RULES AND REGULATIONS

Title 31—INSURANCE

INSURANCE DEPARTMENT

[31 PA. CODE CH. 89]

Medicare Supplement Insurance Minimum Standards

The Insurance Department (Department) amends Chapter 89, Subchapter K (relating to Medicare Supplement Insurance Minimum Standards) 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 amendments include changes to Medicare Supplement Insurance (Medigap) plans and benefits established by Federal law. Specifically, the amendments include changes mandated by the Medicare Improvements for Patients and Providers Act of 2008. (Pub. L. No. 100-275, 122 Stat. 2494) (MIPPA) and the Genetic Information Nondiscrimination Act of 2008. (Pub. L. No. 110-233, 122 Stat. 881) (GINA).

Notice of the 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 changes indicated to Subchapter K are Federally-mandated under MIPAA and GINA, which established strict deadlines for state adoption of these revisions. To continue to regulate the Medigap market, the Commonwealth must adopt the revisions required by GINA by July 1, 2009, and the revisions required by MIPPA by September 24, 2009. Medigap plans must conform to the new requirements by the effective dates, regardless of the Commonwealth's action. However, if the revisions to this subchapter are not adopted by the respective deadlines, the Commonwealth will be considered out of compliance with Federal requirements, and Centers for Medicaid and Medicare Services would regulate Medigap business instead of the Department.

To comply with Federal statutory minimum requirements for Medigap policies, the Commissioner finds that the proposed rulemaking procedures in sections 201 and 202 of the CDL (45 P. S. §§ 1201 and 1202) are impracticable, unnecessary and not contrary to the public interest 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 Medigap 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 Medigap policies as required by MIPAA and GINA, as reflected in amendments to the National Association of Insurance Commissioners (NAIC) model regulation adopted by the NAIC September 24, 2008. Currently there are 17 different standardized Medigap plans in force. After the modernization revisions are implemented, there will be 11 plans available, including two new plans designed to give beneficiaries new options for higher beneficiary cost-sharing with a lower premium. Additionally, all Medigap plans will conform to the requirements set forth in GINA.

These amendments will protect the rights of this Commonwealth's consumers by allowing the Commonwealth to retain its authority to regulate Medigap policies.

Explanation of Regulatory Requirements

Section 89.772 (relating to definitions) has been modified to add definitions for 1990 Standardized Medicare supplement benefit plan, 2010 Standardized Medicare supplement benefit plan, and Prestandardized Medicare supplement benefit plan.

Section 89.774 (relating to exclusions and limitations) has been modified to update cross-references to provisions that must be amended under MIPAA.

Section 89.775 (relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992) is retained for transitional purposes and has been amended to update cross-references and to add a reference to "copayment" or "coinsurance" to mirror the new language in §§ 89.776 and 89.776a (relating to benefits standards for policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010; and benefit standards for policies or certificates issued or delivered on or after June 1, 2010).

Section 89.776 is retained for transitional purposes. This section has been amended to add a reference to "copayment" or "coinsurance," mirroring the language in §§ 89.775 and 89.776a, and to specify requirements for offers and subsequent exchanges involving 1990 Standardized Medicare supplement benefit plan for 2010 Standardized Medicare supplement benefit plans.

Section 89.776a has been added to specify the standards for all modernized 2010 Standardized policies effective on or after June 1, 2010, including the standards for both basic (core) and additional benefits for benefit Plans A—D, F, F with high deductible, G, M and N.

Section 89.777 (relating to standard Medicare supplement benefit plans for 1990 Standardized Medicare supplement benefit plan policies or certificates issued on or after July 30, 1992 and prior to June 1, 2010) is retained for transitional purposes, and has been amended to update cross-references and to conform with the *Pennsylvania Code & Bulletin Style Manual*.

Section 89.777b (relating to Standard Medicare supplement benefit plans for 2010 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010) has been added to specify standards for policies effective on or after June 1, 2010. Specifically, this provision: contains a full description of the benefits contained in Plans K and L; specifies that if a carrier wishes to offer any plan in addition to Plan A, the carrier must also offer Plan C or Plan F; sets forth the make up of plans D and G; adds requirements for plans M and N; adds language describing new or innovative benefits; and deletes reference to prescription drug benefits while reinforcing the principle that these benefits should not impact the goal of simplification and should not be used to change or reduce benefits in any standardized plan.

Section 89.783 (relating to required disclosure provisions) has been amended to update cross-references and to conform with the *Pennsylvania Code & Bulletin Style Manual*.

Section 89.784 (relating to requirements for application forms and replacement coverage) has been amended in accordance with the NAIC model to clarify requirements for delivery of copies of an application, policy, certificate and notice to an applicant. This section was also reformatted to better conform to the format requirements of Chapter 2 of the *Pennsylvania Code & Bulletin Style Manual*.

Section 89.791 (relating to prohibition against use of genetic information and requests for genetic testing) has been added to conform to the requirements established by GINA.

Fiscal Impact

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

The insurance industry will likely not incur additional costs associated with complying with the new Federal requirements.

Effectiveness/Sunset Date

The rulemaking will become effective upon final adoption and publication in the *Pennsylvania Bulletin* as final-form rulemaking. Although the amendments are effective upon publication, the GINA requirements are applicable to all Medicare supplement policies with policy years beginning on or after May 21, 2009. The benefit standards established by MIPAA apply to all policies or certificates issued or delivered on or after June 1, 2010. The Department continues to monitor the effectiveness of the 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. Questions may also be e-mailed to psalvatore@state.pa.us or faxed to (717) 772-1969.

Regulatory Review

Under section 5(a) of the Regulatory Review Act, the Department submitted a copy of the regulations with the proposed rulemaking omitted on February 27, 2009, 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. On the same date, the regulations were submitted to the Office of Attorney General for review and approval under the Commonwealth Attorneys Act (71 P. S. §§ 732-101—732-506).

