§ 1358.146. Format for reporting loss ratio experience

The following format shall be used for reporting loss ratio experience:

MEDICARE SUPPLEMENT
HEALTH CARE SERVICE PLAN
CONTRACT EXPERIENCE EXHIBIT

For the year ended December 31, 20____.
For the State of California.

Of the _____ health care service plan.
Address (City, State, and Zip Code)_____
Person Completing this Exhibit_____

To be filed by June 30th following the filing under Section 1358.14 of the Health and Safety Code.

Costs for Health Care Services

Classification	Prepaid or Periodic Charges Earned	Amount	Percentage of Prepaid or Periodic Charges Earned
Experience on Individual Plan Contracts			
1. Contracts issued through 20 ____			
Reporting State			
Nationwide			
2. Contracts issued after 20 ____			
Reporting State			
Nationwide			
Experience on Group Plan Contracts			
1. Contracts issued through 20 ____			
Reporting State			
Nationwide			
2. Contracts issued after 20 ____			
Reporting State			
Nationwide			

The undersigned officer hereby certifies that the company named above has complied with the requirements contained in the federal Omnibus Budget Reconciliation Act of 1987, Section 4081.

Signature _____

Title and name (please type) _____

INSTRUCTIONS FOR COMPLETING MEDICARE SUPPLEMENT HEALTH CARE SERVICE PLAN CONTRACT EXPERIENCE EXHIBIT

1. Experience on plan contracts issued more than three years prior to the reporting year should be shown separately as indicated on the form. For example, for the reporting year ended 12/31/88 (filed on June 30, 1989), experience on plan contracts issued in 1985 and prior should be shown separately from that of plan contracts issued in 1986 and later. For group coverage, the year of issue should be based on when the contract was issued if available; otherwise use the master plan contract year of issue.

2. Allocation of reserves on a state-by-state basis should be on sound actuarial principles and be consistent from year to year.

3. Membership or plan contract fees, if any, constitute, and should be included with, prepaid or periodic charges earned. Earned prepaid or periodic charges may be shown on an annual basis net of loadings for nonannual modes.

4. Mass marketing group coverage subject to individual loss ratio standards should be included with individual plan contracts.

5. Any dividends paid to subscribers should be included with costs for health care.

6. Neither costs for health care services nor earned prepaid or periodic charges should be adjusted for changes in plan contract (additional) reserves.

DEFINITIONS

For purposes of this form:

1. "Costs for health care services" means payment for health care services plus the increase in claim reserves. Claim reserves include only those unpaid liabilities for claims that have already been incurred. Costs for health care services in this exhibit do not include plan contract additional reserves.

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

§ 1358.15. Approval of contract by director as prerequisite to advertising or issuance; Requirements; Filing of certain changes; Time periods

(a) An issuer shall not advertise, solicit, or issue for delivery a Medicare supplement contract to a resident of this state unless the contract has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. Until January 1, 2001, or 90 days after approval of Medicare supplement contracts submitted for approval pursuant to this section, whichever is later, issuers may continue to offer and market previously approved Medicare supplement contracts.

(b) An issuer shall file any riders or amendments to contract forms to delete outpatient prescription drug benefits, as required by the Medicare Prescription

Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), only in the state where the contract was issued.

(c) An issuer shall not use or change prepaid or periodic charges for a Medicare supplement contract unless the charges and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director.

(d)(1) Except as provided in paragraph (2), an issuer shall not file for approval more than one contract of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the director, up to four additional contracts of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(A) The inclusion of new or innovative benefits.

(B) The addition of either direct response or agent marketing methods.

(C) The addition of either guaranteed issue or underwritten coverage.

(D) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual contract, a group contract, an individual Medicare Select contract, or a group Medicare Select contract.

(e)(1) Except as provided in subdivision (a), an issuer shall continue to make available for purchase any contract issued after January 1, 2001, that has been approved by the director. A contract shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(A) An issuer may discontinue the availability of a contract if the issuer provides to the director in writing its decision at least 30 days prior to discontinuing the availability of the form of the contract. After receipt of the notice by the director, the issuer shall no longer offer for sale the contract in this state.

(B) An issuer that discontinues the availability of a contract pursuant to subparagraph (A) shall not file for approval a new contract of the same type for the same standard Medicare supplement benefit plan as the discontinued contract for a period of five years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section.

(3) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (1) unless the issuer complies with the following requirements:

(A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memo-

randum to change. The director may approve a change to the differential that is in the public interest.

(f)(1) Except as provided in paragraph (2), the experience of all contracts of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 1358.14.

(2) Contracts assumed under an assumption reinsurance agreement shall not be combined with the experience of other contracts for purposes of the refund or credit calculation.

(g) A Medicare supplement contract shall be deemed not to be fair, just, or consistent with the objectives of this chapter at all times, and shall not be advertised, solicited, or issued for delivery at any time, except during that period of time, if any, beginning with the date of receipt by the plan of notification by the director that the provisions of the contract are deemed to be fair, just, and consistent with the objectives of this chapter, and ending with the earlier to occur of the events indicated in subdivision (h).

(h) The period of time indicated in subdivision (g) shall terminate at the earlier to occur of (1) receipt by the plan of written revocation by the director of the immediate past notification referred to in subdivision (g) specifying the basis for the revocation, (2) the last day of the prepaid or periodic charge calculation period, that in no event may exceed one year, or (3) June 30, of the next succeeding calendar year.

(i) An issuer shall secure the director's review of a contract subject to this article by submitting, not less than 30 days prior to any proposed advertising or other use of the contract not already protected by a currently effective notice under subdivision (g), the following for the director's review:

(1) A copy of the contract.

(2) A copy of the disclosure form.

(3) A representation that the contract complies with the provisions of this chapter and the rules adopted thereunder.

(4) A completed copy of the "Medicare Supplement Health Care Service Plan Contract Experience Exhibit" set forth in Section 1358.145.

(5) A copy of the calculations for the actual or expected loss ratio.

(6) Supporting data used in calculating the actual or expected loss ratio as indicated in Section 1358.14.

(7) An actuarial certification, as specified in Section 1358.14, of the loss ratio computations.

(8) If required by the director, actuarial certification, as specified in Section 1358.14, of the loss ratio computations by one or more unaffiliated actuaries acceptable to the director.

(9) An undertaking by the issuer to notify the subscribers in writing within 60 days of decertification, if the contract is identified as a certified contract at the time of sale and later decertified.

(10) A signed statement of the president of the issuer or other officer of the issuer designated by that person attesting that the information submitted for review is accurate and complete and does not misrepresent any material fact.

(j) An issuer that submits information pursuant to subdivision (i) shall provide any additional information as may be requested by the director to

enable the director to conclude that the contract complies with the provisions of this chapter and rules adopted thereunder.

(k) For the purposes of this section, the term "decertified," as applied to a contract, means that the director by written notice has found that the contract no longer complies with the provisions of this chapter and the rules adopted thereunder and has revoked the prior authorization to display on the contract the emblem indicating certification.

(*l*) 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 and the amount of prepaid charges may be modified, as indicated in paragraph (6) of subdivision (a) of Section 1300.67.4 of Title 28 of the California Code of Regulations, to correspond with those changes.

HISTORY:

Added Stats 2000 ch 706 § 2 (SB 764). Amended Stats 2005 ch 206 § 11 (SB 375), effective January 1, 2006.