~~Indicates Matter Stricken~~

Indicates New Matter

COMMITTEE REPORT

March 16, 2010

**S. 1128**

Introduced by Senators Peeler and Shoopman

S. Printed 3/16/10--S. [SEC 3/17/10 1:54 PM]

Read the first time February 2, 2010.

**THE COMMITTEE ON BANKING AND INSURANCE**

To whom was referred a Bill (S. 1128) to amend the Code of Laws of South Carolina, 1976, by adding Section 38-71-225 so as to establish certain requirements for issuing Medicare supplement policies, including, etc., respectfully

**REPORT:**

That they have duly and carefully considered the same and recommend that the same do pass with amendment:

Amend the bill, as and if amended, by striking all after the enacting words and inserting:

/SECTION 1. Article 1, Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑225. (A) No Medicare supplement policy or certificate may contain benefits that duplicate benefits provided by Medicare.

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

(C) The department shall promulgate reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates. These standards must be in addition to and in accordance with applicable laws of this State. No requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this section or promulgated pursuant to this section, apply to Medicare supplement policies and certificates. The standards may cover, but are not limited to:

(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 department shall promulgate regulations to establish minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies and certificates.

(E) The department may promulgate regulations necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated under federal law, 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, 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 department may promulgate regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the director, are unjust, unfair, or unfairly discriminatory to an applicant or individual covered under a Medicare supplement policy or certificate.

(G) An issuer of Medicare supplement policies or certificates shall offer coverage under any Medicare supplement policy or certificate to individuals under sixty‑five years of age who are eligible for and enrolled in Medicare by reason of disability or end‑stage renal disease. Except as otherwise provided in this section and regulations promulgated under this section, all benefits, protections, policies, and procedures that apply to individuals sixty‑five years of age or older also must apply to individuals under sixty‑five years of age who are eligible for and enrolled in Medicare by reason of disability or end‑stage renal disease.

(H)(1) An issuer of Medicare supplement policies and certificates shall offer the opportunity of enrolling in a Medicare supplement policy or certificate, without conditioning the issuance or effectiveness of the policy or certificate on, and without discriminating in the pricing of the policy or certificate because of, the health status, claims experience, receipt of health care, or medical condition of an applicant, to:

(a) any individual who is sixty‑five years of age or older, or under sixty‑five years of age and eligible for Medicare by reason of disability or end‑stage renal disease, upon the request of the individual during the six-month period beginning with the first month in which the individual has attained sixty‑five years of age and is enrolled in Medicare Part B or is eligible for Medicare by reason of disability or end‑stage renal disease and is enrolled in Medicare Part B;

(b) any individual who is sixty‑five years of age or older, or under sixty‑five years of age and eligible for Medicare by reason of disability or end‑stage renal disease, and who is enrolled in Medicare Part B upon the request of the individual during the six-month period following termination of coverage under a policy or certificate of:

(i) group health insurance;

(ii) employer‑sponsored Medicare supplement insurance; or

(iii) Medicare Advantage plan; or

(c) any individual who is sixty‑five years of age or older, or under sixty‑five years of age and eligible for Medicare by reason of disability or end‑stage renal disease, who has been retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration upon the request of the individual during the six-month period beginning with the date of the individual’s receipt of the retroactive eligibility decision.

(2) An issuer of Medicare supplement policies and certificates shall offer the opportunity of enrolling in a Medicare supplement policy or certificate pursuant to the provisions of subitem (1) for a six-month period beginning January 1, 2011, in the case of an individual who:

(a) is under sixty‑five years of age and is eligible for Medicare by reason of disability or end‑stage renal disease;

(b) is otherwise eligible under subitem (1); and

(c) first enrolled in Medicare Part B prior to January 1, 2011.

(I) At the option of the applicant for or individual covered under a Medicare supplement policy or certificate, all or a portion of the premiums may be paid to the issuer of the policy or certificate by a third party on behalf of the applicant or individual.

(J) Premium rates for Medicare supplement policies and certificates may differ between individuals sixty‑five years of age or older who are enrolled in Medicare and individuals under sixty‑five years of age who are eligible for and enrolled in Medicare by reason of disability or end‑stage renal disease. Benefits provided in a Medicare supplement policy or certificate must be reasonable in relation to the premiums charged.”

SECTION 2. Section 38‑71‑530 of the 1976 Code is amended by adding:

“(c) Individual Medicare supplement policies must comply with the provisions of Section 38‑71‑225 and regulations promulgated under Section 38-71-225.”

SECTION 3. Section 38‑71‑730(6) of the 1976 Code is amended as follows:

“(6) A group policy or subscriber contract of accident and health insurance 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 must equal, and may exceed, the minimum standards for group Medicare supplement policies and certificates as contained in Section 38‑71‑225 and regulations promulgated ~~by the department~~ under Section 38-71-225.”

SECTION 4. This act takes effect upon approval by the Governor./

Renumber sections to conform.

Amend title to conform.

DAVID L. THOMAS for Committee.