In accordance with section 5(c) of the Regulatory Review Act, the amendments were deemed approved by the Senate Banking and Insurance Committee and by the House Insurance Committee on April 1, 2009. The Attorney General approved the amendments on March 25, 2009. IRRC met on April 2, 2009, and approved the amendments.

Findings

The Insurance Commissioner finds that:

(1) There is good cause to amend Chapter 89, Subchapter K, effective upon publication with the proposed rulemaking omitted. Deferral of the effective date of the amendments is impracticable or contrary to the public interest. These effective dates 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 Chapter 89, Subchapter K, because notice of the amendments under the circumstances is unnecessary, impractical and not contrary to the public interest (45 P. S. § 1204(3)) for the following reasons:

(i) The changes mandated by Federal law will go into effect regardless of the Commonwealth's regulatory action;

(ii) Public comment cannot change the fact that issuers must comply with Federal requirements, nor can public comment have any impact upon the content of the new Federal mandates.

(iii) If the amendments are not implemented by the deadlines established by the Federal law, regulatory oversight will be assumed by the Federal government. This would negatively impact this Commonwealth's consumers due to a shortage in Federal enforcement staffing. Accordingly, it would be more difficult for Commonwealth consumers to have complaints concerning the new requirements addressed by the Federal government in a timely manner.

Order

The Commissioner, acting under the authority in 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, 89.774—89.777, 89.783 and 89.784; and by adding §§ 89.776a, 89.777b and 89.791 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*.

JOEL SCOTT ARIO,
Insurance Commissioner

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 39 Pa.B. 2064 (April 18, 2009).)

Fiscal Note: 11-242. 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:

1990 Standardized Medicare supplement benefit plan—

(i) A group or individual policy of Medicare supplement insurance issued on or after July 20, 1992, and prior to June 1, 2010.

(ii) The term includes Medicare supplement insurance policies and certificates renewed on or after July 20, 1992, which are not replaced by the issuer at the request of the insured.

2010 Standardized Medicare supplement benefit plan—A group or individual policy of Medicare supplement insurance issued on or after June 1, 2010.

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. No. 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. § 1395mm) or a policy issued under a demonstration project specified in section 1882(g)(1), of the Social Security Act (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 under an agreement under section 1833(a)(1)(A) of the Social Security Act (42 U.S.C.A. § 1395l(a)(1)(A)).

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

Prestandardized Medicare supplement benefit plan—A group or individual policy of Medicare supplement insurance issued prior to July 30, 1992.

Producer—An insurance producer as defined by the Article VI-A of The Insurance Department Act of 1921 (40 P. S. §§ 310.1—310.99a), known as the Producer Licensing Modernization Act.

§ 89.774. Exclusions and limitations.

(a) Except for permitted preexisting condition clauses as described in §§ 89.775(1)(i), 89.776(1)(i) and 89.776a(1)(i) (relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992; benefit standards for policies or certificates issued or delivered on or after July 30, 1992 and prior to June 1, 2010; and benefit standards for policies or certificates issued or delivered on or after June 1, 2010), 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, and prior to June 1, 2010), 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.

The following standards apply to Prestandardized Medicare supplement benefit plans. 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, copayment, and coinsurance 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 § 89.776a(2) (relating to benefit standards for policies or certificates issued or delivered on or after June 1, 2010).

(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. No. 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 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 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, and prior to June 1, 2010.

The following standards apply to 1990 Standardized Medicare supplement benefit plans. 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, copayment or coinsurance 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. No. 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.

(viii) If an issuer makes a written offer to a Medicare supplement policyholder or certificateholder of one or more of its plans to exchange, during a specified period, a 1990 Standardized Medicare supplement benefit plan with a 2010 Standardized Medicare supplement benefit plan, the offer and subsequent exchange shall comply with the following requirements:

(A) The issuer need not provide justification to the Commissioner if the insured replaces the 1990 Standardized Medicare supplement benefit plan policy or certificate with an issue age rated 2010 Standardized Medicare supplement benefit plan policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of the offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by the issuer must be filed with and approved by the Commissioner in accordance with the filing requirements and procedures required by the Commissioner.

(B) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(C) The issuer may not apply new preexisting condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized Medicare supplement benefit plan policy or certificate of the insured, but may apply pre-existing condition limitations of no more than 6 months to any added benefits contained in the new 2010 Standardized Medicare supplement benefit plan policy or certificate not contained in the exchanged policy.

(D) The new policy or certificate shall be offered to all policyholders or certificateholders within a given plan, except if the offer or issue would be in violation of State or Federal law.

(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 three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

(v) Coverage for the coinsurance amount, or in the case of hospital outpatient department services 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 or State law, including 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 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 three pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations) unless replaced in accordance with Federal regulations until the out-of-pocket limitation is met as described in 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 HHS Secretary.

(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.

§ 89.776a. Benefit standards for policies or certificates issued or delivered on or after June 1, 2010.

The following standards apply to 2010 Standardized Medicare supplement benefit plans. An issuer may not offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. 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 all other requirements of this regulation.

(i) *Exclusions or limitations.* A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months after 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 any changes in the applicable Medicare deductible, copayment or coinsurance amounts. 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 is 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 any 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 certificate holder 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 all 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.

(vi) *Extension of benefits.* Termination of a Medicare supplement policy or certificate is without prejudice to any continuous loss which began while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(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 certificate holder 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 entitlement) as of the termination of entitlement if the policyholder or certificateholder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of the termination of 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 coverages as described in clauses (B) and (C):

(I) May not provide for any 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 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—D, F, F with high deductible, G, M and N.* 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 also make available to prospective insureds any Medicare Supplement Insurance Benefit Plan in addition to the basic core package, but not instead of it. The core packages are as follows:

(i) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from day 61 through day 90 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 three pints of blood, or equivalent quantities of packed red blood cells as defined under Federal regulations, unless replaced in accordance with Federal regulations.

(v) Coverage for the coinsurance amount, or in the case of hospital outpatient department services 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.

