SENATE BILL NO. 241

INTRODUCED BY HAZELBAKER

BY REQUEST OF THE DEPARTMENT OF INSURANCE

IN THE SENATE

Introduced and referred to January 22, 1981 Committee on Public Health, Welfare, and Safety. February 9, 1981 Committee recommend bill do pass. Report adopted. Statement of intent attached. February 10, 1981 Bill printed and placed on members' desks. February 11, 1981 Second reading, do pass. February 12, 1981 Correctly engrossed. February 13, 1981 Third reading, passed. Ayes, 50; Noes, 0. Transmitted to House. IN THE HOUSE

> Introduced and referred to Committee on Business and Industry.

> > Committee recommend bill be concurred in as amended. Report adopted.

Second reading, concurred in.

Third reading, concurred in as amended. Ayes, 92; Noes, 0.

February 14, 1981

March 11, 1981

Narch 19, 1981

March 21, 1981

IN THE SENATE

March 21, 1981

March 23, 1981

March 24, 1981

March 26, 1981

Returned from House with amendments.

On motion, consideration be passed for the day.

Second reading, amendments concurred in.

Third reading, amendments concurred in. Ayes, 47; Noes, 0. Sent to enrolling.

Reported correctly enrolled.

each BILL NO. 241 1 INTRODUCED BY 2

BY REQUEST OF THE DEPARTMENT OF INSURANCE

A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING MINIMUM 5 STANDARDS FOR MEDICARE SUPPLEMENT INSURANCE: REQUIRING THE 6 COMMISSIONER OF INSURANCE TO ADOPT RULES ESTABLISHING POLICY 7 PROVISION REQUIREMENTS. MINIMUM BENEFIT STANDARDS. LOSS 8 9 RATIO STANDARDS. AND DISCLOSURE STANDARDS FOR SUCH POLICIES: 10 AND GIVING THE COMMISSIONER OF INSURANCE AUTHORITY TO ADOPT 11 RULES ESTABLISHING AN INFORMATIONAL BROCHURE FOR SUCH 12 POLICIES AND AUTHORITY TO ADOPT RULES ESTABLISHING CAPTIONS 13 OR NOTICE REQUIREMENTS FOR CERTAIN NONMEDICARE SUPPLEMENT POLICIES IDENTIFYING THEM AS SUCH; AND PROVIDING AN 14 15 INMEDIATE EFFECTIVE DATE."

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17 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA: 18 Section 1. Short title. [This act] may be cited as the 19 "Medicare Supplement Insurance Minimum Standards Act".

Section 2. Purpose. The purpose of [this act] is to
establish minimum standards for medicare supplement
insurance policies and to establish a regulatory program
that meets the requirements of Public Law 96-265, the Social
Security Disability Amendments of 1980, approved June 9,
1980.

Section 3. Definitions. As used in [this act], the
 following definitions apply:

3 (1) "Applicant" means:

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(a) in the case of an individual medicare supplement
policy or subscriber contract, the person who seeks to
contract for insurance benefits; and

7 (b) in the case of a group medicare supplement policy
8 or subscriber contract, the proposed certificate holder.

9 (2) "Certificate" means a certificate issued under a
10 group medicare supplement policy that has been delivered or
11 issued for delivery in this state.

12 (3) "Medicare" means Health Insurance for the Aged,
13 Title XVIII of the Social Security Amendments of 1965, as
14 then constituted or later amended.

15 (4) "Medicare supplement policy" means a group or 16 individual policy of disability insurance or a subscriber 17 contract of a health service corporation that is advertised, 18 marketed, or designed primarily as a supplement to 19 reimbursements under medicare for the hospital, medical, or 20 surgical expenses of persons eligible for medicare by reason 21 of age. The term does not include:

(a) a policy or contract of one or more employers or
labor organizations or of the trustees of a fund established
by one or more employers or labor organizations, or
combination thereof, for employees or former employees, or

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combination thereof, or for members or former members, or
 combination thereof, of the labor organizations; or

3 (b) a policy or contract of any professional, trade,
4 or occupational association for its members or former or
5 retired members, or combination thereof, if the association:

6 (i) is composed of individuals all of whom are
7 actively engaged in the same profession, trade, or
8 occupation;

9 (ii) has been maintained in good faith for purposes10 other than obtaining insurance; and

(iii) has been in existence for at least 2 years prior
 to the date of its initial offering of the policy or plan to
 its members;

(c) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of [this act] or policies issued to employees or members as additions to franchise plans in existence on [the effective date of this act].

21 Section 4. Standards for policy provisions -- rules. 22 (1) The commissioner shall adopt reasonable rules to 23 establish specific standards for policy provisions of 24 medicare supplement policies. The standards are in addition 25 to and in accordance with applicable laws of this state, 1 including the provisions of Title 33, chapter 22, and may

- 2 cover but are not limited to:
- 3 (a) terms of renewability;
 - (b) initial and subsequent conditions of eligibility;
 - (c) nonduplication of coverage;
 - (d) probationary periods;
 - (e) benefit limitations, exceptions, and reductions;
 - (f) elimination periods;
 - (g) requirements for replacement;
- 10 (h) recurrent conditions; and
- 11 (i) definitions of terms.

12 (2) The commissioner may adopt reasonable rules that 13 prohibit policy provisions not otherwise specifically 14 authorized by statute that, in the opinion of the 15 commissioner, are unjust, unfair, or unfairly discriminatory 16 to any person insured or proposed for coverage under a 17 medicare supplement policy.

(3) Notwithstanding any other provisions of the law, a 18 19 medicare supplement policy may not deny a claim for losses 20 incurred more than 6 months from the effective date of coverage for a preexisting condition. The policy may not 21 22 define a preexisting condition more restrictively than a condition for which medical advice was given or treatment Z3 24 was recommended by or received from a physician within 6 25 months before the effective date of coverage.

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Section 5. Minimum standards for benefits -- rules.
 The commissioner shall issue reasonable rules to establish
 minimum standards for benefits for medicare supplement
 policies.

