HOUSE BILL NO. 535

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

IN THE HOUSE

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| 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

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| 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

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| APRIL 18, 1989 | RECEIVED FROM SENATE. |
| | SENT TO ENROLLING. |
| | REPORTED CORRECTLY ENROLLED. |

HOUSE BILL NO. 535

INTRODUCED BY J. Brown Connelly

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



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HB535

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 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

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

insurance group."

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

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

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

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

(c) The outline of coverage must include:

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





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

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

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

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

(4) The commissioner may adopt reasonable rules for captions or notice requirements, determined to be in the

public interest and designed to inform prospective insureds that particular insurance coverages are not medicare supplement coverages, for all accident and sickness insurance policies sold to persons eligible for medicare by reason of age, other than:

(a) medicare supplement policies;

(b) disability income policies;

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

(d) single premium, nonrenewable policies; or

(e) other policies ~~defined~~ 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

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-

RE-REFFERED 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.

~~(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

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

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

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

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

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

(c) The outline of coverage must include:

(i) a description of the principal benefits and





coverage provided in the policy;

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

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

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

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

(4) The commissioner may adopt reasonable rules for

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

(a) medicare supplement policies;

(b) disability income policies;

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

(d) single premium, nonrenewable policies; or

(e) other policies ~~defined~~ 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 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-

RE-REFFERED 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:



SECOND READING
second printing
no change

(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

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

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

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

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

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

(c) The outline of coverage must include:

(i) a description of the principal benefits and





coverage provided in the policy;

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

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

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

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

(4) The commissioner may adopt reasonable rules for

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

(a) medicare supplement policies;

(b) disability income policies;

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

(d) single premium, nonrenewable policies; or

(e) other policies ~~defined~~ 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 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-

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:



THIRD READING

(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

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

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

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

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

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

(c) The outline of coverage must include:

(i) a description of the principal benefits and





coverage provided in the policy;

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

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

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

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

(4) The commissioner may adopt reasonable rules for

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

(a) medicare supplement policies;

(b) disability income policies;

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

(d) single premium, nonrenewable policies; or

(e) other policies ~~defined~~ 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 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.

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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

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

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

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

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

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

(c) The outline of coverage must include:

(i) a description of the principal benefits and





coverage provided in the policy;

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

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

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

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

(4) The commissioner may adopt reasonable rules for

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

(a) medicare supplement policies;

(b) disability income policies;

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

(d) single premium, nonrenewable policies; or

(e) other policies ~~defined~~ 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 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.

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