(vi) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(3) *Standards for additional benefits.* The following additional benefits shall be included in Medicare supplement benefit Plans B—D, F, F with High Deductible, G, M and N as provided by § 89.777b (relating to Standard Medicare supplement benefit plans for 2010 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010).

(i) *Medicare Part A deductible.* Coverage for 100% of the Medicare Part A inpatient hospital deductible amount per benefit period.

(ii) *Medicare Part A deductible.* Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period.

(iii) *Skilled nursing facility care.* Coverage for the actual billed charges up to the coinsurance amount from day 21 through day 100 in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(iv) *Medicare Part B deductible.* Coverage for 100% of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(v) *Medicare Part B excess charges.* Coverage for 100% of the difference between the Medicare Part B charges billed, not to exceed a charge limitation established by the Medicare program or state law including the Health Care Practitioner Medicare Fee Control Act (35 P. S. §§ 449.31—449.36), and the Medicare-approved Part B charge.

(vi) *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.

§ 89.777. Standard Medicare supplement benefit plans for 1990 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992, and prior to June 1, 2010.

(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, and prior to June 1, 2010). 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.

§ 89.777b. Standard Medicare supplement benefit plans for 2010 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010.

(a) *Applicability*. The following standards apply to 2010 Standardized Medicare supplement benefit plan policies or certificates. 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 plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of § 89.777 (relating to Standard Medicare supplement benefit plans for 1990 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992 and prior to June 1, 2010).

(b) *Basic (core) and additional benefits.*

(1) 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 § 89.776a(2) (relating to benefit standards for policies or certificates issued or delivered on or after June 1, 2010). An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan.

(2) If an issuer makes available any of the additional benefits described in § 89.776a(3), or offers standardized benefit Plans K or L (as described in subsections (f)(8) and (9)), the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in paragraph (1) a policy form or certificate form containing either standardized benefit Plan C as described in subsection (f)(3) or standardized benefit Plan F (as described in subsection (f)(5)).

(c) No groups, packages or combinations of Medicare supplement benefits other than those listed in this section may be offered for sale in this Commonwealth, except as may be permitted in subsection (g) and § 89.777a (relating to Medicare select policies and certificates).

(d) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans 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 § 89.776a(2) and (3) and list the benefits in the order shown in this section. For purposes of this subsection, "structure, language, and format" means style, arrangement and overall content of a benefit.

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

(f) The make up of 2010 Standardized Medicare supplement benefit plans shall be as follows:

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

(2) Standardized Medicare supplement benefit Plan B shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible as defined in § 89.776a(3)(i).

(3) Standardized Medicare supplement benefit Plan C shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of

the Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in § 89.776a(3)(i), (iii), (iv) and (vi).

(4) Standardized Medicare supplement benefit Plan D shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in an foreign county as defined in § 89.776a(3)(i), (iii) and (vi).

(5) Standardized Medicare supplement Plan F shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of 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 § 89.776a(3)(i), (iii) and (iv)—(vi).

(6) Standardized Medicare supplement 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 basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign county as defined in § 89.776a(3)(i), (iii) and (iv)—(vi). 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 basis of the deductible shall be $1,500 and shall be adjusted annually from 1999 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.

(7) Standardized Medicare supplement benefit Plan G shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign county as defined in § 89.776a(3)(i), (iii), (v) and (vi).

(8) Standardized Medicare supplement Plan K shall include only the following:

(i) *Part A hospital coinsurance, day 61 through day 90.* Coverage of 100% of the Part A hospital coinsurance amount for each day used from day 61 through day 90 in any Medicare benefit period.

(ii) *Part A hospital coinsurance, day 91 through day 150.* Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from day 91 through day 150 in any Medicare benefit period.

(iii) *Part A hospitalization after 150 days.* On 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 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) *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 subparagraph (x).

(v) *Skilled nursing facility care.* Coverage for 50% of the coinsurance amount for each day used from day 21 through the day 100 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 subparagraph (x).

(vi) *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 subparagraph (x).

(vii) *Blood.* Coverage for 50% under Medicare Part A or B, of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells, as defined under Federal regulations, unless replaced in accordance with Federal regulations until the out-of-pocket limitation is met as described in subparagraph (x).

(viii) *Part B cost sharing.* Except for coverage provided in subparagraph (ix), 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).

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

(x) *Cost sharing after out-of-pocket limits.* 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 HHS Secretary.

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

(i) The benefits described in paragraph (8)(i), (ii), (iii) and (ix).

(ii) The benefit described in paragraph (8)(iv), (v), (vi), (vii) and (viii), but substituting 75% for 50%.

(iii) The benefit described in paragraph (8)(x), but substituting $2,000 for $4,000.

(10) Standardized Medicare supplement Plan M shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 50% of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in § 89.776a(3)(ii), (iii) and (vi).

(11) Standardized Medicare supplement Plan N shall include only the following: the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in § 89.776a(3)(i), (iii) and (vi), with co-payments in the following amounts:

(i) The lesser of $20 or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit, including visits to medical specialists.

(ii) The lesser of $50 or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, except that the co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(g) *New or innovative benefits.* 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 standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include only 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. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

§ 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 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" may 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 required in this paragraph in no less than 12 point type. All plans 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" may be modified to reflect Medicare changes to rates, deductible and co-payment requirements 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 required 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.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I and J are no longer available for sale. (This paragraph may not appear after June 1, 2011).

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.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

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 as provided in paragraph (6). No more than four plans may be shown on one chart. An issuer may use additional benefit plan designations on these charts pursuant to § 89.777b(e)).

(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 web site at http://www.ins.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 (e)(1) shall disclose the extent to which the policy duplicates Medicare. The disclosure statement shall be provided in the form required 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) *Availability of forms*. 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 web site 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. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(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.*

(i) If a sale involves replacement of Medicare supplement coverage, an issuer, other than a direct response issuer, or its agent shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of the notice signed by the applicant and the agent shall be provided to the applicant and an additional signed copy shall be retained by the issuer, except where the coverage is sold without an agent. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(ii) 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)

_____

_____

_____

(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.

