

BEFORE THE COMMISSIONER OF SECURITIES AND INSURANCE
OFFICE OF THE MONTANA STATE AUDITOR

In the matter of the adoption of New Rule I, the amendment of ARM 6.6.503, 6.6.504, 6.6.506, 6.6.507A, 6.6.507B, 6.6.507C, 6.6.507E, 6.6.508, 6.6.508A, 6.6.509, 6.6.510, 6.6.517, 6.6.519, 6.6.521, and 6.6.526, and the repeal of 6.6.511 and 6.6.511A pertaining to Medicare supplement insurance.)	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, AMENDMENT, AND REPEAL
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TO: All Concerned Persons

1. On October 12, 2017, at 9:00 a.m., the Commissioner of Securities and Insurance, Office of the Montana State Auditor (CSI), will hold a public hearing in the basement conference room, at the Office of the Montana State Auditor, Commissioner of Securities and Insurance, 840 Helena Ave., Helena, Montana, to consider the proposed adoption, amendment, and repeal of the above-stated rules.

2. The CSI will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the CSI no later than 5:00 p.m. on October 3, 2017, to advise us of the nature of the accommodation that you need. Please contact Ramona Bidon, CSI, 840 Helena Avenue, Helena, Montana, 59601; telephone (406) 444-2726; TDD (406) 444-3246; fax (406) 444-3499; or e-mail rbidon@mt.gov.

3. The new rule as proposed to be adopted as follows:

NEW RULE I STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2020 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020 (1)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires that the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare part B deductible may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies must comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of the appropriate rules of this subchapter.

(2) The standards and requirements of ARM 6.6.507E shall apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(a) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in ARM 6.6.507E(7)(c) but shall not provide coverage for 100% or any portion of the Medicare Part B deductible.

(b) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in ARM 6.6.507E(7)(e) but shall not provide coverage for 100% or any portion of the Medicare Part B deductible.

(c) Standardized Medicare supplement benefit Plans C, F, and F with High Deductible may not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(d) Standardized Medicare supplement benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and shall provide the benefits contained in ARM 6.6.507E(7)(g) but shall not provide coverage for 100% or any portion of the Medicare Part B deductible. However, the Medicare Part B deductible paid by the beneficiary shall be considered an out-of-pocket expense in meeting the annual high deductible.

(e) The reference to Plans C or F contained in ARM 6.6.507E(3) is deemed a reference to Plans D or G for purposes of this rule.

(3) This rule applies to only individuals that are newly eligible for Medicare on or after January 1, 2020:

(a) by reason of attaining age 65 on or after January 1, 2020; or

(b) by reason of entitlement to benefits under part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed to be eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020.

(4) For purposes of ARM 6.6.507C, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G With High Deductible), respectively, that meet the requirements of this rule.

(5) In the case of a State described in Section 1882(p)(6) of the Social Security Act ("waivered" alternative simplification states) MACRA prohibits the coverage of the Medicare Part B deductible for any Medicare supplement policy sold or issued to an individual that is newly eligible for Medicare on or after January 1, 2020.

(6) On or after January 1, 2020, the standardized benefit plans described in (2)(d) may be offered to any individual who was eligible for Medicare prior to January 1, 2020, in addition to the standardized plans described in ARM 6.6.507E(7).

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA

IMP: 33-15-303, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

REASON: Federal law (specifically 42 CFR § 1395ss(a)) encourages states to set up regulation of Medicare supplement insurance at least as stringent as the model

adopted by the National Association of Insurance Commissioners (NAIC). Changes to the NAIC model law were recently adopted to account for the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which was signed into law on April 16, 2015. Section 401 of MACRA prohibits the sale of Medigap policies that cover Part B deductibles to "newly eligible" Medicare beneficiaries defined as those individuals who: (a) have attained age 65 on or after January 1, 2020; or (b) first become eligible for Medicare due to age, disability or end-stage renal disease, on or after January 1, 2020. Issuers selling such policies to "newly eligible" Medicare beneficiaries on or after January 1, 2020 are subject to fines, and/or imprisonment of not more than five years, and/or civil money penalties of not more than \$25,000 for each prohibited act. For "newly eligible" persons, references in the law to Medigap Plans C and F are deemed as references to Plans D and G.

Typically, amendments by Congress to Medicare federal statutes have consistently directed that the changes to the Model Regulation must be adopted by the states one year after the date the NAIC adopted the amended Model Regulation. While MACRA did not contain such a requirement, the Commissioner believes that adding this new rule to existing Medicare supplement rules is necessary to ensure that Montana law conforms to the "equal to or more stringent than the NAIC Model Standard" requirement.

4. The rules as proposed to be amended provide as follows, new matter underlined, deleted matter interlined:

6.6.503 APPLICABILITY AND SCOPE (1) and (1)(a) remain the same.
(b) all certificates which have been delivered or issued for delivery in this state and issued under group Medicare supplement policies ~~which have been delivered or issued for delivery in this state.~~
(2) remains the same.

AUTH: 33-1-313, 33-22-904, MCA
IMP: 33-22-904, MCA

Reason: The change to ARM 6.6.503 is to clarify a potential ambiguity in the original language. These rules apply when a certificate is delivered or issued for delivery in Montana, no matter where the group Medicare supplement policy was issued.

6.6.504 DEFINITIONS For purposes of this subchapter, the terms defined in 33-22-903, MCA, will have the same meaning in this subchapter unless clearly designated otherwise. The following definitions are in addition to those in 33-22-903, MCA.

(1) and (2) remain the same.
(3) "Creditable coverage":
(a) means, with respect to an individual, coverage of the individual provided under any of the following:
(a) through (j) remain the same but are renumbered (i) through (x).
~~(4)(b)~~ "Creditable coverage" shall does not include:

(i) one or more, or any combination of, the following:

(a) through (h) remain the same but are renumbered (A) through (H).

