

Article 54.

Medicare Supplement Insurance Minimum Standards.

§ 58-54-1. Definitions.

Unless the context clearly indicates otherwise, the following words, as used in this Article, have the following meanings:

- (1) "Applicant" means (i) in the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and (ii) in the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder.
- (2) "Certificate" means any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this State.
- (3) "Insurer" includes entities subject to Articles 65 through 67 of this Chapter.
- (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.
- (5) "Policy" means a Medicare supplement policy, which is a group or individual policy of accident and health insurance under Articles 1 through 64 of this Chapter, a subscriber contract under Articles 65 and 66 of this Chapter, or an evidence of coverage under Article 67 of this Chapter, other than a policy issued pursuant to a contract under section 1876 or section 1833 of the federal Social Security Act (42 U.S.C. § 1395 et seq.), or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, that 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. (1989, c. 729, s. 1; 1991 (Reg. Sess., 1992), c. 815, s. 1; 1993, c. 553, s. 19.)

§ 58-54-5. Applicability and scope.

- (a) Except as otherwise specifically provided, this Article applies to:
 - (1) All policies delivered or issued for delivery in this State on or after August 7, 1989; and
 - (2) All certificates issued under group policies that have been delivered or issued for delivery in this State on or after August 7, 1989.
- (b) This Article does not apply to an insurance 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 a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.
- (c) This Article does not prohibit or apply to insurance contracts or health care benefit plans, including group conversion policies, that are provided to Medicare eligible persons and that are not marketed or held out to be Medicare supplement policies or benefit plans. (1989, c. 729, s. 1.)

§ 58-54-10. Standards for policy provisions.

- (a) No policy in force in this State shall contain benefits that duplicate benefits provided by Medicare.
- (b) The Commissioner shall adopt rules to establish specific standards for provisions of policies. Such standards shall be in addition to and in accordance with applicable State law. No

requirement of State law relating to minimum required policy benefits, other than the minimum standards contained in this Article, applies to policies. The standards may include without limitation to: terms of renewability; initial and subsequent conditions of eligibility; nonduplication of coverage; probationary periods; benefit limitations, exceptions, and reductions; elimination periods; requirements for replacement; recurrent conditions; and definitions of terms.

(c) The Commissioner may adopt rules that specify prohibited policy provisions not otherwise specifically authorized by State law that, in the opinion of the Commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed for coverage under a policy.

(d) Notwithstanding any other provision of State law, a policy may not deny a claim for losses incurred more than six months from the effective date of coverage for a preexisting condition. A 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.

(e) Repealed by Session Laws 1991 (Regular Session, 1992), c. 815, s. 3. (1989, c. 729, s. 1; 1991, c. 490, s. 6; 1991 (Reg. Sess., 1992), c. 815, s. 3.)

§ 58-54-15. Minimum standards for benefits, marketing practices, compensation arrangements, reporting practices, and claims payments.

The Commissioner shall adopt rules to establish minimum standards for benefits, marketing practices, compensation arrangements, reporting practices, and claims payments under policies. (1989, c. 729, s. 1; 1989 (Reg. Sess., 1990), c. 941, s. 8; 1993, c. 504, s. 38.)

§ 58-54-20. Loss ratio standards and filing requirements.

(a) Every insurer providing group Medicare supplement insurance benefits to a resident of this State pursuant to G.S. 58-54-5 shall file a copy of the master policy and any certificate used in this State in accordance with the filing requirements and procedures applicable to group policies issued in this State.

(b) Policies shall return to policyholders benefits that are reasonable in relation to the premium charged. The Commissioner shall adopt rules to establish minimum standards for loss ratios of policies 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 in accordance with accepted actuarial principles and practices. Every insurer providing policies or certificates in this State shall annually file its rates, rating schedules, and supporting documentation to demonstrate that it is in compliance with the applicable loss ratio standards of this State. All filings of rates and rating schedules shall demonstrate that the actual and expected losses in relation to premiums comply with the requirements of this Article.

(c) No insurer shall provide compensation to its agents or other producers that is greater than the renewal compensation that would have been paid on an existing policy if the existing policy is replaced by another policy with the same insurer where the new policy benefits are substantially similar to the benefits under the old policy and the old policy was issued by the same insurer or insurer group. (1989, c. 729, s. 1; 1991 (Reg. Sess., 1992), c. 815, s. 4.)

§ 58-54-25. Disclosure standards.