5 Section 6. Loss ratio standards. Medicare supplement Б policies are expected to return to policyholders benefits 7 that are reasonable in relation to the premium charged. The commissioner shall adopt reasonable rules to establish 3 9 minimum standards for loss ratios of medicare supplement 10 policies on the basis of incurred claims experience and 11 earned premiums for the entire period for which rates are 12 computed to provide coverage and in accordance with accepted 13 actuarial principles and practices. For purposes of rules 14 adopted pursuant to this section, medicare supplement policies issued as a result of solicitations of individuals 15 16 through the mail or mass media advertising, including both 17 print and broadcast advertising, shall be treated as 18 individual policies.

19 Section 7. Disclosure standards -- informational 20 brochure -- rules. (1) In order to provide for full and fair 21 disclosure in the sale of medicare supplement policies, a 22 medicare supplement policy may not be delivered or issued 23 for delivery in this state and a certificate may not be 24 delivered pursuant to a group medicare supplement policy 25 delivered or issued for delivery in this state unless an outline of coverage is delivered to the applicant at the
 time application is made.

3 (2) (a) The commissioner shall prescribe the format
4 and content of the outline of coverage required by
5 subsection (1).

(b) For purposes of this section, "format" means
style, arrangements, and overall appearance, including such
items as the size, color, and prominence of type and the
arrangement of text and captions.

10 (c) The outline of coverage must include:

11 (i) a description of the principal benefits and 12 coverage provided in the policy;

13 (ii) a statement of the exceptions, reductions, and
14 limitations contained in the policy;

15 (iii) a statement of the renewal provisions including
16 any reservation by the insurer of a right to change
17 premiums;

18 (iv) a statement that the outline of coverage is a
19 summary of the policy issued or applied for and that the
20 policy should be consulted to determine governing
21 contractual provisions.

(3) The commissioner may prescribe by rule a standard
form and the contents of an informational brochure for
persons eligible for medicare by reason of age, which is
intended to improve the buyer's ability to select the most

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1 appropriate coverage and improve the buyer's understanding 2 of medicare. Except in the case of direct response 3 insurance policies, the commissioner may require by rule 4 that the information brochure be provided to any prospective 5 insureds eligible for medicare at the same time the outline 6 of coverage is delivered. With respect to direct response 7 insurance policies, the commissioner may require by rule 8 that the prescribed brochure be provided upon request, but 9 not later than the time of policy delivery, to any 10 prospective insureds eligible for medicare by reason of age. 11 (4) The commissioner may adopt reasonable rules for 12 captions or notice requirements, determined to be in the 13 public interest and designed to inform prospective insureds that particular insurance coverages are not medicare 14 15 supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare by 16 17 reason of age, other than:

18 (a) medicare supplement policies;

19 (b) disability income policies;

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20 (c) basic, catastrophic, or major medical expense
 21 policies;

(d) single premium, nonrenewable policies; or

23 (e) other policies defined in [subsection (4) of 24 section 3].

25 (5) The commissioner may further adopt reasonable

rules to govern the full and fair disclosure of the
 information in connection with the replacement of accident
 and sickness policies, subscriber contracts, or certificates
 by persons eligible for medicare by reason of age.

5 Section 8. Notice of free examination. (1) Medicare 6 supplement policies or certificates, other than those issued 7 pursuant to direct response solicitation, must have a notice 8 prominently printed on the first page of the policy or 9 attached thereto stating in substance that the applicant has 10 the right to return the policy or certificate within 10 days 11 of its delivery and to have the premium refunded if, after 12 examination of the policy or certificate, the applicant is 13 not satisfied for any reason.

14 (2) Medicare supplement policies or certificates 15 issued pursuant to a direct response solicitation to persons 15 eligible for medicare by reason of age must have a notice 17 prominently printed on the first page or -attached thereto 18 stating in substance that the applicant has the right to 19 return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after 20 21 examination, the applicant is not satisfied for any reason. 22 Section 9. Administrative procedures. Rules adopted 23 pursuant to [this act] are subject to the provisions of 33-1-313 and Title 2, chapter 4. 24

25 Section 10. Codification instruction. This act is

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1 intended to be codified as a new part in Title 33, chapter 2 22, and the provisions of Title 33, apply to this act. Section 11. Severability. If a part of this act is 3 4 invalid, all valid parts that are severable from the invalid 5 part remain in effect. If a part of this act is invalid in 6 one or more of its applications, the part remains in effect 7 in all valid applications that are severable from the 8 invalid applications. 9 Section 12. Effective date. This act is effective on

10 passage and approval.

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STATEMENT OF INTENT SENATE BILL 241 Senate Public Health Committee

5 This bill is adopted to enable the State of Montana to 6 meet the requirements of Public Law 96-265, the Social Security Disability Amendments of 1980 (the Baucus 7 8 Amendment). Public Law 96-265 establishes a program of federal certification of medicare supplemental insurance 9 10 policies and provides that medicare supplemental policies 11 issued in a state with an approved regulatory program shall be certified under the federal certification program. [In 12 order to be approved, a state's medicare supplemental 13 insurance policy regulatory program must provide for the 14 15 application of standards with respect to such policies equal to or more stringent than the NAIC Model Regulation to 16 Implement the Individual Accident and Sickness Insurance 17 Minimum Standards Act, adopted by the National Association 18 of Insurance Commissioners on June 6, 1979; include a 19 requirement at least as stringent as the federal provision 20 21 requiring that such policies return to policyholders in the 22 form of aggregate benefits under the policy, at least 75% of 23 the accredate amount of premiums collected in the case of 24 group policies and at least 60% of the aggregate amount of 25 premiums collected in the case of individual policies: and apply these standards and requirements to all medicare

3 A statement of intent is required for this bill because 4 it delegates rulemaking authority to the Commissioner of 5 Insurance. This bill is intended to give the Commissioner of 6 Insurance the authority to adopt rules establishing minimum 7 standards for benefits, contents, and sale of medicare 8 supplemental insurance policies in the State of Montana to 9 insure the implementation of a regulatory program which 10 meets the minimum standards of Public Law 96-265, the Social 11 Security Disability Amendments of 1980.

