L.D. 455

(Filing No. S-120)

STATE OF MAINE
SENATE
110TH LEGISLATURE
FIRST REGULAR SESSION

COMMITTEE AMENDMENT " A" to S.P. 175, L.D. 455, Bill, "AN ACT to Establish Minimum Standards for Medicare Supplement Insurance Policies."

Amend the Bill by striking out everything after the enacting clause and inserting in its place the following:

'Sec. 1. 24 MRSA §2328 is enacted to read:

§2328. Health care contracts; supplementing Medicare; compliance with provisions of Title 24-A, chapter 67

Every nonprofit hospital or medical service organization or nonprofit health care plan which issues group or individual health care contracts which are designed primarily to supplement coverage provided to residents of this State under the "United States Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, Public Law 89-97, as amended, shall be subject to the requirements of Title 24-A, chapter 67, and any rules promulgated by the superintendent under that chapter. Any such requirements shall be in addition to any requirements of this Title.

Sec. 2. 24-A MRSA §2413, sub-§1, ¶E, as enacted by PL 1969, c. 132, §1, is amended to read:

E. As to a life insurance or health insurance policy, if it contains a provision or provisions such as to encourage misrepresentation ; or

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COMMITTEE AMENDMENT " A" to S.P. 175, L.D. 455 Pg. 1-A

Sec. 3 24-A MRSA §2413, sub-§1, ¶F is enacted to read:

F. As to Medicare supplement policies or contracts, as defined in chapter 67, if the policy cannot be anticipated, as estimated for the entire period for which rates are to be computed to provide coverage, on the basis of incurred claims experience and earned premiums for that period and in accordance with accepted actuarial principles and practices, to return to policyholders in

the form of aggregate benefits provided under the policy at least 60% of the aggregate amount of premiums collected in the case of individual policies and at least 75% of the aggregate amount of premiums collected in the case of group policies.

Sec. 4. 24-A MRSA c. 67 is enacted to read:

CHAPTER 67

MEDICARE SUPPLEMENT INSURANCE POLICIES

§5001. Definitions

As used in this chapter, unless the context otherwise indicates, the following terms have the following meanings.

1. Applicant. "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 certificateholder.

2. Certificate. "Certificate" means any certificate issued under a group Medicare supplement policy, which policy has been delivered or issued for delivery in this State.

3. Medicare. "Medicare" means the "United States Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, Public Law 89-97, as amended.

4. Medicare Supplement Policy. "Medicare Supplement Policy" means a group or individual policy of health insurance or a subscriber contract of a nonprofit hospital or medical service or-

ganization or nonprofit health care plan which is advertised, marketed or designed primarily as a supplement to reimbursements made under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age. Such term does not include:

A. A policy or contract issued to 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, or for members or former members, or combination thereof, of the labor organizations;

B. A policy or contract issued to any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:

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

(2) Has been maintained in good faith for purposes other than obtaining insurance; and

(3) Has been in existence for at least 2 years prior to the date of its initial offering of such policy or plan to its members; or

C. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this chapter.

5. Superintendent. "Superintendent" means the Superintendent of Insurance.

§5002. Standards for Policy Provisions

1. Specific Standards. The superintendent shall issue rules to establish specific standards for policy provisions of Medicare supplement policies. The standards shall be in addition to and in accordance with applicable laws of this State, including chapter 33, and may include, 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, which shall not include those which are more restrictive than those of Medicare for any type of care covered under the policy;

F. Elimination periods;

G. Requirements for replacement;

H. Recurrent conditions; and

I. Definitions of terms.

2. Prohibited policy provisions. The superintendent may issue reasonable rules that specify prohibited provisions not otherwise specifically authorized by statute which in the opinion of the superintendent are unjust, unfair, inequitable or unfairly discriminatory to any person insured or proposed for coverage under a Medicare supplement policy.

