MEDICARE SUPPLEMENT INSURANCE ACT

Act of Dec. 15, 1982, P.L. 1291, No. 292 Cl. 40

AN ACT

To provide for the reasonable standardization and minimum loss ratios of coverage and simplification of terms and benefits of group medicare supplement accident and health insurance policies or group subscriber contracts of health plan corporations and nonprofit health service plans; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase thereof or with the settlement of claims; and to provide for full disclosure in the sale of such coverages to persons eligible for medicare by reason of age.

TABLE OF CONTENTS

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Short title.

This act shall be known and may be cited as the "Medicare Supplement Insurance Act."

Section 2. Definitions.

The following words and phrases when used in this act shall have, unless the context clearly indicates otherwise, the meanings given to them in this section:

"Applicant." The proposed certificate holder under a group medicare supplement policy or subscriber contract.

"Certificate." A certificate issued under a group medicare supplement policy, which policy has been delivered, or issued for delivery, in this Commonwealth.

"Medicare." The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

"Medicare supplement policy." A group policy of accident and health insurance or group subscriber contract of health plan corporations and nonprofit health service plans delivered or issued for delivery in this Commonwealth which is advertised, marketed or designed primarily to supplement coverage for the hospital, medical or surgical expenses of persons eligible for medicare by reason of age. This term does not include:

(1) 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

(2) a policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such 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 two years prior to the date of its initial offering of such policy or plan to its members.

Section 3. Definitions in medicare supplement policies.

As used in any medicare supplement policy issued under this act:

(1) "Accident," "accidental injury," "accidental means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. The definition shall not be more restrictive than the following: injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause and occurrence while the insurance is in force. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment or occupation for wage or profit.

(2) "Convalescent nursing home," "extended care facility" or "skilled nursing facility" shall be defined in relation to its status, facilities and available services; and:

(i) a definition of such home or facility shall not be more restrictive than one requiring that it:

(A) be operated pursuant to law;

(B) be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(C) provide continuous 24-hour a day nursing service by or under the supervision of a registered graduate professional nurse; and

(D) maintain a daily medical record of each patient.

(ii) the definition of such home or facility may provide that such term shall not include:

(A) any home, facility or part thereof used primarily for rest;

(B) a home or facility for the aged or for the care of drug addicts or alcoholics; or

(C) a home or facility primarily used for the care and treatment of mental diseases or disorders or custodial or educational care.

(3) "Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of

Hospitals or the American Osteopathic Association: Provided, That:

(i) the definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(A) be an institution operated pursuant to law;

(B) be primarily and continuously engaged in providing the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

(C) provide 24-hour nursing service by or under the supervision of registered graduate professional nurses.

(ii) the definition of the term "hospital" may state that such term shall not include:

(A) convalescent homes, convalescent, rest or nursing facilities;

(B) facilities primarily affording custodial, educational care;

(C) facilities for the aged, drug addicts or alcoholics; or

(D) any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(4) "Mental or nervous disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

(5) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as a registered graduate professional nurse, a licensed practical nurse or a licensed vocational nurse. If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the Commonwealth.

(6) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(7) "Sickness" shall not be defined to be more restrictive than the following: sickness means sickness or disease of an insured person which is diagnosed or treated after the effective date of insurance and while the insurance is in force. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

Section 4. Prohibited policy provisions.

No medicare supplement policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition except to the extent they are excluded or limited by medicare. Such policies may exclude coverage for any expense to the extent of any benefit available to the insured under medicare.

Section 5. Minimum benefit standards.

No policy shall be filed with the department as a medicare supplement policy unless the policy meets or exceeds, either in a single policy or, in the case of health plan corporations and nonprofit health service plans, in one or more policies issued in conjunction with one another, the requirements of the NAIC Model Regulation to Implement the Individual Accident and Sickness Insurance Minimum Standards Act, as adopted by the National Association of Insurance Commissioners on June 6, 1979, as it applies to medicare supplement policies. At least the following provisions and benefits shall be provided in such policy:

(1) A medicare supplement policy may not exclude losses incurred more than six 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 six months prior to the effective date of coverage.

(2) The term "medicare benefit period" shall mean the unit of time used in the medicare program to measure use of services and availability of benefits under Part A, medical hospital insurance.

(3) The term "medicare eligible expenses" shall mean health care expenses of the kinds covered by medicare to the extent recognized as reasonable by medicare. Payment of benefits by insurers for medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to medicare claims.

(4) (i) Coverage shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(ii) Coverage shall provide that benefits designed to cover cost sharing amounts under medicare shall be changed automatically to coincide with any changes in the applicable medicare deductible amount and copayment percentage factors. Premiums may be changed to correspond with such changes.

(5) The medicare supplement policy must include:

(i) Coverage of Part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the 61st day through the 90th day in any medicare benefit period.

(ii) Coverage of Part A medicare eligible expenses incurred as daily hospital charges during use of medicare's lifetime hospital inpatient reserve days.

(iii) Upon exhaustion of all medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all medicare Part A eligible expenses for hospitalization not covered by medicare subject to a lifetime maximum benefit of an additional 365 days.

(iv) Coverage of 20% of the amount of medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of $200 of such expenses and to a maximum benefit of at least $5,000 per calendar year.

