RULES AND REGULATIONS

Title 31—INSURANCE

INSURANCE DEPARTMENT

[31 PA. CODE CH. 89]

Medicare Supplement Insurance Minimum Standards

The Insurance Department (Department) amends §§ 89.772—89.777, 89.777a, 89.778, 89.780—89.784, 89.786, 89.787 and 89.790 to read as set forth in Annex A. Sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P. S. §§ 66, 186, 411 and 412) provide the Insurance Commissioner (Commissioner) with the authority and duty to promulgate regulations governing the enforcement of the laws regarding insurance. The final-omitted rulemaking will also bring the Department's regulations for the approval of Medicare supplement policies into compliance with the Federal statutory requirements of the Social Security Act (42 U.S.C.A. § 1395ss) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), the act of December 8, 2003 (Pub. L. No. 108-173, 117 Stat. 2066).

Notice of proposed rulemaking is omitted in accordance with section 204(3) of the act of July 31, 1968 (P. L. 769, No. 240), known as the Commonwealth Documents Law (CDL), (45 P. S. § 1204(3)). Under section 204(3) of the CDL, notice of proposed rulemaking may be omitted when the agency for good cause finds that public notice of its intention to amend an administrative regulation is, under the circumstances, impracticable and unnecessary.

The amendments to Subchapter K (relating to Medicare supplement insurance minimum standards) are Federally mandated under recent Federal legislation, specifically the MMA, enacted December 8, 2003. Federal law requires that these changes be implemented by the states if they are to remain in compliance with the Federal requirements and maintain regulatory authority in this area. The revised National Association of Insurance Commissioners (NAIC) Medicare Supplement model regulation (NAIC model regulation) was adopted September 8, 2004, and the Department's new regulations must be adopted within 1 year following the NAIC adoption of the NAIC model regulations for the Commonwealth to retain regulatory authority in this area. To comply with Federal statutory minimum requirements for Medicare supplement policies, the Insurance Commissioner finds that the proposed rulemaking procedures in sections 201 and 202 of the CDL (45 P. S. §§ 1201 and 1202) are impracticable and unnecessary in this situation, and that the proposed rulemaking may be properly omitted under section 204(3) of the CDL.

Purpose

Subchapter K was initially promulgated to establish minimum standards for Medicare supplement insurance policies. Standardization of policies was Federally required under the Omnibus Budget Reconciliation Act of 1990. The Department currently seeks to amend Subchapter K to meet the new Federal mandates for Medicare supplement policies as required under the MMA.

The final-omitted rulemaking is necessary to maintain the Commonwealth's compliance with Federal requirements, which will ensure that the Commonwealth retains enforcement authority over Medicare Supplement policies and these new requirements. These standards will be effective for Medicare Supplement issuers on January 1, 2006, under the MMA. The Federal legislation establishes that states that adopt the language of the NAIC model regulation that has been revised to address the Federal changes will be considered to be in compliance with the Federal requirements. The Commonwealth needs to adopt these revisions to the Medicare Supplement regulations by September 8, 2005, to avoid Federal intervention.

The final-omitted rulemaking will protect the rights of consumers purchasing Medicare supplement policies in this Commonwealth.

Explanation of Regulatory Requirements

Section 89.772 (relating to definitions) has been revised to reflect changes to definitions of the terms "bankruptcy," "employee welfare benefit plan," "Medicare Advantage plan" (formerly "Medicare + Choice") and "Medicare supplement policy." The new language is based on the NAIC model regulation. The Department also defined the term "producer" to mean an insurance producer as defined in the act of December 6, 2002 (P. L. 1183, No. 147) (Act 147) (40 P. S. §§ 310.1—310.99a).

Section 89.773(4) (relating to policy definitions and terms) has been revised to relocate the definition of "health care expenses" to § 89.780 (relating to loss ratio standards and refund or credit of premium). This revision is based on the NAIC model regulation.

Section 89.773(7) has been revised to clarify that both Medicare Parts A and B as the types of Medicare expenses that are eligible and covered by Medicare. The new language is based on the NAIC model regulation.

Section 89.774(d) (relating to exclusions and limitations) has been revised to clarify the options available to policyholders after December 31, 2005, when outpatient prescription drug benefits for both prestandardized and standardized Medicare supplement policies will no longer be available for policyholders who enroll in Medicare Part D. The new language is based on the NAIC model regulation.

Section 89.775(1)(vi) (relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992) has been revised to clarify that receipt of Medicare Part D benefits will not be considered in determining a continuous loss. The new language is based on the NAIC model regulation.

Section 89.775(1)(vii) has been revised to clarify a Medicare supplement policy that has eliminated an outpatient prescription drug benefit to conform with the MMA shall be deemed to satisfy the guarantee renewal requirements of this subparagraph. This revision is based on the NAIC model regulation.

Section 89.776(1)(v)(F) (relating to benefit standards for policies or certificates issued or delivered on or after July 30, 1992) has been revised to clarify a Medicare supplement policy that has eliminated an outpatient prescription drug benefit to conform with the MMA shall be deemed to satisfy the guarantee renewal requirements of this clause. This revision is based on the NAIC model regulation.

Section 89.776(1)(vi) has been revised to clarify that receipt of Medicare Part D benefits will not be considered

in determining a continuous loss. This revision is based on the NAIC model regulation.

Section 89.776(1)(vii)(D)(II) has been revised to clarify that if the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, the reinstitution of the policy for Medicare Part D enrollees will be without coverage for outpatient prescription drugs and will otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension. This revision is based on the NAIC model regulation.

Section 89.776(2)(iii) has been revised to clarify Medicare supplement Plans A—J and the change of payment method to applicable prospective payment system rate as required by the MMA. This revision is based on the NAIC model regulation.

Section 89.776(3)(vi) has been revised to clarify that for basic outpatient prescription drug benefit, the outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006. This revision is based on the NAIC model regulation.

Section 89.776(3)(vii) has been revised to clarify that for extended outpatient prescription drug benefit, the outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006. This revision is based on the NAIC model regulation.

Section 89.776(3)(ix) has been revised to delete specific references to preventive screening tests or preventive services. This language has been replaced by general language to contemplate any future changes that Medicare may make in coverage to specific preventive services. This revision is based on the NAIC model regulation.

Section 89.776(3)(xi) has been revised and moved to § 89.777(g) (relating to standard Medicare supplement benefit plans). This revision is based on the NAIC model regulation.

Section 89.776(4) has been added to set forth benefit standards for Medicare supplement Plans K and L. This revision is based on the NAIC model regulation.

Section 89.777(b) (relating to standard Medicare supplement benefit plans) has been revised to clarify the language which sets forth requirements for sale of Medicare Supplement policies in this Commonwealth and provide specific reference to subsection (g) and § 89.777a (relating to Medicare Select policies and certificates). This revision is based on the NAIC model regulation.

Section 89.777(c) has been revised to include reference to the new Medicare supplement plans available as required by the MMA. This revision is based on the NAIC model regulation.

Section 89.777(e)(9) has been revised to specify that outpatient prescription drug benefit may not be included in a Medicare supplement Plan H sold after December 31, 2005. This revision is based on the NAIC model regulation.

Section 89.777(e)(10) has been revised to specify that outpatient prescription drug benefit may not be included in a Medicare supplement Plan I sold after December 31, 2005. This revision is based on the NAIC model regulation.

Section 89.777(e)(11) has been revised to specify that outpatient prescription drug benefit may not be included in a Medicare supplement Plan J and high deductible Plan J sold after December 31, 2005. This revision is based on the NAIC model regulation.

Section 89.777(e)(12) has been revised to specify that outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

Section 89.777(e)(13) has been revised to add requirements for Standardized Medicare Supplement benefit Plan K. This revision is based on the NAIC model regulation.

Section 89.777(e)(14) has been revised to add requirements for Standardized Medicare Supplement benefit Plan L. This revision is based on the NAIC model regulation.

Section 89.777(g) has been added to set forth the requirements for new or innovative benefits, previously under § 89.776(3)(xi). Effective December 31, 2005, the outpatient prescription drug program will not constitute an innovative benefit. This revision is based on the NAIC model regulation.