§5003. Minimum standards for benefits

1. Issuance of rules. The superintendent shall issue reasonable rules to establish minimum standards for benefits under Medicare supplement policies and contracts.

2. Other policies not prohibited. Nothing in this section may be construed to prohibit the sale of insurance policies or contracts to persons eligible for Medicare by reason of age because those policies or contracts fail to meet the requirements of this chapter. Such policies may not <----> be advertised, marketed or designed as Medicare supplement policies.

3. Method of identification.

A. The superintendent shall prescribe the method of identification of Medicare supplement policies.

B. The superintendent shall <----> prescribe a method of identification of health insurance policies, other than Medicare supplement policies or contracts, which are advertised, marketed or designed for persons eligible for Medicare by reason of age. Such method may include, but is not limited to, a requirement that such policies clearly indicate they are limited benefit health coverage policies and clearly specify that they do not meet the minimum standards for Medicare supplement policies.

§5004. Medicare supplement policy rates

Any Medicare supplement policy or contract is subject to the minimum loss ratio standards of section 2413, subsection 1, paragraph F, as well as any other laws of this State as apply to rate filings with respect to health insurance and nonprofit hos-

pital and medical service organizations and nonprofit health care plan contracts.

§5005. Disclosure standards

1. Delivery of outline of coverage. In order to provide for full and fair disclosure in the sale of Medicare supplement policies and contracts, no such policy or contract may be delivered or issued for delivery in this State, unless the outline of coverage described in subsection 2 is delivered to the applicant at the time application is made.

2. Format; content or outline. The superintendent shall prescribe a uniform format and content of the outline of coverage required by subsection 1. 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. The outline of coverage shall include:

A. A description of the principal benefits and coverage provided in the policy;

B. A statement of the exceptions, reductions and limitations contained in the policy;

C. A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums; and

D. 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. Standard form; contents of informational brochure. The superintendent 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 superintendent may require by regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with the delivery of the outline of coverage. With respect to direct response insurance policies, the superintendent may require by rule that the prescribed brochure must be provided to any prospective insureds eligible for Medicare by reason of age upon request, but in no event later than the time of policy delivery.

4. Rules. The superintendent may promulgate reasonable rules to govern the full and fair disclosure of information in connection with the replacement of Medicare supplement policies and contracts.

§5006. Preexisting conditions

Notwithstanding section 2706, subsection 2, no insurer, nonprofit hospital, medical service organization or nonprofit health care plan may deny a claim arising under a Medicare supplement policy or contract for losses incurred more than six months from the effective date of coverage on the basis of 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

STATEMENT OF FACT

The Bill's Statement of Fact remains applicable in general, but this amendment makes the following specific changes:

1. Makes group as well as individual health care contracts issued by nonprofit hospital or medical service organizations subject to the Medicare supplement provisions applicable to group and individual health policies issued by private insurers;

2. Requires group Medicare Supplement policies to meet a 75% loss ratio standard and individual policies to meet a 60% loss ratio standard;

3. Adds certain definitions and broadens "Medicare Supplement Policy" to include group policies;

4. Bars the Superintendent of Insurance from adopting rules concerning preexisting conditions;

5. Removes from the Bill's application policies issued under a conversion privilege;

6. Makes clear that policies failing to meet minimum standards for Medicare Supplement policies are not prohibited, but merely may not be sold as such;

7. Requires the Superintendent of Insurance to adopt rules for identifying Medicare Supplement policies and other health policies designed for persons eligible for Medicare;

8. Requires the Superintendent of Insurance to prescribe uniform format and content for the outline of coverage;

9. Authorizes the Superintendent of Insurance to adopt rules concerning disclosure of information concerning replacement of Medicare Supplement policies; and

10. Permits insurers to use preexisting conditions provisions less restrictive than those prescribed in the bill.

Reported by the Committee on Business Legislation.

Reproduced and distributed pursuant to Senate Rule 11-A.

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