HOUSE BILL NO. 465

INTRODUCED BY RYAN, FRANKLIN, T. NELSON, BARNHART, SQUIRES, WILSON, JACOBSON, BRUSKI-MAUS, STANG, COBB, WELDON, DRISCOLL, YELLOWTAIL, ECK, BIRD, RYE, WANZENRIED, EWER, SCHYE, TOWE, BOHARSKI
BY REQUEST OF THE STATE AUDITOR

IN THE HOUSE

FEBRUARY 4, 1993	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & ECONOMIC DEVELOPMENT.
	FIRST READING.
FEBRUARY 19, 1993	COMMITTEE RECOMMEND BILL DO PASS. REPORT ADOPTED.
FEBRUARY 20, 1993	PRINTING REPORT.
	SECOND READING, DO PASS.
FEBRUARY 22, 1993	ENGROSSING REPORT.
FEBRUARY 23, 1993	THIRD READING, PASSED. AYES, 100; NOES, 0.
FEBRUARY 24, 1993	TRANSMITTED TO SENATE.

IN THE SENATE

MARCH 1, 1993	INTRODUCED AND REFERRED TO COMMITTEE ON BUSINESS & INDUSTRY.
	FIRST READING.
MARCH 10, 1993	COMMITTEE RECOMMEND BILL BE CONCURRED IN. REPORT ADOPTED.
MARCH 11, 1993	ON MOTION, CONSIDERATION PASSED FOR THE DAY.
MARCH 12, 1993	SECOND READING, CONCURRED IN.
MARCH 13, 1993	THIRD READING, CONCURRED IN. AYES, 47; NOES, 0.
	RETURNED TO HOUSE.

IN THE HOUSE

MARCH 15, 1993

RECEIVED FROM SENATE.

SENT TO ENROLLING.

REPORTED CORRECTLY ENROLLED.

House BILL NO. 465

INTRODUCED BY

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE LAWS RELATING TO MEDICARE SUPPLEMENT INSURANCE; REVISING MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS TO COMPLY WITH THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990, PUBLIC LAW 101-508; AMENDING SECTIONS 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-910, AND 33-22-911, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

Section 1. Section 33-22-902, MCA, is amended to read:

"33-22-902. Purpose. The purpose of this part is to establish minimum standards for medicare supplement ~~insurance~~ policies and certificates and to establish a regulatory program that meets the requirements of ~~Public Law 96-265, the Social Security Disability Amendments of 1980, approved June 9, 1980~~ 42 U.S.C. 1395ss(p)(1)(A)."

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 ~~or subscriber contract~~.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

~~(3)~~(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.

~~(4)~~(5) "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.

(6) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health

maintenance organizations, and any entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

~~(5)~~(7) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

~~(6)~~(8) "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of a health service corporation, other than a policy issued pursuant to a contract under 42 U.S.C. 13951 or 1395mm, or a policy issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act, 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 a combination ~~thereof~~ of employers, organizations, and trustees, for employees or former employees, or a combination ~~thereof~~ of current and former employees, or for members or former members, or a combination ~~thereof~~ of current and former members, 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)~~(b) 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.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer."

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. A requirement of this code relating to minimum required policy benefits, other than the minimum standards contained in this part, may not apply to 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 or certificate 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 or certificate.

(4) Notwithstanding any other provisions of the law, a medicare supplement policy or certificate may not ~~deny--a~~

~~claim~~ exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage ~~for~~ because it involved a preexisting condition. The policy or certificate 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.

(5) The commissioner may adopt rules necessary to conform medicare supplement policies and certificates to the requirements of federal law and federal regulations, including but not limited to rules:

(a) requiring refunds or credits if the policies or certificates do not meet loss requirements;

(b) establishing a uniform methodology for calculating and reporting loss ratios;

(c) ensuring public access to policies, premiums, and loss ratio information of issuers of medicare supplement insurance;

(d) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases; and

(e) establishing a policy for holding public hearings prior to approval of premium increases."