Section 89.777a(j)(3) (relating to Medicare select policies and certificates) has been revised to clarify that expenses incurred when using an out-of-network provider in a Medicare Select policy do not count toward the out-of-pocket annual limit contained in Plans K and L. This revision is based on the NAIC model regulation.

Section 89.777a(n)(2) and (o)(2) has been revised to clarify that coverage for prescription drugs does not constitute a "significant benefit" for the purposes of comparing Medicare supplement policies or certificates being replaced. This revision is based on the NAIC model regulation.

Section 89.778(d) (relating to open enrollment) has been revised to clarify that §§ 89.789(b) and (c) and 89.790(a) (relating to prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates; and guaranteed issue for eligible persons) are not to be construed as preventing the exclusions of benefits. This revision is based on the NAIC model regulation.

Section 89.780(a)(2) (relating to loss ratio standards and refund or credit premiums) has been revised to include language relating to home health care expenses previously in § 89.773(4). This revision is based on the NAIC model regulation.

Section 89.780(b)(1) has been revised to delete the reference to Appendix E and to provide this data shall be filed using an applicable Refund Calculation Form prescribed by the Department.

Section 89.781(b) (relating to filing and approval of policies and certificates and premium rates) has been revised to allow issuers to file riders or amendments to delete outpatient prescription drug benefits as required by the MMA. This revision is based on the NAIC model regulation.

Section 89.781(c)(2)(ii) has been renumbered as (d)(2)(ii) and revised to change "agent" to "producer." This revision reflects the changes made by Act 147.

Section 89.782(a) and (b) (relating to permitted compensation agreements) has been revised to change "agent" to "producer." This revision reflects the changes made by Act 147.

Section 89.783(a)(6) (relating to required disclosure provisions) has been revised to change "Health Care

Financing Administration" to "Centers for Medicare & Medicaid Services." This revision is based on the NAIC model regulation.

Section 89.783(a)(8) has been deleted to promote National uniformity and consistency in Medicare supplement standards. This revision is based on the NAIC model regulation.

Section 89.783(c) has been revised to reflect notice requirements for issuers as required by the MMA. This revision is based on the NAIC model regulation.

Section 89.783(c)(3) has been renumbered as subsection (d)(3) and revised to reflect the availability of new Medicare supplement plans. This revision is based on the NAIC model regulation.

Section 89.783(c)(5) has been renumbered as subsection (d)(5) and revised to change "agent" to "producer." This revision reflects the changes made by Act 147.

Section 89.783(c)(6) has been renumbered as subsection (d)(6) and revised to reflect the availability of new Medicare supplement plans. This revision is based on the NAIC model regulation.

Section 89.783(d)(2) has been renumbered as subsection (e)(2), revised to delete the reference to Appendix I and to provide that the disclosure statement shall be on a form prescribed by the Department.

Section 89.783(f) has been added to provide that the Department will maintain all forms regarding Medicare Supplement Chapter 89 in written and electronic form. These forms will be available upon request to assure that Medicare Supplement issuers and subscribers have access to the most up-to-date information and coverage requirements. The Department will also incorporate the forms formerly in Appendices E, F and I into the Department's website to provide consumers and insurers with easier access to the plans. This will allow both consumers and insurers access to the plans 24 hours a day, 7 days a week, not just when the Department is open for business. Furthermore, the Department will publish notice in the *Pennsylvania Bulletin* of the availability of the amended forms when revisions are made available to the Department by the United States Department of Health and Human Services.

Section 89.784 (relating to requirements for application forms and replacement coverage) has been renumbered throughout. This revision was made to clarify and maintain consistency within the regulation.

Section 89.784 has been revised to require application forms to inquire whether the applicant currently has Medicare Advantage or Medicaid coverage. This revision is based on the NAIC model regulation.

Section 89.784(1) has been revised to inform the applicant of important rights and modified the questions to be asked by the issuer to reflect those changes required by the MMA. This revision is based on the NAIC model regulation.

Section 89.784(1)(iv) has been revised to inform the applicant of important rights regarding suspension of coverage as it relates to the changes required by the MMA. This revision is based on the NAIC model regulation.

Section 89.784(1)(v) has been revised to inform the applicant of important rights regarding suspension of coverage in circumstances when, by reason of disability, an individual later becomes covered by an employer or union-based group health plan as it relates to the changes required by the MMA. This revision is based on the NAIC model regulation.

Section 89.784(1)(vi) has been renumbered to accommodate changes required by the MMA.

Section 89.784(2) has been revised to add questions designed to elicit whether an applicant is eligible for guaranteed issue of a Medicare supplement insurance policy. This revision reflects changes required by the MMA. This revision is based on the NAIC model regulation.

Section 89.784(3) has been revised to move the requirement formerly in subsection (d). This revision is based on the NAIC model regulation.

Section 89.784(4) has been revised to add Medicare Advantage insurance. Revisions were made to clarify reasons for replacement of Medicare supplement policies. This revision reflects changes required by the MMA. This revision is based on the NAIC model regulation.

Section 89.786(a)(1) and (b)(3) (relating to standards for marketing) has been revised to change "agent" to "producer." This revision reflects the changes made by Act 147.

Section 89.787(a) (relating to appropriateness of recommended purchase and excessive insurance) has been revised to change "agent" to "producer." This revision reflects the changes made by Act 147.

Section 89.787(c) has been revised to clarify the appropriateness for enrollment in a Medicare supplement policy upon termination of Medicare Part C coverage. This revision is based on the NAIC model regulation.

Section 89.790(a)(1) and (b)(7) (relating to guaranteed issue for eligible persons) has been revised to deem an eligible person as one who has enrolled in Medicare Part D. This revision is based on the NAIC model regulation.

Section 89.790(b)(2), (5) and (6) has been revised to change "Medicare+Choice" to "Medicare Advantage." This revision reflects changes required by the MMA. This revision is based on the NAIC model regulation.

Section 89.790(b)(2)(iv)(B) and (4)(iii) has been revised to change "agent" to "producer." This revision reflects the changes made by Act 147.

Section 89.790(c)(1) has been revised to clarify the time frame for the guarantee issue period. This revision is based on the NAIC model regulation.

Section 89.790(c)(4) has been revised to change "section" to "subsection." This revision was made to clarify and maintain consistency within the regulation.

Section 89.790(c)(5) has been added to provide clarification regarding the guarantee issue period relating to those individuals who enroll in Medicare Part D. This revision is based on the NAIC model regulation.

Section 89.790(e)(1), (2) and (4) has been added to provide clarification regarding products to which an eligible person may be entitled as required by the MMA. This revision is based on the NAIC model regulation.

Fiscal Impact

The Department can review revised Medicare supplement filings in the course of normal business and anticipates that it will experience minimal or no increase in cost in its review.

Insurers are required to comply with the new Federal requirements to sell Medicare Supplement insurance.

Therefore, the insurance industry will not incur additional costs due to the promulgation of this final-omitted rulemaking.

Effectiveness/Sunset Date

The final-omitted rulemaking will become effective upon publication in the *Pennsylvania Bulletin*. The Department continues to monitor the effectiveness of regulations on a triennial basis. Therefore, no sunset date has been assigned.

Contact Person

Questions regarding the final-omitted rulemaking should be addressed to Peter J. Salvatore, Regulatory Coordinator, Insurance Department, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429, fax (717) 772-1969, psalvatore@state.pa.us.

Regulatory Review

Under section 5.1(a) of the Regulatory Review Act (71 P. S. § 745.5a(a)), on February 11, 2005, the Department submitted a copy of the final-omitted rulemaking and a copy of a Regulatory Analysis Form to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Insurance and the Senate Committee on Banking and Insurance. A copy of this material is available to the public upon request.

Under section 5.1(j.2) of the Regulatory Review Act, on April 13, 2005, the final-form rulemaking was deemed approved by the House and Senate Committees. The Attorney General approved the regulation on February 28, 2005. Under section 5.1(e) of the Regulatory Review Act, IRRC met on April 14, 2004, and approved the final-omitted rulemaking.

Findings

The Commissioner finds that:

(1) There is good cause to amend Subchapter K, effective upon publication with the proposed rulemaking omitted. Deferral of the effective date of these regulations would be impractical and not serve the public interest. Under section 204(3) of the CDL, there is no purpose to be served by deferring the effective date. An immediate effective date will best serve the public interest by ensuring the Commonwealth's compliance with the new Federal requirements and retention of enforcement authority over all aspects of Medicare supplement policies.