(iii) *Additional statements*. The notice shall include the following statements, except that clauses (A) and (B), applicable to preexisting conditions, may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation:

(A) If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting 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.

(B) 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.

(C) 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.)

(D) Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

§ 89.791. Prohibition against use of genetic information and requests for genetic testing.

(a) This section applies to all Medicare supplement policies with policy years beginning on or after May 21, 2009.

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

Issuer—The issuer of a Medicare supplement policy or certificate as defined in § 89.772. This term includes a third party administrator, or other person acting for or on behalf of the issuer.

Family member—A first-degree, second-degree, third-degree or fourth-degree relative of an individual.

Genetic counseling—Obtaining, interpreting, or assessing genetic information.

Genetic information—Except for the sex or age of an individual, information regarding:

(i) Genetic tests of an individual or individual's family member.

(ii) The manifestation of a disease or disorder in an individual's family member.

(iv) An individual's request for, or receipt of, genetic services.

(v) Participation in clinical research involving genetic services by an individual or an individual's family member.

(vi) When an individual or family member is a pregnant woman, any reference to information of any fetus carried by the woman.

(vii) Information of any embryo legally held by an individual or family member utilizing reproductive technology.

Genetic services—A genetic test, genetic counseling or genetic education.

Genetic test—An analysis of human DNA, RNA, chromosomes, proteins or metabolites, that detect genotypes, mutations or chromosomal changes. The term does not include an analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes or an analysis of proteins or metabolites directly related to a manifested disease, disorder, or pathological condition that may reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

(c) An issuer of a Medicare supplement policy or certificate may not:

(1) Use an individual's genetic information to deny or condition the issuance or effectiveness of a policy or certificate to that individual, including the imposition of an exclusion of benefits based on a preexisting condition.

(2) Use an individual's genetic information to discriminate in the pricing of the policy or certificate, including the adjustment of premium rates.

(3) Request or require an individual or an individual's family member to undergo a genetic test, except the issuer may:

(i) Obtain and use the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying regulations promulgated under Title XI Part C of the Social Security Act (42 U.S.C.A. §§ 1320d—1320d-9) and section 264 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C.A. § 1320d-2 note 2), consistent with paragraphs (1) and (2) if the issuer requests only the minimum amount of information necessary to accomplish the intended purpose.

(ii) Request, but not require, an individual or individual's family member to undergo a genetic test if the following conditions are met:

(A) The request is made under research that complies with 45 CFR Part 46 (relating to protection of human subjects), or equivalent Federal regulations, and any applicable State or local law or regulations for the protection of human subjects in research.

(B) The issuer clearly indicates to the individual, or the legal guardian of a minor child, to whom the request is made, that compliance with the request is voluntary and that noncompliance will have no effect on enrollment status or premium or contribution amounts.

(C) The issuer does not use genetic information collected or acquired under this clause for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(D) The issuer notifies the HHS Secretary in writing that the issuer is conducting activities under the exception provided for under this subsection, including a description of the activities conducted.

(E) The issuer complies with other conditions as the HHS Secretary may, by regulation, require for activities conducted under this subparagraph.

(4) Request, require, or purchase genetic information for underwriting purposes to:

(i) Determine enrollment, eligibility or continued eligibility for benefits under a policy.

(ii) Compute premium contribution amounts under a policy.

(ii) Apply any preexisting condition exclusion under a policy.

(iii) Conduct any activity related to the creation, renewal or replacement of a contract of health insurance or health benefits.

(5) Request, require or purchase an individual's genetic information prior to that individual's enrollment under the policy in connection with enrollment. If an issuer obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning an individual, the request, requirement, or purchase is not a violation of this paragraph if the request, requirement or purpose does not violate paragraph (4).

(d) Nothing in subsection (c)(1) or (2) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

(1) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant.

(2) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under a group policy; provided that the manifestation of a disease or disorder in one individual may not also be used as genetic information about other group members and to further increase the premium for the group.

[Pa.B. Doc. No. 09-732. Filed for public inspection April 24, 2009, 9:00 a.m.]

Title 49—PROFESSIONAL AND VOCATIONAL STANDARDS

STATE BOARD OF NURSING

[49 PA. CODE CH. 21]

Nursing Education Programs; Provisional Approval; Removal from Approved List; Examination Pass Rates

The State Board of Nursing (Board) adopts amendments to Chapter 21 (relating to State Board of Nursing) regarding approval of nursing education programs for professional nurses (RNs) and practical nurses (LPNs), to read as set forth in Annex A. These amendments will establish a new pass-fail rate for approved registered nursing and licensed practical nurse programs in this Commonwealth. Beginning 1 year after the amendments are promulgated, nursing education programs will remain on full approval status if at least 75% of the programs graduates pass the National licensure examination. Beginning 2 years after the amendments are promulgated, nursing education programs would remain on full approval status if at least 80% of the programs graduates pass the National licensure examination. These provide for oversight and assistance to those programs whose pass rates fall below acceptable standards.

Notice of proposed rulemaking was published at 38 Pa.B. 344 (January 19, 2008). Publication was followed by a 30-day public comment period during which the Board received numerous comments from stakeholders. On February 13, 2008, the House Professional Licensure Committee (HPLC) submitted its comments. The Senate Consumer Protection and Professional Licensure Committee (SCP/PLC) made no comments. The Independent Regulatory Review Commission (IRRC) submitted comments to the proposed rulemaking on March 20, 2008.

