

JUL. 8 1983

COUNCIL OF THE DISTRICT OF COLUMBIA

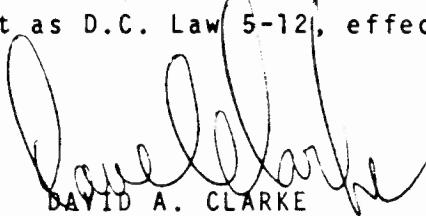
NOTICE

D.C. LAW 5-12

"Medicare Supplement Insurance Act of 1983".

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. 5-71 on first and second readings, April 12, 1983 and April 26, 1983, respectively. Following the signature of the Mayor on May 4, 1983, this legislation was assigned Act No. 5-26, published in the May 20, 1983 edition of the D.C. Register, (Vol. 30 page 2306) and transmitted to Congress May 6, 1983 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 5-12, effective June 22, 1983.



DAVID A. CLARKE
Chairman of the Council

Dates Counted During the 30-day Congressional Review Period:

May 6, 9, 10, 11, 12, 13, 16, 17, 18, 19, 20, 23, 24, 25, 26

June 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 16, 17, 20, 21

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IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

To provide 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 disclosure 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 Act of 1983".

Sec. 2. Definitions.

For the purposes of this act the term:

(1) "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.

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

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

(4) "Mayor" means the Mayor of the District of

CODIFICATION

D.C.Code,
title 35,
new chapter 21
(1982 ed.)

New
D.C.Code,
sec. 35-2101
(1982 ed.)

&
Note,
D.C.Code,
sec. 35-1001
(1982 ed.)

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

(6) "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 surgical expenses of persons eligible for Medicare by reason of age. The term "Medicare supplement policy" does not include:

(2) (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; 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:

(2) (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

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(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.

Sec. 3. Applicability and Scope.

New
D.C.Code,
sec. 35-2102
(1982 ed.)

(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 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; 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 Definition and Terms.

New
D.C.Code,
sec. 35-2102
(1982 ed.)

(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 sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity 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.

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(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 include:

(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.

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(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;

(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 a 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 include:

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

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

(8) (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,

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cept for services rendered on an emergency basis where a legal liability exists for charges made to the individual for those services.

(5) "Medicare" shall be defined in the policy.

The term "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 (9 Stat. 290; 42 U.S.C. sec. 1305 et seq.) (adding title VIII to the Social Security Act), as then constituted and by 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 a registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the term "nurse", "trained nurse", or "registered nurse" is used without specific instruction,

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the use of the term requires the insurer to recognize services of any individual who qualified under the technology in accordance with the applicable statutes or administrative rules of the licensing or registry board of 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 accept, to the extent of its obligation under contract, all providers of medical care and treatment whose 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, except as follows:

New
D.C.Code,
sec. 35-210
(1982 ed.)

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(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 auxiliary 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 the service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part;

(5)(A) 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; and

(B) Treatment provided in a governmental hospital;

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(6)(A) 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;

(B) Services rendered by employees of hospitals, laboratories, or other institutions; and

(C) 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; or

(10) Territorial limitations:

PROVIDED, HOWEVER, Medicare supplement policies may not contain, when issued, limitations or exclusions of the type enumerated in paragraphs (1), (5)(A), (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.

(b) 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.

New
D.C. Code,
sec. 35-21
(1982 ed.)

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Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the 1st 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 1st 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.

New
D.C.Code,
sec. 35-21
(1982 ed.)

(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

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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 amount 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 "noncancelable", "guaranteed renewable", or "noncancelable 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

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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 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 the 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 the

New
D.C.Code,
sec. 35-21C
(1982 ed.)

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iod and in accordance with accepted actuarial principles

practices:

- (1) At least 75% of the aggregate amount of premiums collected in the case of group policies, 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.

New
D.C.Code,
sec. 35-2108
(1982 ed.)

(a) General Rules.