~~(5)(ii) "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan:~~

~~(a) through (c) remain the same but are renumbered (A) through (C).~~

~~(6)(iii) "Creditable coverage" may not include the following benefits if offered as independent, noncoordinated benefits:~~

~~(a) and (b) remain the same but are renumbered (A) and (B).~~

~~(7)(iv) "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate, or contract of insurance:~~

~~(a) through (c) remain the same but are renumbered (A) through (C).~~

~~(8) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits as defined in 29 USC section 1002 (Employee Retirement Income Security Act).~~

~~(9) remains the same but is renumbered and (5).~~

~~(6) "MACRA" means the Medicare Access and CHIP Reauthorization Act of 2015.~~

~~(10) remains the same but is renumbered (7).~~

~~(44)(8) "Medicare supplement policy" has the meaning provided for in 33-22-903, MCA, except that "Medicare supplement policy" does not include Medicare advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan (HCPP) that provides benefits pursuant to an agreement under section 1833(a)(1)(A) of the Social Security Act. Policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare advantage plans (established under Medicare Part C) must comply with the Medicare supplement requirements contained in Montana administrative rule and statute.~~

~~(9) "MMA" means the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.~~

~~(12) remains the same but is renumbered (10).~~

~~(13) and (14) remain the same but are renumbered (12) and (13).~~

~~(15) remains the same but is renumbered (11).~~

AUTH: 33-1-313, 33-22-904, MCA

IMP: 33-22-902, 33-22-903, 33-22-923, MCA

REASON: The proposed changes to this rule are mostly non-substantive. The changes are meant to bring the rule in line with Montana rule drafting procedures. The terms "MACRA" and "MMA" are included because they are used in multiple rules in this subchapter. The last sentence of (8) is being deleted because it is not part of the definition of Medicare supplement policy, and the requirements of Medicare Part C plans are covered by ARM 6.6.507A, 6.6.507E, and New Rule I.

6.6.506 PROHIBITED POLICY PROVISIONS (1) Except for permitted preexisting condition clauses as described in ~~ARM 6.6.510, 6.6.522, and ARM 6.6.507(1)(a)(i) and 6.6.507D(1)(a)(i)~~, no policy or certificate may be advertised,

solicited, or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(2) through (4)(c)(ii) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA

IMP: 33-15-303, 33-22-902, 33-22-904, 33-22-905, MCA

REASON: The purpose of this change is to fix the citation to the correct provisions in other rules in this subchapter dealing with preexisting condition exclusions.

6.6.507A STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 1990 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY ON OR AFTER JULY 1993, AND WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010 (1) through (4) remain the same.

(5) The following descriptions detail the contents of the standardized benefit Plans A through J:

(a) Standardized Medicare Supplement Benefit Plan A must be limited to the basic ("core") benefits common to all benefit plans, as established in ARM 6.6.507(4)(5).

(b) Standardized Medicare Supplement Benefit Plan B must include only the following:

(i) the core benefit as established in ARM 6.6.507(4)(5), plus the Medicare Part A deductible as established in ARM 6.6.507(4)(5)(b)(i).

(c) Standardized Medicare Supplement Benefit Plan C must include only the following:

(i) the core benefit, as established in ARM 6.6.507(4)(5); plus

(ii) the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as established in ARM 6.6.507(4)(5)(b)(i), (ii), (iii), and (viii), respectively.

(d) Standardized Medicare Supplement Benefit Plan D must include only the following:

(i) the core benefit, as established in ARM 6.6.507(4)(5); plus

(ii) the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as established in ARM 6.6.507(4)(5)(b)(i), (ii), (viii), and (x), respectively.

(e) Standardized Medicare Supplement Benefit Plan E must include only the following:

(i) the core benefit as established in ARM 6.6.507(4)(5); plus

(ii) the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in ARM 6.6.507(4)(5)(b)(i), (ii), (viii), and (ix), respectively.

(f) Standardized Medicare Supplement Benefit Plan F must include only the following:

(i) the core benefit as established in ARM 6.6.507(4)(5); plus

(ii) the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, 100% of the Medicare Part B excess charges and medically necessary emergency care in a foreign country as established in ARM 6.6.507(4)(5)(b)(i), (ii), (iii), (v), and (viii), respectively.

(g) Standardized Medicare Supplement Benefit High Deductible Plan F shall include only the following:

(i) 100% of covered expenses following the payment of the annual High Deductible Plan F deductible. ~~The covered expenses include:~~

~~(A)(i) The covered expenses are the core benefit as defined in ARM 6.6.507(5),~~ plus

~~(B) the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in ARM 6.6.507(4)(5)(b)(i), (ii), (iii), (v), and (viii), respectively.~~

(ii) The annual High Deductible Plan F deductible ~~shall~~ must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan F policy, and ~~shall~~ must be in addition to any other specific benefit deductibles. The annual High Deductible Plan F deductible ~~shall~~ will be \$1500.00 for 1998 and 1999, and ~~shall~~ must be based on the calendar year. It ~~shall~~ will be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.00.

(h) Standardized Medicare Supplement Benefit Plan G must include only the following:

(i) core benefit as established in ARM 6.6.507(4)(5), plus

(ii) the Medicare Part A deductible, the skilled nursing facility care, 80% of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as established in ARM 6.6.507(4)(5)(b)(i), (ii), (iv), (viii), and (x), respectively.

(i) Standardized Medicare Supplement Benefit Plan H must include only the following:

(i) the core benefit as established in ARM 6.6.507(4)(5), plus

(ii) the Medicare Part A deductible, the skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as established in ARM 6.6.507(4)(5)(b)(i), (ii), (vi), and (viii), respectively.

(iii) However, the outpatient prescription drug benefit may not be included in a Medicare supplement policy or certificate sold after December 31, 2005.