Statutory Authority

These final-form regulations are authorized under section 6.1 of the Professional Nursing Law (RN act) (63 P. S. § 216.1), which requires the Board to establish standards for the operation and approval of nursing education programs and for the preparation of RNs. Section 9 of the Practical Nurse Law (LPN act) (63 P. S. § 659) authorizes the Board to approve all schools and institutions that educate LPNs. The Board is further authorized to establish rules and regulations for the practice of professional nursing and the administration of the RN act under section 2.1(k) of the RN act (63 P. S. § 212.1(k)) and for the practice of LPNs and the administration of the LPN act under section 17.6 of the LPN act (63 P. S. § 667.6).

Summary of Comments and Responses to Proposed Rulemaking

Comments from Stakeholders

The Board received comments from several nursing education programs. Butler County Community College (Butler) agreed with the proposal to increase the licensure passing rate requirements for nursing education programs. However, Butler suggested that the Board could support nursing education by identifying the appropriate faculty to student ratios for clinical courses. Butler suggested that this requirement would assist program administrators when requesting additional faculty positions. Second, Butler suggested that a program that admits students annually in the fall semester would be including students from two different cohorts in their annual report, which is based on an examination year October 1 through September 30.

The Board has consistently declined to establish a minimum faculty to student ratio for clinical courses because it believes that each program is in the best position to make determinations regarding the effectiveness of its student to faculty ratio based on the program's instructors, the acuity of the patient population in a clinical program and the nature of the program's student body. While establishing the student to faculty ratio by regulation might assist some schools in successfully lobbying their administration for additional faculty positions, other schools might be placed in a position of justifying current faculty assignments and decrease faculty. The Board believes that the best way to ensure an effective student to faculty ratio is to allow each nursing education program to set its ratio consistent with meeting educational objectives.

The Board cannot dictate when program graduates sit for the licensure examination. Therefore, no matter what dates the Board might set for the examination year, it is possible that individuals from more than one cohort from a particular nursing education program may sit for any given administration of the examination. The Board

obtains examination results from the National Council of State Boards of Nursing, which are provided quarterly. The Board chose the October 1 through September 30, examination year to capture the majority of each program's cohorts.

The Clearfield Campus of Lock Haven University (Lock Haven) wrote in support of the increase to 70%, but commented that the additional increase to 80% 2 years following the first increase would not provide nursing education programs ample time to implement and evaluate strategies and their effectiveness. For at least 10 years, the Board has written to all programs with pass rates between 60.1% and 80% and notified these programs that the Board has been planning to raise the minimum pass rate. Included with this notice, the Board provided suggestions for self-assessment and correction and offered assistance from its education advisors. The Board believes that it has given nursing education programs sufficient notice of its intention to increase the minimum pass rate and that the programs will be able to implement and evaluate strategies and their effectiveness.

Lock Haven also commented that the proposal would force nursing programs to "implement stringent admission criteria, decrease enrollment, increase GPA requirements, increase grading scales and utilize standardized exams as a means to weed out students prior to graduation" and suggested that these changes "could affect the numbers of potential registered nurses in the Commonwealth, and have a direct impact on the nursing shortage." The Board disagrees with Lock Haven's conclusion. There are many reasons why a nursing education program's graduates cannot pass the licensure examination. Rather than decreasing enrollment, a program could evaluate its status related to having an adequate number of qualified faculty, a well-defined faculty development plan, and a sound curriculum plan as evidenced through program outcomes in its systematic evaluation plan.

The Board's proposal to increase the minimum pass rate will positively impact the number of potential registered nurses in this Commonwealth. If at least 70%, and, after 2 years, at least 80%, of the graduates of every nursing program in this Commonwealth pass the licensure examination, enabling them to become licensed nurses practicing in this Commonwealth, there will be more nurses than if only 60% of the graduates of the programs pass the licensure examination and become licensed nurses practicing in this Commonwealth.

The Board received two comments from Thomas Jefferson University (TJU). The Dean of the School of Nursing expressed support for the increase in the minimum pass rates for program graduates as essential to ensuring the quality of nursing education programs in this Commonwealth and assuring the safety of the public and the integrity of the nursing profession. The Dean requested that the Board consider establishing regulations to require an individual who was unsuccessful after twice taking the licensure examination to meet additional educational requirements prior to repeating the examination and to require graduates to sit for the examination within 3 years of completing their nursing education. The Board will take up these recommendations at its meetings and consider regulations in these areas.

The Assistant Dean of the School of Nursing sent the second letter from TJU. This letter also expressed support for the Board's proposal to raise the minimum passing standard. The writer proposed that the Board amend its rulemaking to add anther type of approval. The writer suggested that a program that is on provisional approval status and is not improving after 2 years should be placed on probationary approval status for another period of time prior to the program being removed from the approved list. The Board does not agree that adding another step in the process would improve schools' compliance with the regulations.

Comments From Other Interested Parties

The Executive Director of the Pennsylvania Association of County Affiliated Homes (PACAH) wrote in support of the regulation raising the pass rates to around the National average, noting that this Commonwealth had been behind most states in regards to this issue. PACAH suggested that the Board place additional restrictions on nursing education programs to ensure that the programs contain the essential elements/instructional processes to support their students. As part of the process of granting initial approval to nursing education programs, the Board performs a detailed review of the program's curriculum, faculty, resources and clinical sites. The Board's assessment of these areas is ongoing through the annual and triennial reports that programs are required to file with the Board.

PACAH expressed concern about the impact on students if a program is removed from the approved list, and asked for more information about transitioning students to another program. The Board's educational advisors monitor all nursing education programs on provisional status. However, it is the responsibility of the controlling institution to provide for the completion of the program for students currently enrolled either by placing the students in an approved program or continuing the enrolled classes until completion.

The Pennsylvania State Nurses Association (PSNA) wrote to support increasing the pass rates over the 2-year period and downgrading programs to provisional approval status if their pass rate falls below 80%. PSNA noted that the revision would align the Commonwealth with other states that mandate higher standards and will motivate programs that hover near marginal levels to improve. PSNA also wrote in support of the procedures developed by the Board for removal of a program from the approved list.