12 It is contemplated that such rules should address the 13 following:

(a) prohibited policy provisions including the kinds
of coverage that may be excluded from coverage in a medicare
supplemental policy;

17 (b) minimum standards for medicare supplement policy18 provisions and minimum benefit standards;

(c) required disclosure provisions such as provisions regarding renewal, continuation, and nonrenewal, definition and explanation of terms, preexisting condition limitations, "free-look" provisions and forms for a buyer's guide and an outline of policy coverage; and

24 (d) replacement requirements, including a form for25 notice to an applicant regarding replacement of disability

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l insurance.

Z First adopted by the Public Health Committee on the 9th

3 day of February 1981.

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47th Legislature

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Approved by Comm. on

Public Health, Safety and Welfare

SENATE BILL NO. 241 Introduced by Hazelbaker

BY REQUEST OF THE DEPARTMENT OF INSURANCE

A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING MINIMUM 5 STANDARDS FOR MEDICARE SUPPLEMENT INSURANCE; REQUIRING THE 6 COMMISSIONER OF INSURANCE TO ADOPT RULES ESTABLISHING POLICY 7 PROVISION REQUIREMENTS, MINIMUM BENEFIT STANDARDS, LOSS 8 9 RATIO STANDARDS, AND DISCLOSURE STANDARDS FOR SUCH POLICIES: AND GIVING THE COMMISSIONER OF INSURANCE AUTHORITY TO ADOPT 10 RULES ESTABLISHING AN INFORMATIONAL BROCHURE FOR SUCH 11 12 POLICIES AND AUTHORITY TO ADOPT RULES ESTABLISHING CAPTIONS 13 OR NOTICE REQUIREMENTS FOR CERTAIN NONMEDICARE SUPPLEMENT POLICIES IDENTIFYING THEM AS SUCH; AND PROVIDING AN 14 INMEDIATE EFFECTIVE DATE." 15

16

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA: 17 18 Section 1. Short title. [This act] may be cited as the 19 "Medicare Supplement Insurance Minimum Standards Act"-20 Section 2. Purpose. The purpose of [this act] is to 21 establish minimum standards for medicare supplement Z2 insurance policies and to establish a regulatory program 23 that meets the requirements of Public Law 96-265, the Social 24 Security Disability Amendments of 1980, approved June 9, 25 1980.

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Section 3. Definitions. As used in [this act], the
 following definitions apply:

3 (1) "Applicant" means:

4 (a) in the case of an individual medicare supplement
5 policy or subscriber contract, the person who seeks to
6 contract for insurance benefits; and

7 (b) in the case of a group medicare supplement policy
8 or subscriber contract. the proposed certificate holder.

9 (2) "Certificate" means a certificate issued under a 10 group medicare supplement policy that has been delivered or 11 issued for delivery in this state.

12 (3) "Medicare" means Health Insurance for the Aged,
13 Title XVIII of the Social Security Amendments of 1965, as
14 then constituted or later amended.

15 (4) "Medicare supplement policy" means a group or 16 individual policy of disability insurance or a subscriber 17 contract of a health service corporation that is advertised, 18 marketed, or designed primarily as a supplement to 19 reimbursements under medicare for the hospital, medical, or 20 surgical expenses of persons eligible for medicare by reason

21 of age. The term does not include:

(a) a policy or contract of one or more employers or
labor organizations or of the trustees of a fund established
by one or more employers or labor organizations, or
combination thereof, for employees or former employees, or

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combination thereof, or for members or former members, or
 combination thereof, of the labor organizations; or

3 (b) a policy or contract of any professional, trade,
4 or occupational association for its members or former or
5 retired members, or combination thereof, if the association:
6 (i) is composed of individuals all of whom are
7 actively engaged in the same profession, trade, or
8 occupation;

9 (ii) has been maintained in good faith for purposes
10 other than obtaining insurance; and

11 (iii) has been in existence for at least 2 years prior
12 to the date of its initial offering of the policy or plan to
13 its members;

(c) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of [this act] or policies issued to employees or members as additions to franchise plans in existence on [the effective date of this act].

21 Section 4. Standards for policy provisions -- rules. 22 (1) The commissioner shall adopt reasonable rules to 23 establish specific standards for policy provisions of 24 medicare supplement policies. The standards are in addition 25 to and in accordance with applicable laws of this state; 1 including the provisions of Title 33+ chapter 22+ and may

2 cover but are not limited to:

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- (a) terms of renewability;
- 4 (b) initial and subsequent conditions of eligibility;
 - (c) nonduplication of coverage;
 - (d) probationary periods;
 - (e) benefit limitations, exceptions, and reductions;
- 8 (f) elimination periods;
 - (g) requirements for replacement;
- 10 (h) recurrent conditions; and
- 11 (i) definitions of terms.

12 (2) The commissioner may adopt reasonable rules that 13 prohibit policy provisions not otherwise specifically 14 authorized by statute that, in the opinion of the 15 commissioner, are unjust, unfair, or unfairly discriminatory 16 to any person insured or proposed for coverage under a 17 medicare supplement policy.

18 [3] Notwithstanding any other provisions of the law, a medicare supplement policy may not deny a claim for losses 19 incurred more than 6 months from the effective date of 20 21 coverage for a preexisting condition. The policy may not 22 define a preexisting condition more restrictively than a 23 condition for which medical advice was given or treatment was recommended by or received from a physician within 6 24 25 months before the effective date of coverage.

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Section 5. Minimum standards for benefits -- rules.
 The commissioner shall issue reasonable rules to establish
 minimum standards for benefits for medicare supplement
 policies.