(j) Standardized Medicare Supplement Benefit Plan I must include only the following:

(i) the core benefit as established in ARM 6.6.507(4)(5), plus

(ii) the Medicare Part A deductible, the skilled nursing facility care, 100% of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as established in ARM 6.6.507(4)(5)(b)(i), (ii), (v), (vi), (viii), and (x), respectively.

(iii) However, the outpatient prescription drug benefit may not be included in a Medicare supplement policy or certificate sold after December 31, 2005.

(k) Standardized Medicare supplement benefit plan J must include only the following:

(i) the core benefit as established in ARM 6.6.507(4)(5); plus

(ii) the Medicare Part A deductible, the skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as established in ARM 6.6.507(4)(5)(b)(i), (ii), (iii), (v), (vii), (viii), (ix), and (x), respectively.

(iii) However, the outpatient prescription drug benefit shall not be included in a Medicare supplement policy or certificate sold after December 31, 2005.

(l) Standardized Medicare Supplement Benefit High Deductible Plan J shall consist of only the following:

(i) 100% of covered expenses following the payment of the annual High Deductible Plan J deductible. ~~The covered expenses include:~~

(A)(i) The covered expenses must be only the core benefit as defined in ARM 6.6.507(5); plus

(B) the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in ARM 6.6.507(4)(5)(b)(i), (ii), (iii), (v), (vii), (viii), (ix), and (x), respectively. However, the outpatient prescription drug benefit may not be included in a Medicare supplement policy or certificate sold after December 31, 2005.;

(ii) The annual High Deductible Plan J deductible shall must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan J policy, and shall must be in addition to any other specific benefit deductibles. The annual deductible shall will be \$1500.00 for 1998 and 1999, and shall must be based on a calendar year. It shall will be adjusted annually thereafter by the secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.00.

~~(iii) the outpatient prescription drug benefit may not be included in a Medicare supplement policy or certificate sold after December 31, 2005.~~

(6) The following descriptions detail the contents of two Medicare supplement plans mandated by the MMA:

(a) standardized Medicare Supplement Benefit Plan K must consist of only those benefits described in ARM 6.6.507(4)(5)(c)(ii)(i); and

(b) standardized Medicare Supplement Benefit Plan L must consist of only those benefits described in ARM 6.6.507(4)(5)(c)(ii).

(7) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall may not include an outpatient prescription drug benefit.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA
IMP: 33-22-902, 33-22-904, 33-22-905, MCA

REASON: The proposed changes to this rule are mostly non-substantive, and will hopefully both follow the NAIC model more closely and make the rule easier to read. Errors in citations to other rules were fixed, and other changes were made to conform this rule to Montana rule drafting procedures.

6.6.507B OPEN ENROLLMENT (1) No issuer shall may deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for a policy or certificate is submitted:

~~(a) prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B;~~ or

~~(b) during the 63-day period following termination of coverage under a group or individual health insurance policy or certificate for a person enrolled, or eligible for enrollment in Medicare Part B, and who resides in this state, upon the request of the individual.~~

(2) and (3) remain the same.

~~(4) There shall be a one-time open enrollment from October 15, 2015, to December 7, 2015, for individuals who meet the following criteria:~~

~~(a) the individual became eligible and the individual's enrollment became effective for Medicare Part A and Medicare Part B by reason of disability, prior to October 18, 2013; and~~

~~(b) the individual did not apply for coverage from an issuer, or applied for coverage from an issuer and was denied.~~

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA
IMP: 33-22-902, 33-22-904, MCA

REASON: The proposed changes to this rule are mostly non-substantive. The changes are meant to bring the rule in line with Montana rule drafting procedures. Section (4) is being removed because the allotted time period for the special enrollment period has passed. The only substantive change is removing previous subsection (1)(b), because it is already covered in ARM 6.6.507C, and the redundant language was potentially confusing.

6.6.507C GUARANTEED ISSUE FOR ELIGIBLE PERSONS (1) through (1)(b)(i) remain the same.

(ii) discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and
or

(iii) ~~may not~~ impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(c) if an eligible person who originally purchased an issue-age rated plan ~~and then~~ applies for another issue-age plan from any issuer on a guaranteed issue basis, ~~then~~ that issuer must rate the replacement policy or certificate using the age at which the original policy or certificate ~~being replaced~~ was rated.

(2) through (2)(b) remain the same.

(c) The individual: ~~is enrolled with:~~

(i) is enrolled with one of the following organizations:

(A) through (d) remain the same.

(i) of the insolvency of the issuer or bankruptcy of the non-issuer organization; ~~or~~

(ii) through (e)(i) remain the same.

(ii) the subsequent enrollment under (2)(e) is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the Federal Social Security Act); ~~or~~

(f) through (i) remain the same.

(3) ~~The following describes the guaranteed issue time periods in the case of:~~

(a) for an individual described in (2)(a); ~~the guaranteed issue period~~

(i) begins on the later of:

(i) remains the same but is renumbered (A).

~~(ii)(B)~~ (B) the date that the applicable coverage terminates or ceases; ~~and~~ or

(iii) remains the same but is renumbered (ii).

(b) for an individual described in (2)(b), (c), (e), (f), or (h), whose enrollment is terminated involuntarily, ~~the guaranteed issue period~~ begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

(c) for an individual described in (2)(d)(i) or (ii), ~~the guaranteed issue period begins on the earlier of:~~

(i) begins on the earlier of:

~~(i)(A)~~ (A) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other similar notice if any; ~~and~~ or

~~(ii)(B)~~ (B) the date that the applicable coverage is terminated; ~~;~~

(ii) and ends on the date that is 63 days after the date the coverage is terminated;

(d) for an individual described in (2)(b), (d)(iii), (d)(iv), (e), or (f) who disenrolls voluntarily, ~~the guaranteed issue period~~ begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date;

(e) for an individual described in (2)(g), ~~the guaranteed issue period~~ begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D;

(f) ~~for~~ for an individual described in (2) but not described in the preceding provisions of ~~(3) the rule, the guaranteed issue period~~ begins on the effective ~~dates~~ date of disenrollment and ends on the day that is 63 days after the effective date; and

(g) ~~for~~ for an individual described in (2)(i), ~~the guaranteed issue period~~ begins on the date the individual is informed of the individual's eligibility for Medicare by reason of disability and end 63 days after that date.

