September 2006

ANNOUNCEMENT

Out-of-Pocket Limits for Medigap Plans K & L for Calendar Year 2007

SUMMARY: The 2007 out-of-pocket (OOP) limits for Medigap plans K & L are $4,140 and $2,070, respectively. The increases in the limits are based on estimates of the United States Per Capita Costs (USPCC) of the Medicare program published by CMS. The OOP limits for Medigap plans K and L will be updated each year after the announcement of Medicare Advantage payment rates, which includes revised estimates of the USPCCs.

SUPPLEMENTARY INFORMATION:

A. Background

A Medicare supplemental, or Medigap, policy is private health insurance that a beneficiary may purchase to cover certain expenses that Medicare does not cover. For example, the beneficiary is responsible for deductibles and coinsurance amounts for both Part A (hospital insurance) and Part B (supplementary medical insurance) of the Medicare program. Medigap policies offer coverage for some or all of these amounts. Additionally, some Medigap policies provide coverage for some other items and services that are not currently covered under the Medicare program.

Section 1882 of the Social Security Act (the Act) establishes that no Medigap policy may be issued in a State unless the policy complies with the standards and requirements described in that section. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) amended the Act by requiring that Medigap benefits be standardized, and that no more than 10 Medigap benefit packages be offered nationwide. Three States (Wisconsin, Minnesota, and Massachusetts) experimented with standardizing benefits before the enactment of Federal standards. These States were permitted to keep their alternative forms of Medigap standardization and are referred to as the "waivered States."

Therefore, throughout most of the country, until recently, there have been ten permissible benefit packages, designated as plans "A" through "J". Plan "A" is the basic benefit package. It covers Medicare Part A hospital coinsurance, plus coverage for 365 additional days of inpatient hospital care after Medicare hospital benefits are exhausted; Medicare Part B coinsurance (generally 20 percent of the Medicare-approved amount or, in the case of hospital outpatient department services under a prospective payment system, the applicable copayment); and coverage for the first three pints of blood per year. Medigap Plans "B" through "J" contain this basic benefit package, as well as

different combinations of additional benefits, some of which cover non-Medicare covered items or services.

As traditionally designed, and as reflected in the standards required for plans A through J under the 1990 legislation, Medigap policies provide "first dollar coverage" of the coinsurance or deductibles covered under the particular policy. This means that in most cases, especially in the most popular policies, the insurance pays for the policyholder's entire obligation with respect to the particular OOP expense. The primary exception has been that since 1997, issuers are allowed to offer a "high deductible" version of Plans F and J. Those policies offer the same benefits as a regular Plan F or J, but only after the policyholder satisfies the deductible.

B. Medicare Supplemental Insurance - Changes made by the Medicare Modernization Act

1. Addition of Medigap Policies with Partial Cost-Sharing and an OOP Limit

Section 1882(w) of the Act, as added by section 104 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) establishes two new Medigap policies that eliminate first-dollar coverage for most Medicare cost-sharing until an annual OOP limit has been reached. These policies have been designated Plans K and L. Like all other Medigap policies designated Plans A-J, Plans K and L can only provide benefits that supplement benefits under Parts A and B of Original Medicare. MMA, which established the Medicare Prescription Drug Program, also provided that no Medigap policies sold after January 1, 2006 can provide any prescription drug coverage. (Additional information on the MMA changes that affect Medigap policies can be found in the final rule to implement the new Medicare Prescription Drug Benefit that was published in the *Federal Register* on January 28, 2005 (70 Fed. Reg. 4194), and in the National Association of Insurance Commissioners' (NAIC) Model Standards for Regulation of Medicare Supplemental Insurance, as recognized by the Centers for Medicare & Medicaid Services for the purpose of Section 1882 of the Act in the *Federal Register* on March 25, 2005 (70 Fed. Reg. 15,394).)

The fundamental difference between Plans A through J and the two new plans (K and L) is that the new plans generally pay less than 100 percent of beneficiary cost-sharing until the beneficiary's spending reaches a specified level of out-of-pocket expenses. Once the individual's expenditures exceed that limit, the policy pays the full supplemental benefit for the remainder of the calendar year. Plans A through J do not need this kind of OOP limit because they provide full coverage for the whole year.

2. Details of the New Policies

Section 1882(w)(2) of the Act prescribes the benefit structure of the two new packages. The first package (Plan K) generally covers only 50 percent of the cost-sharing otherwise applicable under Medicare Parts A and B. However, it cannot cover any part of the Part B deductible, and must cover 100 percent of any cost-sharing otherwise applicable for

preventive benefits. The only benefit that is the same as Plans A through J is 100 percent coverage for all inpatient hospital coinsurance and 365 extra lifetime days of coverage for inpatient hospital services. Other basic benefits in plans A-J such as the first three pints of blood and the Part B coinsurance are covered, but only at the 50 percent level. In addition, because Plans K and L cover all Part A and B cost-sharing (after the Part B deductible) at least partially, the nominal cost-sharing that is imposed under the hospice care benefit is covered at the 50 percent level. The hospice benefit is not covered at all by Plans A-J. Finally, if the policyholder incurs OOP costs that exceed a specified amount in a given year, the policy covers 100 percent of cost-sharing under Parts A and B for the rest of that year (including the Part B deductible in the rare event that this expense arises after the OOP limit has been met for the year). For 2006, the OOP limit is $4000.

The second package (Plan L) is identical to Plan K except that it covers 75 percent of cost-sharing otherwise applicable under Medicare Parts A and B, and the limit on annual OOP expenditures under Parts A and B is set at $2000 in 2006. Thus in both cases, after the OOP limit has been reached, the policy begins to pay all supplemental benefits at the 100 percent rate for the remainder of the calendar year.

Plans K and L became available in some States starting in 2005—as soon as the State revised its laws or regulations to conform to the new MMA provisions.. It should be noted that States are not required to authorize the sale of these new plans. Section 1882(p)(5) of the Act requires that a State must approve the sale of Plan A, but permits the State to restrict the sale of any of the other standardized plans. In practice, however, all of the States, with the exception of two of the waivered States, have authorized the sale of Plans K and L within their borders; and at least some issuers in each State are offering these new policies.

C. Calculation of the OOP Annual Limits

The annual OOP limits are determined in accordance with section 1882(w)(2) of the Act. That provision prescribed an OOP limit for 2006 of $4,000 for Plan K and $2,000 for Plan L, and directed that these amounts increase each subsequent year by an appropriate inflation adjustment specified by the Secretary. The Secretary has determined that for 2007, the increases in the OOP limits are based on estimates of the United States Per Capita Costs (USPCC) of the Medicare program published by CMS. The 2006 OOP limits are increased by the percent increase from 2006 to 2007 of this year's current estimates of the USPCC for Medicare Part A and Part B, aged and disabled. The resulting values are rounded to the nearest multiple of $20 for Plan K and the nearest multiple of $10 for Plan L, which brings the 2007 OOP limits to $4,140 for Plan K and $2,070 for Plan L.