(2) There is good cause to forego public notice of the intention to amend Subchapter K because notice of the amendment under the circumstances is unnecessary and impractical under section 204(3) of the CDL for the following reasons:

(i) The changes mandated by Federal law will go into effect with or without regulatory action.

(ii) If the amendments are not implemented as established by the Federal law, regulatory oversight of these requirements will be assumed by the Federal government. If this were to occur it would split regulation of Medicare supplement policies between the Commonwealth and the Federal government. Dual regulation would negatively impact consumers in this Commonwealth due to a shortage in Federal enforcement staffing. Accordingly, it would be more difficult for consumers in this Commonwealth to have complaints concerning the new requirements addressed by the Federal government in a timely manner.

(iii) Public comment cannot change the fact that these Federal requirements will be implemented (either by the Commonwealth or the Federal government). Nor can public comment have any impact upon the content of the new Federal mandates.

Order

The Commissioner, acting under the authority of sections 206, 506, 1501 and 1502 of The Administrative Code of 1929, orders that:

(1) The regulations of the Department, 31 Pa Code Chapter 89, are amended by amending §§ 89.772—89.777, 89.777a, 89.778, 89.780—89.784, 89.786, 89.787 and 89.790 and Appendix E to read as set forth in Annex A.

(2) The Department shall submit this order and Annex A to the Office of Attorney General and the Office of General Counsel for approval as to form and legality as required by law.

(3) The Department shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(4) This order shall take effect upon its publication in the *Pennsylvania Bulletin*.

M. DIANE KOKEN,
Insurance Commissioner

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission, relating to this document, see 35 Pa.B. 5019 (April 30, 2005).)

Fiscal Note: 11-224. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 31. INSURANCE

PART IV. LIFE INSURANCE

CHAPTER 89. APPROVAL OF LIFE, ACCIDENT AND HEALTH INSURANCE

Subchapter K. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

§ 89.772. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

Applicant—

(i) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits.

(ii) In the case of a group Medicare supplement policy, the proposed certificateholder.

Bankruptcy—The condition under which a Medicare Advantage organization plan that is not an issuer has filed, or has had filed against it, a petition or other action seeking a declaration of bankruptcy under the provisions of the United States Bankruptcy Code (11 U.S.C.) and has ceased doing business in this Commonwealth.

Certificate—A certificate delivered or issued for delivery in this Commonwealth under a group Medicare supplement policy.

Certificate form—The form on which the certificate is delivered or issued for delivery by the issuer.

Commissioner—The Insurance Commissioner of the Commonwealth.

Continuous period of creditable coverage—The period during which an individual was covered by creditable

coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

Creditable coverage—The definition contained in the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191, 110 Stat. 1936), as adopted by the Commonwealth under the Pennsylvania Health Care Insurance Portability Act (40 P. S. §§ 1302.1—1302.7), is incorporated herein by reference.

Employee welfare benefit plan—A plan, fund or program of employee benefits as defined in section 3 of the Employee Retirement Income Security Act or ERISA (29 U.S.C.A. § 1002).

HHS Secretary—The Secretary of the United States Department of Health and Human Services.

Insolvency—The condition under which an issuer, licensed to transact business in this Commonwealth by the Commissioner, has had a final order of liquidation entered against it, or a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

Issuer—The term includes insurance companies, fraternal benefit societies and nonprofit corporations subject to 40 Pa.C.S. Chapters 61 and 63 (relating to hospital plan corporations; and professional health services plan corporations) and other entities delivering or issuing for delivery Medicare supplement policies or certificates in this Commonwealth.

Medicare—The program established by the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 (42 U.S.C.A. §§ 1395—1395b-4) as then constituted or later amended.

Medicare Advantage plan—A plan of coverage for health benefits under Medicare Part C as defined in section 1859 (b)(1) of the Social Security Act (42 U.S.C.A. § 1395w-28(b)(1)) and includes:

(i) Coordinated care plans which provide health care services, including health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations and preferred provider organization plans.

(ii) Medicare medical savings account plans coupled with a contribution into a Medicare Advantage plan medical savings account.

(iii) Medicare Advantage private fee-for-service plans.

Medicare supplement policy—

(i) A group or individual policy of insurance or a subscriber contract other than a policy issued under a contract under section 1876 of the Social Security Act (42 U.S.C.A. §§ 1395—1395mm) or a policy issued under a demonstration project specified in section 1882 of the SSA (42 U.S.C.A. § 1395ss(g)(1)), 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.

(ii) The term 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 (42 U.S.C.A. 13951 (a)(1)(A)).

Policy form—The form on which the policy is delivered or issued for delivery by the issuer.

Producer—An insurance producer as defined by the act of December 6, 2002 (P. L. 1183, No. 147) (40 P. S. §§ 310.1—310.99a), known as the Producer Licensing Modernization Act.

§ 89.773. Policy definitions and terms.

A policy or certificate may not be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate, unless the policy or certificate contains definitions or terms which conform to the requirements of this section.

(1) The terms "accident," "accidental injury" or "accidental means" shall be defined to employ "result" language and may 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.

(i) The definition may 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."

(ii) The definition may provide that injuries may not include injuries for which benefits are provided or available under workers' compensation, employer's liability or similar law or motor vehicle no-fault plan, unless prohibited by law.

(2) The terms "benefit period" or "Medicare benefit period" may not be defined more restrictively than as defined in the Medicare Program.

(3) The terms "convalescent nursing home," "extended care facility" or "skilled nursing facility" may not be defined more restrictively than as defined in the Medicare Program.

(4) The term "health care expenses" for purposes of § 89.780 (relating to loss ratio standards and refund or credit of premium), shall be defined to mean expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(5) The term "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, but not more restrictively than as defined in the Medicare Program.

(6) The term "Medicare" shall be defined in the policy and certificate. 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 89-97, 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.

(7) The term "Medicare eligible expenses" shall be defined to mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

(8) The term "physician" may not be defined more restrictively than as defined in the Medicare Program.

(9) The term "sickness" may not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which is diagnosed or treated 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.

§ 89.774. Exclusions and limitations.

(a) Except for permitted preexisting condition clauses as described in §§ 89.775(1)(i) and 89.776(1)(i) (relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992; and benefits standards for policies or certificates issued or delivered on or after July 30, 1992), a policy or certificate may not be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(b) A Medicare supplement policy or certificate may not use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) A Medicare supplement policy or certificate in force in this Commonwealth may not contain benefits which duplicate benefits provided by Medicare.

(d) The following applies to issuance and renewal limitations of Medicare supplement policies:

(1) Subject to §§ 89.775 (1)(iv), (v) and (vii) and 89.776 (1)(iv) and (v) (relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992; and benefits standards for policies or certificates issued or delivered on or after July 30, 1992), a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(2) A Medicare supplement policy with benefits for outpatient prescription drugs may not be issued after December 31, 2005.

(3) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless the following conditions apply:

(i) The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan.

(ii) Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

§ 89.775. Minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992.

A policy or certificate may not be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are consistent with this subchapter.

(1) *General standards*. The following standards apply to Medicare supplement policies and certificates and are in addition to the other requirements of this subchapter:

(i) *Exclusion/limitation of benefits*. A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved 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 6 months before the effective date of coverage.

(ii) *Indemnification of sickness and accidents*. A Medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(iii) *Cost sharing amounts under Medicare*. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with these changes.

(iv) *Termination of coverage*. A noncancellable, guaranteed renewable or noncancellable and guaranteed renewable Medicare supplement policy may not:

(A) 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.

(B) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(v) *Restrictions on termination of policies and certificates*.

(A) Except as authorized by the Commissioner, an issuer may neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(B) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in clause (D), the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(I) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy.

(II) An individual Medicare supplement policy which provides only benefits that are required to meet the minimum standards as defined in § 89.776(2) (relating to benefits standards for policies or certificates issued or delivered on or after July 30, 1992).

(C) If membership in a group is terminated, the issuer shall do one of the following:

(I) Offer the certificateholder conversion opportunities that are described in clause (B).