**STATEMENT OF ESTIMATED FISCAL IMPACT**

ESTIMATED FISCAL IMPACT ON GENERAL FUND EXPENDITURES:

A Cost to the General Fund (See Below)

ESTIMATED FISCAL IMPACT ON FEDERAL & OTHER FUND EXPENDITURES:

$0 (No additional expenditures or savings are expected)

**EXPLANATION OF IMPACT:**

The Department of Insurance indicates that this bill would require one-time funding by the General Fund of the State totaling $20,992. This cost would cover salary and fringe benefits of one temporary employee for approximately six months to receive, organize and review additional rate and form filings. Other operating costs, including office set up, would be absorbed within existing resources.

*Approved By:*

Harry Bell

Office of State Budget

**A** **BILL**

TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 38‑71‑225 SO AS TO ESTABLISH CERTAIN REQUIREMENTS FOR ISSUING MEDICARE SUPPLEMENT POLICIES, INCLUDING, BUT NOT LIMITED TO, PROHIBITING SUCH POLICIES FROM DUPLICATING BENEFITS PROVIDED BY MEDICARE; PROHIBITING EXCLUSION OF OR LIMITING BENEFITS FOR LOSSES INCURRED MORE THAN SIX MONTHS FROM THE EFFECTIVE DATE OF COVERAGE BECAUSE IT INVOLVED A PREEXISTING CONDITION; TO REQUIRE THE DEPARTMENT OF INSURANCE TO PROMULGATE REGULATIONS ESTABLISHING SPECIFIC STANDARDS FOR MEDICARE SUPPLEMENT POLICY PROVISIONS AND MINIMUM STANDARDS FOR BENEFITS, CLAIMS PAYMENT, MARKETING PRACTICES AND TO CONFORM SUCH POLICIES TO FEDERAL REQUIREMENTS; TO REQUIRE INSURERS OFFERING MEDICARE SUPPLEMENT POLICIES TO PERSONS SIXTY‑FIVE YEARS OF AGE AND OLDER TO ALSO OFFER SUCH POLICIES TO PERSONS WHO ARE ENROLLED IN MEDICARE BECAUSE OF DISABILITY OR END‑STAGE RENAL DISEASE; TO PROVIDE ENROLLMENT TIME REQUIREMENTS; TO PROVIDE THAT CERTAIN THIRD PARTY PAYMENTS MAY NOT BE PROHIBITED; AND TO SPECIFY THAT PREMIUM DIFFERENCES CHARGED PERSONS RECEIVING MEDICARE UNDER DIFFERENT ELIGIBILITY CRITERIA MUST NOT BE EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. Article 1, Chapter 71, Title 38 of the 1976 Code is amended by adding:

“Section 38‑71‑225. (A) No Medicare supplement insurance policy or certificate in force in this State may contain benefits that duplicate benefits provided by Medicare.

(B) Notwithstanding any other provision of law, a Medicare supplement policy or certificate must not exclude or limit benefits for losses incurred more than six 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 months before the effective date of coverage.

(C) The department shall promulgate reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates. These standards must be in addition to and in accordance with applicable laws of this State. No requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this section or promulgated pursuant to this section, apply to Medicare supplement policies and certificates. The standards may cover, but are not limited to:

(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 department shall promulgate regulations to establish minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement policies and certificates.

(E) The department may promulgate such regulations as are necessary to conform 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, 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 department may promulgate 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 a person insured or proposed to be insured under a Medicare supplement policy or certificate.

(G) Insurers offering Medicare supplement insurance policies in this State to persons sixty‑five years of age or older also shall offer Medicare supplement in insurance policies to persons who are eligible for and enrolled in Medicare because of disability or end‑stage renal disease. Except as otherwise provided in this section, all benefits, protections, policies, and procedures that apply to persons sixty‑five years of age or older also must apply to persons who are eligible for and enrolled in Medicare because of disability or end‑stage renal disease.

(H) A person may enroll in a Medicare supplement insurance policy at any time authorized or required by the federal government, or within six months of:

(1) enrolling in Medicare, or by January 1, 2011, for an individual who is under sixty‑five years of age and is eligible for Medicare because of disability or end‑stage renal disease, whichever is later;

(2) receiving notice that the person has been retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration; or

(3) having had a prior health insurance policy, accident and health policy, employer‑sponsored Medicare supplement insurance policy, or Medicare Advantage plan terminated or canceled for reason of the applicant’s employment status, a decision of the individual applicant’s employer, or an action by an insurer unrelated to the applicant’s status or conduct.

(I) No policy or certificate issued pursuant to this section shall prohibit payment made by third parties on behalf of individual applicants or individuals within a group so long as full payment is made in a timely manner as provided in the policy.

(J) Premiums for Medicare supplement insurance policies may differ between persons who qualify for Medicare for being sixty‑five years of age or older and persons who qualify because of disability or end‑stage renal disease; however, such differences in premiums must not be excessive, inadequate, or unfairly discriminatory.”

SECTION 2. This act takes effect upon approval by the Governor.

‑‑‑‑XX‑‑‑‑