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 adopt reasonable rules to establish minimum standards for benefits, ~~and~~ payment of claims, marketing practices, compensation arrangements, and reporting practices for medicare supplement policies and certificates."

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)~~(1) Medicare supplement policies and certificates ~~are expected to~~ must return to policyholders or certificate holders 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 and certificates 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 and certificates issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, ~~shall~~ must be treated as ~~individual~~ group 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~~ certificate that meets the minimum loss ratio standards for medicare supplement policies and certificates 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~~ certificate.

~~(3)~~(2) 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 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)~~(3) An entity may not provide compensation to its insurance producers that is greater than the renewal compensation that would be paid on an existing policy or certificate if:

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

(b) the old policy or certificate 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 and certificates, 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 or certificate;

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

(iii) a statement of the renewal provisions including any reservation by the ~~insurer~~ issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(iv) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate 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 or certificates;

(b) disability income policies;

(c) basic, catastrophic, or major medical expense

policies;

(d) single premium, nonrenewable policies; or

(e) other policies excepted in 33-22-903~~(6)~~(8).

(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~~ certificate."

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

"33-22-908. Notice of free examination. Medicare supplement policies ~~or~~ and certificates must have a notice prominently printed on the first page of the policy or certificate or attached ~~thereto~~ to the policy or certificate 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 of the policy or certificate, the applicant is

not satisfied for any reason. The ~~insurer~~ issuer shall pay any refund made pursuant to this section directly to the applicant in a timely manner."

Section 8. Section 33-22-910, MCA, is amended to read:

"33-22-910. Filing requirements for advertising. Every ~~entity providing~~ issuer of medicare supplement ~~insurance--or benefits~~ policies or certificates in this state shall provide to the commissioner for ~~his~~ the commissioner's review or approval a copy of any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium."

Section 9. Section 33-22-911, MCA, is amended to read:

"33-22-911. Penalties. In addition to any other penalties for violations of the insurance code, the commissioner may after hearing require ~~entities~~ issuers 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 that 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.** 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 11.** Effective date. [This act] is effective on passage and approval.

-End-

APPROVED BY COMM. ON BUSINESS AND ECONOMIC DEVELOPMENT

House BILL NO. 465

INTRODUCED BY

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE LAWS RELATING TO MEDICARE SUPPLEMENT INSURANCE; REVISING MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS TO COMPLY WITH THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990, PUBLIC LAW 101-508; AMENDING SECTIONS 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-910, AND 33-22-911, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

Section 1. Section 33-22-902, MCA, is amended to read:

"33-22-902. Purpose. The purpose of this part is to establish minimum standards for medicare supplement ~~insurance~~ policies and certificates and to establish a regulatory program that meets the requirements of ~~Public Law 96-265, the Social Security Disability Amendments of 1980, approved June 9, 1980~~ 42 U.S.C. 1395ss(p)(1)(A)."

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 ~~or subscriber contract~~.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

~~(3)~~(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.

~~(4)~~(5) "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.

(6) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health

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maintenance organizations, and any entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

~~(5)~~(7) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

~~(6)~~(8) "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of a health service corporation, other than a policy issued pursuant to a contract under 42 U.S.C. 13951 or 1395mm, or a policy issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act, 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 a combination ~~thereof~~ of employers, organizations, and trustees, for employees or former employees, or a combination ~~thereof~~ of current and former employees, or for members or former members, or a combination ~~thereof~~ of current and former members, 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)~~(b) 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.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer."

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, ~~or 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. A requirement of this code relating to minimum required policy benefits, other than the minimum standards contained in this part, may not apply to 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 or certificate 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 or certificate.

(4) Notwithstanding any other provisions of the law, a medicare supplement policy or certificate may not ~~deny--a~~

~~claim~~ exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage ~~for~~ because it involved a preexisting condition. The policy or certificate 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.