5 Section 6. Loss ratio standards. Medicare supplement policies are expected to return to policyholders benefits 6 7 that are reasonable in relation to the premium charged. The 8 commissioner shall adopt reasonable rules to establish 9 minimum standards for loss ratios of medicare supplement 10 policies on the basis of incurred claims experience and earned premiums for the entire period for which rates are 11 12 computed to provide coverage and in accordance with accepted actuarial principles and practices. For purposes of rules 13 adopted pursuant to this section, medicare supplement 14 15 policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both 16 print and broadcast advertising, shall be treated as 17 18 individual policies.

19 Section 7. Disclosure standards -- informational 20 brochure -- rules. (1) In order to provide for full and fair 21 disclosure in the sale of medicare supplement policies, a 22 medicare supplement policy may not be delivered or issued 23 for delivery in this state and a certificate may not be 24 delivered pursuant to a group medicare supplement policy 25 delivered or issued for delivery in this state unless an SB 0241/02

1 outline of coverage is delivered to the applicant at the 2 time application is made.

3 (2) (a) The commissioner shall prescribe the format
4 and content of the outline of coverage required by
5 subsection (1).

(b) For purposes of this section, "format" means
style, arrangements, and overall appearance, including such
items as the size, color, and prominence of type and the
arrangement of text and captions.

10 (c) The outline of coverage must include:

(i) a description of the principal benefits and
 coverage provided in the policy;

(ii) a statement of the exceptions, reductions, and
 limitations contained in the policy;

15 (iii) a statement of the renewal provisions including
16 any reservation by the insurer of a right to change
17 premiums;

18 (iv) a statement that the outline of coverage is a 19 summary of the policy issued or applied for and that the 20 policy should be consulted to determine governing 21 contractual provisions.

22 (3) The commissioner may prescribe by rule a standard 23 form and the contents of an informational brochure for 24 persons eligible for medicare by reason of age, which is 25 intended to improve the buyer's ability to select the most

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ľ appropriate coverage and improve the buyer's understanding z of medicare. Except in the case of direct response 3 insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective 4 5 insureds eligible for medicare at the same time the outline 6 of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule 7 8 that the prescribed brochure be provided upon request, but 9 not later than the time of policy delivery, to any 10 prospective insureds eligible for medicare by reason of age. 11 (4) The commissioner may adopt reasonable rules for 12 captions or notice requirements, determined to be in the 13 public interest and designed to inform prospective insureds 14 that particular insurance coverages are not medicare supplement coverages, for all accident and sickness 15 insurance policies sold to persons eligible for medicare by 16 17 reason of age, other than: 18 (a) medicare supplement policies; 19 (b) disability income policies;

20 (c) basic. catastrophic. or major medical expense
21 policies;

22 (d) single premium, nonrenewable policies; or

23 (e) other policies defined in [subsection (4) of 24 section 3].

25 (5) The commissioner may further adopt reasonable

rules to govern the full and fair disclosure of the
 information in connection with the replacement of accident
 and sickness policies, subscriber contracts, or certificates
 by persons eligible for medicare by reason of age.

Section 8. Notice of free examination. (1) Medicare 5 6 supplement policies or certificates, other than those issued 7 pursuant to direct response solicitation, must have a notice 8 prominently printed on the first page of the policy or attached thereto stating in substance that the applicant has 9 10 the right to return the policy or certificate within 10 days of its delivery and to have the premium refunded if. after 11 examination of the policy or certificate, the applicant is 12 13 not satisfied for any reason.

(2) Medicare supplement policies or certificates 14 issued pursuant to a direct response solicitation to persons 15 eligible for medicare by reason of age must have a notice 16 17 prominently printed on the first page or attached thereto stating in substance that the applicant has the right to 18 19 return the policy or certificate within 30 days of its 20 delivery and to have the premium refunded if, after 21 examination, the applicant is not satisfied for any reason. 22 Section 9. Administrative procedures. Rules adopted

23 pursuant to [this act] are subject to the provisions of
24 33-1-313 and Title 2, chapter 4.

25 Section LO. Codification instruction. This act is

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intended to be codified as a new part in Title 33, chapter
 22, and the provisions of Title 33, apply to this act.

3 Section 11. Severability. If a part of this act is 4 invalid, all valid parts that are severable from the invalid 5 part remain in effect. If a part of this act is invalid in 6 one or more of its applications, the part remains in effect 7 in all valid applications that are severable from the 8 invalid applications.

9 Section 12. Effective date. This act is effective on
10 passage and approval.

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STAT	EMENT OF INTENT
SE	NATE BILL 241
Senate Pul	blic Health Committee

5 This bill is adopted to enable the State of Montana to 6 meet the requirements of Public Law 96-265, the Social Security Disability Amendments of 1980 (the Baucus 7 R Amendment), Public Law 96-265 establishes a program of 9 federal certification of medicare supplemental insurance 10 policies and provides that medicare supplemental policies issued in a state with an approved regulatory program shall 11 be certified under the federal certification program. [In 12 order to be approved, a state's medicare supplemental 13 insurance policy regulatory program must provide for the 14 application of standards with respect to such policies equal 15 to or more stringent than the NAIC Model Regulation to 16 17 Implement the Individual Accident and Sickness Insurance 18 Minimum Standards Act, adopted by the National Association 19 of Insurance Commissioners on June 6, 1979; include a requirement at least as stringent as the federal provision 20 21 requiring that such policies return to policyholders in the 22 form of addregate benefits under the policy, at least 75% of 23 the aggregate amount of premiums collected in the case of 24 group policies and at least 60% of the aggregate amount of 25 premiums collected in the case of individual policies; and

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apply these standards and requirements to all medicare
 supplemental policies issued in the state.]

3 A statement of intent is required for this bill because 4 it delegates rulemaking authority to the Commissioner of 5 Insurance. This bill is intended to give the Commissioner of 6 Insurance the authority to adopt rules establishing minimum 7 standards for benefits, contents, and sale of medicare 8 supplemental insurance policies in the State of Montana to 9 insure the implementation of a regulatory program which 10 meets the minimum standards of Public Law 96-265, the Social 11 Security Disability Amendments of 1980.

