

HOUSE BILL NO. 535

INTRODUCED BY J. BROWN, CONNELLY, COHEN,
SQUIRES, QUILICI, -HARDING

IN THE HOUSE

FEBRUARY 2, 1989	INTRODUCED AND REFERRED TO COMMITTEE ON APPROPRIATIONS. FIRST READING.
FEBRUARY 3, 1989	ON MOTION BY CHIEF SPONSOR, REPRESENTATIVES SQUIRES AND QUILICI AND SENATOR HARDING ADDED AS SPONSORS.
FEBRUARY 6, 1989	ON MOTION, TAKEN FROM COMMITTEE ON APPROPRIATIONS AND REREFERRED TO COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT.
FEBRUARY 14, 1989	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
FEBRUARY 15, 1989	PRINTING REPORT.
FEBRUARY 18, 1989	SECOND READING, DO PASS.
FEBRUARY 20, 1989	ON MOTION, TAKEN FROM ENGROSSING AND REREFERRED TO COMMITTEE ON APPROPRIATIONS.
MARCH 18, 1989	COMMITTEE RECOMMEND BILL DO PASS. REPORT ADOPTED.
MARCH 20, 1989	PRINTING REPORT. SECOND READING, DO PASS.
MARCH 21, 1989	ENGROSSING REPORT.
MARCH 22, 1989	THIRD READING, PASSED. AYES, 93; NOES, 4. TRANSMITTED TO SENATE.

IN THE SENATE

MARCH 22, 1989

INTRODUCED AND REFERRED TO COMMITTEE
ON FINANCE & CLAIMS.

FIRST READING.

APRIL 13, 1989

COMMITTEE RECOMMEND BILL BE
CONCURRED IN. REPORT ADOPTED.

APRIL 14, 1989

SECOND READING, CONCURRED IN.

APRIL 17, 1989

THIRD READING, CONCURRED IN.
AYES, 49; NOES, 0.

RETURNED TO HOUSE.

IN THE HOUSE

APRIL 18, 1989

RECEIVED FROM SENATE.

SENT TO ENROLLING.

REPORTED CORRECTLY ENROLLED.

1 *HOUSE* BILL NO. *535*
2 INTRODUCED BY *J. Brian Connelly*
3
4 A BILL FOR AN ACT ENTITLED: "AN ACT REVISING MEDICARE
5 SUPPLEMENT INSURANCE MINIMUM STANDARDS TO COMPLY WITH THE
6 FEDERAL MEDICARE CATASTROPHIC COVERAGE ACT OF 1988, P.L.
7 100-360; PROVIDING A PENALTY FOR VIOLATION OF MEDICARE
8 SUPPLEMENT INSURANCE MINIMUM STANDARDS; APPROPRIATING MONEY
9 TO THE STATE AUDITOR TO MONITOR COMPLIANCE; AMENDING
10 SECTIONS 33-16-103 AND 33-22-903 THROUGH 33-22-908, MCA; AND
11 PROVIDING AN IMMEDIATE EFFECTIVE DATE FOR THE EXTENSION OF
12 RULEMAKING AUTHORITY."

14 STATEMENT OF INTENT

15 A statement of intent is required for this bill because
16 it authorizes the state commissioner of insurance to make
17 and amend reasonable rules relating to specific standards
18 that medicare supplement insurance policies or certificates
19 must meet, minimum standards for benefits and claims
20 payment, minimum standards for loss ratios, and the timing
21 and manner of premium adjustments. The legislature intends
22 that the rules that the commissioner adopts to implement
23 this bill be designed to allow the commissioner to comply
24 with the federal standards established by the Medicare
25 Catastrophic Coverage Act of 1988, P.L. 100-360.



1
2 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:
3
4 **Section 1.** Section 33-16-103, MCA, is amended to read:
5
6 **"33-16-103. Application.** This chapter applies to all
7 insurers and all kinds of insurance, except that nothing
8 contained in this chapter ~~shall apply~~ applies to:
9
10 (1) life insurance;
11 (2) disability insurance, except medicare supplement
12 insurance subject to the provisions of chapter 22, part 9;
13 (3) reinsurance, except joint reinsurance as provided
14 in 33-16-307;
15 (4) insurance against loss of or damage to aircraft,
16 their hulls, accessories, and equipment, or against
17 liability, other than workers' compensation and employers'
18 liability, arising out of the ownership, maintenance, or use
19 of aircraft;
20 (5) insurance of vessels or craft, their cargoes,
21 marine builders' risks, marine protection and indemnity, or
22 other risks commonly insured under marine, as distinguished
23 from inland marine, insurance policies."
24
25 **Section 2.** Section 33-22-903, MCA, is amended to read:
26
27 **"33-22-903. Definitions.** As used in this part, the
28 following definitions apply:
29
30 (1) "Applicant" means:
31 (a) in the case of an individual medicare supplement

1 policy or subscriber contract, the person who seeks to
2 contract for insurance benefits; and

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

5 (2) "Certificate" means a certificate delivered or
6 issued for delivery in this state under a group medicare
7 supplement policy ~~that--has--been--delivered--or--issued--for~~
8 delivery in this state or subscriber contract.

9 (3) "Health care expenses":

10 (a) means expenses of a health maintenance
11 organization associated with the delivery of health care
12 services that are analogous to incurred losses of an
13 insurer;

14 (b) does not include home office and overhead costs,
15 advertising costs, commissions and other acquisition costs,
16 taxes, capital costs, administrative costs, or claims
17 processing costs.

18 (4) "Entity" means an insurer as defined in 33-1-201,
19 a health service corporation as defined in 33-30-101, and a
20 health maintenance organization as defined in 33-31-102.

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

24 (6) "Medicare supplement policy" means a group or
25 individual policy of disability insurance or a subscriber

1 contract of a health service corporation that is advertised,
2 marketed, or designed primarily as a supplement to
3 reimbursements under medicare for the hospital, medical, or
4 surgical expenses of persons eligible for medicare by reason
5 of age. The term does not include:

6 (a) a policy or contract of one or more employers or
7 labor organizations or of the trustees of a fund established
8 by one or more employers or labor organizations, or
9 combination thereof, for employees or former employees, or
10 combination thereof, or for members or former members, or
11 combination thereof, of the labor organizations; or

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

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

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

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

23 (c) individual policies or contracts issued pursuant
24 to a conversion privilege under a policy or contract of
25 group or individual insurance when the group or individual

policy or contract includes provisions that are inconsistent with the requirements of this part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981."

Section 3. Section 33-22-904, MCA, is amended to read:

"33-22-904. Standards for policy provisions -- rules.

(1) A medicare supplement insurance policy, contract, or certificate in force in this state may not contain benefits that duplicate benefits provided by medicare.

~~(1)~~(2) The commissioner shall adopt reasonable rules to establish specific standards for policy provisions of medicare supplement policies and certificates. 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)~~(3) 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)~~(4) 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 4. Section 33-22-905, MCA, is amended to read:

"33-22-905. Minimum standards for benefits and payment of claims -- rules. The commissioner shall ~~issue~~ adopt reasonable rules to establish minimum standards for benefits and payment of claims for medicare supplement policies."