(4) ~~The following describes the~~ An individual is entitled to an extension of the guarantee issue time periods for extended Medicare supplement and Medicare select access for if there is an interrupted trial period, as follows periods in the case of:

(a) if an individual described in (2)(e) (or deemed to be so described, pursuant to this subsection) whose enrollment with an organization or provider described in (2)(e)(i) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, then the subsequent enrollment shall be deemed to be an initial enrollment described in (2)(e);

(b) if an individual described in (2)(f) (or deemed to be so described, pursuant to this subsection) whose enrollment with a plan or in a program described in (2)(f) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, then the subsequent enrollment shall be deemed to be an initial enrollment described in (2)(f); and

(c) through (6)(b) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA

IMP: 33-22-902, 33-22-904, 33-22-905, MCA

REASON: The proposed changes to this rule are non-substantive. The changes are meant to bring the rule in line with Montana rule drafting procedures.

6.6.507E STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2010 STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010 (1) and (2) remain the same.

(3) If an issuer makes available any of the additional benefits described in ARM 6.6.507D(4)(b) or offers standardized benefits Plans K or L (as described in ARM 6.6.507E(8)(a) and (b) of this subchapter), then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic core benefits as ~~describe~~ described in (2), a policy form or certificate form containing either Standardized Benefit Plan C (as described in ARM 6.6.507E(7)(c) of this subchapter) or Standardized Benefit Plan F (as described in ARM 6.6.507E(7)(e) of this subchapter).

(4) through (7)(a) remain the same.

(b) Standardized Medicare Supplement Benefit Plan B must include only the following:

(i) the core benefit as established in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible as established in ARM 6.6.507D(4)(b)(i).

(c) Standardized Medicare Supplement Benefit Plan C must include only the following:

(i) the core benefit, as established in ARM 6.6.507D(4)(a); plus

(ii) 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as established in ARM 6.6.507D(4)(b)(i), (iii), (iv), and (vi), respectively.

(d) standardized Medicare Supplement Benefit Plan D must include only the following:

(i) the core benefit, as established in ARM 6.6.507D(4)(a); plus

(ii) 100% of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country, as established in ARM 6.6.507D(4)(b)(i), (iii), and (vi), respectively.

(e) Standardized Medicare Supplement Benefit regular Plan F must include only the following:

(i) the core benefit as established in ARM 6.6.507D(4)(a); plus

(ii) 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country, established in ARM 6.6.507D(4)(b)(i), (iii), (iv), (v), and (vi), respectively.

(f) standardized Medicare Supplement Benefit High Deductible Plan F shall include only the following:

(i) 100% of covered expenses following the payment of the annual High Deductible Plan F deductible. ~~The covered expenses include:~~

~~(A)(i) "Covered expenses" for this subsection are the core benefit as defined in ARM 6.6.507D(4)(a); plus~~

~~(B) 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in ARM 6.6.507D(4)(b)(i), (iii), (iv), (v), and (vi), respectively.~~

(ii) The "annual high deductible Plan F deductible" shall must consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement regular Plan F policy, and shall must be in addition to any other specific benefit deductibles. The basis for the deductible shall will be \$1500 and shall will be adjusted annually from 1999 by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

(g) Standardized Medicare Supplement Benefit Plan G must include only the following:

(i) core benefit as established in ARM 6.6.507D(4)(a); plus

(ii) 100% of the Medicare Part A deductible, ~~the~~ skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as established in ARM 6.6.507D(4)(b)(i), (iii), (v), and (vi), respectively. Effective January 1, 2020, the standardized benefit plans described in

[New Rule I(2)(d)] (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(8) remains the same.

(9) Standardized Medicare Supplement Plan M shall include only the following:

~~(a)~~ the basic ~~(core)~~ benefit as defined in ARM 6.6.507D(4)(a), plus 50% of the Medicare Part A deductible;

~~(b)~~ skilled nursing facility care, and

~~(c)~~ medically necessary emergency care in a foreign country as defined in ARM 6.6.507D(4)(b)(ii), (iii), and (vi), respectively.

(10) Standardized Medicare Supplement Plan N shall include only the following:

~~(a)~~ the basic ~~(core)~~ benefit as defined in ARM 6.6.507D(4)(a), plus 100% of the Medicare Part A deductible;

~~(b)~~ skilled nursing facility care; and

~~(c)~~ medically necessary emergency care in a foreign country as defined in ARM 6.6.507D(4)(b)(i), (iii), and (vi), respectively, with copayments in the following amounts:

(i) and (ii) remain the same but are renumbered (a) and (b).

(11) An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits must include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, are cost-effective, and are offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. New or innovative benefits must not include an outpatient prescription drug benefit. New or innovative benefits shall may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

AUTH: 33-1-313, 33-22-904, 33-22-905, MCA

IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

REASON: The proposed changes to this rule are mostly non-substantive, and will hopefully both follow the NAIC model more closely and make the rule easier to read. The one substantive change is the inclusion of language to subsection (7)(g) necessary to comply with MACRA, as explained in the reason for New Rule I, above.

6.6.508 LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM (1) A Medicare supplement policy form or certificate form must:

~~(a)~~ not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

~~(i)(a)~~ at least 75% of the aggregate amount of premiums earned in the case of group policies, ~~calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health care maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices; or~~

~~(ii)(b)~~ at least 65% of the aggregate amount of premiums earned in the case of individual policies, ~~calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices; or~~

~~(iii)(2)~~ The loss ratio must be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. ~~incurred~~ Incurred health care expenses where coverage is provided by a health maintenance organization must not include:

(A) through (E) remain the same but are renumbered (a) through (e).

