**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 ISSUERS OF MEDICARE SUPPLEMENT POLICIES TO OFFER SUPPLEMENT COVERAGE TO INDIVIDUALS UNDER SIXTY‑FIVE YEARS OF AGE WHO ARE ENROLLED IN MEDICARE BECAUSE OF DISABILITY OR END‑STAGE RENAL DISEASE; TO PROVIDE ENROLLMENT TIME REQUIREMENTS; TO PROVIDE THAT AT THE OPTION OF THE INDIVIDUAL COVERED UNDER A MEDICARE SUPPLEMENT POLICY, THE PREMIUMS MAY BE PAID BY A THIRD PARTY ON BEHALF OF THE INDIVIDUAL; AND TO PROVIDE THAT PREMIUM RATES MAY DIFFER BETWEEN INDIVIDUALS RECEIVING MEDICARE UNDER DIFFERENT ELIGIBILITY CRITERIA BUT BENEFITS IN THE SUPPLEMENT POLICY MUST BE REASONABLE IN RELATION TO THE PREMIUMS CHARGED; TO AMEND SECTION 38‑71‑530, RELATING TO REGULATIONS ESTABLISHING STANDARDS FOR MANNER, CONTENT, AND REQUIRED DISCLOSURES FOR SALES OF INDIVIDUAL POLICIES, SO AS TO PROVIDE THAT MEDICARE SUPPLEMENT POLICIES MUST COMPLY WITH THIS ACT AND REGULATIONS PROMULGATED PURSUANT TO IT; AND TO AMEND SECTION 38‑71‑730, RELATING TO REQUIREMENTS FOR GROUP ACCIDENT, GROUP HEALTH, AND GROUP ACCIDENT AND HEALTH POLICIES, SO AS TO PROVIDE THAT SUCH A GROUP POLICY THAT IS PRIMARILY A MEDICARE SUPPLEMENT POLICY MUST EQUAL BUT MAY EXCEED THE MINIMUM STANDARDS AS PROVIDED FOR IN THIS ACT AND REGULATIONS PROMULGATED PURSUANT TO IT.

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 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.

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