Section 5. Section 33-22-906, MCA, is amended to read:

"33-22-906. Loss ratio standards and filing requirements -- limits on compensation. (1) Every entity providing group medicare supplement insurance benefits to a resident of this state shall file a copy of the master policy and each certificate used in this state with the commissioner as required by 33-1-501. The filing must be

1 made not less than 60 days in advance of the delivery of any
 2 certificate or policy to a resident of this state.

3 (2) Medicare supplement policies are expected to
 4 return to policyholders benefits that are reasonable in
 5 relation to the premium charged. The commissioner shall
 6 adopt reasonable rules to establish minimum standards for
 7 loss ratios of medicare supplement policies on the basis of
 8 incurred claims experience or incurred health care expenses,
 9 where coverage is provided by a health maintenance
 10 organization on a service rather than reimbursement basis,
 11 and earned premiums for the entire period for which rates
 12 are computed to provide coverage and in accordance with
 13 accepted actuarial principles and practices. For purposes of
 14 rules adopted pursuant to this section, medicare supplement
 15 policies issued as a result of solicitations of individuals
 16 through the mail or mass media advertising, including both
 17 print and broadcast advertising, shall be treated as
 18 individual policies. Every entity providing medicare
 19 supplement insurance benefits to a resident of this state
 20 shall make premium adjustments:

21 (a) necessary to produce an expected loss ratio under
 22 the policy or contract that meets the minimum loss ratio
 23 standards for medicare supplement policies as established by
 24 rule; and

25 (b) expected to result in a loss ratio at least as

1 great as that originally anticipated by the entity when it
 2 established current premiums for the medicare supplement
 3 insurance policy or contract.

4 (3) The commissioner shall by rule establish the
 5 timing and manner of the premium adjustments. Every entity
 6 providing medicare supplement policies or certificates in
 7 this state shall annually file with the commissioner its
 8 rates, rating schedule, and supporting documentation
 9 demonstrating that it is in compliance with the applicable
 10 loss ratio standards of this part. An entity transacting
 11 medicare supplement insurance in this state may not adjust
 12 its rates more than once a year and may not adjust its rates
 13 for the first year a policy is in force, except to allow for
 14 changes in federal laws or regulations relating to medicare.
 15 Each filing of rates and rating schedules must demonstrate
 16 that the actual and expected losses in relation to premiums
 17 complies with the requirements of this part.

18 (4) An entity may not provide compensation to its
 19 agents or solicitors that is greater than the renewal
 20 compensation that would be paid on an existing policy if:

21 (a) the existing policy were replaced by another
 22 policy with the same insurer and the new policy benefits are
 23 substantially similar to the benefits under the old policy;
 24 and

25 (b) the old policy was issued by the same insurer or

1 insurance group."

2 **Section 6.** Section 33-22-907, MCA, is amended to read:

3 "33-22-907. Disclosure standards -- informational
4 brochure -- rules. (1) In order to provide for full and fair
5 disclosure in the sale of medicare supplement policies, a
6 medicare supplement policy may not be delivered or issued
7 for delivery in this state and a certificate may not be
8 delivered pursuant to a group medicare supplement policy
9 delivered or issued for delivery in this state unless an
10 outline of coverage is delivered to the applicant at the
11 time application is made. The outline of coverage must be
12 filed with the commissioner as required by 33-1-501. The
13 filing must be made at least 60 days in advance of the date
14 the outline of coverage is delivered to any resident of this
15 state.

16 (2) (a) The commissioner shall prescribe the format
17 and content of the outline of coverage required by
18 subsection (1).

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

23 (c) The outline of coverage must include:

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

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

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

6 (iv) a statement that the outline of coverage is a
7 summary of the policy issued or applied for and that the
8 policy should be consulted to determine governing
9 contractual provisions.

10 (3) The commissioner may prescribe by rule a standard
11 form and the contents of an informational brochure for
12 persons eligible for medicare by reason of age, which is
13 intended to improve the buyer's ability to select the most
14 appropriate coverage and improve the buyer's understanding
15 of medicare. Except in the case of direct response
16 insurance policies, the commissioner may require by rule
17 that the information brochure be provided to any prospective
18 insureds eligible for medicare at the same time the outline
19 of coverage is delivered. With respect to direct response
20 insurance policies, the commissioner may require by rule
21 that the prescribed brochure be provided upon request, but
22 not later than the time of policy delivery, to any
23 prospective insureds eligible for medicare by reason of age.

24 (4) The commissioner may adopt reasonable rules for
25 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 excepted in 33-22-903~~(4)~~(6).

(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.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders, and certificate holders, in a format that the commissioner prescribes by rule, of the changes it has made to the medicare supplement insurance policy or contract."

Section 7. Section 33-22-908, MCA, is amended to read:

"33-22-908. 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 certificate or attached thereto stating in substance that the applicant has the right to return the policy or certificate within ~~10~~ 30 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. The insurer shall pay any refund made pursuant to this section directly to the applicant in a timely manner.

~~{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."~~

NEW SECTION. Section 8. Filing requirements for advertising. Every entity or representative providing medicare supplement insurance or benefits in this state shall provide to the commissioner for his review a copy of any medicare supplement advertising intended for use in this

1 state, whether through written, radio, or television medium.

2 NEW SECTION. Section 9. Penalties. In addition to any
3 other penalties for violations of the insurance code, the
4 commissioner may after hearing require entities violating
5 any provision of or rule adopted under Title 33, chapter 16,
6 or this part to cease marketing a medicare supplement policy
7 or certificate in this state that is related directly or
8 indirectly to the violation or take such action as is
9 necessary to comply with the provisions of Title 33, chapter
10 16, or this part or the rules adopted under Title 33,
11 chapter 16, or this part, or both.

12 NEW SECTION. Section 10. Appropriation. There is
13 appropriated to the state auditor's office from the
14 insurance regulatory trust account \$25,891.00 for the fiscal
15 year ending June 30, 1990, and \$22,697.00 for the fiscal
16 year ending June 30, 1991, for one staff position to review
17 medicare supplement insurance advertising, assist with
18 preparation of the Medicare Supplement Insurance Buyer's
19 Guide, and monitor compliance with applicable federal
20 regulations.

21 NEW SECTION. Section 11. Extension of authority. Any
22 existing authority to make rules on the subject of the
23 provisions of [this act] is extended to the provisions of
24 [this act].

25 NEW SECTION. Section 12. Codification instruction.

1 [Sections 8 and 9] are intended to be codified as an
2 integral part of Title 33, chapter 22, part 9, and the
3 provisions of Title 33, chapter 22, part 9, apply to
4 [sections 8 and 9].

5 NEW SECTION. Section 13. Saving clause. [This act]
6 does not affect rights and duties that matured, penalties
7 that were incurred, or proceedings that were begun before
8 October 1, 1989.

9 NEW SECTION. Section 14. Severability. If a part of
10 [this act] is invalid, all valid parts that are severable
11 from the invalid part remain in effect. If a part of [this
12 act] is invalid in one or more of its applications, the part
13 remains in effect in all valid applications that are
14 severable from the invalid applications.