(5) The commissioner may adopt rules necessary to conform medicare supplement policies and certificates to the requirements of federal law and federal regulations, including but not limited to rules:

(a) requiring refunds or credits if the policies or certificates do not meet loss requirements;

(b) establishing a uniform methodology for calculating and reporting loss ratios;

(c) ensuring public access to policies, premiums, and loss ratio information of issuers of medicare supplement insurance;

(d) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases; and

(e) establishing a policy for holding public hearings prior to approval of premium increases."

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 adopt reasonable rules to establish minimum standards for benefits, and payment of claims, marketing practices, compensation arrangements, and reporting practices for medicare supplement policies and certificates."

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)~~(1) Medicare supplement policies and certificates ~~are expected to~~ must return to policyholders or certificate holders 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 and certificates 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 and certificates issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, ~~shall~~ must be treated as ~~individual~~ group 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~~ certificate that meets the minimum loss ratio standards for medicare supplement policies and certificates 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~~ certificate.

~~(3)~~(2) 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 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)~~(3) An entity may not provide compensation to its insurance producers that is greater than the renewal compensation that would be paid on an existing policy or certificate if:

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

(b) the old policy or certificate 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 and certificates, 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 or certificate;

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

(iii) a statement of the renewal provisions including any reservation by the ~~insurer~~ issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(iv) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate 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 or certificates;

(b) disability income policies;

(c) basic, catastrophic, or major medical expense

policies;

(d) single premium, nonrenewable policies; or

(e) other policies excepted in 33-22-903~~(6)~~(8).

(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~~ certificate."

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

"33-22-908. Notice of free examination. Medicare supplement policies ~~or~~ and certificates must have a notice prominently printed on the first page of the policy or certificate or attached ~~thereto~~ to the policy or certificate 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 of the policy or certificate, the applicant is

not satisfied for any reason. The ~~insurer~~ issuer shall pay any refund made pursuant to this section directly to the applicant in a timely manner."

Section 8. Section 33-22-910, MCA, is amended to read:

"33-22-910. Filing requirements for advertising. Every ~~entity providing~~ issuer of medicare supplement ~~insurance or benefits~~ policies or certificates in this state shall provide to the commissioner for ~~his~~ the commissioner's review or approval a copy of any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium."

Section 9. Section 33-22-911, MCA, is amended to read:

"33-22-911. Penalties. In addition to any other penalties for violations of the insurance code, the commissioner may after hearing require ~~entities~~ issuers 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 that 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.** 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 11.** Effective date. [This act] is effective on passage and approval.

-End-

House BILL NO. 465

INTRODUCED BY [signatures]

BY REQUEST OF THE STATE AUDITOR

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING THE LAWS RELATING TO MEDICARE SUPPLEMENT INSURANCE; REVISING MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS TO COMPLY WITH THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990, PUBLIC LAW 101-508; AMENDING SECTIONS 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-910, AND 33-22-911, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

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

Section 1. Section 33-22-902, MCA, is amended to read:

"33-22-902. Purpose. The purpose of this part is to establish minimum standards for medicare supplement ~~insurance~~ policies and certificates and to establish a regulatory program that meets the requirements of ~~Public Law 96-265, the Social Security Disability Amendments of 1980, approved June 9, 1980~~ 42 U.S.C. 1395ss(p)(1)(A)."

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 ~~or subscriber contract~~.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

~~(3)~~(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.

~~(4)~~(5) "Health care expenses":

(a) means expenses of a health maintenance organization associated with the delivery of health care services that

THERE ARE NO CHANGES IN THIS BILL AND WILL NOT BE REPRINTED. PLEASE REFER TO YELLOW COPY FOR COMPLETE TEXT.

HB 465
THIRD READING

HOUSE BILL NO. 465

INTRODUCED BY RYAN, FRANKLIN, T. NELSON, BARNHART, SQUIRES, WILSON, JACOBSON, BRUSKIE-MAUS, STANG, COBB, WELDON, DRISCOLL, YELLOWTAIL, ECK, BIRD, RYE, WANZENRIED, EWER, SCHYE, TOWE, BOHARSKI

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(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

~~(3)~~(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.

