COUNCIL OF THE DISTRICT OF COLUMBIA

NOTICE

D.C LAW 4-162

"Medicare Supplement Insurance Temporary Act of 1982".

Pursuant to Section 412 of the District of Columbia Self-Government and Governmental Reorganization Act, P. L. 93-198, "the Act", the Council of the District of Columbia adopted Bill No. 4-491 on first and second readings, June 22, 1982, and July 6, 1982, respectively. Following the signature of the Mayor on July 29, 1982, this legislation was assigned Act No. 4-236, published in the September 10, 1982 edition of the D.C. Register, (Vol. 29 page 3953) and transmitted to Congress on August 2, 1982 for a 30-day review, in accordance with Section 602 (c)(1) of the Act.

The Council of the District of Columbia hereby gives notice that the 30-day Congressional Review Period has expired, and therefore, cites this enactment as D.C. Law 4-162, effective September 29, 1982.

ARRINGTON DIXON
Chairman of the Council

Dates Counted During the 30-day Congressional Review Period:

August 2,3,4,5,6,9,10,11,12,13,16,17,18,19,20

September 8,9,10,13,14,15,16,17,20,21,22,23,24,27,28

D.C. LAW 4-162
EFFECTIVE DATE SEP 29 1982

Enrolled Original

AN ACT

D.C. ACT 4-236

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

JUL 29 1982

To provide, on a temporary basis, for the reasonable standardization of coverage and simplification of terms and benefits of medicare supplement policies; to facilitate public understanding and comparison of these policies; to eliminate provisions contained in these policies which may be misleading or confusing in connection with purchase of these policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and health insurance coverages to persons eligible for Medicare by reason of age.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Medicare Supplement Insurance Temporary Act of 1982".

Sec. 2. Definitions.

CODIFICATION
Note,
D.C.Code,
secs. 3-202.4
& 35-102
(1981 ed.)

For purposes of this act the term:

(1) "District" means the District of Columbia.

(2) "Mayor" means the Mayor of the District of Columbia.

(3) "Applicant" means:

(A) in the case of an individual medicare supplement policy, that person who seeks to contract for insurance benefits; and

(B) in the case of a group medicare supplement policy, the proposed certificate holder.

(4) "Certificate" means a certificate issued under a group Medicare Supplement Policy, which policy has been delivered or issued for delivery in the District.

(5) "Medicare Supplement Policy" means a group or individual policy of accident and health insurance which is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or sugical expenses of persons eligible for Medicare by reason of age. The term "Medicare Supplement Policy" does not include:

(A) A policy or contract of 1 or more employers or labor organizations, trustees of a fund established by 1 or more employers or labor organizations, or combination thereof; for employees, former employees, or combination thereof; or for members, former members, or combination thereof of the labor organizations;

(B) A policy or contract of any professional, trade, or occupational association for its members, former, or retired members, or combination thereof, if the 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 2 years prior to the date of the initial offering of the 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 the group or individual policy or contract includes provisions which are inconsistent with the requirements of this act.

(6) "Medicare" means title XVIII of the Social Security Act, approved July 30, 1965 (79 Stat. 291; 42 U.S.C. sec. 1305 et seq.).

Sec. 3. 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 the District on or after the effective date of this act; and

(2) All certificates issued under group Medicare Supplement Policies, which policies have been delivered or issued for delivery in the District.

(b) This act shall not apply to:

(1) Individual policies or contracts issued purusant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions which are inconsistent with the requirements of this act; or

(2) Medicare Supplement Policies issued to

employees or members as additions to franchise plans in existence on the effective date of this act.

Sec. 4. Policy Definitions and Terms.

(a) No insurance policy may be advertised, solicited or issued for delivery in the District as a Medicare Supplement Policy unless the policy contains definitions or terms which conform to the requirements of this section.

(b) The terms specifically defined by this section include:

(1) "Accident", "Accidental Injury", or "Accidental Means" shall be defined to employ "result" language and shall not be defined to include words which establish an accidental means test of use words such as "external, violent, visible wounds" or similar words of description or characterization.

(A) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury substained by the insured person which is the direct result of an accident, independent of disease or bodily informity or any other cause, and occurs while insurance coverage is in force.".

(B) The 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) "Benefit Period" or "Medicare Benefit Period" shall not be defined as more restrictive than as that defined in the Medicare program.

(3) "Convalescent Nursing Home", "Extended Care Facility", or "Skilled Nursing Facility" shall be defined in relation to its status, facilities, and available services.

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

(i) be operated pursuant to law;

(ii) be approved for payment of Medicare benefits or be qualified to receive approval, if so requested;

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

(iv) provide continuous 24-hour nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

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

(B) The definition of a home or facility may provide that the term shall not be

inclusive of:

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

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

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

(4) "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.