15 NEW SECTION. Section 15. Applicability. Except as
16 otherwise specifically provided, [this act] applies to every
17 medicare supplement policy and membership contract delivered
18 or issued for delivery in this state after October 1, 1989,
19 and every certificate delivered or issued for delivery in
20 this state after October 1, 1989.

21 NEW SECTION. Section 16. Effective date. [Section 11
22 and this section] are effective on passage and approval.

-End-

RE-REFERRED AND
APPROVED BY COMM. ON BUSINESS
AND ECONOMIC DEVELOPMENT

HOUSE BILL NO. 535

INTRODUCED BY J. BROWN, CONNELLY, COHEN,
SQUIRES, QUILICI, HARDING

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING MEDICARE
SUPPLEMENT INSURANCE MINIMUM STANDARDS TO COMPLY WITH THE
FEDERAL MEDICARE CATASTROPHIC COVERAGE ACT OF 1988, P.L.
100-360; PROVIDING A PENALTY FOR VIOLATION OF MEDICARE
SUPPLEMENT INSURANCE MINIMUM STANDARDS; APPROPRIATING MONEY
TO THE STATE AUDITOR TO MONITOR COMPLIANCE; AMENDING
SECTIONS 33-16-103 AND 33-22-903 THROUGH 33-22-908, MCA; AND
PROVIDING AN IMMEDIATE EFFECTIVE DATE FOR THE EXTENSION OF
RULEMAKING AUTHORITY."

STATEMENT OF INTENT

A statement of intent is required for this bill because
it authorizes the state commissioner of insurance to make
and amend reasonable rules relating to specific standards
that medicare supplement insurance policies or certificates
must meet, minimum standards for benefits and claims
payment, minimum standards for loss ratios, and the timing
and manner of premium adjustments. The legislature intends
that the rules that the commissioner adopts to implement
this bill be designed to allow the commissioner to comply
with the federal standards established by the Medicare

Catastrophic Coverage Act of 1988, P.L. 100-360.

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

Section 1. Section 33-16-103, MCA, is amended to read:

"33-16-103. **Application.** This chapter applies to all
insurers and all kinds of insurance, except that nothing
contained in this chapter ~~shall apply~~ applies to:

(1) life insurance;

(2) disability insurance, except medicare supplement
insurance subject to the provisions of chapter 22, part 9;

(3) reinsurance, except joint reinsurance as provided
in 33-16-307;

(4) insurance against loss of or damage to aircraft,
their hulls, accessories, and equipment, or against
liability, other than workers' compensation and employers'
liability, arising out of the ownership, maintenance, or use
of aircraft;

(5) insurance of vessels or craft, their cargoes,
marine builders' risks, marine protection and indemnity, or
other risks commonly insured under marine, as distinguished
from inland marine, insurance policies."

Section 2. Section 33-22-903, MCA, is amended to read:

"33-22-903. **Definitions.** As used in this part, 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 delivered or issued for delivery in this state under a group medicare supplement policy ~~that--has--been--delivered--or--issued--for--delivery--in--this--state~~ or subscriber contract.

(3) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer;

(b) does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

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

{4}(6) "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 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 part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981."

Section 3. Section 33-22-904, MCA, is amended to read:

"33-22-904. Standards for policy provisions -- rules.

(1) A medicare supplement insurance policy, contract, or certificate in force in this state may not contain benefits that duplicate benefits provided by medicare.

(2) The commissioner shall adopt reasonable rules to establish specific standards for policy provisions of medicare supplement policies and certificates. 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.

(3) 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.

(4) 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 4. Section 33-22-905, MCA, is amended to read:

"33-22-905. Minimum standards for benefits and payment of claims -- rules. The commissioner shall issue adopt reasonable rules to establish minimum standards for benefits and payment of claims for medicare supplement policies."

Section 5. Section 33-22-906, MCA, is amended to read:

"33-22-906. Loss ratio standards and filing requirements -- limits on compensation. (1) Every entity providing group medicare supplement insurance benefits to a resident of this state shall file a copy of the master policy and each certificate used in this state with the

commissioner as required by 33-1-501. The filing must be made not less than 60 days in advance of the delivery of any certificate or policy to a resident of this state.

(2) 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 or incurred health care expenses, where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, 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. Every entity providing medicare supplement insurance benefits to a resident of this state shall make premium adjustments:

(a) necessary to produce an expected loss ratio under the policy or contract that meets the minimum loss ratio standards for medicare supplement policies as established by rule; and

(b) expected to result in a loss ratio at least as great as that originally anticipated by the entity when it established current premiums for the medicare supplement insurance policy or contract.

(3) The commissioner shall by rule establish the timing and manner of the premium adjustments. Every entity providing medicare supplement policies or certificates in this state shall annually file with the commissioner its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this part. An entity transacting medicare supplement insurance in this state may not adjust its rates more than once TWICE a year and may not adjust its rates for the first year a policy is in force, except to allow for changes in federal laws or regulations relating to medicare. Each filing of rates and rating schedules must demonstrate that the actual and expected losses in relation to premiums complies with the requirements of this part.

(4) An entity may not provide compensation to its agents or solicitors that is greater than the renewal compensation that would be paid on an existing policy if:

(a) the existing policy were replaced by another policy with the same insurer and the new policy benefits are substantially similar to the benefits under the old policy; and

1 (b) the old policy was issued by the same insurer or
 2 insurance group."

3 **Section 6.** Section 33-22-907, MCA, is amended to read:

4 "33-22-907. Disclosure standards -- informational
 5 brochure -- rules. (1) In order to provide for full and fair
 6 disclosure in the sale of medicare supplement policies, a
 7 medicare supplement policy may not be delivered or issued
 8 for delivery in this state and a certificate may not be
 9 delivered pursuant to a group medicare supplement policy
 10 delivered or issued for delivery in this state unless an
 11 outline of coverage is delivered to the applicant at the
 12 time application is made. The outline of coverage must be
 13 filed with the commissioner as required by 33-1-501. The
 14 filing must be made at least 60 days in advance of the date
 15 the outline of coverage is delivered to any resident of this
 16 state.

17 (2) (a) The commissioner shall prescribe the format
 18 and content of the outline of coverage required by
 19 subsection (1).

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

24 (c) The outline of coverage must include:

25 (i) a description of the principal benefits and

1 coverage provided in the policy;

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

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

7 (iv) a statement that the outline of coverage is a
 8 summary of the policy issued or applied for and that the
 9 policy should be consulted to determine governing
 10 contractual provisions.

11 (3) The commissioner may prescribe by rule a standard
 12 form and the contents of an informational brochure for
 13 persons eligible for medicare by reason of age, which is
 14 intended to improve the buyer's ability to select the most
 15 appropriate coverage and improve the buyer's understanding
 16 of medicare. Except in the case of direct response
 17 insurance policies, the commissioner may require by rule
 18 that the information brochure be provided to any prospective
 19 insureds eligible for medicare at the same time the outline
 20 of coverage is delivered. With respect to direct response
 21 insurance policies, the commissioner may require by rule
 22 that the prescribed brochure be provided upon request, but
 23 not later than the time of policy delivery, to any
 24 prospective insureds eligible for medicare by reason of age.