(II) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(D) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy will not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(vi) Termination of a Medicare supplement policy or certificate shall be without prejudice to a 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 predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(vii) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the act of December 8, 2003 (Pub. L. 108-173, 117 Stat. 2066), the modified policy shall be deemed to satisfy the guaranteed renewal requirement of this subsection.

(viii) If a hospital plan corporation or a professional health services plan corporation issues a subscriber contract which does not include the required benefits, the contract shall be issued in conjunction with another contract, including at least the remainder of the benefits in this subchapter, to qualify as Medicare supplement insurance. In the alternative, two or more corporations may act jointly and issue a single contract which contains the required benefits.

(2) *Minimum benefit standards.* The following represent minimum benefit standards:

(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 for all or none of the Medicare Part A inpatient hospital deductible amount. If the insurer desires, in consideration of a reduced premium, to offer a contract without coverage for the initial deductible under Part A, it may do so only if the insured is given the option of purchasing the contract from that insurer with coverage for all of the Part A deductible.

(iii) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during the use of Medicare's lifetime hospital inpatient reserve days.

(iv) Upon exhaustion of Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 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.

(v) Coverage under Medicare Part A 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 or already paid for under Part B.

(vi) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.

(vii) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first 3 pints of blood, or equivalent quantities of packed red blood cells, as defined under Federal regulations, unless replaced in accordance with Federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(viii) If a hospital plan corporation or a professional health service plan corporation issues a subscriber contract which does not include the required benefits, the contract shall be issued in conjunction with another contract, including at least the remainder of the benefits in this subchapter, to qualify as Medicare supplement insurance. In the alternative, two or more corporations may act jointly and issue a single contract which contains the required benefits.

§ 89.776. Benefits standards for policies or certificates issued or delivered on or after July 30, 1992.

The following standards apply to Medicare supplement policies or certificates delivered or issued for delivery in this Commonwealth on or after July 30, 1992. A policy or certificate may not be advertised, solicited, delivered or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it complies with these benefit standards.

(1) *General standards.* The following standards apply to Medicare supplement policies and certificates and are in addition to other requirements of this subchapter:

(i) *Exclusions and limitations.* A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved 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 6 months before the effective date of coverage.

(ii) *Indemnification of sickness and accidents.* A Medicare supplement policy or certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(iii) *Cost sharing amounts under Medicare.* A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with these changes.

(iv) *Termination of coverage.* A Medicare supplement policy or certificate may not 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) *Cancellation or nonrenewal of policy.* Each Medicare supplement policy shall be guaranteed renewable.

(A) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual.

(B) The issuer may not cancel or nonrenew the policy for a reason other than nonpayment of premium or material misrepresentation.

(C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under clause (E), the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder, does one of the following:

(I) Provides for continuation of the benefits contained in the group policy.

(II) Provides for benefits that otherwise meet the requirements of this section.

(D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall do one of the following:

(I) Offer the certificateholder the conversion opportunity described in clause (C).

(II) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(F) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the act of December 8, 2003 (Pub. L. 108-173, 117 Stat. 2066), the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(vi) *Extension of benefits.* Termination of a Medicare supplement policy or certificate shall be without prejudice to a 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, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(vii) *Suspension by policyholder.*

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall 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 (42 U.S.C.A. §§ 1396—1396u), but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to this assistance.

(B) If a suspension occurs and if the policyholder or certificateholder loses entitlement to Medical Assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of the entitlement) as of the termination of the entitlement if the policyholder or certificateholder provides notice of loss of the entitlement within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of the entitlement.

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act (42 U.S.C.A. § 426(b)) and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act (42 U.S.C.A. § 1395y(b)(1)(A)(v)). 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 the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(D) Reinstitution of these coverages as described in clauses (B) and (C):

(I) May not provide for a waiting period with respect to treatment of preexisting conditions.

(II) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension.

(III) Shall 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 if the coverage had not been suspended.

(2) *Standards for basic (core) benefits common to benefit Plans A—J.* Every issuer shall make available a policy or certificate, including only the following basic core package of benefits to each prospective insured. An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan. An issuer may make available to prospective insureds Medicare Supplement Insurance Benefit Plans C, D, E, F, G, H, I and J as listed in § 89.777(e) (relating to standard Medicare supplement benefit plans). The core packages are as follows:

(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 incurred 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 any balance.

(iv) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 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 paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

(3) *Standards for additional benefits.* The following additional benefits shall be included in Medicare Supplement Benefit Plans B, C, D, E, F, G, H, I and J only as provided by § 89.777.

(i) *Medicare Part A deductible.* Coverage for the Medicare Part A inpatient hospital deductible amount per benefit period.

(ii) *Skilled nursing facility care.* 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 posthospital skilled nursing facility care eligible under Medicare Part A.

(iii) *Medicare Part B deductible.* Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(iv) *Eighty percent of the Medicare Part B excess charges.* Coverage for 80% of the difference between the actual Medicare Part B charges as billed, not to exceed a charge limitation established by the Medicare Program, State Law, including, but not limited, to the Health Care Practitioner Medicare Fee Control Act (35 P. S. §§ 449.31—449.36), and the Medicare-approved Part B charge.

(v) *Medicare Part B excess charges.* One hundred percent of the Medicare Part B excess charges: coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed a charge limitation established by the Medicare Program, State law, including, but not limited to, the Health Care Practitioner Medicare Fee Control Act and the Medicare-approved Part B charge.

(vi) *Basic outpatient prescription drug benefit.* Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 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 until January 1, 2006.

(vii) *Extended outpatient prescription drug benefit.* Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 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 until January 1, 2006.

(viii) *Medically necessary emergency care in a foreign country.* 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, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(ix) *Preventive medical care benefit.* 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 annually under this benefit. This benefit may not include payment for a procedure covered by Medicare. Coverage for the preventive health services not covered by Medicare is as follows:

(A) An annual clinical preventive medical history and physical examination that may include tests and services described in clause (B) and patient education to address preventive health care measures.

(B) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

(x) *At-home recovery benefit.* 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*—The term includes bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered and changing bandages or other dressings.

(II) *Care provider*—A qualified or licensed home health aid or homemaker, personal care aid or nurse provided through a licensed home health care agency or referred by a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(III) *Home*—A place used by the insured as a place of residence, if the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility may not be considered the insured's place of residence.

(IV) *At-home recovery visit*—The period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except that each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(B) Coverage requirements and limitations are as follows:

(I) At-home recovery services provided shall be primarily services which assist in activities of daily living.

(II) The insured's attending physician must 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.

(III) Coverage is limited to:

(-a-) 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 may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

(-b-) The actual charges for each visit up to a maximum reimbursement of $40 per visit.

(-c-) One thousand six hundred dollars per calendar year.

(-d-) Seven visits in 1 week.

(-e-) Care furnished on a visiting basis in the insured's home.

(-f-) Services provided by a care provider as defined in this section.

(-g-) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(-h-) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than 8 weeks after the service date of the last Medicare approved home health care visit.

(C) Coverage is excluded for:

(I) Home care visits paid for by Medicare or other government programs.

(II) Care provided by family members, unpaid volunteers or providers who are not care providers.

(4) *Standards for Plans K and L.*

(i) Standardized Medicare supplement benefit Plan K shall consist of the following:

(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 the 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 any balance.

(D) Medicare Part A Deductible: 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 clause (J).

(E) Skilled nursing facility care: 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 posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (J).

(F) Hospice care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (J).

(G) Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first 3 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 clause (J).

(H) Except for coverage provided in clause (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 clause (J).

(I) Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible.

(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 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the United States Department of Health and Human Services.

(ii) Standardized Medicare supplement benefit Plan L shall consist of the following:

(A) The benefits described in subparagraph (i)(A), (B), (C) and (I).

(B) The benefits described in subparagraph (i)(D), (E), (F), (G) and (H), but substituting 75% for 50%.

(C) The benefit described in subparagraph (i)(J) but substituting $2,000 for $4,000.

§ 89.777. Standard Medicare supplement benefit plans.

(a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in § 89.776(2) (relating to benefits standards for policies or certificates issued for delivery on or after July 30, 1992). An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan.

(b) Groups, packages or combinations of Medicare supplement benefits other than those listed in this section may not be offered for sale in this Commonwealth except as may be permitted in subsection (f) and § 89.777a (relating to Medicare Select policies and certificates).

