SENATE BILL NO. 241

INTRODUCED BY HAZELBAKER

BY REQUEST OF THE DEPARTMENT OF INSURANCE

IN THE SENATE

January 22, 1981	Introduced and referred to 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

February 14, 1981	Introduced and referred to Committee on Business and Industry.
March 11, 1981	Committee recommend bill be concurred in as amended. Report adopted.
March 19, 1981	Second reading, concurred in.
March 21, 1981	Third reading, concurred in as amended. Ayes, 92; Noes, 0.

IN THE SENATE

March 21, 1981	Returned from House with amendments.
March 23, 1981	On motion, consideration be passed for the day.
March 24, 1981	Second reading, amendments concurred in.
March 26, 1981	Third reading, amendments concurred in. Ayes, 47; Noes, 0. Sent to enrolling.
	Reported correctly enrolled.

BILL NO. 241

INTRODUCED BY

BY REQUEST OF THE DEPARTMENT OF INSURANCE

A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT INSURANCE; REQUIRING THE COMMISSIONER OF INSURANCE TO ADOPT RULES ESTABLISHING POLICY PROVISION REQUIREMENTS, MINIMUM BENEFIT STANDARDS, LOSS RATIO STANDARDS, AND DISCLOSURE STANDARDS FOR SUCH POLICIES; AND GIVING THE COMMISSIONER OF INSURANCE AUTHORITY TO ADOPT RULES ESTABLISHING AN INFORMATIONAL BROCHURE FOR SUCH POLICIES AND AUTHORITY TO ADOPT RULES ESTABLISHING CAPTIONS OR NOTICE REQUIREMENTS FOR CERTAIN NONMEDICARE SUPPLEMENT POLICIES IDENTIFYING THEM AS SUCH; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

Section 1. Short title. [This act] may be cited as the "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.

LC 0476/01

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

(1) "Applicant" means:

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

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

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

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

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

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

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

(ii) has been maintained in good faith for purposes 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].

Section 4. Standards for policy provisions -- rules. (1) The commissioner shall adopt reasonable rules to establish specific standards for policy provisions of medicare supplement policies. The standards are in addition 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:

(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;

(h) recurrent conditions; and

(i) definitions of terms.

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

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

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

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

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

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

(2) (a) The commissioner shall prescribe the format and content of the outline of coverage required by 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.

(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;

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

(iv) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing 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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appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare at the same time the outline of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request, but not later than the time of policy delivery, to any prospective insureds eligible for medicare by reason of age.

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare by reason of age, other than:

(a) medicare supplement policies;

(b) disability income policies;

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

(d) single premium, nonrenewable policies; or

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

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

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

Section 9. Administrative procedures. Rules adopted pursuant to [this act] are subject to the provisions of 33-1-313 and Title 2, chapter 4.

Section 10. Codification instruction. This act is

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

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

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

-End-

STATEMENT OF INTENT

SENATE BILL 241

Senate Public Health Committee

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

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

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

It is contemplated that such rules should address the following:

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

(b) minimum standards for medicare supplement policy 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 notice to an applicant regarding replacement of disability

insurance.

First adopted by the Public Health Committee on the 9th day of February 1981.

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 STANDARDS FOR MEDICARE SUPPLEMENT INSURANCE; REQUIRING THE COMMISSIONER OF INSURANCE TO ADOPT RULES ESTABLISHING POLICY PROVISION REQUIREMENTS, MINIMUM BENEFIT STANDARDS, LOSS RATIO STANDARDS, AND DISCLOSURE STANDARDS FOR SUCH POLICIES; AND GIVING THE COMMISSIONER OF INSURANCE AUTHORITY TO ADOPT RULES ESTABLISHING AN INFORMATIONAL BROCHURE FOR SUCH POLICIES AND AUTHORITY TO ADOPT RULES ESTABLISHING CAPTIONS OR NOTICE REQUIREMENTS FOR CERTAIN NONMEDICARE SUPPLEMENT POLICIES IDENTIFYING THEM AS SUCH; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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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:

(1) "Applicant" means:

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

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

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

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

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

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

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

(ii) has been maintained in good faith for purposes 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].