25 (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 excepted in 33-22-903(4)(6).

(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.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders, and certificate holders, in a format that the commissioner prescribes by rule, of the changes it has made to the medicare supplement insurance

policy or contract."

Section 7. Section 33-22-908, MCA, is amended to read:

"33-22-908. Notice of free examination. ~~††~~ 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 certificate or attached thereto stating in substance that the applicant has the right to return the policy or certificate within ~~10~~ 30 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. The insurer shall pay any refund made pursuant to this section directly to the applicant in a timely manner.

~~†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."~~

NEW SECTION. Section 8. Filing requirements for advertising. Every entity or representative providing medicare supplement insurance or benefits in this state shall provide to the commissioner for his review a copy of

1 any medicare supplement advertising intended for use in this
2 state, whether through written, radio, or television medium.

3 NEW SECTION. Section 9. Penalties. In addition to any
4 other penalties for violations of the insurance code, the
5 commissioner may after hearing require entities violating
6 any provision of or rule adopted under Title 33, chapter 16,
7 or this part to cease marketing a medicare supplement policy
8 or certificate in this state that is related directly or
9 indirectly to the violation or take such action as is
10 necessary to comply with the provisions of Title 33, chapter
11 16, or this part or the rules adopted under Title 33,
12 chapter 16, or this part, or both.

13 NEW SECTION. Section 10. Appropriation. There is
14 appropriated to the state auditor's office from the
15 insurance regulatory trust account \$25,891.00 for the fiscal
16 year ending June 30, 1990, and \$22,697.00 for the fiscal
17 year ending June 30, 1991, for one staff position to review
18 medicare supplement insurance advertising, assist with
19 preparation of the Medicare Supplement Insurance Buyer's
20 Guide, and monitor compliance with applicable federal
21 regulations.

22 NEW SECTION. Section 11. Extension of authority. Any
23 existing authority to make rules on the subject of the
24 provisions of [this act] is extended to the provisions of
25 [this act].

1 NEW SECTION. Section 12. Codification instruction.
2 [Sections 8 and 9] are intended to be codified as an
3 integral part of Title 33, chapter 22, part 9, and the
4 provisions of Title 33, chapter 22, part 9, apply to
5 [sections 8 and 9].

6 NEW SECTION. Section 13. Saving clause. [This act]
7 does not affect rights and duties that matured, penalties
8 that were incurred, or proceedings that were begun before
9 October 1, 1989.

10 NEW SECTION. Section 14. Severability. If a part of
11 [this act] is invalid, all valid parts that are severable
12 from the invalid part remain in effect. If a part of [this
13 act] is invalid in one or more of its applications, the part
14 remains in effect in all valid applications that are
15 severable from the invalid applications.

16 NEW SECTION. Section 15. Applicability. Except as
17 otherwise specifically provided, [this act] applies to every
18 medicare supplement policy and membership contract delivered
19 or issued for delivery in this state after October 1, 1989,
20 and every certificate delivered or issued for delivery in
21 this state after October 1, 1989.

22 NEW SECTION. Section 16. Effective date. [Section 11
23 and this section] are effective on passage and approval.

-End-

RE-REFERRER AND
APPROVED BY COMMITTEE
ON APPROPRIATIONS

HOUSE BILL NO. 535

INTRODUCED BY J. BROWN, CONNELLY, COHEN,

SQUIRES, QUILICI, HARDING

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING MEDICARE
SUPPLEMENT INSURANCE MINIMUM STANDARDS TO COMPLY WITH THE
FEDERAL MEDICARE CATASTROPHIC COVERAGE ACT OF 1988, P.L.
100-360; PROVIDING A PENALTY FOR VIOLATION OF MEDICARE
SUPPLEMENT INSURANCE MINIMUM STANDARDS; APPROPRIATING MONEY
TO THE STATE AUDITOR TO MONITOR COMPLIANCE; AMENDING
SECTIONS 33-16-103 AND 33-22-903 THROUGH 33-22-908, MCA; AND
PROVIDING AN IMMEDIATE EFFECTIVE DATE FOR THE EXTENSION OF
RULEMAKING AUTHORITY."

STATEMENT OF INTENT

A statement of intent is required for this bill because
it authorizes the state commissioner of insurance to make
and amend reasonable rules relating to specific standards
that medicare supplement insurance policies or certificates
must meet, minimum standards for benefits and claims
payment, minimum standards for loss ratios, and the timing
and manner of premium adjustments. The legislature intends
that the rules that the commissioner adopts to implement
this bill be designed to allow the commissioner to comply
with the federal standards established by the Medicare

Catastrophic Coverage Act of 1988, P.L. 100-360.

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

Section 1. Section 33-16-103, MCA, is amended to read:

"33-16-103. **Application.** This chapter applies to all
insurers and all kinds of insurance, except that nothing
contained in this chapter ~~shall apply~~ applies to:

(1) life insurance;

(2) disability insurance, except medicare supplement
insurance subject to the provisions of chapter 22, part 9;

(3) reinsurance, except joint reinsurance as provided
in 33-16-307;

(4) insurance against loss of or damage to aircraft,
their hulls, accessories, and equipment, or against
liability, other than workers' compensation and employers'
liability, arising out of the ownership, maintenance, or use
of aircraft;

(5) insurance of vessels or craft, their cargoes,
marine builders' risks, marine protection and indemnity, or
other risks commonly insured under marine, as distinguished
from inland marine, insurance policies."

Section 2. Section 33-22-903, MCA, is amended to read:

"33-22-903. **Definitions.** As used in this part, 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 delivered or issued for delivery in this state under a group medicare supplement policy ~~that--has--been--delivered--or--issued--for delivery in this state~~ or subscriber contract.

(3) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer;

(b) does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

~~(3)~~(5) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

~~(4)~~(6) "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 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 part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981."

Section 3. Section 33-22-904, MCA, is amended to read:

"33-22-904. Standards for policy provisions -- rules.

(1) A medicare supplement insurance policy, contract, or certificate in force in this state may not contain benefits that duplicate benefits provided by medicare.

{1}(2) The commissioner shall adopt reasonable rules to establish specific standards for policy provisions of medicare supplement policies and certificates. 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}(3)~~ 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}(4)~~ 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 4. Section 33-22-905, MCA, is amended to read:

"33-22-905. Minimum standards for benefits and payment of claims -- rules. The commissioner shall issue adopt reasonable rules to establish minimum standards for benefits and payment of claims for medicare supplement policies."

Section 5. Section 33-22-906, MCA, is amended to read:

"33-22-906. Loss ratio standards and filing requirements -- limits on compensation. (1) Every entity providing group medicare supplement insurance benefits to a resident of this state shall file a copy of the master policy and each certificate used in this state with the

commissioner as required by 33-1-501. The filing must be made not less than 60 days in advance of the delivery of any certificate or policy to a resident of this state.