PSNA asked that the Board further investigate whether individuals who successfully take the licensure examination on the first try are safer practitioners than those who pass on their second attempt. The Board has never collected data to correlate the efficacy of practitioners and the number of times practitioners took the licensure examination nor is the Board aware of any research that even suggests a correlation between safe practice and number of times an individual examined. Nevertheless, it is not clear to the Board that any relation that might be revealed would indicate the quality of particular nursing education programs. To the Board's knowledge, all states consider only first time test takers when evaluating the success of their nursing education programs.

The Hospital and Healthsystem Association of Pennsylvania (HAP) wrote in support of increasing the accountability of nursing education programs for achieving increased pass rate standards, but expressed concern that the regulations might have the unintended effect of negatively impacting the supply of nurses in this Commonwealth. The Board believes that the increased pass rate standard will increase the number of nurses licensed in this Commonwealth. By way of illustration, the Board compared the number of nurses eligible for licensure from

programs with pass rates below 80% during the October 1, 2006, through September 30, 2007, period to the number of nurses eligible for licensure if those programs met the 80% pass rate. During this period of time, 1,962 students from nursing programs with a pass rate below 80% took the examination and 1,422 passed the examination. If, during this same period of time, 1,962 students from nursing programs with a pass rate of 80% took the examination, 1,570 would have passed, resulting in an increase of 148 new nurses who could be licensed in this Commonwealth.

HAP suggested that the Board amend its rulemaking to provide a 3-year phase in of the 80% standard to give programs more time to meet the upgraded standards. HAP opined that "it generally takes considerable effort—often over several years time—to assess what . . . issues [have resulted in low pass rates], develop plans for correction, implement changes, and monitor those changes to evaluate effectiveness." As noted previously, the Board has, for at least 10 years, notified all programs with pass rates between 60.1% and 80% of the Board's intention to raise the minimum pass rate. Also, it has requested that the programs assess the factors contributing to the low pass rate and address those factors. The Board does not believe that programs need more time to implement changes; rather, by virtue of the new regulation, programs that do not assess shortcomings and implement changes will be faced with the consequence of being placed on provisional approval status. Once on provisional status, the programs will be subject to a timetable for assessing the programs' weaknesses and improving the program so that at least 80% of program graduates are prepared to pass the licensure examination and begin their careers as nurses.

HAP also suggested that the Board determine a program's pass rate based on a 3-year average. The vast majority of states evaluate programs based on annual NCLEX performance. Several states consider NCLEX performance of program graduates over more than 1 year.

Delaware Board of Nursing, which uses an 80% pass rate standard, places a program on provisional approval status if pass rates are below 80% for 2 consecutive years. Looking at examination results for this Commonwealth's programs for the examination year October 1, 2005, through September 30, 2006, 16 programs failed to achieve a minimum 80% pass rate and would be subject to provisional approval status. Using Delaware's standards, that is, schools below the 80% minimum in the 2005-2006 year and still below the 80% minimum in the October 1, 2006, through September 30, 2007, examination year, 15 programs would be subject to provisional approval status.

Georgia Board of Nursing also uses 80% as the minimum pass rate standard. If a program fails to meet the 80% standard in any given year, the Board will consider a 4-year average of the program's pass rates. Applying Georgia's standard to this Commonwealth, 16 programs failed to achieve the minimum 80% standard in the 2005-2006 examination year. Seventeen programs failed to achieve the minimum 80% standard when all 4 years of examination score data, from 2003-2004 through 2006-2007, were considered.

North Carolina Board of Nursing uses 95% of the National pass rate as its minimum pass rate standard, but uses a 3-year average to determine a program's pass rate. Using North Carolina's system, 21 programs would fall below the minimum pass rate in the 2005-2006 examination year, as compared to 16 that would fall below the proposed Pennsylvania standard in the same year. In addition, using the 3-year average, over 16 programs would be subject to provisional approval status in the 2005-2006 examination year under the North Carolina Standard.

Maryland Board of Nursing uses 90% as the minimum pass rate standard. Applying Maryland's rules in this Commonwealth during the 2005-2006 examination year, 47 programs would have been placed on "warning status" and given only 1 year to improve performance. Using the model proposed by the Board, only 16 programs would have been placed on provisional status and given 2 years to improve performance.

In short, the Board is aware that there are different approaches by the states to calculate and evaluate pass standards as one method of evaluating the effectiveness of the state's nursing education programs. Remediation programs also vary from state to state. The Board considered other states' regulatory schemes. The Board is satisfied that its proposal, which emphasizes early intervention with programs experiencing difficulty and the emphasis on a plan to ensure improvement so that programs can be returned to full approval status, will be an effective method to improve the quality of nursing education programs in this Commonwealth.

Regarding HAP's comments about the licensure examination and test plan, the Board is confident that the examination, which is used in by every Board of Nursing in the United States, has not placed graduates of Pennsylvania nursing programs in a negative position in comparison with their colleagues in other states. Changes to the test plan and passing standard occur through a rigorous scientific methodology in accordance with psychometric principles at most once every 3 years. The 2005 RN Practice Analysis conducted by the National Council of State Boards of Nursing demonstrated that the RNs surveyed "worked an average of 3.64 months as RNs" and not the 6 to 12 months asserted. In addition, approximately one-third of this Commonwealth's programs experienced an increase in their pass rate in the October 2006-September 2007 reporting period as compared to the prior reporting period. Of this Commonwealth's programs whose pass rates declined in the October 2006-September 2007 reporting period, approximately one-third experienced a decline in their pass rate of less than 2 percentage points.

HAP next questioned whether the Board would have sufficient resources to monitor and assist programs on provisional approval status. The Board is committed to having appropriate resources available for monitoring all nursing education programs with the intent to assure regulatory compliance and overall program quality provided in the education of nurses in this Commonwealth.