~~(F)(f)~~ administrative costs; ~~and or~~

~~(G)(g)~~ claims processing costs.

~~(b)(3)~~ all All filings of rates and rating schedules must demonstrate that expected claims in relation to premiums comply with the requirements of this rule when combined with actual experience to date. Filings of rate revisions must also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(4) The experience used to calculate an expected loss ratio must be the separate experience of any plan. However, if there is more than one Plan H, I, or J because of the requirements of the MMA, the experience of each plan issued before September 9, 2005, and of each H, I, or J Plan of any type issued on or after September 9, 2005, must be combined for the purpose of determining the expected loss ratio. The experience must also be provided separately for each of these plans for the department's records.

~~(e)(5)~~ Policy forms or plans utilizing for purposes of this rule, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including print, broadcast, and electronic advertising) on or before December 8, 2017, must be regarded as group policies for purposes of rate increase filings. This does not change the yearly benchmark filing required by (7). For policy forms or plans using advertising after December 8, 2017, the loss ratios required by this rule do not change regardless of any advertising methods used. ~~and~~

~~(d)(6)~~ For policies issued prior to September 30, 1993, expected claims in relation to premiums shall meet:

~~(i)(a)~~ the originally filed anticipated loss ratio when combined with the actual experience since inception;

~~(ii)(b)~~ the appropriate loss ratio requirement from (1)(a)~~(i)~~ and ~~(ii)(b)~~ when combined with actual experience beginning with June 21, 1996 to date; and

~~(iii)(c)~~ the appropriate loss ratio requirement from (1)(a)~~(i)~~ and ~~(ii)(b)~~ over the entire future period for which the rates are computed to provide coverage.

~~(2)(7)~~ Annual reporting and refund or credit calculations must conform to the following requirements An issuer shall collect and file with the commissioner by May 31 of each year:

(a) an issuer shall collect and file with the commissioner by May 31 of each year the data contained in the reporting form contained in Appendix A of the NAIG Model Regulation To Implement The NAIC Medicare Supplement Insurance Minimum Standards Model Act, April 2001 (see ARM 6.6.524), for each type in a standard Medicare supplement benefit plan;

(b) If if, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation (see ARM 6.6.524) must be done on a statewide basis for each type in a standard Medicare Supplement Benefit Plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded;

(c) for the purposes of this subsection, for policies or certificates issued prior to September 30, 1993, the issuer shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after February 13, 2004. ~~The first report shall be due by May 31, 2005;~~ and

(d) a refund or credit ~~shall~~ must be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. ~~Such~~ The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of interest for 13-week treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

~~(3)(8)~~ An issuer of Medicare supplement policies and certificates issued before or after the effective date of these rules in this state must file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums by policy duration, for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner, ~~demonstrating that it is in compliance with the foregoing.~~ The supporting documentation must also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. ~~Such~~ The demonstration must exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

~~(a)(9)~~ As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in the state must file with the commissioner, in accordance with the applicable filing procedures of this state:

~~(+)(a)~~ appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates; and ~~Such supporting documents as necessary to justify the adjustment must accompany the filing. An issuer must make such premium adjustments as are necessary to~~

~~produce and expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.~~

~~(ii) an issuer must make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.~~

~~(A) the experience used to calculate an expected loss ratio must be the separate experience of any plan. If there is more than one Plan H, I, or J because of the requirements of the MMA, the experience of each plan issued before September 9, 2005, and of each H, I, or J Plan of any type issued on or after this date must be combined for the purpose of determining the expected loss ratio. The experience must also be provided separately for each of these plans for the department's records.~~

~~(iii) if an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this rule; and~~

~~(b) any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.~~

(10) An issuer must make such premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy, other than the adjustments described in this rule, should be made with respect to a policy at any time other than upon its renewal date or anniversary date. Any premium adjustment filings must include all necessary supporting documents to justify the adjustment.

(11) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this rule.

~~(4)~~(12) The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this rule if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. Any ~~such~~ determination of compliance is should be made without consideration of any refund or credit for ~~such~~ the reporting period. Public notice of ~~such~~ the hearing shall be furnished in a manner deemed appropriate by the commissioner.

AUTH: 33-1-313, 33-22-904, 33-22-906, MCA

IMP: 33-15-303, 33-22-902, 33-22-906, MCA

REASON: Most of the proposed changes to this rule are non-substantive. The changes are meant to provide clarity and to conform the language to Montana rule drafting requirements. In addition, surplus language accidentally not removed from previous amendments has been deleted.

The only substantive change is the modification of previous subsection (1)(c)—proposed (5)—regarding loss ratio standards based on mass media advertising of Medicare supplement policies. The proposed changes clarify that policies which do mass media or direct mail advertising must be treated as group only for purposes of rate increase filings. The rule was never meant to change the benchmark form that insurers use to report yearly benchmark calculations. Moving forward, the commissioner has determined that it is not appropriate to modify the loss ratio standard for either individual or group Medicare supplement policies based on how those policies are advertised. This rule change is anticipated to be effective December 8, 2017, when the final adoption notice is published.

6.6.508A FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES (1) remains the same.

(2) An issuer must file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the MMA, ~~only~~ with the commissioner in the state in which the policy or certificate was issued.

(3) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation, together with the outline of coverage, have been filed with and approved by the commissioner in accordance with the filing requirements and procedures adopted by the commissioner.

(4) Except as provided in (4)(a), an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare Supplement Benefit Plan supplement benefit plan.

(a) through (ii) remain the same.

(iii) the addition of either guaranteed issue or underwritten coverage; or

(iv) the offering of coverage to individuals eligible for Medicare by reason of disability.

(b) through (5)(d) remain the same.