(2) 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 or incurred health care expenses, where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, 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. Every entity providing medicare supplement insurance benefits to a resident of this state shall make premium adjustments:

(a) necessary to produce an expected loss ratio under the policy or contract that meets the minimum loss ratio standards for medicare supplement policies as established by rule; and

(b) expected to result in a loss ratio at least as great as that originally anticipated by the entity when it established current premiums for the medicare supplement insurance policy or contract.

(3) The commissioner shall by rule establish the timing and manner of the premium adjustments. Every entity providing medicare supplement policies or certificates in this state shall annually file with the commissioner its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this part. An entity transacting medicare supplement insurance in this state may not adjust its rates more than once TWICE a year and may not adjust its rates for the first year a policy is in force, except to allow for changes in federal laws or regulations relating to medicare. Each filing of rates and rating schedules must demonstrate that the actual and expected losses in relation to premiums complies with the requirements of this part.

(4) An entity may not provide compensation to its agents or solicitors that is greater than the renewal compensation that would be paid on an existing policy if:

(a) the existing policy were replaced by another policy with the same insurer and the new policy benefits are substantially similar to the benefits under the old policy; and

1 (b) the old policy was issued by the same insurer or
 2 insurance group."

3 **Section 6.** Section 33-22-907, MCA, is amended to read:

4 "33-22-907. Disclosure standards -- informational
 5 brochure -- rules. (1) In order to provide for full and fair
 6 disclosure in the sale of medicare supplement policies, a
 7 medicare supplement policy may not be delivered or issued
 8 for delivery in this state and a certificate may not be
 9 delivered pursuant to a group medicare supplement policy
 10 delivered or issued for delivery in this state unless an
 11 outline of coverage is delivered to the applicant at the
 12 time application is made. The outline of coverage must be
 13 filed with the commissioner as required by 33-1-501. The
 14 filing must be made at least 60 days in advance of the date
 15 the outline of coverage is delivered to any resident of this
 16 state.

17 (2) (a) The commissioner shall prescribe the format
 18 and content of the outline of coverage required by
 19 subsection (1).

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

24 (c) The outline of coverage must include:

25 (i) a description of the principal benefits and

1 coverage provided in the policy;

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

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

7 (iv) a statement that the outline of coverage is a
 8 summary of the policy issued or applied for and that the
 9 policy should be consulted to determine governing
 10 contractual provisions.

11 (3) The commissioner may prescribe by rule a standard
 12 form and the contents of an informational brochure for
 13 persons eligible for medicare by reason of age, which is
 14 intended to improve the buyer's ability to select the most
 15 appropriate coverage and improve the buyer's understanding
 16 of medicare. Except in the case of direct response
 17 insurance policies, the commissioner may require by rule
 18 that the information brochure be provided to any prospective
 19 insureds eligible for medicare at the same time the outline
 20 of coverage is delivered. With respect to direct response
 21 insurance policies, the commissioner may require by rule
 22 that the prescribed brochure be provided upon request, but
 23 not later than the time of policy delivery, to any
 24 prospective insureds eligible for medicare by reason of age.

25 (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 excepted in 33-22-903(4)(6).

(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.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders, and certificate holders, in a format that the commissioner prescribes by rule, of the changes it has made to the medicare supplement insurance

policy or contract."

Section 7. Section 33-22-908, MCA, is amended to read:

"33-22-908. Notice of free examination. ~~††~~ 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 certificate or attached thereto stating in substance that the applicant has the right to return the policy or certificate within ~~10~~ 30 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. The insurer shall pay any refund made pursuant to this section directly to the applicant in a timely manner.

~~†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."~~

NEW SECTION. Section 8. Filing requirements for advertising. Every entity or representative providing medicare supplement insurance or benefits in this state shall provide to the commissioner for his review a copy of

any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium.

NEW SECTION. Section 9. Penalties. In addition to any other penalties for violations of the insurance code, the commissioner may after hearing require entities violating any provision of or rule adopted under Title 33, chapter 16, or this part to cease marketing a medicare supplement policy or certificate in this state that is related directly or indirectly to the violation or take such action as is necessary to comply with the provisions of Title 33, chapter 16, or this part or the rules adopted under Title 33, chapter 16, or this part, or both.

NEW SECTION. Section 10. Appropriation. There is appropriated to the state auditor's office from the insurance regulatory trust account \$25,891.00 for the fiscal year ending June 30, 1990, and \$22,697.00 for the fiscal year ending June 30, 1991, for one staff position to review medicare supplement insurance advertising, assist with preparation of the Medicare Supplement Insurance Buyer's Guide, and monitor compliance with applicable federal regulations.

NEW SECTION. Section 11. Extension of authority. Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. Section 12. Codification instruction. [Sections 8 and 9] are intended to be codified as an integral part of Title 33, chapter 22, part 9, and the provisions of Title 33, chapter 22, part 9, apply to [sections 8 and 9].

NEW SECTION. Section 13. Saving clause. [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before October 1, 1989.

NEW SECTION. Section 14. 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.

NEW SECTION. Section 15. Applicability. Except as otherwise specifically provided, [this act] applies to every medicare supplement policy and membership contract delivered or issued for delivery in this state after October 1, 1989, and every certificate delivered or issued for delivery in this state after October 1, 1989.

NEW SECTION. Section 16. Effective date. [Section 11 and this section] are effective on passage and approval.

-End-

1 HOUSE BILL NO. 535

2 INTRODUCED BY J. BROWN, CONNELLY, COHEN,

3 SQUIRES, QUILICI, HARDING

4
5 A BILL FOR AN ACT ENTITLED: "AN ACT REVISING MEDICARE
6 SUPPLEMENT INSURANCE MINIMUM STANDARDS TO COMPLY WITH THE
7 FEDERAL MEDICARE CATASTROPHIC COVERAGE ACT OF 1988, P.L.
8 100-360; PROVIDING A PENALTY FOR VIOLATION OF MEDICARE
9 SUPPLEMENT INSURANCE MINIMUM STANDARDS; APPROPRIATING MONEY
10 TO THE STATE AUDITOR TO MONITOR COMPLIANCE; AMENDING
11 SECTIONS 33-16-103 AND 33-22-903 THROUGH 33-22-908, MCA; AND
12 PROVIDING AN IMMEDIATE EFFECTIVE DATE FOR THE EXTENSION OF
13 RULEMAKING AUTHORITY."

14
15 STATEMENT OF INTENT

16 A statement of intent is required for this bill because
17 it authorizes the state commissioner of insurance to make
18 and amend reasonable rules relating to specific standards
19 that medicare supplement insurance policies or certificates
20 must meet, minimum standards for benefits and claims
21 payment, minimum standards for loss ratios, and the timing
22 and manner of premium adjustments. The legislature intends
23 that the rules that the commissioner adopts to implement
24 this bill be designed to allow the commissioner to comply
25 with the federal standards established by the Medicare

1 Catastrophic Coverage Act of 1988, P.L. 100-360.

2
3 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

4 Section 1. Section 33-16-103, MCA, is amended to read:

5 "33-16-103. Application. This chapter applies to all
6 insurers and all kinds of insurance, except that nothing
7 contained in this chapter ~~shall apply~~ applies to:

8 (1) life insurance;

9 (2) disability insurance, except medicare supplement
10 insurance subject to the provisions of chapter 22, part 9;

11 (3) reinsurance, except joint reinsurance as provided
12 in 33-16-307;

13 (4) insurance against loss of or damage to aircraft,
14 their hulls, accessories, and equipment, or against
15 liability, other than workers' compensation and employers'
16 liability, arising out of the ownership, maintenance, or use
17 of aircraft;

18 (5) insurance of vessels or craft, their cargoes,
19 marine builders' risks, marine protection and indemnity, or
20 other risks commonly insured under marine, as distinguished
21 from inland marine, insurance policies."