12 It is contemplated that such rules should address the 13 following:

(a) prohibited policy provisions including the kinds
of coverage that may be excluded from coverage in a medicare
supplemental policy;

17 (b) minimum standards for medicare supplement policy18 provisions and minimum benefit standards;

(c) required disclosure provisions such as provisions
regarding renewal, continuation, and nonrenewal, definition
and explanation of terms, preexisting condition limitations,
"free-look" provisions and forms for a buyer's guide and an
outline of policy coverage; and
(d) replacement requirements, including a form for

25 notice to an applicant regarding replacement of disability

1 insurance.

2 First adopted by the Public Health Committee on the 9th

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3 day of February 1981.

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least BILL NO. 241 INTRODUCED BY

BY REQUEST OF THE DEPARTMENT OF INSURANCE

5 A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING MINIMUM 6 STANDARDS FOR MEDICARE SUPPLEMENT INSURANCE: REQUIRING THE 7 COMMISSIONER OF INSURANCE TO ADOPT RULES ESTABLISHING POLICY 8 PROVISION REQUIREMENTS, MINIMUM BENEFIT STANDARDS, LOSS 9 RATIO STANDARDS. AND DISCLOSURE STANDARDS FOR SUCH POLICIES: 10 AND SIVING THE COMMISSIONER OF INSURANCE AUTHORITY TO ADOPT 11 RULES ESTABLISHING AN INFORMATIONAL BROCHURE FOR SUCH 12 POLICIES AND AUTHORITY TO ADOPT RULES ESTABLISHING CAPTIONS 13 OR NOTICE REQUIREMENTS FOR CERTAIN NONREDICARE SUPPLEMENT 14 POLICIES IDENTIFYING THEM AS SUCH: AND PROVIDING AN 15 IMMEDIATE EFFECTIVE DATE."

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17 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

18 Section 1. Short title. [This act] may be cited as the 19 "Medicare Supplement Insurance Minimum Standards Act".

23 Section 2. Purpose. The purpose of [this act] is to 21 establish minimum standards for medicare supplement 22 insurance policies and to establish a regulatory program 23 that meets the requirements of Public Law 96-265, the Social 24 Security Disability Amendments of 1980, approved June 9, 25 1980. Section 3. Definitions. As used in [this act], the following definitions apply:

3 (1) "Applicant" means:

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4 (a) in the case of an individual medicare supplement 5 policy or subscriber contract, the person who seeks to 6 contract for insurance benefits; and

7 (b) in the case of a group medicare supplement policy 8 or subscriber contract, the proposed certificate holder.

9 (2) "Certificate" means a certificate issued under a
10 group medicare supplement policy that has been delivered or
11 issued for delivery in this state.

12 (3) "Medicare" means Health Insurance for the Aged,
13 Title XVIII of the Social Security Amendments of 1965, as
14 then constituted or later amended.

15 (4) "Medicare supplement policy" means a group or 16 individual policy of disability insurance or a subscriber 17 contract of a health service corporation that is advertised, 18 marketed, or designed primarily as a supplement to 19 reimbursements under medicare for the hospital, medical, or 20 surgical expenses of persons eligible for medicare by reason 21 of age. The term does not include:

(a) a policy or contract of one or more employers or
labor organizations or of the trustees of a fund established
by one or more employers or labor organizations, or
combination thereof, for employees or former employees, or

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combination thereof, or for members or former members, or
 combination thereof, of the labor organizations; or

3 (b) a policy or contract of any professional, trade,
4 or occupational association for its members or former or
5 retired members, or combination thereof, if the association:
6 (i) is composed of individuals all of whom are

7 actively engaged in the same profession, trade, or 8 occupation;

9 (ii) has been maintained in good faith for purposes10 other than obtaining insurance; and

(iii) has been in existence for at least 2 years prior
 to the date of its initial offering of the policy or plan to
 its members;

(c) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of [this act] or policies issued to employees or members as additions to franchise plans in existence on [the effective date of this act].

21 Section 4. Standards for policy provisions -- rules. 22 (1) The commissioner shall adopt reasonable rules to 23 establish specific standards for policy provisions of 24 medicare supplement policies. The standards are in addition 25 to and in accordance with applicable laws of this state, including the provisions of Title 33, chapter 22, and may
 cover but are not limited to:

3 (a) terms of renewability;

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(b) initial and subsequent conditions of eligibility;

(c) nonduplication of coverage;

(d) probationary periods;

(e) benefit limitations, exceptions, and reductions;

8 (f) elimination periods;

(g) requirements for replacement;

10 (h) recurrent conditions; and

11 (i) definitions of terms.

12 (2) The commissioner may adopt reasonable rules that 13 prohibit policy provisions not otherwise specifically 14 authorized by statute that, in the opinion of the 15 commissioner, are unjust, unfair, or unfairly discriminatory 16 to any person insured or proposed for coverage under a 17 medicare supplement policy.

18 (3) Notwithstanding any other provisions of the law, a 19 medicare supplement policy may not deny a claim for losses 20 incurred more than 6 months from the effective date of 21 coverage for a preexisting condition. The policy may not 22 define a preexisting condition more restrictively than a 23 condition for which medical advice was given or treatment 24 was recommended by or received from a physician within 6 25 months before the effective date of coverage.

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Section 5. Minimum standards for benefits -- rules. 1 2 The commissioner shall issue reasonable rules to establish з minimum standards for benefits for medicare supplement policies. 4

5 Section 6. Loss ratio standards. Medicare supplement 6 policies are expected to return to policyholders benefits 7 that are reasonable in relation to the premium charged. The 3 commissioner shall adopt reasonable rules to establish minimum standards for loss ratios of medicare supplement 9 10 policies on the basis of incurred claims experience and 11 earned premiums for the entire period for which rates are 12 computed to provide coverage and in accordance with accepted 13 actuarial principles and practices. For purposes of rules 14 adopted pursuant to this section, medicare supplement 15 policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both 16 17 print and broadcast advertising, shall be treated as 18 individual policies.

