

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

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(ii) Issued for delivery in that State.

(c) A policy issued in a State with an approved regulatory program is considered to meet the NAIC model standards in § 403.210 and loss ratio standards in § 403.215.

VOLUNTARY CERTIFICATION PROGRAM: GENERAL PROVISIONS

§ 403.231 Emblem.

(a) The emblem is a graphic symbol, approved by HHS, that indicates that CMS has certified a policy as meeting the requirements of the voluntary certification program, specified in § 403.232.

(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) The manner in which the emblem may be displayed and the conditions and restrictions relating to its use will be stated in the letter with which CMS notifies the insuring organization that a policy has been certified. The insuring organization must comply with these conditions and restrictions.

(d) If a certified policy is issued in a State that later has an approved regulatory program, as provided for in § 403.222, the insuring organization may display the emblem on the policy until the earliest of the following—

(1) When prohibited by State law or regulation.

(2) When the policy no longer meets the requirements for Medicare supplemental policies specified in § 403.206.

(3) The date the insuring organization would be required to submit material to CMS for annual review in order to retain certification, if the State did not have an approved program (see § 403.239).

§ 403.232 Requirements and procedures for obtaining certification.

(a) To be certified by CMS, a policy must meet—

(1) The NAIC model standards specified in § 403.210;

(2) The loss ratio standards specified in § 403.215; and

(3) Any State requirements applicable to a policy—

(i) Issued in that State; or

(ii) Marketed in that State.

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

(1) A copy of the policy form (including all the documents that would constitute the contract of insurance that is proposed to be marketed as a certified policy).

(2) A copy of the application form including all attachments.

(3) A copy of the uniform certificate issued under a group policy.

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

(5) A copy of the Medicare supplement buyers' guide to be provided to all applicants if the buyers' guide is not the CMS/NAIC buyers' guide.

(6) A statement of when and how the outline of coverage and the buyers' guide will be delivered and copies of applicable receipt forms.

(7) A copy of the notice of replacement and statement as to when and how that notice will be delivered.

(8) A list of States in which the policy is authorized for sale. If the policy was approved under a deemer provision in any State, the conditions involved must be specified.

(9) A copy of the loss ratio calculations, as specified in § 403.250.

(10) Loss ratio supporting data, as specified in § 403.256.

(11) A statement of actuarial opinion, as specified in § 403.258.

(12) A statement that the insuring organization will notify the policyholders in writing, within the period of time specified in § 403.245(c), if the policy is identified as a certified policy at the time of sale and later loses certification.

(13) A signed statement in which the president of the insuring organization, or a designee, attests that—

(i) The policy meets the requirements specified in paragraph (a) of this section; and

(ii) The information submitted to CMS for review is accurate and complete and does not misrepresent any material fact.