22 Section 2. Section 33-22-903, MCA, is amended to read:

23 "33-22-903. Definitions. As used in this part, the
24 following definitions apply:

25 (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 delivered or issued for delivery in this state under a group medicare supplement policy ~~that--has--been--delivered--or--issued--for delivery in this state~~ or subscriber contract.

(3) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer;

(b) does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

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

(6) "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 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 part or policies issued to employees or members as additions to franchise plans in existence on April 8, 1981."

Section 3. Section 33-22-904, MCA, is amended to read:

"33-22-904. Standards for policy provisions -- rules.

(1) A medicare supplement insurance policy, contract, or certificate in force in this state may not contain benefits that duplicate benefits provided by medicare.

(2) The commissioner shall adopt reasonable rules to establish specific standards for policy provisions of medicare supplement policies and certificates. 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.

(3) 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.

(4) 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 4. Section 33-22-905, MCA, is amended to read:

"33-22-905. Minimum standards for benefits and payment of claims -- rules. The commissioner shall issue adopt reasonable rules to establish minimum standards for benefits and payment of claims for medicare supplement policies."

Section 5. Section 33-22-906, MCA, is amended to read:

"33-22-906. Loss ratio standards and filing requirements -- limits on compensation. (1) Every entity providing group medicare supplement insurance benefits to a resident of this state shall file a copy of the master policy and each certificate used in this state with the

1 commissioner as required by 33-1-501. The filing must be
 2 made not less than 60 days in advance of the delivery of any
 3 certificate or policy to a resident of this state.

4 (2) Medicare supplement policies are expected to
 5 return to policyholders benefits that are reasonable in
 6 relation to the premium charged. The commissioner shall
 7 adopt reasonable rules to establish minimum standards for
 8 loss ratios of medicare supplement policies on the basis of
 9 incurred claims experience or incurred health care expenses,
 10 where coverage is provided by a health maintenance
 11 organization on a service rather than reimbursement basis,
 12 and earned premiums for the entire period for which rates
 13 are computed to provide coverage and in accordance with
 14 accepted actuarial principles and practices. For purposes of
 15 rules adopted pursuant to this section, medicare supplement
 16 policies issued as a result of solicitations of individuals
 17 through the mail or mass media advertising, including both
 18 print and broadcast advertising, shall be treated as
 19 individual policies. Every entity providing medicare
 20 supplement insurance benefits to a resident of this state
 21 shall make premium adjustments:

22 (a) necessary to produce an expected loss ratio under
 23 the policy or contract that meets the minimum loss ratio
 24 standards for medicare supplement policies as established by
 25 rule; and

1 (b) expected to result in a loss ratio at least as
 2 great as that originally anticipated by the entity when it
 3 established current premiums for the medicare supplement
 4 insurance policy or contract.

5 (3) The commissioner shall by rule establish the
 6 timing and manner of the premium adjustments. Every entity
 7 providing medicare supplement policies or certificates in
 8 this state shall annually file with the commissioner its
 9 rates, rating schedule, and supporting documentation
 10 demonstrating that it is in compliance with the applicable
 11 loss ratio standards of this part. An entity transacting
 12 medicare supplement insurance in this state may not adjust
 13 its rates more than once TWICE a year and may not adjust its
 14 rates for the first year a policy is in force, except to
 15 allow for changes in federal laws or regulations relating to
 16 medicare. Each filing of rates and rating schedules must
 17 demonstrate that the actual and expected losses in relation
 18 to premiums complies with the requirements of this part.

19 (4) An entity may not provide compensation to its
 20 agents or solicitors that is greater than the renewal
 21 compensation that would be paid on an existing policy if:

22 (a) the existing policy were replaced by another
 23 policy with the same insurer and the new policy benefits are
 24 substantially similar to the benefits under the old policy;
 25 and

1 (b) the old policy was issued by the same insurer or
2 insurance group."

3 Section 6. Section 33-22-907, MCA, is amended to read:

4 "33-22-907. Disclosure standards -- informational
5 brochure -- rules. (1) In order to provide for full and fair
6 disclosure in the sale of medicare supplement policies, a
7 medicare supplement policy may not be delivered or issued
8 for delivery in this state and a certificate may not be
9 delivered pursuant to a group medicare supplement policy
10 delivered or issued for delivery in this state unless an
11 outline of coverage is delivered to the applicant at the
12 time application is made. The outline of coverage must be
13 filed with the commissioner as required by 33-1-501. The
14 filing must be made at least 60 days in advance of the date
15 the outline of coverage is delivered to any resident of this
16 state.

17 (2) (a) The commissioner shall prescribe the format
18 and content of the outline of coverage required by
19 subsection (1).

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

24 (c) The outline of coverage must include:

25 (i) a description of the principal benefits and

1 coverage provided in the policy;

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

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

7 (iv) a statement that the outline of coverage is a
8 summary of the policy issued or applied for and that the
9 policy should be consulted to determine governing
10 contractual provisions.

11 (3) The commissioner may prescribe by rule a standard
12 form and the contents of an informational brochure for
13 persons eligible for medicare by reason of age, which is
14 intended to improve the buyer's ability to select the most
15 appropriate coverage and improve the buyer's understanding
16 of medicare. Except in the case of direct response
17 insurance policies, the commissioner may require by rule
18 that the information brochure be provided to any prospective
19 insureds eligible for medicare at the same time the outline
20 of coverage is delivered. With respect to direct response
21 insurance policies, the commissioner may require by rule
22 that the prescribed brochure be provided upon request, but
23 not later than the time of policy delivery, to any
24 prospective insureds eligible for medicare by reason of age.

25 (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 excepted in 33-22-903(4)(6).

(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.

(6) As soon as practicable, but no later than 30 days before the annual effective date of a medicare benefit change, every entity providing medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders, and certificate holders, in a format that the commissioner prescribes by rule, of the changes it has made to the medicare supplement insurance

policy or contract."

Section 7. Section 33-22-908, MCA, is amended to read:

"33-22-908. 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 certificate or attached thereto stating in substance that the applicant has the right to return the policy or certificate within 10 30 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. The insurer shall pay any refund made pursuant to this section directly to the applicant in a timely manner.

~~(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."~~

NEW SECTION. Section 8. Filing requirements for advertising. Every entity or representative providing medicare supplement insurance or benefits in this state shall provide to the commissioner for his review a copy of

1 any medicare supplement advertising intended for use in this
2 state, whether through written, radio, or television medium.