(1) Medicare supplement policies shall include a renewal, continuation, or renewal provision. The language 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 1st page of the policy, and shall state clearly 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

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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 1st 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

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of Columbia Register
son. Medicare supplement policies or certificates issued
suant to a direct response solicitation to persons
igible for Medicare by reason of age shall have a notice
minently printed on the 1st page or attached thereto
ting in substance that the policyholder or
rtificateholder shall have the right to return the policy
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 indemnity basis, other
than incidentally, to a person 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 the policies or certificates are
advertised, solicited, or issued as Medicare supplement
polices as defined in this act, except that 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 acknowledgement 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

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Similar import shall not be used unless the policy is issued
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
acknowledgement of receipt of the outline from the
applicant;

(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."; and

(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 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 1st page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the 1st 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.

New
D.C.Code,
sec. 35-210
(1982 ed.)

(b) Upon determining that a sale will involve replacement, an insurer, other than a direct response

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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 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. Severability.

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 the provision to other persons or circumstances shall not be affected thereby.

Sec. 12. Effective Date.

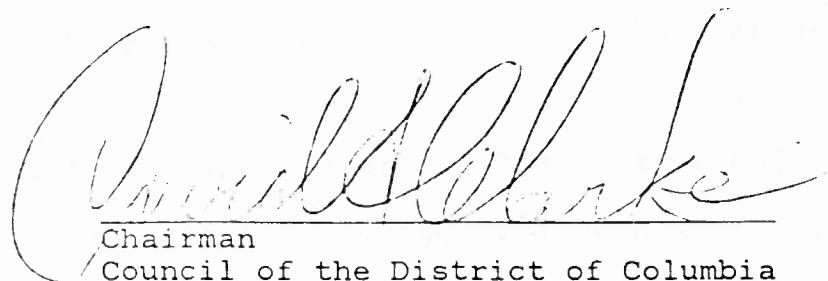
This act shall take effect after a 30-day period of Congressional review following approval by the Mayor (or in the event of veto by the Mayor, action by the Council of the District of Columbia to override the veto) as provided in section 602(c)(1) of the District of Columbia

Note,
D.C.Code,
secs. 35-210
to -2109
(1982 ed.)

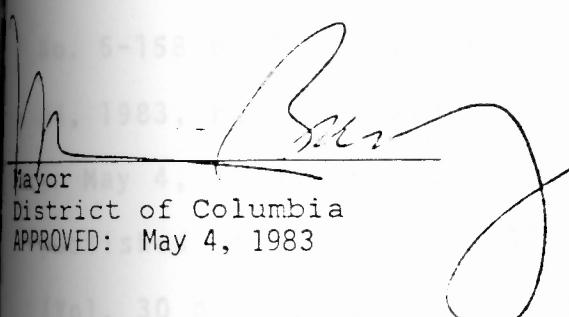
Self-Government and Governmental Reorganization Act,

Approved December 24, 1973 (87 Stat. 813; D.C. Code, sec.

-233(c)(1)).

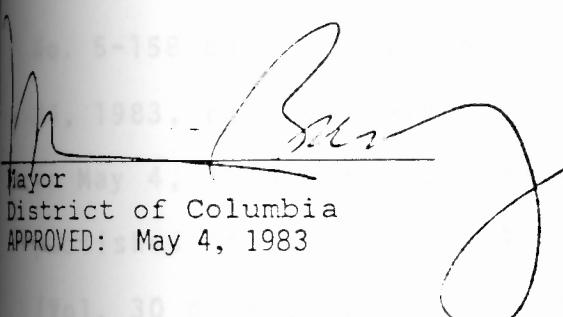

Chairman
Council of the District of Columbia

Introduced as Bill 5-71 on June 15, 1982
by Chairman Dixon at the request of the
Mayor.

 FIRST READING: 4-12-83; Adopted by unanimous
voice vote; all present.

FINAL READING: 4-26-83; Adopted by unanimous
voice vote; Ray absent.

Transmitted to the Mayor: April 29, 1983


Mayor
District of Columbia

APPROVED: May 4, 1983

June 22, 1983