19 Section 7. Disclosure standards -- informational brochure -- rules. (1) In order to provide for full and fair 20 21 disclosure in the sale of medicare supplement policies, a 22 medicare supplement policy may not be delivered or issued 23 for delivery in this state and a certificate may not be delivered pursuant to a group medicare supplement policy 24 delivered or issued for delivery in this state unless an 25

1 outline of coverage is delivered to the applicant at the 2 time application is made.

3 (2) (a) The commissioner shall prescribe the format 4 and content of the outline of coverage required by 5 subsection (1).

6 (b) For purposes of this section. "format" means 7 style, arrangements, and overall appearance, including such 8 items as the size, color, and prominence of type and the 9 arrangement of text and captions.

(c) The outline of coverage must include: 10

11 (i) a description of the principal benefits and 12 coverage provided in the policy:

13 (ii) a statement of the exceptions, reductions, and limitations contained in the policy; 14

15 (iii) a statement of the renewal provisions including any reservation by the insurer of a right to change 16 17 premiums;

18 (iv) a statement that the outline of coverage is a 19 summary of the policy issued or applied for and that the policy should be consulted to determine governing 20 contractual provisions. 21

(3) The commissioner may prescribe by rule a standard 22 23 form and the contents of an informational brochure for persons eligible for medicare by reason of age, which is 24 25 intended to improve the buyer's ability to select the most

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1 appropriate coverage and improve the buyer's understanding 2 of medicare. Except in the case of direct response 3 insurance policies. the commissioner may require by rule 4 that the information brochure be provided to any prospective 5 insureds eligible for medicare at the same time the outline 6 of coverage is delivered. With respect to direct response 7 insurance policies, the commissioner may require by rule 8 that the prescribed brochure be provided upon request, but 9 not later than the time of policy delivery, to any 10 prospective insureds eligible for medicare by reason of age. [4] The commissioner may adopt reasonable rules for 11 12 captions or notice requirements, determined to be in the 13 public interest and designed to inform prospective insureds 14 that particular insurance coverages are not medicare 15 supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare by 16 17 reason of age, other than: (a) medicare supplement policies; 18 19 disability income policies; (b)

20 (c) basic, catastrophic, or major medical expense
21 policies;

22 (d) single premium, nonrenewable policies; or

23 (e) other policies defined in [subsection (4) of24 section 3].

25 (5) The commissioner may further adopt reasonable

rules to govern the full and fair disclosure of the
 information in connection with the replacement of accident
 and sickness policies, subscriber contracts, or certificates
 by persons eligible for medicare by reason of age.

5 Section 8. Notice of free examination. (1) Medicare supplement policies or certificates, other than those issued 6 7 pursuant to direct response solicitation, must have a notice prominently printed on the first page of the policy or 8 attached thereto stating in substance that the applicant has 9 10 the right to return the policy or certificate within 10 days of its delivery and to have the premium refunded if, after 11 12 examination of the policy or certificate, the applicant is 13 not satisfied for any reason.

14 (2) Medicare supplement policies or certificates issued pursuant to a direct response solicitation to persons 15 16 eligible for medicare by reason of age must have a notice 17 prominently printed on the first page or attached thereto 18 stating in substance that the applicant has the right to return the policy or certificate within 30 days of its 19 20 delivery and to have the premium refunded if, after 21 examination, the applicant is not satisfied for any reason. 22 Section 9. Administrative procedures. Rules adopted 23 pursuant to [this act] are subject to the provisions of

24 33-1-313 and Title 2, chapter 4.

25 Section 10. Codification instruction. This act is

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intended to be codified as a new part in Title 33, chapter 1 Z 22, and the provisions of Title 33, apply to this act. 3 Section 11. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid 4 5 part remain in effect. If a part of this act is invalid in ά one or more of Ats applications, the part remains in effect 7 in all valid applications that are severable from the invalid applications. 8

9 Section 12. Effective date. This act is effective on
10 passage and approval.

-End-

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2 SENATE BILL 241 Senate Public Health Committee 3 4 This bill is adopted to enable the State of Montana to meet the requirements of Public Law 96-265, the Social 5 Security Disability Amendments of 1980 (the Baucus 6 7 Amendment). Public Law 96-265 establishes a program of 8 federal certification of medicare supplemental insurance 9 policies and provides that medicare supplemental policies issued in a state with an approved regulatory program shall 10 11 be certified under the federal certification program. [In order to be approved, a state's medicare supplemental 12 insurance policy regulatory program must provide for the 13 14 application of standards with respect to such policies equal 15 to or more stringent than the NAIC Model Regulation to [mplement the Individual Accident and Sickness Insurance 16 Minimum Standards Act, adopted by the National Association 17 of Insurance Commissioners on June 6, 1979; include a 18 19 requirement at least as stringent as the federal provision requiring that such policies return to policyholders in the 20 21 form of aggregate benefits under the policy, at least 75% of the aggregate amount of premiums collected in the case of 22 group policies and at least 60% of the aggregate amount of 23 24 premiums collected in the case of individual policies; and 25 apply these standards and requirements to all medicare

STATEMENT OF INTENT

supplemental policies issued in the state.]

A statement of intent is required for this bill because 2 it delegates rulemaking authority to the Commissioner of 3 4 Insurance. This bill is intended to give the Commissioner of Insurance the authority to adopt rules establishing minimum 5 standards for benefits, contents, and sale of medicare 6 supplemental insurance policies in the State of Montana to 7 insure the implementation of a regulatory program which A 9 meets the minimum standards of Public Law 96-265. the Social 10 Security Disability Amendments of 1980.

11 It is contemplated that such rules should address the 12 following:

13 (a) prohibited policy provisions including the kinds
14 of coverage that may be excluded from coverage in a medicare
15 supplemental policy;

16 (b) minimum standards for medicare supplement policy17 provisions and minimum benefit standards;

18 . (c) required disclosure provisions such as provisions 19 regarding renewal, continuation, and nonrenewal, definition 20 and explanation of terms, pre-existing condition 21 limitations, "free-look" provisions and forms for a buyer's 22 guide and an outline of policy coverage; and

23 (d) replacement requirements, including a form for
24 notice to an applicant regarding replacement of disability
25 insurance.

