BULLETIN NO. 02-31

TO: **ALL INSURERS OFFERING MEDICARE SUPPLEMENT COVERAGE**

FROM: **HOLLY C. BAKKE, COMMISSIONER OF BANKING AND INSURANCE**

RE: **GUARANTEED ISSUE FOLLOWING TERMINATION OF MEDICARE + CHOICE PLANS**

The Department of Banking and Insurance (Department) has become aware that some Medicare + Choice HMO plans will be terminating all or a part of their contracts with the Federal Centers for Medicare and Medicaid Services (CMS) effective December 31, 2002. Federal law (the Balanced Budget Act of 1997 (P.L. 105-33, 42 U.S.C. 1395), the Balanced Budget Refinement Act of 1999 (P.L. 10-113, 42 U.S.C. 1395, and the Benefits Improvement and Protection Act of 2000 (P.L. 106-554)) provides beneficiaries whose coverage terminates at the end of this year with certain guarantees regarding replacement coverage. The purpose of this Bulletin is to remind insurers offering Medicare supplement coverage of these guarantees.

Beneficiaries may elect to remain in their terminating plans through December 31, 2002. If the HMO is offering another Medicare + Choice plan in 2003 to replace the terminated plan, the beneficiary will be automatically enrolled in the replacement plan. If the terminating HMO is not offering a replacement plan, the beneficiary will automatically return to original Medicare. Beneficiaries may also elect to disenroll from their current plan before December 31. If a beneficiary elects this option, he or she may either return to original Medicare or enroll in another Medicare + Choice plan if available.

Beneficiaries who return to original Medicare, whether or not their terminating HMO is offering a replacement Medicare + Choice plan, have a guaranteed right by Federal law to buy any Medigap policy designated as Plans A, B, C or F that is available in the State so long as they apply no later than 63 days after the coverage with the non-renewing HMO ends (or by March 4, 2003). If the beneficiary applies for one of these Medigap policies no later than March 4, 2003, an insurer selling the policy cannot exclude benefits based on a pre-existing condition, or discriminate in the price of the policy because of health status, claims experience, receipt of health care or medical condition. Disabled

Medicare beneficiaries ages 50-64 and those under age 50 cannot be denied coverage under Plan C so long as they apply for coverage by March 4, 2003.

12/18/02
Date

/s/ Holly C. Bakke
Holly C. Bakke
Commissioner