3 NEW SECTION. Section 9. Penalties. In addition to any
4 other penalties for violations of the insurance code, the
5 commissioner may after hearing require entities violating
6 any provision of or rule adopted under Title 33, chapter 16,
7 or this part to cease marketing a medicare supplement policy
8 or certificate in this state that is related directly or
9 indirectly to the violation or take such action as is
10 necessary to comply with the provisions of Title 33, chapter
11 16, or this part or the rules adopted under Title 33,
12 chapter 16, or this part, or both.

13 NEW SECTION. Section 10. Appropriation. There is
14 appropriated to the state auditor's office from the
15 insurance regulatory trust account \$25,891.00 for the fiscal
16 year ending June 30, 1990, and \$22,697.00 for the fiscal
17 year ending June 30, 1991, for one staff position to review
18 medicare supplement insurance advertising, assist with
19 preparation of the Medicare Supplement Insurance Buyer's
20 Guide, and monitor compliance with applicable federal
21 regulations.

22 NEW SECTION. Section 11. Extension of authority. Any
23 existing authority to make rules on the subject of the
24 provisions of [this act] is extended to the provisions of
25 [this act].

1 NEW SECTION. Section 12. Codification instruction.
2 [Sections 8 and 9] are intended to be codified as an
3 integral part of Title 33, chapter 22, part 9, and the
4 provisions of Title 33, chapter 22, part 9, apply to
5 [sections 8 and 9].

6 NEW SECTION. Section 13. Saving clause. [This act]
7 does not affect rights and duties that matured, penalties
8 that were incurred, or proceedings that were begun before
9 October 1, 1989.

10 NEW SECTION. Section 14. Severability. If a part of
11 [this act] is invalid, all valid parts that are severable
12 from the invalid part remain in effect. If a part of [this
13 act] is invalid in one or more of its applications, the part
14 remains in effect in all valid applications that are
15 severable from the invalid applications.

16 NEW SECTION. Section 15. Applicability. Except as
17 otherwise specifically provided, [this act] applies to every
18 medicare supplement policy and membership contract delivered
19 or issued for delivery in this state after October 1, 1989,
20 and every certificate delivered or issued for delivery in
21 this state after October 1, 1989.

22 NEW SECTION. Section 16. Effective date. [Section 11
23 and this section] are effective on passage and approval.

-End-

HOUSE BILL NO. 535

INTRODUCED BY J. BROWN, CONNELLY, COHEN,

SQUIRES, QUILICI, HARDING

A BILL FOR AN ACT ENTITLED: "AN ACT REVISING MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS TO COMPLY WITH THE FEDERAL MEDICARE CATASTROPHIC COVERAGE ACT OF 1988, P.L. 100-360; PROVIDING A PENALTY FOR VIOLATION OF MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS; APPROPRIATING MONEY TO THE STATE AUDITOR TO MONITOR COMPLIANCE; AMENDING SECTIONS 33-16-103 AND 33-22-903 THROUGH 33-22-908, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE FOR THE EXTENSION OF RULEMAKING AUTHORITY."

STATEMENT OF INTENT

A statement of intent is required for this bill because it authorizes the state commissioner of insurance to make and amend reasonable rules relating to specific standards that medicare supplement insurance policies or certificates must meet, minimum standards for benefits and claims payment, minimum standards for loss ratios, and the timing and manner of premium adjustments. The legislature intends that the rules that the commissioner adopts to implement this bill be designed to allow the commissioner to comply with the federal standards established by the Medicare

Catastrophic Coverage Act of 1988, P.L. 100-360.

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

Section 1. Section 33-16-103, MCA, is amended to read:

"33-16-103. Application. This chapter applies to all insurers and all kinds of insurance, except that nothing contained in this chapter ~~shall apply~~ applies to:

(1) life insurance;

(2) disability insurance, except medicare supplement insurance subject to the provisions of chapter 22, part 9;

(3) reinsurance, except joint reinsurance as provided in 33-16-307;

(4) insurance against loss of or damage to aircraft, their hulls, accessories, and equipment, or against liability, other than workers' compensation and employers' liability, arising out of the ownership, maintenance, or use of aircraft;

(5) insurance of vessels or craft, their cargoes, marine builders' risks, marine protection and indemnity, or other risks commonly insured under marine, as distinguished from inland marine, insurance policies."

Section 2. Section 33-22-903, MCA, is amended to read:

"33-22-903. Definitions. As used in this part, 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 delivered or issued for delivery in this state under a group medicare supplement policy that--has--been--delivered--or--issued--for delivery--in--this--state or subscriber contract.

(3) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that are analogous to incurred losses of an insurer;

(b) does not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs, or claims processing costs.

(4) "Entity" means an insurer as defined in 33-1-201, a health service corporation as defined in 33-30-101, and a health maintenance organization as defined in 33-31-102.

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

(6) "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 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

1 group or individual insurance when the group or individual
2 policy or contract includes provisions that are inconsistent
3 with the requirements of this part or policies issued to
4 employees or members as additions to franchise plans in
5 existence on April 8, 1981."

6 **Section 3.** Section 33-22-904, MCA, is amended to read:

7 "33-22-904. Standards for policy provisions -- rules.

8 (1) A medicare supplement insurance policy, contract, or
9 certificate in force in this state may not contain benefits
10 that duplicate benefits provided by medicare.

11 (2) The commissioner shall adopt reasonable rules
12 to establish specific standards for policy provisions of
13 medicare supplement policies and certificates. The standards
14 are in addition to and in accordance with applicable laws of
15 this state, including the provisions of Title 33, chapter
16 22, and may cover but are not limited to:

- 17 (a) terms of renewability;
- 18 (b) initial and subsequent conditions of eligibility;
- 19 (c) nonduplication of coverage;
- 20 (d) probationary periods;
- 21 (e) benefit limitations, exceptions, and reductions;
- 22 (f) elimination periods;
- 23 (g) requirements for replacement;
- 24 (h) recurrent conditions; and
- 25 (i) definitions of terms.

1 ~~(2)(3)~~ The commissioner may adopt reasonable rules
2 that prohibit policy provisions not otherwise specifically
3 authorized by statute that, in the opinion of the
4 commissioner, are unjust, unfair, or unfairly discriminatory
5 to any person insured or proposed for coverage under a
6 medicare supplement policy.

7 ~~(3)(4)~~ Notwithstanding any other provisions of the
8 law, a medicare supplement policy may not deny a claim for
9 losses incurred more than 6 months from the effective date
10 of coverage for a preexisting condition. The policy may not
11 define a preexisting condition more restrictively than a
12 condition for which medical advice was given or treatment
13 was recommended by or received from a physician within 6
14 months before the effective date of coverage."

15 **Section 4.** Section 33-22-905, MCA, is amended to read:

16 "33-22-905. Minimum standards for benefits and payment
17 of claims -- rules. The commissioner shall issue adopt
18 reasonable rules to establish minimum standards for benefits
19 and payment of claims for medicare supplement policies."