(a) In order to provide for full and fair disclosure in the sale of policies, no policy or certificate shall be delivered in this State unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The Commissioner shall prescribe the format and content of the outline of coverage required by subsection (a) of this section. For purposes of this section, "format" means style, arrangement, and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. Such outline of coverage shall include:

- (1) A description of the principal benefits and coverage provided in the policy;
- (2) A statement of the exceptions, reductions, and limitations contained in the policy;
- (3) A statement of the renewal provisions, including any reservation by the insurer of a right to change premiums; and
- (4) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(c) The Commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the Commissioner may require by rule that the information brochure be provided to any prospective insured eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the Commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insured eligible for Medicare, but in no event later than the time of policy delivery.

(d) The Commissioner may adopt rules for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for Medicare, other than: Medicare supplement policies; disability income policies; basic, catastrophic, or major medical expense policies; or single premium, nonrenewable policies.

(e) The Commissioner may further adopt rules to govern the full and fair disclosure of the information in connection with the replacement of accident and health insurance policies, subscriber contracts, or certificates by persons eligible for Medicare.

(f) No insurer shall use attained age as a structure or methodology for its Medicare supplement insurance rates unless the structure or methodology is fully disclosed to the applicant at the time of application or to the insured at the time of delivery if the purchase is by mail order. All types of solicitation materials shall clearly indicate that the premiums are based on attained age, which means that those premiums will increase each year. The Commissioner shall prescribe by rule the format and content of the attained age rating disclosure notice. The notice shall include:

- (1) A statement that attained age rating means that rates increase as the insured ages or by the age group in which the insured is.
- (2) An illustration based on actual attained age that states the dollar amount of premium increase for the insured over a period of not less than 10 policy years and that displays the life expectancy of the insured at the beginning of the period.
- (3) A statement that premiums for other Medicare supplement policies that are on issue age bases do not increase as the insured ages.

- (4) A statement that other Medicare supplement policies that are on issue age bases should be compared to policies on attained age bases. (1989, c. 729, s. 1; 1991 (Reg. Sess., 1992), c. 815, s. 2; 1998-211, s. 12.)

§ 58-54-30. Notice of free examination.

Policies or certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereon stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the insurer in a timely manner. (1989, c. 729, s. 1.)

§ 58-54-35. Filing requirements for advertising.

Every insurer providing Medicare supplement insurance or benefits in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State whether through written, radio, or television medium to the Commissioner for review or approval by the Commissioner. (1989, c. 729, s. 1.)

§ 58-54-40. Penalties.

In addition to any other applicable penalties for violations of Articles 1 through 64 or 65 and 66 or 67 of this Chapter, the Commissioner may require any person that has violated or is violating any provision of this Article or any rule adopted under this Article to either (i) cease marketing any policy or certificate in this State that is related directly or indirectly to a violation or (ii) take such actions as are necessary to comply with this Article or such rules. (1989, c. 729, s. 1.)

§ 58-54-45. By reason of disability.

(a) For Persons Whose Eligibility for Medicare Occurred Before January 1, 2020. – In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plan A available to persons eligible for Medicare by reason of disability before age 65 and also standardized Plan C or F if marketing either Plan to persons eligible for Medicare before January 1, 2020, due to age. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision.

(a1) For Persons Whose Eligibility for Medicare Occurs on or After January 1, 2020. – In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plan A available to persons eligible for Medicare by reason of disability before age 65 and also standardized Plan D or G if marketing either Plan to persons eligible for Medicare on or after January 1, 2020, due to age. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security

Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision.

(b) Persons eligible for Medicare by reason of disability before age 65 who are enrolled in a managed care plan and whose coverage under the managed care plan is terminated through cancellation, nonrenewal, or disenrollment have the guaranteed right to purchase Medicare Supplement Plans A, D, or G from any insurer within 63 days after the date of termination or disenrollment.

(c) An insurer may develop premium rates specific to the disabled population. No insurer shall discriminate in the pricing of the Medicare supplement plans referred to in this section because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for the plan is submitted during an open enrollment or is submitted within 63 days after the managed care plan is terminated. The rates and any applicable rating factors for the Medicare supplement plans referred to in this section shall be filed with and approved by the Commissioner. (1998-211, s. 13; 2001-334, ss. 10.1, 10.2; 2005-223, s. 6; 2009-382, s. 11; 2019-179, s. 11(a).)

§ 58-54-50. Rules for compliance with federal law and regulations.

The Commissioner may adopt temporary rules necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations, including:

- (1) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements.
- (2) Establishing a uniform methodology for calculating and reporting loss ratios.
- (3) Assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance.
- (4) Establishing standards for Medicare Select policies and certificates.
- (5) Any other changes required by Congress or the U.S. Department of Health and Human Services, or any successor agency. (1998-211, s. 13; 2001-334, s. 11.1.)