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

(i) be an institution operated pursuant to law; and

(ii) be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of licensed physicians, medical, diagnostic, and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and

(iii) provide 24-hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

(B) The definition of the term "hospital" may state that the term shall not be inclusive of:

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

(ii) facilities primarily affording custodial, educational, or rehabilitory care;

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

(iv) any military or veterans hospital, 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.

(5) "Medicare" shall be defined in the policy. Medicare may be substantially defined as the Health Insurance for the Aged Act, section 102(a) of the Social Security Amendments of 1965, approved July 30, 1965 (79 Stat. 290; 42 U.S.C. sec. 1305 et seq.) (adding title XVIII to the Social Security Act), as then constituted and any later amendments or substitutes thereof, or words of similar import.

(6) "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.

(7) "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.

(8) "Nurses" may be defined so that the description of a nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the word or phrase "nurse", "trained nurse", or "registered nurse" is used without specific instruction, then the use of the 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 District.

(9) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician". The use of these 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.

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

Sec. 5. Prohibited Policy Provisions.

(a) Except as provided in subsection (b), no insurance policy may be advertised, solicited or issued for delivery in the District as a Medicare Supplement Policy if the policy limits or excludes coverage by type of illness, accident, treatment, or medical condition.

(b) permitted exceptions include:

(1) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(2) mental or emotional disorders, alcoholism, and drug addiction;

(3) illness, treatment, or medical condition arising out of:

(A) war or act of war (whether declared or undeclared); participation in a felony, riot, or insurrection; service in the armed forces or units

auxilliary thereto;

(B) suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury; or

(C) aviation;

(4) cosmetic surgery, except that the term "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting form trauma, infection, or other diseases of the involved part;

(5) care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where the interference is the result of or related to distortion, misalignment, or subluxation of, or in the vertebral column;

(6) treatment provided in a governmental hospital; benefits provided under Medicare or other governmental programs (except Medicaid), any state, District, or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories, or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(7) dental care or treatment;

(8) eye glasses, hearing aids, and

examination for the prescription or fitting thereof;

(9) rest cures, custodial care, transportation, and routine physical examinations;

(10) territorial limitations:

PROVIDED, HOWEVER, Medicare Supplement Policies may not contain, when issued, limitations or exclusions of the type enumerated in paragraphs (1), (5), (9), or (10) that are more restrictive than those of Medicare. Medicare Supplement Policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

(c) No Medicare Supplement Policies may use waivers to exclude, limit, or reduce coverage or benefits for the specifically named or described preexisting diseases or physical conditions.

Sec. 6. Notice of Free Examination.

Medicare Supplement Policies or certificates, other than those issued pursuant to direct response solicitation, 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 10 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. Medicare Supplement Policies or 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 applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination, the applicant is not satisfied for any reason.

Sec. 7. Minimum Benefit Standards.

No insurance policy may be advertised, solicited or issued for delivery in the District as a Medicare Supplement Policy which does not meet the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(a) General Standards.

The following standards apply to Medicare Supplement Policies and are in addition to all other requirements of this act:

(1) A Medicare Supplement Policy may not deny a claim for losses incurred more than 6 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 6 months before the effective date of coverage;

(2) A Medicare Supplement Policy may not indemnify against losses resulting from sickness on a

different basis than losses resulting from accidents;

(3) A Medicare Supplement Policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with the changes;

(4) A "noncancellable", "guaranteed renewable", or "noncancellable and guaranteed renewable" Medicare Supplement Policy shall not:

(A) provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(B) be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health; and

(5) Termination of a Medicare Supplement Policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(b) Minimum Benefit Standards.

(1) Coverage of Part A Medicare eligible

expenses for hospitalization to the extent not covered by Medicare from the 61st day through 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(3) 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; and

(4) 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.

Sec. 8. Loss Ratio Standards.

(a) 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 in the case of group p licies, and

(2) At least 60% of the aggregate amount of premium collected in the case of individual policies.

(b) For the purposes of this section, Medicare Supplement Policies issued as a result of solicitations of individuals through the mail or mass media advertising, including both print and broadcast advertising, shall be treated as individual policies.

Sec. 9. Required Disclosure Provisions.

(a) General Rules.

(1) Medicare Supplement Policies shall include a renewal, continuation, or nonrenewal provision. The language or specifications of the provision must be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, 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.

(2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the insured or exercises a specifically reserved right under a Medicare Supplement Policy, all riders or endorsements added to a Medicare Supplement Policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy issue, any rider or

endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) 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 these terms and an explanation of these terms in its accompanying outline of coverage.

(4) If a Medicare Supplement Policy contains any limitations with respect to preexisting conditions, the limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations".

(5) Medicare Supplement Policies or certificates, other than those issued pursuant to direct response solicitations, shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within 10 days of its delivery and to have the premiums refunded if, after examination of the policy or certificate, the

insured person is not satisfied for any reason. Medicare Supplement Policies or 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 policyholder or certificateholder shall have the right to return the policy or 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.

