

Medicare Part D and its implications for Plans H, I, and J

The purpose of the call was to discuss changes needed in the Compliance Manual as the result of the implementation of Medicare Part D on 1/1/2006. The goal is to have the Referral Subgroup recommendations ready 4 weeks prior to the March NAIC meeting. There will be a follow up call to this one on November 18, 2004. Written comments should be sent to Dennis Hare at the NAIC by November 12. Julia Phillips from Minnesota led the call.

The Subgroup is working on principles for reducing premiums for Plans H, I and J for individuals who elect to take Medicare Part D and to drop the drug benefits currently in H, I and J. Effective 1/1/2006, current insureds will have the option to:

- A. Keep current Plan with the current drug benefit (and current premium)
- B. Keep current Plan without the drug benefit (and lower premium)
- C. Change to another Plan without the drug benefit.

In a document dated July 23, 2004, AHIP proposed that the coverage for Plans H, I, and J be split into coverage other than drug benefits and a drug benefit coverage. The coverage other than drug benefits would apply to all individuals in the Plan, including those who kept the Plan but dropped the drug benefit, those who kept the Plan with the drug benefit, and those who purchased the Plan after 1/1/2006 without the drug benefit. Any health anti-selection by those who kept the drug benefit would be spread across everyone in the Plan. The separate cost of the drug benefit would be totally borne by those who kept the drug benefit.

While there was general consensus among the regulators that the above approach was reasonable, Linda Ziegler from FL had proposed in a letter dated September 2, 2004, that each of H, I, and J be paired with its counterpart Plan that did not include a drug benefit and the rates for H, I, and J without the drug benefits should be similar to that of the other Plans based on benefits. Other regulators stated that while they had struggled with similar issues, they ultimately decided that each Plan was its own risk class, and that different risk classes result in different premiums for similar benefits. They said that this was particularly true in light of the refund formula requirements. Ms Ziegler was not able to be on this call so the discussion will carry over to the next call.

Maine stated that they had issued a Bulletin 327 last week that would require disclosure when rates were disproportionate to benefits. This would include, for example, a Plan C where the premium exceeded that of Plans D and E by more than the amount of the Part B deductible.

Another topic discussed was that companies have different practices on switching from Plan to Plan and whether the new policy is given a new issue date or whether the new policy keeps the original date. At first there seemed to be consensus among the states



that each company could develop its own practice, but then a concern about issue age policies was raised.

Frank Dino from FL stated that his state has not had any trouble requiring voluntary policy exchanges to be at the original issue age. Bill Weller, representing AHIP, said that what was true in Florida may not be true across all states and that the Compliance Manual should not require that exchanges of issue age policies be at the original issue age. This could result in policies showing up in durations for which the Plan was never actually issued.

There was a discussion on whether the active life reserves went with the individual or stayed with the original plan. Some advocates of having the individual keep his original issue age stated that the reserve should follow the individual. Others thought that the reserve was for the benefit of the original plan. There was some concern about the effect on experience studies of large reserves leaving one plan and showing up in another. Due to time limitations, the discussion on how to handle issue age policies will continue on the next call.

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