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit Plans A—L listed in this section and conform to the definitions in § 89.773 (relating to policy definitions and terms). Each benefit shall be structured in accordance with the format in §§ 89.776(2) and (3) or (4) and list the benefits in the order shown in this section. For purposes of this section, "structure, language and format" means style, arrangement and overall content of a benefit.

(d) An issuer may use, in addition to the benefit plan designations required in subsection (c), other designations to the extent permitted by law.

(e) The make-up of benefit plans shall be as follows:

(1) Standardized Medicare supplement benefit Plan A shall be limited to the basic (core) benefits common to all benefit plans, as defined in § 89.776(2).

(2) Standardized Medicare supplement benefit Plan B shall include only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A Deductible as defined in § 89.776(3)(i).

(3) Standardized Medicare supplement benefit Plan C shall include only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in § 89.776(3)(i)—(iii) and (viii).

(4) Standardized Medicare supplement benefit Plan D shall include only the following: the core benefit (as defined in § 89.776(2)), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in § 89.776(3)(i), (ii), (viii) and (x).

(5) Standardized Medicare supplement benefit Plan E shall include only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in § 89.776(3)(i), (ii), (viii) and (ix).

(6) Standardized Medicare supplement benefit Plan F shall consist of only the following: the core benefit as defined in § 89.776(2), plus 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 § 89.776(3)(i)—(iii), (v) and (viii).

(7) Standardized Medicare supplement benefit high deductible Plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible Plan "F" deductible. The covered expenses

include the core benefit as defined in § 89.776(2), plus 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 § 89.776(3)(i)—(iii), (v) and (viii) respectively. The annual high deductible Plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the HHS 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.

(8) Standardized Medicare supplemental benefit Plan G shall include only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, 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 defined in § 89.776(3)(i), (ii), (iv), (viii) and (x).

(9) Standardized Medicare supplement benefit Plan H shall consist of only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in § 89.776(3)(i), (ii), (vi) and (viii). The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(10) Standardized Medicare supplement benefit Plan I shall consist of only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, 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 defined in § 89.776(3)(i), (ii), (v), (vi), (viii) and (x). The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit Plan J shall consist of only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, 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 defined in § 89.776(3)(i)—(iii), (v) and (vii)—(x). The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible Plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible Plan "J" deductible. The covered expenses include the core benefit as defined in § 89.776(2) plus 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 § 89.776(3)(i)—(iii), (v) and (vii)—(x) respectively. The annual high deductible Plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the HHS 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. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(13) Standardized Medicare Supplement benefit Plan K shall consist of only those benefits described in § 89.776 (4)(i).

(14) Standardized Medicare Supplement benefit Plan L shall consist of only those benefits described in § 89.776 (4)(ii).

(f) New or innovative benefits must conform to this subsection. 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 may not include an outpatient prescription drug program.

§ 89.777a. Medicare select policies and certificates.

(a) This section applies to Medicare Select policies and certificates, as defined in this section.

(b) A policy or certificate may not be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(c) For the purposes of this section, the following words and terms have the following meanings, unless the context clearly indicates otherwise:

Complaint—Dissatisfaction expressed orally or in writing by an individual insured under a Medicare Select policy or certificate concerning a Medicare Select issuer or its network providers.

Grievance—Dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate concerning the administration, claims practices or provision of services with a Medicare Select issuer or its network providers.

Medicare Select issuer—An issuer offering, or seeking to offer, a Medicare Select policy or certificate.

Medicare Select policy or *Medicare Select certificate*—A Medicare supplement policy or certificate, respectively, that contains restricted network provisions.

Network provider—A provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

Restricted network provision—A provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

Service area—The geographic area approved by the Commissioner within which an issuer is authorized to offer a Medicare Select policy.

(d) The Commissioner may authorize an issuer to offer a Medicare Select policy or certificate, under this section, and section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (42 U.S.C.A. § 1395b-2) if the Commissioner finds that the issuer has satisfied the requirements of this section.

(e) A Medicare Select issuer may not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the Commissioner.

(f) A Medicare Select issuer shall file a proposed plan of operation with the Commissioner in a format prescribed by the Commissioner. The plan of operation shall contain at least the following information:

(1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(i) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect the usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(ii) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, to either:

(A) Deliver adequately all services that are subject to a restricted network provision.

(B) Make appropriate referrals.

(iii) There are written agreements with network providers describing both parties' specific responsibilities.

(iv) Emergency care is available 24 hours per day and 7 days per week.

(v) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subparagraph does not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A statement or map providing a clear description of the service area.

(3) A description of the grievance procedure to be utilized.

(4) A description of the complaint procedure to be utilized.

(5) A description of the quality assurance program, including the following:

(i) The formal organizational structure.

(ii) The written criteria for selection, retention and removal of network providers.

(iii) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(6) A list and description, by specialty, of the network providers.

(7) Copies of the written information proposed to be used by the issuer to comply with subsection (j).

(8) Other information pertinent to the plan of operation requested by the Commissioner.

(g) A Medicare Select issuer shall file:

(1) Proposed changes to the plan of operation, except for changes to the list of network providers, with the Commissioner prior to implementing the changes. Changes shall be considered approved by the Commissioner after 30 days unless specifically disapproved.

(2) An updated list of network providers with the Commissioner at least quarterly, if changes occur.

(h) A Medicare Select policy or certificate may not restrict payment for covered services provided by nonnetwork providers if the following apply:

(1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition.

(2) It is not reasonable to obtain services through a network provider.

(i) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(j) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(i) Medicare supplement policies or certificates offered by the issuer.

(ii) Other Medicare Select policies or certificates.

(2) A description, including the address, phone number and hours of operation, of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

(3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-pocket providers do not count toward the out-of-pocket annual limit contained in Plans K and L.

(4) A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

(5) A description of limitations on referrals to restricted network providers and to other providers.

(6) A description of the policyholder's rights to purchase another Medicare supplement policy or certificate otherwise offered by the issuer.

(7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

(k) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided under subsection (j) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(l) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. The procedures shall be

aimed at mutual agreement for settlement and may include arbitration procedures.

(1) The complaint and grievance procedure shall be described in the policy and certificates and in the outline of coverage.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a complaint or grievance may be registered with the issuer.

(3) Complaints and grievances shall be considered within 45 days. If a benefit determination by Medicare is necessary, the 45-day review period may not begin until after the Medicare determination has been made. The complaint or grievance shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a complaint or grievance is found to be valid, corrective action shall be taken within 45 days.

(5) The concerned parties shall be notified about the results of a complaint or grievance within 45 days of the decision.

(6) The issuer shall report by March 31 to the Commissioner regarding its grievance procedure. The report shall be in a format prescribed by the Commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of the grievances.

(m) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(n) For purposes of this section the following apply:

(1) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for 6 months.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a "significant benefit" means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(o) Medicare Select policies and certificates shall provide for continuation of coverage in the event the United States Department of Health and Human Services Secretary determines that Medicare Select policies and certificates issued under this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a "significant benefit" means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

(p) A Medicare Select issuer shall comply with reasonable requests for data made by State or Federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

§ 89.778. Open enrollment.

(a) An issuer may not deny or condition the issuance or effectiveness of a Medicare supplement policy or certificate available for sale in this Commonwealth, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the 6-month period beginning with the first day of the first month in which an individual enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to applicants who qualify under this subsection without regard to age. In the case of group policies, an issuer may condition issuance on whether an applicant is a member or is eligible for membership in the insured group.

(b) If an applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage of at least 6 months, the issuer may not exclude benefits based on a preexisting condition.

(c) If the applicant qualifies under subsection (a) and submits an application during the time period referenced in subsection (a) and, as of the date of application, has had a continuous period of creditable coverage that is less than 6 months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The HHS Secretary shall specify the manner of the reduction under this subsection.

(d) Except as provided in subsections (b) and (c) and § 89.789 and 89.790 (relating to prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates; and guarantee issue for eligible persons), subsection (a) will not be construed as preventing the exclusion of benefits under a policy, during the first 6 months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the 6 months before it became effective.

§ 89.780. Loss ratio standards and refund or credit of premium.