HAP next recommended that the Board use the pass rate only as a first-level screening tool to determine whether any nursing education program should be placed on provisional status, and that the Board "fully consider other data" before placing a program on provisional status. Specifically, HAP suggested that the Board consider the pass rate of program graduates who tested in another state. When a candidate applies for licensure by examination, the candidates must provide on the application the Program Code assigned by NCSBN to the nursing education program. This program code identifies the program the candidate graduate from and their results are reported to that respective program. The

Board already considers the test results reported to each program, which includes program graduates who tested in another state.

HAP also suggested the Board consider whether the examination year test results included a mixing of cohort groups. The Board is not clear why this is a concern, considering HAP's suggestion to average 3 years of pass rates, which would clearly involve mixing cohort groups. The Board does not have a method to track individual cohorts from programs, nor does the Board require individuals to test at any particular time. The Board does not believe that having examination year results include students from several cohorts decreases the validity of the pass rate data. HAP next suggested that the Board consider the diversity of the program's student population. The Board is not clear how HAP foresees a regulatory scheme to address any relationship that might exist between the diversity of a program's student population and NCLEX performance.

Next, HAP suggested that the Board recalculate the pass rate of programs by considering second-time pass rate success due to generational differences and approaches to the examination. First, the Board has no way to correlate the age of the test takers with their scores. Second, the NCLEX has been a computer based examination for 14 years. The Board knows of no basis for HAP's suggestion that some students view the first time taking of the NCLEX as a practice examination. The cost of the examination is around $200; the Board has not received reports that students view it as a "practice" examination.

HAP then suggested that the Board should consider the number of students that sat for the examination. The Board is aware that if only a small number of students sit for the examination, even a small number of failures will affect the pass rate. However, percentage-based assessment inherently treats large and small programs with equality. The Board's education advisors consider the size of the graduating class and the program's historic pass rate performance when working with a program to improve performance.

Finally, HAP suggested that the Board consider the retention rates of the programs. HAP stated that some schools have implemented periodic testing throughout the program to "weed out students before graduation to ensure that the school attains the NCLEX pass rate standards." Students pay tuition to the program with the intention of gaining an education that will permit them to successfully pass the NCLEX, obtain licensure and work in their chosen profession. The Board does not agree with HAP's implication that a program should continue to take tuition payments from students in a nursing education program when the program has every indication that the student will not be able to pass the licensure examination and practice the profession. In fact, the Board believes that a program that does so is doing a disservice to the student, who should either be given the tools to succeed in the program or encouraged to choose another course of study that will enable the student to find employment upon graduation. By increasing the minimum pass rate standard, the Board is requiring nursing education programs to be more responsible and accountable to their students by providing a high quality educational program that will ultimately lead graduates to the practice of the profession.

Next, HAP suggested that there may be serious unintended consequences of the Board's proposal, including having nursing programs institute more stringent admission criteria resulting in the acceptance of fewer nursing students, particularly fewer minority students, into the programs; limiting the pool of applicants for admission by excluding those that don't perform as well on standardized tests such as the SAT; limiting the number of diverse students because demographically, certain populations of students don't perform well on standardized tests; and encouraging schools to "weed out" students before graduation. HAP suggested that these unintended consequences would exacerbate the current nursing shortage. The Board disagrees with HAP's predictions. It is the responsibility of the school to determine its admissions criteria. Programs should provide sound, ongoing evaluation for students' progression through the program to ensure that graduates will be prepared to enter the workforce.

HAP also suggested exploring the implementation of a monitoring program that could be used to assist at-risk programs. For at least the past 10 years, the Board has been notifying programs that the Board has identified as at-risk and offering suggestions and assistance to these programs in identifying and correcting factors that might have led to substandard pass rates. A monitoring program has been in place for many years.

HAP next suggested that the requirement that nursing programs apprise applicants and students whenever the program's approval status changes would place an operational burden on schools. The Board believes that programs must be responsible for and accountable to their students. Moreover, the Board believes that prospective students and current students should be aware of the approval status of programs they are intending to enroll in or in which they are currently enrolled. The Board purposefully left to the programs the means by which this notification would be made to give programs flexibility. At the request of IRRC, the Board will clarify the means of notification. The Board does not believe that the requirement places an undue burden on nursing education programs.

Finally, HAP proposed that programs be given 3 years to correct deficiencies. The Board stands by its proposal that programs be required to correct deficiencies in 2 years, and has allowed that an extension of time may be granted if a program is showing progress toward correction.

HPLC Comments

The HPLC submitted nine comments to the Board. HPLC asked if a program that had been removed from the approved list could reapply to be placed on the approved list and the procedure the program would follow. A program that has been removed from the approved list would be treated the same as any other program that does not have Board approval, that is, as if a new program were being established under § 21.51 (relating to establishment). If approved, the program would be placed on initial approval status, as set forth in § 21.33 (relating to types of approval).

The HPLC noted that the Board used the numeral "2" in §§ 21.33a(g) and 21.162a(g) (relating to types of approval). The Board's usage appears to be consistent with § 4.11 of the *Pennsylvania Code & Bulletin Style Manual*. The Board is confident that if its usage is erroneous, the editors of the *Pennsylvania Code* will make an appropriate correction.

The HPLC suggested that the informal process to correct deficiencies should be separated from the formal process for removal in §§ 21.33a and 21.162a. The Board has deleted the last part of subsections (a), (d) and (e) from these subsections, which seem to mingle the infor-

mal process and the process when a program is on provisional approval with the removal process. As the entire section relates to failure to comply with standards, the last part of subsections (a), (d) and (e) is more properly placed in its own subsection. The Board has created a new subsection (k) for the provision.

The HPLC noted that Wilson College had commented on the proposal during the predraft comment period and requested that certain restrictions, such as only daytime programming, be placed on schools on provisional approval status. The Board noted in the preamble to proposed rulemaking that the Board already imposes restrictions as appropriate. The HPLC asked what other restrictions the Board might impose and how they might improve pass rates. The Board has imposed a variety of restrictions, such as requiring a program to institute a program of student testing to identify deficiencies in the curriculum, collecting data to correlate preadmission GPA and student performance, raising the GPA admission standard and instituting tutoring programs for at-risk students. Identifying deficiencies in the curriculum allows a program to make targeted improvements in teaching methodology or personnel, or both, correlating preadmission GPA to student performance allows a program to determine if remedial programs for students will improve NCLEX performance.

