



ADMINISTRATIVE RULES OF MONTANA

6.6.507 BENEFIT STANDARDS FOR MEDICARE SUPPLEMENT BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED OR DELIVERED WITH AN EFFECTIVE DATE FOR COVERAGE PRIOR TO JUNE 1, 2010

- (1) The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.
 - (a) the following standards are in addition to all other requirements of this subchapter and Title 33, chapter 22, part 9, MCA, Medicare Supplement Insurance Minimum Standards:
 - (i) a Medicare supplement policy or certificate shall not exclude or limit benefits for a loss incurred more than six months from the effective date of coverage because it involves a preexisting condition. The policy or certificate 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;
 - (ii) a Medicare supplement policy or certificate must not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;
 - (iii) A Medicare supplement policy or certificate must 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 copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes;
 - (iv) no Medicare supplement policy or certificate may 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;
 - (v) each Medicare supplement policy shall be guaranteed renewable and:
 - (A) the issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and
 - (B) the issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;
 - (vi) if the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (1)(a)(viii), the issuer must offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):
 - (A) provides for continuation of the benefits contained in the group policy; or

- (B) provides for such benefits as are required to meet the minimum standards as defined in 6.6.507D(4)];
 - (vii) if an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
 - (A) offer the certificateholder the conversion opportunity described in (1)(a)(vi);
 - (B) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy;
 - (viii) if a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy must not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced; and
 - (ix) if a Medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), the modified policy or certificate shall be deemed to satisfy the guaranteed renewal requirements of this rule.
- (2) Termination of a Medicare supplement policy or certificate must be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
- (3) A Medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance. 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.
- (a) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate must be automatically reinstituted effective as of the date of termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period.
 - (b) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under 226(b) of the Social Security Act and is covered under a group health plan (as defined in 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted

(effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of loss;

- (c) Reinstitution of coverages as described in (3)(a) and (b); must
 - (i) not provide for any limitation period with respect to treatment of preexisting conditions;
 - (ii) provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy or certificate provided coverage for outpatient prescription drugs, reinstatement of the policy or certificate for Medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and
 - (iii) provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.
- (4) If an issuer makes a written offer to the Medicare supplement policyholders or certificateholders of one or more of its plans, to exchange during a specified period from his or her pre-standardized plan or 1990 standardized plan to a 2010 standardized plan as described in ARM 6.6.507E, the offer and subsequent exchange shall comply with the following requirements:
 - (a) An issuer need not provide justification to the commissioner if the insured replaces a pre-standardized plan or a 1990 standardized policy or certificate with an issue age rate 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner for approval as part of the rate filing;
 - (b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage;
 - (c) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged pre-standardized plan or 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged policy; and
 - (d) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or Federal law.
- (5) Standards for basic ("core") benefits common to benefit Plans A through J include the following:
 - (a) every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "core" package, but not in lieu thereof:

- (i) 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;
 - (ii) coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;
 - (iii) upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for the balance;
 - (iv) coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
 - (v) coverage for the coinsurance amount (or in the case of hospital outpatient department services under a prospective payment system, the co-payment amount) of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.
- (b) The following additional benefits must be included in Medicare supplement benefit Plans B through J only as provided by ARM 6.6.507A:
- (i) coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period;
 - (ii) coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;
 - (iii) coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;
 - (iv) coverage for 80% of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
 - (v) coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge;
 - (vi) coverage for 50% of outpatient prescription drug charges, after a \$250.00 calendar year deductible, to a maximum of \$1,250.00 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy or certificate until January 1, 2006;
 - (vii) coverage for 50% of outpatient prescription drug charges, after a \$250.00 calendar year deductible to a maximum of \$3,000.00 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription

drug benefit may be included for sale or issuance in a Medicare supplement policy or certificate until January 1, 2006;

- (viii) coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of \$250.00, and a lifetime maximum benefit of \$50,000.00. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset; and
- (ix) coverage for the following preventive health services not covered by Medicare:
 - (A) an annual clinical preventive medical history and physical examination that may include tests and services from (4)(b)(ix)(B) and patient education to address preventive health care measure;
 - (B) preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician;
 - (C) reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120.00 annually under this benefit. This benefit must not include payment for any procedure covered by Medicare;
- (x) coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.
 - (A) for purposes of this benefit, the following definitions apply:
 - (I) "activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;
 - (II) "care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;
 - (III) "home" means any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence; and
 - (IV) "at-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive four hours in a 24-hour period of services provided by a care provider is one visit;
 - (B) for the purposes of this benefit, the following coverage requirements apply:

- (I) at-home recovery services provided must be primarily services which assist in activities of daily living.
 - (II) the insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.
 - (C) coverage is limited to:
 - (I) no more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;
 - (II) the actual charges for each visit up to a maximum reimbursement of \$40.00 per visit;
 - (III) \$1,600.00 per calendar year;
 - (IV) seven visits in any one week;
 - (V) care furnished on a visiting basis in the insured's home;
 - (VI) services provided by a care provider as defined in this rule;
 - (VII) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded; and
 - (VIII) at-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight weeks after the service date of the last Medicare approved home health care visit;
 - (D) coverage is excluded for:
 - (I) home care visits paid for by Medicare or other government programs; and
 - (II) care provided by family members, unpaid volunteers or providers who are not care providers.
- (c) the following are the standards for plans K and L:
- (i) Standardized Medicare Supplement Benefit Plan K must consist of the following benefits:
 - (A) coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;
 - (B) coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;
 - (C) upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable PPS rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365

days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

- (D) coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (4)(c)(i)(J);
 - (E) coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in (4)(c)(i)(J);
 - (F) coverage for 50% of cost sharing for all Part A Medicare eligible expenses for hospice and respite care until the out-of-pocket limitation is met as described in (4)(c)(i)(J);
 - (G) coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (4)(c)(i)(J);
 - (H) except for coverage provided in (4)(c)(i)(I), coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (4)(c)(i)(J);
 - (I) coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and
 - (J) coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of \$4,000.00 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary of the U.S. department of health and human services;
- (ii) Standardized Medicare Supplement Benefit Plan L must consist of the following:
- (A) the benefits described in (4)(c)(i)(A), (B), (C) and (I);
 - (B) the benefits described in (4)(c)(i)(D), (E), (F), (G) and (H), but substituting 75% for 50%; and
 - (C) the benefits described in (4)(c)(i)(J), but substituting \$2,000.00 for \$4,000.00.

Authorizing statute(s): 33-1-313, 33-22-904, 33-22-905, MCA

Implementing statute(s): 33-15-303, 33-22-902, 33-22-904, 33-22-905, MCA

History: NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 6/21/96; AMD, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2000 MAR

p. 3518, Eff. 12/22/00; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1672, Eff. 9/9/05; AMD, 2009 MAR p. 1107, Eff. 7/17/09.