(a) *Loss ratio standards.*

(1) A Medicare Supplement policy form or certificate form may 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 return to policyholders and certificateholders in the form of aggregate benefits, a percentage of the aggregate amount of premiums earned as listed in this paragraph. The amount returned to policyholders and certificateholders shall be calculated on the basis of incurred claims experience or incurred health care expenses when coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and on earned premiums for the period. The calculation shall be made in accordance with accepted actuarial principles and practices. This does not include anticipated refunds or credits provided under the policy form or certificate form. The amount returned as benefits shall be equal to:

(i) At least 75% of the aggregate amount of premiums earned in the case of group policies.

(ii) At least 65% of the aggregate amount of premiums earned in the case of individual policies.

(2) Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(i) Home office and overhead costs.

(ii) Advertising costs.

(iii) Commissions and other acquisition costs.

(iv) Taxes.

(v) Capital costs.

(vi) Administrative costs.

(vii) Claims processing costs.

(3) Filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with this section when combined with actual experience to date. Filings of rate revisions shall 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) For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet the following:

(i) The originally filed anticipated loss ratio when combined with the actual experience since inception.

(ii) The appropriate loss ratio requirement from paragraph (1) when combined with actual experience beginning with May 11, 1996, to date.

(iii) The appropriate loss ratio requirement from paragraph (1) over the entire future period for which the rates are computed to provide coverage.

(b) *Refund or credit calculation*.

(1) An issuer shall collect data for each standard Medicare supplement benefit plan and file the data with the Commissioner on or by May 31 of each year using an applicable Refund Calculation Form, as prescribed by the Department.

(2) 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 shall 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.

(3) For the purposes of this section, for policies or certificates issued prior to July 30, 1992, the issuer shall make the refund or credit calculation separately for all individual policies combined and all other group policies combined for experience after May 11, 1996. The first report is due by May 31, 1998.

(4) A refund or credit shall 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. This 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 it may not 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.

(c) *Annual filing of premium rates*. An issuer of Medicare supplement policies and certificates issued before, on or after July 30, 1992, in this Commonwealth shall 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. The supporting documentation shall 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. That demonstration shall exclude active life reserves. An expected 3rd-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than 3 years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare polices or certificates in this Commonwealth shall file with the Commissioner, in accordance with the applicable filing procedures of the Commonwealth:

(1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Supporting documents as necessary to justify the adjustment shall accompany the filing.

(i) An issuer shall make premium adjustments as necessary to produce an expected loss ratio under the policy or certificate that will conform with minimum loss ratio standards for the Medicare supplement policies, and that will result in an expected loss ratio at least as great as that originally anticipated by the issuer for that policy or certificate. A premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described in this section may not be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(ii) 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 section.

(2) Appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. These riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

(d) *Public hearings*. 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, on or after July 30, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the Commissioner.

§ 89.781. Filing and approval of policies and certificates and premium rates.

(a) *Approval of policy or certificate*. An issuer may not deliver or issue for delivery a policy or certificate to a resident of this Commonwealth, unless the policy form or certificate form has been filed with and approved by the Commissioner in accordance with filing requirements and procedures prescribed by the Commissioner.

(b) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the act of December 8, 2003 (Pub. L. No. 108-173, 117 Stat. 2066), only with the commissioner in the state in which the policy or certificate was issued.

(c) *Filing of rating schedule and supporting documentation*. An issuer may not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner.

(d) *Exceptions*.

(1) Except as provided in paragraph (2), an issuer may not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the Commissioner, up to three additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan. These additional forms may include one or more of the following three variations. Forms with only these variations will be regarded as new policy forms under each type:

(i) The inclusion of new or innovative benefits.

(ii) The addition of either direct response or producer marketing methods.

(iii) The addition of either guaranteed issue or underwritten coverage.

(3) For the purpose of this section, a "type" means an individual policy, a group policy, an individual Medicare Select Policy or a group Medicare Select Policy.

(e) *Availability of policy form*.

(1) Except as provided in subsection (a), an issuer shall continue to make available for purchase any policy form or certificate form issued after July 30, 1992, that has been approved by the Commissioner. A policy form or certificate form may not be considered to be available for purchase, unless the issuer has actively offered it for sale in the previous 12 months.

(i) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Commissioner, the issuer may not offer for sale the policy form or certificate form in this Commonwealth.

(ii) An issuer that discontinues the availability of a policy form or certificate form under subsection (a) may not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for 5 years after the issuer provides notice to the Commissioner of the discontinuance. The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this section.

(3) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (1), unless the issuer complies with the following requirements:

(i) 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.

(ii) 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.

(f) *Combination of forms*.

(1) Except as provided in paragraph (2), the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in § 89.780 (relating to loss ratio standards and refund or credit of premium).

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

§ 89.782. Permitted compensation arrangements.

(a) An issuer or other entity may provide a commission or other compensation to a producer or other representative for the sale of a Medicare supplement policy or certificate only if the 1st-year commission or other 1st-year compensation is no more than 200% of the commission or other compensation paid for selling or servicing the policy or certificate in the 2nd year or period.

(b) The commission or other compensation provided in subsequent (renewal) years shall be the same as that provided in the 2nd year or period and shall be provided for no fewer than 5 renewal years.

(c) An issuer or other entity may not provide compensation to its producers or its other representatives and a producer may not 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.

(d) For purposes of this section, compensation includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including bonuses, gifts, prizes, awards and finders fees.

§ 89.783. Required disclosure provisions.

(a) *General rules.*

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of this provision shall be consistent with the type of contract issued. This provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, a rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. When a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

(3) Medicare supplement policies or certificates may not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or similar words.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, these limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder has have 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 insured person is not satisfied. The notice shall contain a company mailing address to which the policyholder or certificateholder should direct the return policy or certificate. Upon receipt of a request for a refund, the company shall promptly refund the total premium amount paid directly to the policyholder or certificateholder. When an insurer asks questions in the application concerning the medical history of an individual applying for "coverage," a notice shall be given to the individual urging them to verify the accuracy and completeness of the medical history information on the application and warning them that erroneous or incomplete application data could jeopardize their claim.

(6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person eligible for Medicare, shall provide to these applicants a *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and Centers for Medicare & Medicaid Services (CMS) and in a type size no smaller than 12-point type. Delivery of the *Guide* shall be made whether or not these policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this subchapter. Except in the case of direct response issuers, delivery of the *Guide* shall be made to the applicant at the time of application and acknowledgment of receipt of the *Guide* shall be obtained by the issuers. Direct response issuers shall deliver the *Guide* to the applicant upon request but not later than at the time the policy is delivered.

(7) For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character and line spacing.

(b) *Notice requirements.*

(1) As soon as practicable, but no later than 30 days prior to the annual effective date of Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Commissioner. The notice shall:

(i) Include a description of revisions to the Medicare Program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate.

(ii) Inform each policyholder or certificateholder as to when a premium adjustment is to be made due to changes in Medicare.

(2) The notice of benefit modifications and premium adjustments shall be in outline form and in clear and simple terms to facilitate comprehension.

(3) These notices may not contain or be accompanied by solicitation.

(4) Once the Department has approved the form, a "Notice of Change" can be used to modify the deductible and co-payment amounts to reflect Medicare changes without submitting the notice for additional approval. Once the Department has approved the form, only format changes are required to be submitted for review.

(c) *MMA notice requirements.* Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the act of December 8, 2003 (Pub. L. No. 108-173, 117 Stat. 2066).

(d) *Outline of coverage requirements for Medicare supplement policies.*

(1) Issuers shall provide an outline of coverage to applicants at the time the application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant.

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the 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 under this section consists of four parts: a cover page,

premium information, disclosure pages and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in this paragraph in no less than 12 point type. All Plans A—L shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(4) Once the Department has approved the format, an "Outline of Coverage" can be modified to have the deductible and co-payment requirements reflect Medicare changes, and the rate changes reflected, without submitting the Outline of Coverage for review. Only those forms containing a format change are required to be submitted for review.

(5) The following items shall be included in the outline of coverage in the order prescribed in this paragraph:

PREMIUM INFORMATION (Boldface Type)

We (insert issuer's name) can only raise your premium if we raise the premium for all policies like yours in this Commonwealth. (If the premium is based on the increasing age of the insured, include information specifying when premiums will change.)