~~(4)~~(5) "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.

(6) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any entity delivering or issuing for delivery in this state medicare supplement policies or certificates.

~~(5)~~(7) "Medicare" means Health Insurance for the Aged, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

~~(6)~~(8) "Medicare supplement policy" means a group or individual policy of disability insurance or a subscriber contract of a health service corporation, other than a policy issued pursuant to a contract under 42 U.S.C. 1395l or 1395mm, or a policy issued under a demonstration project authorized pursuant to amendments to the federal Social Security Act, 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 a combination ~~thereof~~ of employers, organizations, and trustees, for employees or former employees, or a

combination ~~thereof~~ of current and former employees, or for members or former members, or a combination ~~thereof~~ of current and former members, 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)~~(b) 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.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer."

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. A requirement of this code relating to minimum required policy benefits, other than the minimum standards contained in this part, may not apply to 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 or certificate 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 or certificate.

(4) Notwithstanding any other provisions of the law, a medicare supplement policy or certificate may not ~~deny--a claim~~ exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage ~~for~~ because it involved a preexisting condition. The policy or certificate 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.

(5) The commissioner may adopt rules necessary to conform medicare supplement policies and certificates to the requirements of federal law and federal regulations, including but not limited to rules:

(a) requiring refunds or credits if the policies or certificates do not meet loss requirements;

(b) establishing a uniform methodology for calculating and reporting loss ratios;

(c) ensuring public access to policies, premiums, and loss ratio information of issuers of medicare supplement insurance;

(d) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases; and

(e) establishing a policy for holding public hearings prior to approval of premium increases."

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 adopt reasonable rules to establish minimum standards for benefits, and payment of claims, marketing practices, compensation arrangements, and reporting practices for medicare supplement policies and certificates."

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)~~(1) Medicare supplement policies and certificates ~~are expected to~~ must return to policyholders or certificate holders 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 and certificates 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 and certificates issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, ~~shall~~ must be treated as ~~individual~~ group 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~~ certificate that meets the minimum loss ratio standards for medicare supplement policies and certificates 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~~ certificate.

~~(3)~~(2) 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 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)~~(3) An entity may not provide compensation to its insurance producers that is greater than the renewal compensation that would be paid on an existing policy or certificate if:

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

(b) the old policy or certificate 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 and certificates, 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 or certificate;

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

(iii) a statement of the renewal provisions including any reservation by the ~~insurer~~ issuer of a right to change premiums and disclosure of the existence of any automatic renewal premium increases based on the policyholder's or certificate holder's age;

(iv) a statement that the outline of coverage is a summary of the policy or certificate issued or applied for and that the policy or certificate 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 or certificates;

(b) disability income policies;

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

(d) single premium, nonrenewable policies; or

(e) other policies excepted in 33-22-903~~(6)~~(8).

(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~~ certificate."

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

"33-22-908. Notice of free examination. Medicare supplement policies ~~or~~ and certificates must have a notice prominently printed on the first page of the policy or certificate or attached ~~thereto~~ to the policy or certificate 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 of the policy or certificate, the applicant is not satisfied for any reason. The ~~insurer~~ issuer shall pay any refund made pursuant to this section directly to the applicant in a timely manner."

Section 8. Section 33-22-910, MCA, is amended to read:

"**33-22-910. Filing requirements for advertising.** Every ~~entity providing~~ issuer of medicare supplement ~~insurance or benefits~~ policies or certificates in this state shall provide to the commissioner for ~~his~~ the commissioner's review or approval a copy of any medicare supplement advertising intended for use in this state, whether through written, radio, or television medium."

Section 9. Section 33-22-911, MCA, is amended to read:

"**33-22-911. Penalties.** In addition to any other penalties for violations of the insurance code, the commissioner may after hearing require ~~entities~~ issuers 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~~ that 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.** **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 11.** **Effective date.** [This act] is effective on passage and approval.

-End-