Section 4. Standards for policy provisions -- rules. (1) The commissioner shall adopt reasonable rules to establish specific standards for policy provisions of medicare supplement policies. The standards are in addition 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:

(a) terms of renewability;

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(d) probationary periods;

(e) benefit limitations, exceptions, and reductions;

(f) elimination periods;

(g) requirements for replacement;

(h) recurrent conditions; and

(i) definitions of terms.

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

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

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(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

appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare at the same time the outline of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request, but not later than the time of policy delivery, to any prospective insureds eligible for medicare by reason of age.

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare by reason of age, other than:

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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.

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

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Section 9. Administrative procedures. Rules adopted pursuant to [this act] are subject to the provisions of 33-1-313 and Title 2, chapter 4.

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

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

insurance.

First adopted by the Public Health Committee on the 9th day of February 1981.

Senate BILL NO. 241

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(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

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

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

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

(ii) has been maintained in good faith for purposes 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].

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(b) initial and subsequent conditions of eligibility;

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(d) probationary periods;

(e) benefit limitations, exceptions, and reductions;

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(i) definitions of terms.

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

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

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

(2) (a) The commissioner shall prescribe the format and content of the outline of coverage required by 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.

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

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

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STATEMENT OF INTENT

SENATE BILL 241

Senate Public Health Committee

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

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

It is contemplated that such rules should address the following:

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

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

(c) required disclosure provisions such as provisions regarding renewal, continuation, and nonrenewal, definition and explanation of terms, pre-existing 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 notice to an applicant regarding replacement of disability insurance.

First adopted by the Public Health Committee on the 9th day of February, 1981.

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.

SENATE BILL NO. 241

INTRODUCED BY HAZELBAKER

BY REQUEST OF THE DEPARTMENT OF INSURANCE

A BILL FOR AN ACT ENTITLED: "AN ACT ESTABLISHING MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT INSURANCE; REQUIRING THE COMMISSIONER OF INSURANCE TO ADOPT RULES ESTABLISHING POLICY PROVISION REQUIREMENTS, MINIMUM BENEFIT STANDARDS, LOSS RATIO STANDARDS, AND DISCLOSURE STANDARDS FOR SUCH POLICIES; AND GIVING THE COMMISSIONER OF INSURANCE AUTHORITY TO ADOPT RULES ESTABLISHING AN INFORMATIONAL BROCHURE FOR SUCH POLICIES AND AUTHORITY TO ADOPT RULES ESTABLISHING CAPTIONS OR NOTICE REQUIREMENTS FOR CERTAIN NONMEDICARE SUPPLEMENT POLICIES IDENTIFYING THEM AS SUCH; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

Section 1. Short title. [This act] may be cited as the "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.

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

(1) "Applicant" means:

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

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

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

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

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

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

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

(ii) has been maintained in good faith for purposes 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].

Section 4. Standards for policy provisions -- rules. (1) The commissioner shall adopt reasonable rules to establish specific standards for policy provisions of medicare supplement policies. The standards are in addition 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:

(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;

(h) recurrent conditions; and

(i) definitions of terms.

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

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

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

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

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

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

(2) (a) The commissioner shall prescribe the format and content of the outline of coverage required by 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.

(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;

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

(iv) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing 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

appropriate coverage and improve the buyer's understanding of medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the information brochure be provided to any prospective insureds eligible for medicare at the same time the outline of coverage is delivered. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request, but not later than the time of policy delivery, to any prospective insureds eligible for medicare by reason of age.

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare by reason of age, other than:

(a) medicare supplement policies;

(b) disability income policies;

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

(d) single premium, nonrenewable policies; or

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

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

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

Section 9. Administrative procedures. Rules adopted pursuant to [this act] are subject to the provisions of 33-1-313 and Title 2, chapter 4.

Section 10. Codification instruction. This act is

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

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

Section 12. Effective date. This act is effective on 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.

XXXXXXX BE CONCURRED IN AS AMENDED