DISCLOSURES (Boldface Type)

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY (Boldface Type)

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY (Boldface Type)

If you find that you are not satisfied with your policy, you may return it to (insert issuer's address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT (Boldface Type)

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE (Boldface Type)

This policy may not fully cover all of your medical costs. (for producers:) Neither (insert company's name) nor its producers are connected with Medicare.

(for direct response:) (insert company's name) is not connected with Medicare.

COMPLETE ANSWERS ARE VERY IMPORTANT (Boldface Type)

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this subchapter. An issuer may use additional benefit plan designations on these charts pursuant to § 89.777(d)).

(Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Commissioner.)

(6) The cover page and the accompanying charts for Plan A to Plan L of the Outlines of Coverage are available upon request from the Department in printed and electronic formats. In addition, notice will be published, in the *Pennsylvania Bulletin*, of the availability of the amended outlines when revisions are made available to the Department by the United States Department of Health and Human Services as published in the *Federal Register*. The Outlines of Coverages will be made available on the Department's website at http://www.insurance.state.pa.us.

(e) *Notice regarding policies or certificates which are not Medicare supplement policies.*

(1) An accident and sickness insurance policy or certificate, other than a Medicare supplement policy; a policy issued under a contract under section 1876 of the Social Security Act (42 U.S.C.A. § 1395mm), disability income policy; or other policy identified in § 89.771(b) (relating to applicability and scope) issued for delivery in this Commonwealth to persons eligible for Medicare, shall notify the insured under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds.

The notice shall be at least 12 point type and shall contain the following language:

"THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(2) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection (d)(1) shall disclose the extent to which the policy duplicates Medicare. The disclosure statement shall be provided in the form prescribed by the Department as set forth in the Medicare Supplement forms relating to Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare as a part of, or together with, the application for the policy or certificate.

(f) Applicable forms relating to Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare, Refund Calculations and Reporting of Duplicate Medicare Policies for Medicare Supplement Chapter 89 are available upon request from the Department in printed and electronic formats. In addition, notice will be published, in the *Pennsylvania Bulletin*, of the availability of amended Medicare Supplement forms when revisions are

made. These Medicare Supplement forms will be made available on the Department's website at http://www.insurance.state.pa.us.

§ 89.784. Requirements for application forms and replacement coverage.

Application forms shall include the following requirements and 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 insurance 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 these questions and statements may be used.

(1) *Statements.*

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

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

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

(iv) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can 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. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy or, if the Medicare supplement policy is no longer available, a substantially equivalent policy will be reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(v) 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

(vi) 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).

(2) *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 insurance 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,

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

Yes _____ NO _____

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

YES _____ NO _____

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

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

YES _____ NO _____

(A) 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.

(B) If yes,

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

YES _____ NO _____

(2) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium?

YES _____ NO _____

(v) If you had any from any Medicare plan other than the original Medicare within the last 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 _____ / _____ / _____

(vi) 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 _____

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

YES _____ NO _____

(viii) Did you drop a Medicare supplement policy to enrollment in the Medicare Plan?

YES _____ NO _____

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

YES _____ NO _____

(A) If so, with what company and what plan do you have (optional for Direct Mailers)?

_____

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

YES _____ NO _____

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

START _____ / _____ / _____ END _____ / _____ / _____

(3) Producers shall list on the application form the following health insurance policies they have sold to the applicant:

(i) Policies sold which are still in force.

(ii) Policies sold in the past 5 years which are no longer in force.

(4) *Notice*. The notice for an issuer shall be provided in substantially the following form in at least 12 point type.

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 supplement or Medicare Advantage and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, PRODUCER (OR OTHER REPRESENTATIVE):

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 premium.

_____ 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 (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. 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 and 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.)

4. 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, producer or other representative)

_____

(Applicant's Signature)

_____

(Date)

*Signature not required for direct response sales.

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

§ 89.786. Standards for marketing.

(a) An issuer, directly or through its producers, shall:

(1) Establish marketing procedures to assure that comparison of policies by its producers will be fair and accurate.

(2) Establish marketing procedures to assure excessive insurance is not sold or issued.

(3) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

(4) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of this insurance.

(5) Establish auditable procedures for verifying compliance with this subsection.

(b) In addition to the practices prohibited by the Unfair Insurance Practices Act (40 P. S. §§ 1171.1—1171.15), the following acts and practices are prohibited:

(1) *Twisting.* Knowingly making any misleading representation or incomplete or fraudulent comparison of insurance policies or insurers for the purpose of inducing, or tending to induce, a person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on or convert an insurance policy or to take out a policy of insurance with another insurer.

(2) *High pressure tactics.* Employing a method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

(3) *Cold lead advertising.* Making use directly or indirectly of a method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by a producer or insurance company.

(c) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and similar words may not be used unless the policy is issued in compliance with this subchapter.

§ 89.787. Appropriateness of recommended purchase and excessive insurance.

(a) In recommending the purchase or replacement of a Medicare supplement policy or certificate, a producer shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) A sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

(c) An issuer may not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

§ 89.790. Guaranteed issue for eligible persons.

(a) *Guaranteed issue.*

(1) Eligible persons are those individuals described in subsection (b) who, seek to enroll under the policy during the period specified in subsection (c), and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer may not:

(i) Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (e) that is offered and is available for issuance to new enrollees by the issuer.

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

(iii) Impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(b) *Eligible persons.* An eligible person is an individual described in paragraphs (1)—(7):

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all supplemental Medicare health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates, or the plan ceases to provide health benefits to the individual because the individual leaves the plan.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act (42 U.S.C.A. § 1395eee), and there are circumstances similar to those described as follows that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan:

(i) The certification of the organization or plan under this part has been terminated.

(ii) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides.

(iii) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the HHS Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (42 U.S.C.A. § 1395w-21(g)(3)(B)) (when the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856 of the Social Security Act (42 U.S.C.A. § 1395w-26), or the plan is terminated for all individuals within a residence area).

(iv) The individual demonstrates, in accordance with guidelines established by the HHS Secretary, that one of the following applies:

(A) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available

under the plan or the failure to provide the covered care in accordance with applicable quality standards.

(B) The organization, or producer or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual.

(v) The individual meets other exceptional conditions the HHS Secretary may provide.

(3) The individual's enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) and the individual is enrolled with one of the following:

(i) An eligible organization under a contract under section 1876 of the Social Security Act (42 U.S.C.A. § 1395mm) (Medicare cost).

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999.

(iii) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (42 U.S.C.A. § 1395l(a)(1)(A)) (health care prepayment plan).

(iv) An organization under a Medicare Select policy.

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because one of the following applies:

(i) The insolvency of the issuer or bankruptcy of the nonissuer organization or of other involuntary termination of coverage or enrollment under the policy.

(ii) The issuer of the policy substantially violated a material provision of the policy.

(iii) The issuer, or a producer or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual.

(5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost) (42 U.S.C.A. § 1395mm), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or any Medicare Select policy and the subsequent enrollment under this paragraph is terminated by the enrollee during the first 12 months of the subsequent enrollment (during which the enrollee is permitted to terminate the subsequent enrollment under section 1851(e) of the Social Security Act).

(6) The individual, upon first becoming eligible for benefits under Part A and enrolled in Part B, if eligible, of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program within 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (e)(4).

(c) *Guaranteed issue time periods.*

(1) In the case of an individual described in subsection (b)(1), the guaranteed issue period begins on the later of one of the following:

(i) The date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation).

(ii) The date that the applicable coverage terminates or ceases; and ends 63 days thereafter.

(2) In the case of an individual described in subsection (b)(2), (3), (5) or (6) 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.

(3) In the case of an individual described in subsection (b)(4)(i), the guaranteed issue period begins on the earlier of the following:

(i) The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any.

(ii) The date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

(4) In the case of an individual described in subsection (b)(2), (4)(ii), (4)(iii), (5) or (6) 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.

(5) In the case of an individual described in subsection (b)(7), 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.

(6) In the case of an individual described in subsection (b) but not described in subsections (d)—(f), the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

(d) *Extended medigap access for interrupted trial periods.*

(1) In the case of an individual described in subsection (b)(5) (or deemed to be so described, under this paragraph) whose enrollment with an organization or provider described in subsection (b)(5) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in subsection (b)(5).