20 **Section 5.** Section 33-22-906, MCA, is amended to read:

21 "33-22-906. Loss ratio standards and filing
22 requirements -- limits on compensation. (1) Every entity
23 providing group medicare supplement insurance benefits to a
24 resident of this state shall file a copy of the master
25 policy and each certificate used in this state with the

commissioner as required by 33-1-501. The filing must be made not less than 60 days in advance of the delivery of any certificate or policy to a resident of this state.

(2) 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 or incurred health care expenses, where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, 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. Every entity providing medicare supplement insurance benefits to a resident of this state shall make premium adjustments:

(a) necessary to produce an expected loss ratio under the policy or contract that meets the minimum loss ratio standards for medicare supplement policies as established by rule; and

(b) expected to result in a loss ratio at least as great as that originally anticipated by the entity when it established current premiums for the medicare supplement insurance policy or contract.

(3) The commissioner shall by rule establish the timing and manner of the premium adjustments. Every entity providing medicare supplement policies or certificates in this state shall annually file with the commissioner its rates, rating schedule, and supporting documentation demonstrating that it is in compliance with the applicable loss ratio standards of this part. An entity transacting medicare supplement insurance in this state may not adjust its rates more than once twice a year and may not adjust its rates for the first year a policy is in force, except to allow for changes in federal laws or regulations relating to medicare. Each filing of rates and rating schedules must demonstrate that the actual and expected losses in relation to premiums complies with the requirements of this part.

(4) An entity may not provide compensation to its agents or solicitors that is greater than the renewal compensation that would be paid on an existing policy if:

(a) the existing policy were replaced by another policy with the same insurer and the new policy benefits are substantially similar to the benefits under the old policy; and

1 (b) the old policy was issued by the same insurer or
2 insurance group."

3 **Section 6.** Section 33-22-907, MCA, is amended to read:

4 **"33-22-907. Disclosure standards -- informational**
5 **brochure -- rules.** (1) In order to provide for full and fair
6 disclosure in the sale of medicare supplement policies, a
7 medicare supplement policy may not be delivered or issued
8 for delivery in this state and a certificate may not be
9 delivered pursuant to a group medicare supplement policy
10 delivered or issued for delivery in this state unless an
11 outline of coverage is delivered to the applicant at the
12 time application is made. The outline of coverage must be
13 filed with the commissioner as required by 33-1-501. The
14 filing must be made at least 60 days in advance of the date
15 the outline of coverage is delivered to any resident of this
16 state.

17 (2) (a) The commissioner shall prescribe the format
18 and content of the outline of coverage required by
19 subsection (1).

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

24 (c) The outline of coverage must include:

25 (i) a description of the principal benefits and

1 coverage provided in the policy;

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

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

7 (iv) a statement that the outline of coverage is a
8 summary of the policy issued or applied for and that the
9 policy should be consulted to determine governing
10 contractual provisions.

11 (3) The commissioner may prescribe by rule a standard
12 form and the contents of an informational brochure for
13 persons eligible for medicare by reason of age, which is
14 intended to improve the buyer's ability to select the most
15 appropriate coverage and improve the buyer's understanding
16 of medicare. Except in the case of direct response
17 insurance policies, the commissioner may require by rule
18 that the information brochure be provided to any prospective
19 insureds eligible for medicare at the same time the outline
20 of coverage is delivered. With respect to direct response
21 insurance policies, the commissioner may require by rule
22 that the prescribed brochure be provided upon request, but
23 not later than the time of policy delivery, to any
24 prospective insureds eligible for medicare by reason of age.

25 (4) The commissioner may adopt reasonable rules for

1 captions or notice requirements, determined to be in the
2 public interest and designed to inform prospective insureds
3 that particular insurance coverages are not medicare
4 supplement coverages, for all accident and sickness
5 insurance policies sold to persons eligible for medicare by
6 reason of age, other than:

7 (a) medicare supplement policies;

8 (b) disability income policies;

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

11 (d) single premium, nonrenewable policies; or

12 (e) other policies defined excepted in
13 33-22-903(4)(6).

14 (5) The commissioner may further adopt reasonable
15 rules to govern the full and fair disclosure of the
16 information in connection with the replacement of accident
17 and sickness policies, subscriber contracts, or certificates
18 by persons eligible for medicare by reason of age.

19 (6) As soon as practicable, but no later than 30 days
20 before the annual effective date of a medicare benefit
21 change, every entity providing medicare supplement insurance
22 or benefits to a resident of this state shall notify its
23 policyholders, contract holders, and certificate holders, in
24 a format that the commissioner prescribes by rule, of the
25 changes it has made to the medicare supplement insurance

1 policy or contract."

2 **Section 7.** Section 33-22-908, MCA, is amended to read:

3 "33-22-908. Notice of free examination. (1) Medicare
4 supplement policies or certificates, ~~other than those issued~~
5 ~~pursuant to direct response solicitation~~, must have a notice
6 prominently printed on the first page of the policy or
7 certificate or attached thereto stating in substance that
8 the applicant has the right to return the policy or
9 certificate within ~~10~~ 30 days of its delivery and to have
10 the premium refunded if, after examination of the policy or
11 certificate, the applicant is not satisfied for any reason.
12 The insurer shall pay any refund made pursuant to this
13 section directly to the applicant in a timely manner.

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 **NEW SECTION.** Section 8. Filing requirements for
23 advertising. Every entity or representative providing
24 medicare supplement insurance or benefits in this state
25 shall provide to the commissioner for his review a copy of

any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium.

NEW SECTION. Section 9. Penalties. In addition to any other penalties for violations of the insurance code, the commissioner may after hearing require entities violating any provision of or rule adopted under Title 33, chapter 16, or this part to cease marketing a medicare supplement policy or certificate in this state that is related directly or indirectly to the violation or take such action as is necessary to comply with the provisions of Title 33, chapter 16, or this part or the rules adopted under Title 33, chapter 16, or this part, or both.

NEW SECTION. Section 10. Appropriation. There is appropriated to the state auditor's office from the insurance regulatory trust account \$25,891.00 for the fiscal year ending June 30, 1990, and \$22,697.00 for the fiscal year ending June 30, 1991, for one staff position to review medicare supplement insurance advertising, assist with preparation of the Medicare Supplement Insurance Buyer's Guide, and monitor compliance with applicable federal regulations.

NEW SECTION. Section 11. Extension of authority. Any existing authority to make rules on the subject of the provisions of [this act] is extended to the provisions of [this act].

NEW SECTION. Section 12. Codification instruction.

[Sections 8 and 9] are intended to be codified as an integral part of Title 33, chapter 22, part 9, and the provisions of Title 33, chapter 22, part 9, apply to [sections 8 and 9].

NEW SECTION. Section 13. Saving clause. [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before October 1, 1989.

NEW SECTION. Section 14. 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.

NEW SECTION. Section 15. Applicability. Except as otherwise specifically provided, [this act] applies to every medicare supplement policy and membership contract delivered or issued for delivery in this state after October 1, 1989, and every certificate delivered or issued for delivery in this state after October 1, 1989.

NEW SECTION. Section 16. Effective date. [Section 11 and this section] are effective on passage and approval.

-End-