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1 First adopted by the Public Health Committee on the 9th 2 day of February, 1981. 3 IT IS THE INTENT OF THE LEGISLATURE IN ENACTING SENATE 4 BILL 241 TO ENABLE THE INSURANCE COMMISSIONER TO IMPLEMENT A 5 PROGRAM FOR CONTROL OF MEDICARE SUPPLEMENTAL POLICIES WHICH 6 WILL ENABLE MONTANA TO BE EXEMPTED FROM THE VOLUNTARY 7 CERTIFICATION PROGRAM FOR SUCH POLICIES ESTABLISHED BY 8 PUBLIC LAW 96-265. IT IS ALSO THE INTENT OF THE LEGISLATURE 9 THAT POLICIES SUPPLEMENTING MEDICARE BE AVAILABLE TO AS 10 BROAD & SEGNENT OF SENIOR CITIZENS AS POSSIBLE. TO THAT 11 END, SENATE BILL 241 SHOULD NOT BE CONSTRUED SO AS TO 12 PROHIBIT THE SALE OF MEDICARE SUPPLEMENTAL POLICIES WITH 13 BENEFIT LEVELS LESS THAN THOSE ESTABLISHED BY PUBLIC LAW 14 96-265+ IF THE INSURANCE COMMISSIONER FINDS THAT SUCH SALES 15 WOULD NOT PREVENT MONTANA FROM OBTAINING THE AFOREMENTIONED 16 EXEMPTION.

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1	SENATE BILL NO. 241
z	INTRODUCED BY HAZELBAKER
3	BY REQUEST OF THE DEPARTMENT OF INSURANCE
4	
5	A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING MINIMUM
6	STANDARDS FOR MEDICARE SUPPLEMENT INSURANCE; REQUIRING THE
7	COMMISSIONER OF INSURANCE TO ADOPT RULES ESTABLISHING POLICY
8	PROVISION REQUIREMENTS, MINIMUM BENEFIT STANDARDS, LOSS
9	RATID STANDARDS, AND DISCLOSURE STANDARDS FOR SUCH POLICIES;
FO	AND GIVING THE COMMISSIONER OF INSURANCE AUTHORITY TO ADOPT
11	RULES ESTABLISHING AN INFORMATIONAL BROCHURE FOR SUCH
12	POLICIES AND AUTHORITY TO ADOPT RULES ESTABLISHING CAPTIONS
13	OR NOTICE REQUIREMENTS FOR CERTAIN NONMEDICARE SUPPLEMENT
14	POLICIES IDENTIFYING THEM AS SUCH; AND PROVIDING AN
15	IMMEDIATE EFFECTIVE DATE."
16	
17	BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
18	Section 1. Short title. [This act] may be cited as the
19	*Medicare Supplement Insurance Minimum Standards Act*.
20	Section 2. Purpose. The purpose of [this act] is to
21	establish minimum standards for medicare supplement
22	insurance policies and to establish a regulatory program
23	that meets the requirements of Public Law 96-265; the Social
24	Security Disability Amendments of 1980, approved June 9,
25	1980.

1	Section 3. Definitions. As used in [this act], the
2	following definitions apply:
3	<pre>(1) "Applicant" means:</pre>
4	(a) in the case of an individual medicare supplement
5	policy or subscriber contract, the person who seeks to
6	contract for insurance benefits; and
7	(b) in the case of a group medicare supplement policy
8	or subscriber contract, the proposed certificate holder.
9	{2} "Certificate" means a certificate issued under a
10	group medicare supplement policy that has been delivered or
11	issued for delivery in this state.
12	{3} "Nedicare" means Health Insurance for the Aged.
13	Title XVIII of the Social Security Amendments of 1965, as
14	then constituted or later amended.
15	(4) "Medicare supplement policy" means a group or
16	individual policy of disability insurance or a subscriber
17	contract of a health service corporation that is advertised,
18	marketed, or designed primarily as a supplement to
19	reimbursements under medicare for the hospital, medical, or
20	surgical expenses of persons eligible for medicare by reason
21	of age. The term does not include:
22	(a) a policy or contract of one or more employers or
23	labor organizations or of the trustees of a fund established
24	by one or more employers or labor organizations+ or
25	combination thereof, for employees or former employees, or

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1 combination thereof, or for members or former members, or 2 combination thereof, of the labor organizations; or 3 (b) a policy or contract of any professional, trade, 4 or occupational association for its members or former or 5 retired members, or combination thereof, if the association;

6 (i) is composed of individuals all of whom are
7 actively engaged in the same profession, trade, or
8 occupation;

9 (ii) has been maintained in good faith for purposes10 other than obtaining insurance; and

11 (iii) has been in existence for at least 2 years prior
12 to the date of its initial offering of the policy or plan to
13 its members;

(c) individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions that are inconsistent with the requirements of [this act] or policies issued to employees or members as additions to franchise plans in existence on [the effective date of this act].

21 Section 4. Standards for policy provisions -- rules. 22 (1) The commissioner shall adopt reasonable rules to 23 establish specific standards for policy provisions of 24 medicare supplement policies. The standards are in addition 25 to and in accordance with applicable laws of this state,

- 1 including the provisions of Title 33+ chapter 22+ and may
- 2 cover but are not limited to:
- 3 (a) terms of renewability;
- 4 (b) initial and subsequent conditions of eligibility;
- 5 (c) nonduplication of coverage;
- (d) probationary periods;

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- (e) benefit limitations, exceptions, and reductions;
- 8 (f) elimination periods;
- 9 (g) requirements for replacement;
- 10 (h) recurrent conditions; and
- 11 (i) definitions of terms.

12 (2) The commissioner may adopt reasonable rules that 13 prohibit policy provisions not otherwise specifically 14 authorized by statute that, in the opinion of the 15 commissioner, are unjust, unfair, or unfairly discriminatory 16 to any person insured or proposed for coverage under a 17 medicare supplement policy.

