments shall provide a clear description of the Medicare supplement benefits provided by the contract.

(d)(1) The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a contract form issued before or after the effective date of January 1, 2001, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

(2) The director may conduct a public hearing to gather information if the experience of the form filed under paragraph (1) of subdivision (b) for the previous reporting period is not in compliance with the applicable loss ratio standard.

The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

HISTORY:

Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 10 (SB 375), effective January 1, 2006.

§ 1358.145. Calculation of loss ratios; Copies to department; Compliance with standards

(a) The calculation of actual or expected loss ratios shall be pursuant to the formula in subdivision (a) of Section 1358.14, and pursuant to definitions, procedures, and other provisions as may be deemed by the director, with due

consideration of the circumstances of the particular issuer, to be fair, reasonable, and consistent with the objectives of this chapter.

(b) Each issuer shall submit to the department a copy of the calculations for the actual or expected loss ratio as required by Section 1358.14. The calculations shall include the following data: the actual loss ratio for the entire period in which the contract has been in force, as well as for the immediate past three years and for each year in which the contract has been in force, the scale of prepaid or periodic charges for the loss ratio calculation period, a description of all assumptions, the formula used to calculate gross prepaid or periodic charges, the expected level of earned prepaid or periodic charges in the loss ratio calculation period, and the expected level of incurred claims for reimbursement, including paid claims and incurred but not paid claims, in the loss ratio calculation period. The calculations shall be accompanied by an actuarial certification, consisting of a signed declaration of an actuary who is a member in good standing of the American Academy of Actuaries in which the actuary states that the assumptions used in calculating the expected loss ratio are appropriate and reasonable, taking into account that the calculations are in accordance with the provisions of subdivision (a) and the provisions referred to therein. In addition, the director may require the issuer to submit actuarial certification, as described above, by one or more unaffiliated actuaries acceptable to the director.

(c) Notwithstanding the calculations required by subdivision (b), contracts shall be deemed to comply with the loss ratio standards if, and shall be deemed not to comply with the loss standards unless: (1) for the most recent year, the ratio of the incurred losses to earned prepaid charges for contracts that have been in force for three years or more is greater than or equal to the applicable percentages contained in this section; and (2) the expected losses in relation to charges over the entire period for which the contract is rated comply with the requirements of this section. An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for contracts in force less than three years.

HISTORY:

Added Stats 2000 ch 706 § 2 (SB 764), effective January 1, 2001.