HOUSE BILL 770
By Hazlewood

SENATE BILL 1130

By Swann

AN ACT to amend Tennessee Code Annotated, Title 56, relative to health insurance.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Section 56-7-1504, is amended by deleting the section and substituting the following:

(a) Each medicare supplement policy or certificate in force in this state must not contain benefits that duplicate benefits provided by medicare.

(b) Notwithstanding any other law to the contrary, a medicare supplement policy or certificate must not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate must 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 no more than six (6) months before the effective date of coverage.

(c) The commissioner shall promulgate reasonable rules to establish specific standards for policy provisions of medicare supplement policies and certificates. The standards are in addition to, and must be in accordance with, applicable laws of this state, including chapter 26 of this title. No requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this part, applies to medicare supplement policies and certificates. The standards may cover, but are not limited to:

(1) Terms of renewability;

(2) Initial and subsequent conditions of eligibility;

(3) Nonduplication of coverage;

(4) Probationary periods;

(5) Benefits limitations, exceptions, and reductions;

(6) Elimination periods;

(7) Requirements for replacement;

(8) Recurrent conditions; and

(9) Definitions of terms.

(d) The commissioner shall promulgate reasonable rules to establish minimum standards for benefits, claims payment, marketing practices, and compensation arrangements and reporting practices for medicare supplement policies and certificates.

(e) The commissioner may promulgate reasonable rules necessary to conform medicare supplement policies and certificates to the requirements of federal law and regulations, including, but not limited to:

(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 a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(5) Establishing a policy for holding public hearings prior to approval of premium increases; and

(6) Establishing standards for medicare select policies and certificates.

(f) The commissioner shall promulgate reasonable rules that specify prohibited policy provisions not otherwise specifically authorized by statute that, in the opinion of

the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a medicare supplement policy or certificate.

(g)

(1) Insurers offering medicare supplement policies and certificates in this state to persons sixty-five (65) years of age or older shall also offer medicare supplement policies to persons in this state who are under sixty-five (65) years of age and eligible for and enrolled in medicare by reason of disability or end stage renal disease. Except as otherwise provided in this subdivision (g)(3), all benefits, protections, policies, and procedures that apply to persons sixty-five (65) years of age or older also apply to persons who are eligible for and enrolled in medicare by reason of disability or end stage renal disease.

(2) Individuals who are under sixty-five (65) years of age and eligible for medicare by reason of disability or end stage renal disease may enroll in a medicare supplement policy at any time authorized or required by the federal government, or within six (6) months after:

(A) Enrolling in medicare part B, or by January 1, 2011, whichever is later;

(B) The date of the notice that the person has been retroactively enrolled in medicare part B due to a retroactive eligibility decision made by the social security administration;

(C) No longer having access to alternative forms of health insurance coverage such as accident and sickness policies, employer-sponsored group health coverage, or medicare advantage plans due to termination or cancellation of the coverage because of the individual's

employment status, or an action by a health insurer or employer that is unrelated to the individual's status, conduct, or failure to pay premiums; or

(D) Being involuntarily disenrolled from Title XIX Medicaid (42 U.S.C. § 1396 et seq.) or the Title XXI state children's health insurance program of the Social Security Act (42 U.S.C. § 1397aa et. seq.).

(3) Premium rates for medicare supplement policies and certificates issued pursuant to this subsection (g) may differ between persons who qualify for medicare who are sixty-five (65) years of age or older and those who qualify for medicare by reason of disability or end stage renal disease and who are younger than sixty-five (65) years of age as long as the difference in premium rates are pursuant to rate schedules that are based on sound actuarial principles and are reasonable in relation to the benefits provided.

SECTION 2. This act shall take effect upon becoming a law, the public welfare requiring it, and shall apply to policies and certificates issued, amended, or renewed on or after the effective date of this act.