(3) Notwithstanding any other provisions of the law, a 18 19 medicare supplement policy may not deny a claim for losses incurred more than 6 months from the effective date of 20 coverage for a preexisting condition. The policy may not 21 22 define a preexisting condition more restrictively than a 23 condition for which medical advice was given or treatment 24 was recommended by or received from a physician within 6 25 months before the effective date of coverage.

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1 Section 5. Minimum standards for benefits -- rules. Z The commissioner shall issue reasonable rules to establish 3 minimum standards for benefits for medicare supplement policies.

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5 Section 6. Loss ratio standards. Medicare supplement 6 policies are expected to return to policyholders benefits 7 that are reasonable in relation to the premium charged. The commissioner shall adopt reasonable rules to establish 8 9 minimum standards for loss ratios of medicare supplement 10 policies on the basis of incurred claims experience and 11 earned premiums for the entire period for which rates are 12 computed to provide coverage and in accordance with accepted actuarial principles and practices. For purposes of rules 13 14 adopted pursuant to this section, medicare supplement policies issued as a result of solicitations of individuals 15 through the mail or mass media advertising, including both 16 17 print and broadcast advertising, shall be treated as 18 individual policies.

19 Section 7. Disclosure standards -- informational brochure -- rules. (1) In order to provide for full and fair 20 disclosure in the sale of medicare supplement policies, a 21 medicare supplement policy may not be delivered or issued 22 23 for delivery in this state and a certificate may not be 24 delivered pursuant to a group medicare supplement policy 25 delivered or issued for delivery in this state unless an

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Ł outline of coverage is delivered to the applicant at the 2 time application is made.

(2) (a) The commissioner shall prescribe the format 3 and content of the outline of coverage required by 4 subsection (1). 5

(b) For purposes of this section, "format" means 6 7 style, arrangements, and overall appearance, including such items as the size, color, and prominence of type and the 8 9 arrangement of text and captions.

(c) The outline of coverage must include: 10

(i) a description of the principal benefits and 11 12 coverage provided in the policy:

13 (ii) a statement of the exceptions, reductions, and limitations contained in the policy: 14

(iii) a statement of the renewal provisions including 15 any reservation by the insurer of a right to change 16 17 oremiums;

(iv) a statement that the outline of coverage is a 18 19 summary of the policy issued or applied for and that the policy should be consulted to determine governing 20 contractual provisions. 21

(3) The commissioner may prescribe by rule a standard 22 23 form and the contents of an informational brochure for persons eligible for medicare by reason of age, which is 24 intended to improve the buyer's ability to select the most 25

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1 appropriate coverage and improve the buyer's understanding 2 of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule 3 4 that the information brochure be provided to any prospective 5 insureds eligible for medicare at the same time the outline 6 of coverage is delivered. With respect to direct response 7 insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request; but 8 not later than the time of policy delivery, to any 9 10 prospective insureds eligible for medicare by reason of age. 11 (4) The commissioner may adopt reasonable rules for 12 captions or notice requirements, determined to be in the 13 public interest and designed to inform prospective insureds 14 that particular insurance coverages are not medicare 15 supplement coverages, for all accident and sickness 16 insurance policies sold to persons eligible for medicare by 17 reason of age, other than:

18 (a) medicare supplement policies;

19 (b) disability income policies;

20 (c) basic, catastrophic, or major medical expense 21 policies;

22 (d) single premium, nonrenewable policies; or

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23 (e) other policies defined in [subsection (4) of 24 section 3].

25 (5) The commissioner may further adopt reasonable

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rules to govern the full and fair disclosure of the
 information in connection with the replacement of accident
 and sickness policies, subscriber contracts, or certificates
 by persons eligible for medicare by reason of age.

5 Section 8. Notice of free examination. (1) Medicare supplement policies or certificates, other than those issued 6 7 pursuant to direct response solicitation, must have a notice prominently printed on the first page of the policy or 8 Q attached thereto stating in substance that the applicant has 10 the right to return the policy or certificate within 10 days of its delivery and to have the premium refunded if, after 11 12 examination of the policy or certificate, the applicant is 13 not satisfied for any reason.

14 (2) Medicare supplement policies or certificates 15 issued pursuant to a direct response solicitation to persons 16 eligible for medicare by reason of age must have a notice 17 prominently printed on the first page or attached thereto 18 stating in substance that the applicant has the right to 19 return the policy or certificate within 30 days of its 20 delivery and to have the premium refunded if, after 21 examination, the applicant is not satisfied for any reason. 22 Section 9. Administrative procedures. Rules adopted 23 pursuant to [this act] are subject to the provisions of 24 33-1-313 and Title 2, chapter 4.

25 Section 10. Codification instruction. This act is

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1 intended to be codified as a new part in Title 33, chapter 2 22: and the provisions of Title 33, apply to this act. 3 Section 11. Severability. If a part of this act is invalid, all valid parts that are severable from the invalid 4 5 part remain in effect. If a part of this act is invalid in 6 one or more of its applications, the part remains in effect 7 in all valid applications that are severable from the invalid applications. 8

9 Section 12. Effective date. This act is effective on
 10 passage and approval.

-End-

March 10 19 81

Respectfully report as follows: That the Statement of Intent, SENATE Bill No. 241

be amended in the third reading copy as follows:

HOUSE

BUSINESS AND INDUSTRY

1. Statement of Intent page 3, line 3. Following: line 3

Insert: "It is the intent of the Legislature in enacting Senate Bill 241 to enable the Insurance Commissioner to implement a program for control of Medicare supplemental policies which will enable Montana to be exempted from the voluntary certification program for such policies established by Public Law 96-265. It is also the intent of the Legislature that policies supplementing Medicare be available to as broad a segment of senior citizens as possible. To that end, Senate Bill 241 should not be construed so as to prohibit the sale of Medicare supplemental policies with benefit levels less than those established by Public Law 96-265, if the Insurance Commissioner finds that such sales would not prevent Montana from obtaining the aforementioned exemption.

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