MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS MODEL ACT

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Section 1. Definitions

A. "Applicant" means:

(1) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(2) In the case of a group Medicare supplement policy, the proposed certificateholder.

B. "Certificate" means, for the purposes of this Act, any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

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

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

Drafting Note: It is intended that nonprofit hospital and medical service associations be subject to this model act. In those states where such associations are prohibited from issuing subscriber contracts that include all of the benefits required by Section 3 of this Act, they shall include so much of those benefits as are permitted and they shall be issued in conjunction with another contract including at least the remainder of the minimum benefits required. In such event, the combination of contracts will be considered to have been issued in compliance with Section 3 of this Act.

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

F. "Medicare supplement policy" means a group or individual policy of [accident and sickness] insurance or a subscriber contract [of hospital and medical service associations or health maintenance organizations], other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et. seq.), or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), which 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.

Drafting Note: OBRA 1990 contained an exception from this definition for policies issued pursuant to an agreement under Section 1833 (42 U.S.C. 1395l) of the federal Social Security Act. The Social Security Act Amendments of 1994 eliminated the exemption for Section 1833 plans effective December 31, 1995. These plans, commonly know as health care prepayment plans (HCPPs), arrange for certain Part B services on a pre-paid basis. The federal law continues to authorize HCPP agreements. However, since they are now included in the federal definition of a Medicare supplement policy, HCPPs are subject to the requirements of this model, unless they are exempt under Section 2B. In states authorized for the Medicare Select program, these plans may be able to comply with Medicare supplement requirements.

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

Section 2. Applicability and Scope

A. Except as otherwise specifically provided this Act shall apply to:

(1) All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this Act, and

(2) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

B. This Act shall not apply to a policy 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 a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

C. Except as otherwise specifically provided in section 5D, the provisions of this Act are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons when the policies are not marketed or held to be Medicare supplement policies or benefit plans.

Section 3. Standards for Policy Provisions and Authority to Promulgate Regulations

A. No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.

B. Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate shall not exclude or limit benefits for loss incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall 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 six (6) months before the effective date of coverage.

C. The commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates. The standards shall be in addition to and in accordance with applicable laws of this state, including Sections [insert the applicable statutory reference, if any, to the NAIC Uniform Accident and Sickness Policy Provision Law]. No requirement of the Insurance Code relating to minimum required policy benefits, other than the minimum standards contained in this Act, shall apply to Medicare supplement policies and certificates. The standards may cover, but not be limited to:

Drafting Note: Wherever the term "commissioner" appears, the title of the chief insurance regulatory official of the state should be inserted.

(1) Terms of renewability;

(2) Initial and subsequent conditions of eligibility;

(3) Nonduplication of coverage;

(4) Probationary periods;

(5) Benefit limitations, exceptions and reductions;

(6) Elimination periods;

(7) Requirements for replacement;

(8) Recurrent conditions; and

(9) Definitions of terms.

D. The commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements and reporting practices, for Medicare supplement policies and certificates.

E. The commissioner may adopt from time to time reasonable regulations necessary to confirm Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including but not limited to:

(1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

(2) Establishing a uniform methodology for calculating and reporting loss ratios;

(3) Assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance;

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

(5) Establishing a policy for holding public hearings prior to approval of premium increases; and

(6) Establishing standards for Medicare Select policies and certificates.

F. The commissioner may adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

Drafting Note: Each state should examine its statutory authority to promulgate regulations and revise this section accordingly so that sufficient rulemaking authority is present and that unnecessary duplication of unfair practice provisions does not occur.

Section 4. Loss Ratio Standards

Medicare supplement policies shall return to policyholders' benefits which are reasonable in relation to the premium charged. The commissioner shall issue reasonable regulations 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 in accordance with accepted actuarial principles and practices.

Section 5. Disclosure Standards

A. In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

B. The commissioner shall prescribe the format and content of the outline of coverage required by Subsection A. For purposes of this section, "format" means style, arrangements and overall appearance, including such items as the size, color and prominence of type and arrangement of text and captions. The outline of coverage shall include:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age.

(3) 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.

C. The commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for Medicare, 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 regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

D. The commissioner may adopt regulations 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, other than:

(1) Medicare supplement policies; or

(2) Disability income policies.

E. The commissioner may adopt reasonable regulations 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.

Section 6. Notice of Free Examination

Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (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. A refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

Section 7. Filing Requirements for Advertising

Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the Commissioner of Insurance of this state for review or approval by the commissioner to the extent it may be required under state law.

Drafting Note: States should examine their existing laws regarding the filing of advertisements to determine the extent to which review or approval is required.

Section 8. Administrative Procedures

Regulations adopted pursuant to this Act shall be subject to the provisions of [cite section of state insurance code relating to the adoption and promulgation of rules and regulations or cite the state's administrative procedures act, if applicable].

Section 9. Penalties

In addition to any other applicable penalties for violations of the Insurance Code, the commissioner may require issuers violating any provision of this Act or regulations promulgated pursuant to this Act to cease marketing any Medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require the issuer to take actions necessary to comply with the provisions of this Act, or both.

Section 10. Separability

If any provision of this Act or the application of it to any person or circumstances is for any reason held to be invalid, the remainder of the Act and the application of the provision to other persons or circumstances shall not be affected.

Section 11. Effective Date

The Act shall be effective on [insert date].

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Chronological Summary of Actions (all references are to the Proceedings of the NAIC).

1980 Proc. II 22, 26, 588, 591, 593, 603-605 (adopted).
1981 Proc. I 47, 51, 420, 424, 446, 453-456 (amended and reprinted).
1988 Proc. I 9, 20-21, 629-630, 652-654, 665-668 (amended and reprinted).
1988 Proc. II 5, 13, 568, 601, 604, 624-626 (amended and reprinted).
1989 Proc. I 14, 813-814, 836.1-836.4 (amended at special plenary session September 1988).
1990 Proc. I 6, 27-28, 477, 574-575, 577-580 (amended and reprinted).
1992 Proc. I 12, 12-16, 1085 (amended at special plenary in July 1991).
1995 Proc. 1st Quarter 7, 12, 501, 575, 586, 588-591 (amended and reprinted).