(i) ~~The~~ the issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

(ii) ~~The~~ the issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest; and

~~(iii) The issuer applies the revised rating methodology to in force business as well as to new business. The issuer must refund the difference between the total amount of premium each insured individual actually paid under the existing rating methodology and the total amount of premium the individual would have paid if the revised rating methodology had been applied since the issue date of that individual's coverage, if the difference is greater than zero dollars. The refund process must be carried out in a form and manner prescribed and approved by the commissioner.~~

(6) ~~Except as provided in (6)(a), the~~ The experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan must be combined for purposes of the refund or credit calculation prescribed in ARM 6.6.508, except that

~~(a) Forms~~ forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(7) An issuer may not file a rate structure for its Medicare supplement policies and certificates after January 1, 2006, based upon a structure or methodology with any groupings of attained ages greater than one year for each year the rate increases. The rate change may be flat at the beginning and end of the rate structure, but otherwise the ratio between rates for successive ages must exhibit a smooth pattern as age increases. For example, the commissioner may allow a rate structure that has the same rate for policyholders younger than 68, a rate that smoothly increases some percentage each successive year through age 90, and then maintains the same rate for policyholders older than 90.

(8) An issuer has the option of offering Medicare supplement plans on an attained age basis, issue age basis, or a dual rating basis. Only one rating methodology may be chosen per Medicare supplement benefit plan, except as provided in (4)(a).

(a) Regardless of the rating methodology chosen, an issuer must provide adequate information to consumers so they may make informed decisions on their Medicare supplement purchases.

(b) If an issuer elects to offer dual rating, the issuer must:

(i) provide a choice between an issue age or attained age rating methodology to individual policyholders, for individual policies, or to group policyholders (not certificate holders) for group policies;

(ii) develop materials which disclose both rating methodologies, including how the methodologies differ in the near term and the long term;

(iii) provide the same commission for both methodologies;

(iv) allow consumers to switch from an attained age rating methodology to an issue age rating methodology; and

(v) prohibit consumers from switching from an issue age rating methodology to an attained age rating methodology.

(9) As a one-time exception to (5), between [the adoption of this amendment] and July 1, 2018, issuers may discontinue currently existing plans and re-file the same plan for the sole purpose of applying the individual or group loss ratio to rate filings regardless of advertising methods, as set forth in ARM 6.6.508(1) and (5). All other details of the re-filed plan must remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-905, 33-22-906, MCA
IMP: 33-22-904, 33-22-906, MCA

REASON: Most of the proposed changes to this rule are non-substantive. Most of the changes are meant to provide clarity and to conform the language to Montana rule drafting requirements. The first substantive change is to (7), which is meant to conform the rule to current standard practice. Most insurers that have attained age rates do not change the rates for either very young or very old policyholders. The commissioner does not see any reason to curtail this practice.

The second substantive change is the inclusion of (8) on rating methodologies. The purpose of this section is to expressly allow dual rating, which has been allowed in the past but was not clearly defined in rule. New (8) will expressly allow this practice, and ensure that the practice will not harm consumers.

Finally, (9) allows insurers to re-file current Medicare supplement plans under the new ARM 6.6.508(5), applying loss ratios to those plans regardless of the advertising method used. Typically insurers are not allowed to discontinue existing plans without a 5-year moratorium on re-entering the market pursuant to (5), but the Commissioner has determined that it would be in the public interest to allow this one-time exception, given the proposed changes to existing rules.

6.6.509 REQUIRED DISCLOSURE PROVISIONS (1) through (9) remain the same.

(10) The CSI adopts and incorporates by reference the National Association of Insurance Commissioners (NAIC) Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, (MDL-651), page 651-563 through page 651-1064, which was last adopted in the 1st quarter of 2017, and is available online at http://www.naic.org/prod_serv_model_laws.htm. sets forth the Medicare payment tables for insurers, and specifically in this rule are the Outlines of Medicare Supplement Coverage - Cover Page: 1 of 2: Benefit Plan(s) A, B, C, D, E, F, G, H, I, J, and High Deductible Plans F & J; Outline of Medicare Supplement Coverage - Cover Page 2: Benefit Plan(s) K, L, M & N, which include similar services as Plans A-J, but cost-sharing for the basic benefits is at different levels, adopted 7/17/09. Specifically, those pages of the NAIC MDL-651 set forth benefit charts, disclosures to insureds, and outlines of coverage for Medicare supplement plans that must be included in the outline of coverage provided to the

consumer in the same order as set forth in NAIC MDL-651. Copies of the NAIC MDL-651 Model rule containing Plans A – N are also available for public inspection at the Office of the Commissioner of Securities and Insurance, Montana State Auditor, Legal Department, 840 Helena Avenue, Helena, Montana 59601, ~~or on the department's web site.~~ Persons obtaining a copy of these forms must pay the cost of providing such copies.

(11) and (12) remain the same.

AUTH: 33-1-313, 33-22-904, 33-22-907, MCA

IMP: 33-15-303, 33-22-902, 33-22-904, 33-22-907, MCA

REASON: The incorporation by reference to NAIC model regulation MDL-651 has been updated to reference the correct page numbers and the web address where the model may be found online.

6.6.510 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE (1) Application forms must include the following questions designed to elicit information as to whether, as of the date of application, the applicant currently has Medicare supplement, Medicare advantage, Medicaid coverage, or another health policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements as the following may be used: Application forms must use the following statements and questions in substantially the same format as follows:

(a) ~~—————~~ (STATEMENTS)

~~(1) You do not need more than one Medicare supplement policy.~~

~~(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.~~

~~(3) You may be eligible for benefits under Medicaid and may not need a medicare supplement policy.~~

~~(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy must be suspended if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstated policy will not have~~

~~outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.~~

~~(5) If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstated policy will not have prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.~~

~~(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary (SLMB).~~

~~(b) _____ (QUESTIONS)~~

~~If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.~~

~~[Please mark yes or no below with an "X"]~~

~~To the best of your knowledge:~~

~~(1)(a) Did you turn age 65 in the last 6 months?~~

~~YES _____ NO _____~~

~~(b) Did you enroll in Medicare Part B in the last 6 months? YES _____ NO _____~~

~~(c) If yes, what is the effective date? _____~~

~~(d) Did you enroll in Medicare Part C in the last 6 months? YES _____ NO _____~~

~~(e) If yes, what is the effective date? _____~~

~~(f) Did you enroll in Medicare Part D in the last 6 months? YES _____ NO _____~~

~~(g) If yes, what is the effective date? _____~~

~~(2) Are you covered for medical assistance through the state Medicaid program? [NOTE TO APPLICANT: If you are participating in a "spend-down"~~

program and have not met your "share of cost," please answer NO to this question.]
YES _____ NO _____ If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

YES _____ NO _____

(b) Do you receive any benefits from Medicaid other than payments toward your Medicare part B premium?

