NORTH CAROLINA GENERAL ASSEMBLY
1981 SESSION

CHAPTER 503
SENATE BILL 449

AN ACT TO ESTABLISH MINIMUM STANDARDS FOR MEDICARE SUPPLEMENT INSURANCE.

The General Assembly of North Carolina enacts:

Section 1. Chapter 58 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 27B.
"Medicare Supplement Insurance Minimum Standards.

"**§ 58-262.8. Definitions. —** Unless the context clearly indicates otherwise, the following words and phrases shall have the following meanings:

(1) 'Applicant' means:
   a. in the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and
   b. in the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder.

(2) 'Certificate' means, for the purposes of this Article, any certificate issued under a group Medicare supplement policy, which policy has been delivered or issued for delivery in this State.

(3) 'Medicare Supplement Policy' means a group or individual policy of accident and sickness insurance or a subscriber contract of a hospital, medical and/or dental service corporation organized under Chapter 57 of the General Statutes 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. Such term does not include:
   a. A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations, or
   b. A policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:
      1. is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;
      2. has been maintained in good faith for purposes other than obtaining insurance; and
      3. has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members.
   c. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance

when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this Article.

(4) 'Medicare' means the 'Health Insurance for the Aged Act', Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"**§ 58-262.9. Standards for policy provisions definitions. —** No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy unless that policy or subscriber contract contains definitions or terms which conform to the requirement of this section.

(1) 'Accident', 'Accidental Injury', or 'Accidental Means' shall be defined to employ 'result' language and shall not include words which establish an accidental means test or 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. Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

(2) 'Benefit Period' or 'Medicare Benefit Period' shall not be defined as more restrictive than as that defined in the Medicare program.

(3) 'Convalescent Nursing Home', 'Extended Care Facility', or 'Skilled Nursing Facility' shall be defined in relation to its status, facilities and available services.
   a. A definition of such home or facility shall not be more restrictive than one requiring that it:
      1. be operated pursuant to law;
      2. be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;
      3. be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;
      4. provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and
      5. maintains a daily medical record of each patient.
   b. The definition of such home or facility may provide that such term shall not be inclusive of:
      1. any home, facility or part thereof used primarily for rest;
      2. a home or facility for the aged or for the care of drug addicts or alcoholics; or
      3. a home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(4) 'Hospital' may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.
   a. The definition of the term 'hospital' shall not be more restrictive than one requiring that the hospital:

1. be an institution operated pursuant to law; and
2. 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 duly 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
3. 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 such term shall not be inclusive of:

1. convalescent homes, convalescent, rest, or nursing facilities; or
2. facilities primarily affording custodial, educational or rehabilitative care; or
3. facilities for the aged, drug addicts or alcoholics; or
4. any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(5) 'Medicare' shall be defined in the policy. Medicare may be substantially defined as 'The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended', or 'Title I, Part I of Public Law 39-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act', 'as then constituted and any later amendments or substitutes thereof', or words of similar import.

(6) 'Medicare Eligible Expenses' shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims.

(7) 'Mental or Nervous Disorders' shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(8) 'Nurses' may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words 'nurse', 'trained nurse' or 'registered nurse' are used without specific instruction, then the use of these terms requires the insurer to recognize the services of any individual who qualified under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the State.

(9) 'Physician' may be defined by including words like 'duly qualified physician' or 'duly licensed physician'. The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when the 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.

"**§ 58-262.10. Prohibited policy provisions. —** (a) No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if that policy or subscriber contract limits or excludes coverage by type of illness, accident, treatment or medical condition, except as follows:

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

(2) illness, treatment or medical condition arising out of;

a. war or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary thereto;

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

c. aviation;

(3) cosmetic surgery, except that '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;

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

(5) dental care or treatment;

(6) eye glasses, hearing aids and examination for the prescription or fitting thereof;

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

(8) territorial limitations;

provided, however, Medicare supplement policies may not contain, when issued, limitations or exclusion of the type enumerated in subdivisions (7) or (8) of this subsection 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) Medicare supplement policy coverages for the following shall not be more restrictive than those of Medicare:

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

(2) 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 such interference is the result of or related to distortion, misalignment or subluxation of, or in the vertebral column.

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

"**§ 58-262.11. Minimum benefit standards. —** No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this State 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.

(1) General Standards. The following standards apply to Medicare supplement policies and are in addition to all other requirements of this Article.

a. A Medicare supplement policy may not deny a claim for losses incurred more than six 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 six months before the effective date of coverage.

b. A Medicare supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

d. A 'noncancellable', 'guaranteed renewable', or 'noncancellable and guaranteed renewable' Medicare supplement policy shall not:

1. 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

2. be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health; and

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

(2) Minimum Benefit Standards.

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

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

c. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (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;

d. Coverage of twenty percent (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 two

hundred dollars ($200.00) of such expenses and to a maximum benefit of at least five thousand dollars ($5,000) per calendar year.

"**§ 58-262.12. Loss ratio standards. —** Medicare supplement policies shall be expected to return to policyholders in the form of aggregate benefits under the policy, as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices:

(1) At least seventy-five percent (75%) of the aggregate amount of premiums collected in the case of group policies, and

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

For 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.

"**§ 58-262.13. Disclosure standards. —** (a) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy shall be delivered or issued for delivery in this State and no certificate shall be delivered pursuant to a group Medicare supplement policy delivered or issued for delivery in this State unless an outline of coverage is delivered to the applicant at the time application is made.

