

§ 403.200

403.1110 Evaluation of models.

Subpart L—Requirements for Direct-to-Consumer Television Advertisements of Drugs and Biological Products To Include the List Price of That Advertised Product

403.1200 Scope.
403.1201 Definitions.
403.1202 Pricing information.
403.1203 Specific presentation requirements.
403.1204 Compliance.

AUTHORITY: 42 U.S.C. 1302 and 1395hh.

Subpart A [Reserved]

Subpart B—Medicare Supplemental Policies

SOURCE: 47 FR 32400, July 26, 1982, unless otherwise noted.

§ 403.200 Basis and scope.

(a) *Provisions of the legislation.* This subpart implements, in part, section 1882 of the Social Security Act. The intent of that section is to enable Medicare beneficiaries to identify Medicare supplemental policies that do not duplicate Medicare, and that provide adequate, fairly priced protection against expenses not covered by Medicare. The legislation establishes certain standards for Medicare supplemental policies and provides two methods for informing Medicare beneficiaries which policies meet those standards:

(1) Through a State approved program, that is, a program that a Supplemental Health Insurance Panel determines to meet certain minimum requirements for the regulation of Medicare supplemental policies; and

(2) In a State without an approved program, through certification by the Secretary of policies voluntarily submitted by insuring organizations for review against the standards.

(b) *Scope of subpart.* This subpart sets forth the standards and procedures CMS will use to implement the voluntary certification program.

GENERAL PROVISIONS

§ 403.201 State regulation of insurance policies.

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

42 CFR Ch. IV (10–1–23 Edition)

(b) Approval of a policy under the voluntary certification program, as provided for in § 403.235(b), does not authorize the insuring organization to market a policy that does not conform to applicable State laws and regulations.

§ 403.205 Medicare supplemental policy.

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

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

(2) Is primarily designed, or is advertised, marketed, or otherwise purported to provide 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) The term policy includes both policy form and policy as specified in paragraphs (b)(1) and (b)(2) of this section.

(1) *Policy form.* Policy form is the form of health insurance contract that is approved by and on file with the State agency for the regulation of insurance.

(2) *Policy.* Policy is the contract—

(i) Issued under the policy form; and

(ii) Held by the policy holder.

(c) If the policy otherwise meets the definition in this section, a Medicare supplemental policy includes—

(1) An individual policy;

(2) A group policy;

(3) A rider attached to an individual or group policy; or

(4) As of January 1, 2006, a stand-alone limited health benefit plan or policy that supplements Medicare benefits and is sold primarily to Medicare beneficiaries.

(d) Any rider attached to a Medicare supplemental policy becomes an integral part of the basic policy.

(e) Medicare supplemental policy does not include a Medicare Advantage plan, a Prescription Drug Plan under Part D, or any of the other types of health insurance policies or health benefit plans that are excluded from the

Centers for Medicare & Medicaid Services, HHS

§ 403.222

definition of a Medicare supplemental policy in section 1882(g)(1) of the Act.

[70 FR 4525, Jan. 28, 2005]

§ 403.206 General standards for Medicare supplemental policies.

(a) For purposes of the voluntary certification program described in this subpart, a policy must meet—

(1) The National Association of Insurance Commissioners (NAIC) model standards as defined in § 405.210; and

(2) The loss ratio standards specified in § 403.215.

(b) Except as specified in paragraph (c) of this section, the standards specified in paragraph (a) of this section must be met in a single policy.

(c) In the case of a nonprofit hospital or a medical association where State law prohibits the inclusion of all benefits in a single policy, the standards specified in paragraph (a) of the section must be met in two or more policies issued in conjunction with one another.

§ 403.210 NAIC model standards.

(a) *NAIC model standards* means the National Association of Insurance Commissioners (NAIC) “Model Regulation to Implement the Individual Accident and Insurance Minimum Standards Act” (as amended and adopted by the NAIC on June 6, 1979, as it applies to Medicare supplemental policies). Copies of the NAIC model standards can be purchased from the National Association of Insurance Commissioners at 350 Bishops Way, Brookfield, Wisconsin 53004, and from the NIARS Corporation, 318 Franklin Avenue, Minneapolis, Minnesota 55404.

(b) The policy must comply with the provisions of the NAIC model standards, except as follows—

(1) *Policy*, for purposes of this paragraph, means individual and group policy, as specified in § 403.205. The NAIC model standards limit “policy” to individual policy.

(2) The policy must meet the loss ratio standards specified in § 403.215.

[47 FR 32400, July 26, 1982; 49 FR 44472, Nov. 7, 1984]

§ 403.215 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) For purposes of loss ratio requirements, policies issued as a result of solicitation of individuals through the mail or by mass media advertising are considered individual policies.

STATE REGULATORY PROGRAMS

§ 403.220 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

(2) Four State Commissioners or Superintendents of Insurance appointed by the President. (The terms Commissioner or Superintendent of Insurance include persons of similar rank.)

(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 specified in section 1882 of the Social Security Act.

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

§ 403.222 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 policy issued in that State, that are equal to or more stringent than those specified in section 1882 of the Social Security Act.

(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 the policy is—

(i) Issued in that State; or