YES _____ NO _____

(3)(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

Start / / End / /

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? YES _____ NO _____

(c) Was this your first time in this type of Medicare plan? YES _____ NO _____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? YES _____ NO _____

(4)(a) Do you have another Medicare supplement policy in force? YES _____ NO _____

(b) If so, with what company, and what plan do you have [optional for direct mailers]?

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

YES _____ NO _____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) YES _____ NO _____

(a) If so, with what company and what kind of policy?

(b) What are your dates of coverage under the other policy? Start / /
End / /

(If you are still covered under the other policy, leave "end" blank.)

(STATEMENTS)

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

- (4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy must be suspended if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- (5) If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare part D while your policy was suspended, the reinstated policy will not have prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(QUESTIONS)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please

include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark Yes or No below with an "X"]

To the best of your knowledge:

(1)(a) Did you turn age 65 in the last 6 months?

YES _____ NO _____

(b) Did you enroll in Medicare Part B in the last 6 months?

YES _____ NO _____

(c) If yes, what is the effective date? _____

(d) Did you enroll in Medicare Part C in the last 6 months?

YES _____ NO _____

(e) If yes, what is the effective date? _____

(f) Did you enroll in Medicare Part D in the last 6 months?

YES _____ NO _____

(g) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are participating in a "spend-down" program and have not met your "share of cost," please answer NO to this question.]

YES _____ NO _____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

YES _____ NO _____

(b) Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

YES _____ NO _____

(3)(a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

Start / / End / /

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

YES _____ NO _____

(c) Was this your first time in this type of Medicare plan?

YES _____ NO _____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

YES _____ NO _____

(4)(a) Do you have another Medicare supplement policy in force?

YES _____ NO _____

(b) If so, with what company, and what plan do you have [optional for direct mailers]?

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

YES _____ NO _____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)

YES _____ NO _____

(a) If so, with what company and what kind of policy?

(b) What are your dates of coverage under the other policy?

Start / / End / / _____

(If you are still covered under the other policy, leave "end" blank.)

[End Statements and Questions Form]

~~(6)~~(2) Producers shall list any other health insurance policies they have sold to the applicant, including:

(a) Policies sold which are still in force; and

(b) Policies sold in the past five years which are no longer in force.

~~(7)~~(3) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

~~(8)~~(4) Upon determining that a sale will involve replacement of medicare supplement coverage, and prior to the issuance or delivery of the medicare supplement policy or certificate, an issuer, other than a direct response insurer, or its producer must furnish the applicant a notice regarding replacement of medicare supplement coverage. One copy of the notice signed by the applicant and the

producer, except where coverage is sold without a producer, must be provided to the applicant and an additional signed copy must be retained by the issuer for three years. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement coverage.

(9)(5) The notice required by (4) for an issuer must be in substantially the same form as below and be in no less than 12 point type.:

~~(c) — NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE~~

~~(Insurance Company's Name and Address)~~

~~SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.~~

~~According to (your application) (information you have furnished), you intend to terminate existing Medicare or Medicare advantage supplement insurance and replace it with a policy to be issued by (Company Name). Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.~~

~~You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement or Medicare advantage coverage is a wise decision.~~

~~STATEMENT TO APPLICANT BY ISSUER, OR PRODUCER:~~

~~I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare advantage plan. The replacement policy is being purchased for the following reason(s) (check one):~~

- ~~_____ Additional benefits.~~
- ~~_____ No change in benefits, but lower premiums.~~
- ~~_____ Fewer benefits and lower premiums.~~
- ~~_____ Other. (please specify)~~
- ~~_____ My plan has outpatient prescription drug coverage and I am enrolling in part D.~~
- ~~_____ Disenrollment from a Medicare advantage plan. Please explain reason for disenrollment. [optional only for direct mailers.]~~

~~_____

_____~~

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE**

(Insurance Company's Name and Address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to terminate existing Medicare or Medicare advantage supplement insurance and replace it with a policy to be issued by (Company Name). Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement or Medicare advantage coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare advantage plan.—The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ My plan has outpatient prescription drug coverage and I am enrolling in part D.

_____ Disenrollment from a Medicare advantage plan. Please explain reason for disenrollment. [optional only for direct mailers.]

_____ Other. (please specify)

{1.} **Note**: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement {2} below. Health conditions which you may presently have

(pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

{2.} State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

{3.} If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Producer or Other Representative)*

[Typed Name and Address of Issuer or Producer]

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

*Signature not required for direct response sales.

[END OF NOTICE FORM]

**(6) Paragraphs {1.} and {2.} of the replacement notice, above (applicable to preexisting conditions), may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

AUTH: 33-1-313, 33-22-904, 33-22-907, MCA

IMP: 33-15-303, 33-22-904, 33-22-907, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

REASON: The proposed changes to this rule are non-substantive. The changes to the rule numbering are meant to correct errors in numbering between substantive sections of this rule, and numbering of forms to be provided to the consumer. The changes to the format of the forms are meant to make the forms more readable.

6.6.517 PERMITTED COMPENSATION ARRANGEMENTS (1) An issuer or other entity may provide commission or other compensation to a producer ~~or other representative~~ for the sale of a ~~medicare~~ Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(2) remains the same.