(b) General Rules.

(1) Medicare supplement policies shall include a renewal, continuation or nonrenewal provision. The language or specifications of that provision must be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(2) Except for riders or endorsements by which the insured 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 signed acceptance by the insured. After the date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to in writing signed by the insured, except if the increased benefits of coverage are required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such 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 'Pre-existing Condition Limitations'.

(5) Medicare supplement policies or certificates, other than those issued pursuant to direct response solicitation, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance that the policyholder or certificate holder 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 insured person is not satisfied for any reason, if the benefits have not been used. Medicare supplement policies or certificates issued pursuant to a direct response solicitation to persons eligible for Medicare by reason of age shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(6) Insurers issuing accident and sickness policies, certificates or subscriber contracts which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to all applicants a Medicare supplement 'buyer's guide' in the form prescribed by the commissioner. Delivery of the 'buyer's guide' shall be made whether or not the policies, certificates or subscriber contracts are advertised, solicited or issued as Medicare supplement policies as defined in this regulation. Except in the case of direct response insurers, delivery of the 'buyer's guide' shall be made to the applicant at the time of application and acknowledgment of receipt of the 'buyer's guide' shall be obtained by the insurer. Direct response insurers shall deliver the 'buyer's guide' to the applicant upon request but not later than at the time the policy is delivered.

(7) Except as otherwise provided in subsection d. of this section, the terms 'Medicare Supplement', 'Medigap' and words of similar import shall not be used unless the policy is issued in compliance with G.S. 58-262.11.

(c) Outline of Coverage Requirements for Medicare Supplement Policies.

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

(2) If a Medicare supplement policy or certificate is issued on a basis which would require revision of the outline of coverage delivered at the time of application, a substitute outline of coverage properly describing the policy or certificate actually issued must accompany such 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 of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.'

(3) The outline of coverage provided to applicants pursuant to subsections (1) or (2) shall be in the form prescribed below:

(COMPANY NAME)
OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE

(1) Read Your Policy Carefully — This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY.

(2) Medicare Supplement Coverage — Policies of this category are designed to supplement Medicare by covering some hospital, medical, and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).

(3) (a) (for agents:)
Neither (insert company's name) nor its agents are connected with Medicare.
(b) (for direct responses:) (insert company's name) is not connected with Medicare.

(4) (A brief summary of the major benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts, provided by the Medicare supplement coverage in the following order:)

SERVICE	BENEFIT	PAYS	THIS POLICY PAYS	YOU PAY
HOSPITALIZATION — semiprivate room and board, general nursing and miscellaneous hospital services and supplies. Includes means, special care units, drugs, lab test, diagnostic x-rays, medical supplies, operating and recovery room anesthesia and rehabilitation services.	First 60 days			
	61st to 90th day			
	91st to 150th day			
	Beyond 150 days			
POSTHOSPITAL SKILLED NURSING CARE – In a facility approved by Medicare, you must have been in a hospital for at least three days and enter the facility within 14 days after hospital discharge	First 20 days			
	Additional 80 days			
	Beyond 100 days			
MEDICAL EXPENSE	Physicians services in-patient and out-patient medical			

services and
supplies at a
hospital, physical
and speech therapy
and ambulance.

(5) (Statement that the policy does or does not cover the following:)
- (a) Private duty nursing;
- (b) Skilled nursing home care costs (beyond what is covered by Medicare);
- (c) Custodial nursing home care costs;
- (d) Intermediate nursing home care costs;
- (e) Home health care above number of visits covered by Medicare;
- (f) Physician charges (above Medicare's reasonable charge);
- (g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay);
- (h) Care received outside of U.S.A.;
- (i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for the cost of eyeglasses or hearing aids.

(6) (A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described in (4) above, including conspicuous statements.)
- (a) (That the chart summarizing Medicare benefits only briefly describes such benefits.)
- (b) (That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.)

(7) (A description of policy provisions respecting renewability or continuation of coverage, including any reservation or rights to change premium.)

(8) (The amount of premium for this policy.)

(d) Notice regarding policies or subscriber contracts which are not Medicare supplement policies. Any accident and sickness insurance policy or subscriber contract, other than a Medicare supplement policy; disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or policy identified in G.S. 58-262. 8(3)b. issued for delivery in this State to persons eligible for Medicare by reason of age shall notify insureds under the policy or subscriber contract that the policy or subscriber contract is not a Medicare supplement policy. This notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or subscriber contract, or if no outline of coverage is delivered, to the first page of the policy, certificate or subscriber contract delivered to insureds. This notice shall be in no less than 12 point type and shall contain the following language: 'THIS (POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for Medicare review the Medicare Supplement Buyers Guide available from the company.'

"**§ 58-262.14. 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 sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant containing this question may be used.

(b) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and

sickness coverage. One copy of this notice shall be provided to the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness 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) above for an insurer, other than a direct response insurer, shall be provided, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (preexisting 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) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, 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, reread it carefully to be certain that all information has been properly recorded.

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

_____
(Date)

_____
(Applicant's Signature)

(d) The notice required by subsection (b) above for a direct response shall be as follows:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (preexisting 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) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and corrected. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____

(Company Name)

"**§ 58-262.15. Administrative procedure. —** Regulations promulgated pursuant to G.S. 58-262.13(b)(6) shall be subject to the provisions of Chapter 150A of the General Statutes."

Sec. 2. This act shall become effective July 1, 1982.

In the General Assembly read three times and ratified, this the 4th day of June, 1981.