(6) Insurers issuing accident and health policies and certificates which provide hospital or medical expense coverage on an expense incurred or indeminity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to all applicants a Medicare Supplement "buyer's guide" in a form consistent with the model adopted by the National Association of Insurance Commissioners. Delivery of the "buyer's guide" shall be made whether or not such policies as defined in this act, except in the case of direct response insurers, delivery of the "buyer's guide" shall be made to the applicant at the time of application and acknowledgment of receipt of the "buyer's guide" shall be obtained by the insurer. Direct response insurers shall deliver the "buyer's guide" to the applicant upon request but not later than at the time the policy is delivered.

(7) Except as otherwise provided in section 9(c), the terms "Medicare Supplement", "Medigap", and words of similar import shall not be used unless the policy is issued in compliance with section 7.

(b) Outline of Coverage Requirements of Medicare Supplement Policies.

(1) Insurers issuing Medicare Supplement Policies for delivery in the District must provide an outline of coverage to all applicants at the time application is made and except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant; and

(2) If an outline of coverage is provided at the time of application and the Medicare Supplement Policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

"NOTICE: Read this outline 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 consistent with the model adopted by the National Association of Insurance

Commissioners as amended to reflect changes in the Medicare program.

(c) Notice Regarding Policies which are not Medicare Supplement Policies.

Any accident and health insurance policy, other than a Medicare Supplement Policy, disability policy, disability income policy, basic catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in section 3(b), issued for delivery in the District to persons eligible for Medicare by reason of age shall notify insureds under the policy that the policy is not a Medicare Supplement Policy. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than 12 point type and shall contain the following language:

"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare review the Medicare Supplement Buyers Guide Available from the company.".

Sec. 10. Requirements for Replacement.

(a) Application forms shall include a question designed to elicit information as to whether a Medicare Supplement Policy or certificate is intended to replace any other accident and health policy or certificate

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 Medicare Supplement Policy or certificate, a notice regarding replacement of accident and health coverage. One copy of the notice shall be provided to the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and health coverage. In no event, however, will a notice be required in the solicitation of "accident only" and "single premium nonrenewable" policies.

(c) The notice required by subsection (b) for an insurer, other than a direct response insurer, shall be provided in a form consistent with the model notification form adopted by the National Association of Insurance Commissioners.

Sec. 11. Separability.

If any provision of this act or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this act and the application of such provision to other persons or

circumstances shall not be affected thereby.

Sec. 12. Effective Date.

(a) This act shall take effect after a 30-day period of Congressional review following approval by the Mayor (or in the event of veto by the Mayor, action by the Council of the District of Columbia to override the veto) as provided in section 602(c)(1) of the District of Columbia Self-Government and Governmental Reorganization Act, approved December 24, 1973 (87 Stat. 813; D.C. Code, sec. 1-233(c)(1)).

(b) This act shall expire on the 180th day of its having taken effect.

Chairman
Council of the District of Columbia

Mayor
District of Columbia

APPROVED: July 29, 1982

COUNCIL OF THE DISTRICT OF COLUMBIA

Council Period Four

Second Session

DOCKET NO: B 4-491

[ ] Item on Consent Calendar

ACTION: Adopted First Reading, 6-22-82

[X] VOICE VOTE: By Majority, Members Clarke, Jarvis and Kane voted persent

Absent: Moore

[ ] ROLL CALL VOTE:

COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.
CHMN. DIXON					KANE					SHACKLETON				
WINTER					MASON					SPAULDING				
CLARKE					MOORE, JR.					WILSON				
CRAWFORD					RAY									
JARVIS					ROLARK									

X - Indicates Vote A.B. - Absent N.V. - Not Voting

CERTIFICATION OF RECORD

William R. Cunningham — July 14 1982
Secretary to the Council — Date

[X] Item on Consent Calendar

ACTION: Adopted Final Reading, 7-6-82

[X] VOICE VOTE: Unanimous

Absent: all present

[ ] ROLL CALL VOTE:

COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.
CHMN. DIXON					KANE					SHACKLETON				
WINTER					MASON					SPAULDING				
CLARKE					MOORE, JR.					WILSON				
CRAWFORD					RAY									
JARVIS					ROLARK									

X - Indicates Vote A.B. - Absent N.V. - Not Voting

CERTIFICATION OF RECORD

William R. Cunningham — July 14 1982
Secretary to the Council — Date

[ ] Item on Consent Calendar

ACTION: _____

[ ] VOICE VOTE: _____

Absent: _____

[ ] ROLL CALL VOTE:

COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.	COUNCIL MEMBER	AYE	NAY	N.V.	A.B.
CHMN. DIXON					KANE					SHACKLETON				
WINTER					MASON					SPAULDING				
CLARKE					MOORE, JR.					WILSON				
CRAWFORD					RAY									
JARVIS					ROLARK									

X - Indicates Vote A.B. - Absent N.V. - Not Voting

CERTIFICATION OF RECORD

_____ _____
Secretary to the Council — Date