(3) No issuer or other entity shall provide compensation to its producers, ~~or other representatives~~ and no producer ~~or other representative~~ shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(4) remains the same.

(5) As part of the annual filing under ARM 6.6.508~~(3)~~(6), the entity providing ~~medicare~~ Medicare supplement policies shall provide copies of commission schedules.

(a) An issuer must provide reasonable compensation, as provided under the plan of operation of the program, to a producer, if any, for the sale of a Medicare supplement insurance policy or certificate. For purposes of this rule, "reasonable compensation" shall be at least 3% of the premium paid for the policy or certificate.

(b) An issuer may not vary the commission paid on the sale or renewal of a Medicare supplement insurance policy or certificate due to any factor other than the first year or renewal status of the policy or certificate. For example, issuers may not vary the commission based on the plan marketed or the age, health status, location, or claims experience of the insured. Issuers may pay a different commission on a policy transferred to a different producer for servicing purposes following the initial sale, or on a policy sold over the internet, so long as there is no other variation in the commission for any other reason.

AUTH: 33-1-313, 33-22-904, MCA

IMP: ~~33-15-303~~, 33-22-902, 33-22-904, 33-22-906, MCA

REASON: The language "or other representative" is being deleted because allowing compensation to entities not licensed as insurance producers in Montana would violate 33-17-1103, MCA. The Commissioner proposes adding subsections (5)(a) and (5)(b) in order to prohibit insurers from discriminating between Medicare supplement policyholders, some of whom only qualify for Medicare because of a preexisting condition or illness. In addition, the Commissioner seeks to establish a minimum commission level to make sure insurers are actively marketing their open

Medicare supplement plans, as required by ARM 6.6.508A. The reference to 33-15-303, MCA, as an implementing statute has been removed, because this rule does not address the contents of insurance policies. Finally, the word "Medicare" has been capitalized for consistency in this subchapter.

6.6.519 STANDARDS FOR MARKETING (1) through (1)(f) remain the same.

(g) provide to the enrollee an appropriate disclosure statement if the enrollee has accident and sickness insurance. These statements must be identical to the disclosure statements in ~~Appendix C of the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, April 2001, (see ARM 6.6.526).~~

(2) and (3) remain the same.

AUTH: 33-1-313, 33-18-235, 33-22-904, MCA

IMP: 33-15-303, 33-18-202, 33-18-204, 33-22-907, 33-22-908, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

REASON: The department proposes to remove the reference to the NAIC model regulation because it was outdated, and is redundant with the content of ARM 6.6.526.

6.6.521 REPORTING OF MULTIPLE POLICIES (1) On or before March 1 of each year, every issuer shall report, on the form contained in ~~Appendix B of the NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act, April 2001 (see ARM 6.6.525),~~ information for every individual resident of this state for which the issuer has in force more than one ~~medicare~~ Medicare supplement insurance policy or certificate. The following information must be reported:

(a) through (2) remain the same.

AUTH: 33-1-313, 33-22-904, MCA

IMP: 33-15-303, 33-22-904, 33-22-907, MCA

REASON: The department proposes to remove the reference to the NAIC model regulation because it was outdated, and is redundant with the content of ARM 6.6.525.

6.6.526 APPENDIX C DISCLOSURE STATEMENTS (1) through (1)(b) remain the same.

(c) [Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

<p>IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS</p>

This is not Medicare Supplement Insurance.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare Supplement insurance, review the "Guide to Health Insurance for People with Medicare," available from the insurance company.
- √ For help in understanding your health insurance, contact your state insurance department or state [health] insurance [assistance] program [SHIP].

(d) through (n) remain the same.

AUTH: 33-22-904, 33-22-905, MCA

IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

REASON: This change corrects a small error in the Montana rule from the NAIC model.

5. The department proposes to repeal the following rules:

6.6.511 FORMS OUTLINING COVERAGE on page 6-141 of the Administrative Rules of Montana.

AUTH: 33-1-313, 33-22-904, MCA

IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

6.6.511A FORMS OUTLINING COVERAGE on page 6-143 of the Administrative Rules of Montana.

AUTH: 33-1-313, 33-22-904, MCA

IMP: 33-15-303, 33-22-901, 33-22-902, 33-22-903, 33-22-904, 33-22-905, 33-22-906, 33-22-907, 33-22-908, 33-22-909, 33-22-910, 33-22-911, 33-22-921, 33-22-922, 33-22-924, MCA

REASON: The department is proposing to repeal ARM 6.6.511 and 6.6.511A because they are redundant. The forms outlining coverage are already incorporated by reference into Montana law by ARM 6.6.509(10).

6. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Michael A. Kakuk, Attorney, Office of the Montana State Auditor, 840 Helena Ave., Helena, Montana, 59601; telephone (406) 444-0385; fax (406) 444-3497; or e-mail mkakuk@mt.gov, and must be received no later than 5:00 p.m., October 20, 2017.

7. Michael A. Kakuk, Attorney, has been designated to preside over and conduct this hearing.

8. The CSI maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list may sign up by clicking on the blue button on the CSI's website at: <http://csimt.gov/laws-rules/> and may specify the subject matter they are interested in. Notices will be sent by e-mail unless a mailing preference is noted in the request. Requests may also be sent to the CSI in writing. Such written request may be mailed or delivered to the contact information in 2 above, or may be made by completing a request form at any rules hearing held by the CSI.

9. The bill sponsor contact requirements of 2-4-302, MCA do not apply.

10. With regard to the requirements of 2-4-111, MCA, the department has determined that the adoption, amendment, and repeal of the above-referenced rules will significantly and directly impact small businesses.

/s/ Michael A. Kakuk
Michael A. Kakuk
Rule Reviewer

/s/ Kris Hansen
Kris Hansen
Chief Legal Counsel

Certified to the Secretary of State September 11, 2017.