(6) (i) Insurers which made available within the Commonwealth of Pennsylvania any medicare supplement policy subject to this act shall also simultaneously offer to the same prospective insured persons an

additional benefit plan medicare supplement coverage which both conforms to the terms and conditions of section 4 and which also provides at least the following coverages:

(A) the initial Part A deductible;

(B) skilled nursing home charges incurred in addition to those covered by medicare; and

(C) coverage of 20% of eligible expenses incurred under Part B of medicare in excess of the deductible amount applied to such expenses by medicare.

(ii) Such offer shall be given prominence in any solicitation of the medicare supplement policy benefits described in section 5 and shall provide the prospective insured the opportunity to simultaneously enroll or apply for the additional benefit plan medicare supplement coverage. The description of the additional benefit plan medicare supplement coverage shall include a statement of the coverages, the premium charges, and any additional applicable exclusions and limitations permitted for the additional benefit plan medicare supplement coverage.

(iii) Such additional benefit plan coverage, if elected by the prospective insured person, shall take effect no later than 15 days following the effective date which applies to medicare supplement coverage described in section 5.

Section 6. Loss ratio standards.

Medicare supplement policies shall be expected to return to policyholders in the form of aggregate benefits under the policy, as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period, and in accordance with accepted actuarial principles and practices:

(1) at least 75% of the aggregate amount of premiums collected; and

(2) at least 60% of the aggregate amount of premiums collected in the case of certificates issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising.

Section 7. Required disclosure provisions.

(a) Each medicare supplement policy shall include a renewal, continuation, or nonrenewal provision. The language or specifications of such provision must be consistent with the type of contract to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the certificate, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(b) A medicare supplement policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import, shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.

(c) If a medicare supplement policy contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the certificate and be labeled as "Preexisting Condition Limitations."

(d) Certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the certificate or attached thereto stating

in substance that the certificate holder shall have the right to return the certificate within ten days of its delivery and to have the premium refunded if, after examination of the certificate, the insured person is not satisfied for any reason. Medicare supplement certificates issued pursuant to a direct response solicitation to persons eligible for medicare by reason of age shall have a notice prominently printed on the first page, or attached thereto, stating in substance that the certificate holder shall have the right to return the certificate within 30 days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(e) Insurers issuing accident and health certificates under group policies delivered or issued for delivery in this Commonwealth which provide hospital or medical expense coverage on an expense incurred or indemnity basis other than incidentally, to a person eligible for medicare by reason of age, shall provide to the certificate holder a medicare supplement buyer's guide in the form consistent with the then current edition of the model jointly developed by the National Association of Insurance Commissioners and the Health Care Financing Administration of the United States Department of Health and Human Services. Delivery of the buyer's guide shall be made whether or not such group policy qualifies as a medicare supplement policy as defined in this act. Except in the case of direct response insurers, delivery of the buyer's guide shall be made at the time of application, and acknowledgment of receipt of certification of delivery of the buyer's guide shall be provided to the insurer. Direct response insurers issuing medicare supplement policies shall deliver the buyer's guide upon request, but not later than at the time the certificate is delivered.

(f) The terms "medicare supplement," "medigap" and words of similar import shall not be used unless the policy is issued in compliance with section 5.

(g) (1) Insurers issuing medicare supplement policies subject to this act shall deliver an outline of coverage to the applicant at the time application is made and, except for the direct response policy, acknowledgment of receipt or certification of delivery of such outline of coverage shall be provided to the insurer.

(2) If an outline of coverage was delivered at the time of application and the certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the certificate shall accompany such certificate when it is delivered and shall contain the following statement, in no less than 12-point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(3) The outline of coverage required under this subsection shall be in a form consistent with the then current model adopted by the National Association of Insurance Commissioners and amended to reflect changes in the medicare program.

Section 8. Requirements for replacement.

(a) Application or enrollment forms shall include a question designed to elicit information as to whether a certificate to be issued under a medicare supplement policy is intended to replace any other accident and health insurance presently in

force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(b) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the certificate, a notice designed to inform the applicant of the essential differences in coverage on a form consistent with the then current model notification form adopted by the National Association of Insurance Commissioners. One copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver the notice to the applicant upon issuance of the certificate.

Section 9. Regulations.

The Insurance Commissioner may promulgate regulations changing the requirements of sections 1 through 8 to the extent necessary within the judgment of the Insurance Commissioner, to comply with changes made by the Congress of the United States as to the requirements contained in Section 1882 of Section 507(a) Title XVIII of the Social Security Act, as such requirements were in effect on the effective date of this act. Such regulations shall take effect within 60 days after their adoption or promulgation. All regulations promulgated pursuant to this act shall be made in accordance with the applicable provisions of 45 Pa.C.S. Part II (relating to publication and effectiveness of Commonwealth documents). Public hearings shall be held prior to the promulgating of any such regulation unless such regulation is insubstantial. The order promulgating any such regulation shall contain findings and reasons for the regulation: Provided, That this section shall not create or permit any right of action at law or equity not otherwise authorized or permitted under the law of the Commonwealth.

Section 10. Mandated coverages inapplicable to medicare supplement policies unless specifically made applicable.

No coverage which, by any law of this Commonwealth enacted on or after the effective date of this act, is required to be included in any group, or blanket accident and health policy, must be included in any medicare supplement policy, as defined herein, unless inclusion thereof in such medicare supplement policy is specifically required by the terms of such law.

Section 11. Application.

This act shall apply to all group accident and health policies and group subscriber contracts issued or renewed in this Commonwealth on or after July 1, 1983.

Section 12. Effective date.

This act shall take effect July 1, 1983.