(2) In the case of an individual described in subsection (b)(6) (or deemed to be so described, under this paragraph) whose enrollment with a plan or in a program described in subsection (b)(6) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subsection (b)(6).

(3) For the purposes of subsection (b)(5) and (6), no enrollment of an individual with an organization or provider described in subsection (b)(5), or with a plan or in a program described in subsection (b)(6), may be deemed to be an initial enrollment under this paragraph after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(e) *Products to which eligible persons are entitled*. The Medicare supplement policy to which eligible persons are entitled under:

(1) Subsection (b)(1)—(4) is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by an issuer.

(2) Subsection (b)(5) is one of the following:

(i) Subject to subparagraph (ii), the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (1).

(ii) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, one of the following:

(A) The policy available from the same issuer but modified to remove outpatient prescription drug coverage.

(B) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.

(3) Subsection (b)(6) includes any Medicare supplement policy offered by an issuer.

(4) Subsection (b)(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F, (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(f) *Notification provisions*.

(1) At the time of an event described in subsection (b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy or plan, the organization that terminates the contract or agreement, the issuer terminating the policy or the administrator of the plan being terminated, respectively, shall notify individuals of their rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a). The notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in subsection (b) because of which an individual ceases enrollment under a contract or agreement, policy or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify individuals of their rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (a). The notice shall be communicated within 10 working days of the issuer receiving notification of disenrollment.

Appendix E. (Reserved)

[Pa.B. Doc. No. 05-885. Filed for public inspection May 6, 2005, 9:00 a.m.]

Title 49—VOCATIONAL AND PROFESSIONAL STANDARDS

STATE BOARD OF OCCUPATIONAL THERAPY EDUCATION AND LICENSURE

[49 PA. CODE CH. 42]

Oral Orders

The State Board of Occupational Therapy Education and Licensure (Board) amends § 42.25 (pertaining to oral orders) to read as set forth in Annex A.

Omission of Proposed Rulemaking

Under section 204 of the act of July 31, 1968 (P. L. 469, No. 240) (45 P. S. § 1204), known as the Commonwealth Documents Law (CDL) the Board has omitted procedures for proposed rulemaking set forth in sections 201 and 202 of the CDL (45 P. S. §§ 1201 and 1202). Proposed rulemaking has been omitted because public comment is unnecessary. The amendment merely revises § 42.25 to conform to a change in the Occupational Therapy Practice Act (act) (63 P. S. §§ 1501—1519) that was amended by the act of May 14, 2004 (P. L. 220, No. 30) (Act 30). The regulated community has been informed of the statutory change through the Board's newsletter, which is distributed to all licensees, and through a revised copy of the act and a special notice that appear on the Occupational Therapy page of the Department of State's website.

Description of Amendment

Prior to the passage of Act 30, section 14 of the act (63 P. S. § 1514) authorized an occupational therapist to implement direct occupational therapy to an individual for a specific medical condition based on a referral from a licensed physician or a licensed podiatrist. Act 30 added licensed optometrists to the categories of health care practitioners who may refer an individual to an occupational therapist for the implementation of direct occupational therapy for a specific medical condition. Currently, § 42.25 only refers to accepting referrals from licensed physicians and licensed podiatrists. This rulemaking amends § 42.25 to reflect that a licensed optometrist may also make referrals.

Statutory Authority

Section 5(b) of the act (63 P. S. § 1505(b)) authorizes the Board to promulgate and adopt rules and regulations not inconsistent with law as it deems necessary for the performance of its duties and the proper administration of the act.

Fiscal Impact and Paperwork Requirements

The amendment will not have a fiscal impact on, or create additional paperwork for, the regulated community or the political subdivisions of the Commonwealth. There may be fiscal savings to the general public. Prior to Act 30, when an optometrist determined that a patient would benefit from occupational therapy, the optometrist had to first obtain the referral from a physician or refer the patient back to the physician to obtain a referral. Commonwealth agencies whose regulations and policy statements limit implementation of direct occupational therapy to situations in which a physician has made a referral or order may consider revising their regulations.

Regulatory Review

Under section 5.1(c) of the Regulatory Review Act (act) (71 P. S. § 745.5a(c)), on March 11, 2005, the Board submitted copies of the regulation with proposed rulemaking omitted to the Independent Regulatory Review Commission (IRRC), the Senate Consumer Protection and Professional Licensure Committee and the House Professional Licensure Committee. On the same date, the Board submitted a copy of the regulation to the Office of Attorney General under the Commonwealth Attorneys Act (71 P. S. §§ 732-101—732-506)

Under section 5.1(e) and (j.2) of the act (71 P. S. § 745.5a(e) and (j.2)), the regulation was approved by the House and Senate Committees on April 13, 2005, and approved by IRRC on April 14, 2005.

Additional Information

For additional information about the amendments, submit inquiries to Lisa Burns, State Board of Occupational Therapy Education and Licensure, P. O. Box 2649, Harrisburg, PA 17105-2649, (717) 783-1389, ST-OCCUPATIONAL@state.pa.us.

Findings

The Board finds that:

(1) Public notice of the Board's intention to amend its regulations under the procedures in sections 201 and 202 of the CDL has been omitted under section 204 of the CDL because public comment is unnecessary in that the amendments adopted by this order merely implement an amendment to the act.

(2) The amendment of the Board's regulations in the manner provided in this order is necessary and appropriate for the administration of the act.

Order

The Board, acting under its authorizing statute, orders that:

(a) The regulations of the Board, 49 Pa. Code Chapter 42, are amended by amending § 42.25 to read as set forth in Annex A.

(b) The Board shall submit this order and Annex A to the Office of General Counsel and the Office of Attorney General for approval as to form and legality as required by law.

(c) The Board shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(d) This order shall take effect upon publication in the *Pennsylvania Bulletin*.

MELANIE A. WENNICK,
Chairperson

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 35 Pa.B. 2703 (April 30, 2005).)

Fiscal Note: 16A-675. No fiscal impact; (8) recommends adoption.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 42. STATE BOARD OF OCCUPATIONAL THERAPY EDUCATION AND LICENSURE

MINIMUM STANDARDS OF PRACTICE

§ 42.25. Oral orders.

(a) An occupational therapist shall accept a referral in the form of a written order from a licensed physician, licensed optometrist or licensed podiatrist in accordance with section 14 of the act (63 P. S. § 1514) unless the urgency of the medical circumstances requires immediate treatment. In these circumstances, an occupational therapist may accept an oral order for occupational therapy from a licensed physician, licensed optometrist or licensed podiatrist, if the oral order is immediately transcribed, including the date and time, in the patient's medical record and signed by the occupational therapist taking the order.

(b) The countersignature of the licensed physician, licensed optometrist or licensed podiatrist shall be obtained within 5 days of receipt of the oral order in the case of an occupational therapist providing ordered services in a private office setting. In the case of an occupational therapist providing services in a setting that is independent of the prescribing physician's, optometrist's or podiatrist's office, the countersignature on a written copy of the order may be mailed or faxed to the occupational therapist.

(c) In the case of an occupational therapist providing services in a facility licensed by the Department of Health, the countersignature of the licensed physician, licensed optometrist or licensed podiatrist shall be obtained in accordance with applicable regulations of the Department of Health governing the facility, including 28 Pa. Code §§ 211.3 and 601.31 (relating to oral and telephone orders; and acceptance of patients, plan of treatment and medical supervision).

[Pa.B. Doc. No. 05-886. Filed for public inspection May 6, 2005, 9:00 a.m.]

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CHS. 2600 AND 2620]

[Correction]

Personal Care Homes

An error occurred in the ordering language of the final-form rulemaking which appeared at 35 Pa.B. 2499, 2539 (April 23, 2005). The effective date of § 2600.65(d) was published incorrectly. The correct version of the ordering language is as follows, with ellipses referring to the existing text:

Order

The Department, acting under the Public Welfare Code, orders that:

* * * * *

(d) This Order shall take effect on October 24, 2005, with the exception of § 2600.65(d) that shall take effect on April 24, 2006, § 2600.19(g) that shall take effect on October 24, 2006, and §§ 2600.122, 2600.130(e) and 2600.182 that shall take effect on April 24, 2007.

[Pa.B. Doc. No. 05-823. Filed for public inspection April 22, 2005, 9:00 a.m.]