The HPLC next asked for examples of the additional reports that may be required of a program on provisional approval status under §§ 21.33a(e) and 21.162a(e). Different reports may be required depending on the status of the program's self-assessment of the underlying causes for failing to meet the regulations and the educational advisor's identified deficiencies. Reports might include detail from the program's systematic evaluation plan, such as curriculum plans, admission and progression policies and competency determination tools.

The HPLC noted that §§ 21.33a(g) and 21.162a(g) provide for a 2-year period for a program to become compliant with the Board's regulations. HPLC asked whether the Board had considered a period of time for correction of deficiencies. The Board has used the terms come into compliance or become compliant and correct deficiencies interchangeably. The same time period applies. The Board has rewritten these subsections for clarity.

The HPLC's next comment related to a draft copy of the rulemaking that was corrected by the *Pennsylvania Code* and *Bulletin* editors prior to publication as proposed rulemaking.

The HPLC asked at what specific points in time a program could appeal the Board's decision that a program has a deficiency. Specifically, the HPLC asked if there could be an appeal before formal action was taken and whether the restrictions in §§ 21.33a(g) and 21.162a(g) were appealable. Finally, the HPLC asked the Board to enumerate the appeals process in the regulation. Sections 21.33a(j) and 21.162a(j) provide that a program may appeal the decision to place the program on provisional status in accordance with 1 Pa. Code § 35.20 (relating to appeals from actions of the staff). This section of the General Rules of Administrative Practice and Procedure (GRAPP) applies to appeals from actions taken by administrative agency staff, such as actions of the Board's nursing education advisors. The section allows a party to appeal the action of staff within 10 days after service of notice of the action by the staff. The appeal would be filed with the Board. The GRAPP contemplate the appeal of all staff action; therefore, the Board believes that a program could appeal any restriction placed on the program by Board staff. These sections have been expanded to further explicate the appeal process provided by the GRAPP.

Finally, the HPLC asked why the proposal did not require notice to current students of the changes in approval status or provide students the opportunity to transfer to another program with full approval status. Sections 21.33(b) and 21.162(b) require a program to notify applicants and students whenever the program's approval status changes. The provisions assume that the students know the status of the program upon enrollment. The Board does not have any authority to "provide students the opportunity to transfer to another program." Students, as consumers of educational services, are free to apply to other programs and, if accepted, transfer, at any time.

IRRC Comments

IRRC first addressed the clarity of §§ 21.31(d) and 21.162(c), noting that the word "approval" was confusing. The Board's nursing education advisors are authorized to move a program from initial approval status to full approval status. In addition, the Board's nursing education advisors conduct the compliance review and monitor the performance and improvement plan processes on behalf of the Board. Only the Board may grant initial approval status to a program or remove a program from the approved list. Based on comments received, the Board has amended this section to include, as a function solely of the Board, the authority to extend the 2-year maximum period for the correction of deficiencies. These sections have been rewritten for clarity. In addition, a typographical error was detected by IRRC and corrected.

IRRC next suggested that the Board provide a time period for the notice programs are required to give to applicants and students under §§ 21.33(b) and 21.162(b). The Board will add a 30-day time period for the notice. In addition, the Board will add direction concerning the methods of acceptable notice, as requested by IRRC.

IRRC suggested that §§ 21.33a(a) and 21.162a(a) specifically provide that the Board provide written notice to the program describing the reported deficiencies. The Board had anticipated that written notice would be provided and has added this provision. IRRC also asked, regarding the notice provision in subsections (b), whether this was a different notice than that in subsection (c). Depending on the circumstances, the education advisors may provide one notice or separate notices. In some cases, multiple notices may be provided. The process is intended to remain informal to permit the programs to address concerns without a formal, public proceeding. To this end, the Board seeks to encourage a collegial flow of information between the program director and the educational advisors.

IRRC asked the Board what criteria or factors the Board would consider in making the determination to place a program on provisional approval status. Section 21.33(a)(3), and its counterpart for LPN programs, § 21.162(a)(3), provide that the Board may exercise its discretion to place a program on provisional approval status if the program does not meet the standards of the subchapter. The standards set forth in the subchapter are the criteria or factors that the Board considers. The Board also considers the steps a program takes to return to compliance.

IRRC asked whether the provisions of subsections (c) and (g) were in conflict. The Board has amended subsec-

tion (g) to clarify that only the Board, and not the education advisors, may extend the correction period beyond 2 years.

IRRC requested that the Board provide that its education advisors will provide written notice and requests in subsections (d) and (e). The Board anticipated that these requests would be in writing and has added the requested provisions.

Many of the questions raised by IRRC under its question number 4 have been addressed in response to other commentators' concerns. IRRC also asked if the Board had any information on how many programs will be able to reach the 80% standard in 2 years, and what kind of changes would be required to meet the standard. As noted previously, programs with a pass rate between 60.1% and 80% have been receiving communication and assistance from the Board for the past 10 to 12 years. In answering IRRC's question, the Board considered the pass rates for the Commonwealth's nursing education programs for the examination years 2003-2004, 2004-2005, 2005-2006 and 2006-2007.

Exam Year	*PN programs below 75%*	*PN programs 75.1—79.9%*	*RN programs below 75%*	*RN programs 75.1—79.9%*
2003-2004	2	3	12	13
2004-2005	0	2	6	9
2005-2006	2	2	7	9
2006-2007	4	2	19	11

Of the RN programs with pass rates below 80% for the 2003-2004 examination year, 15 programs increased their pass rate to over 80% in the 2004-2005 examination year, an additional five increased their pass rate to over 80% by the 2005-2006 examination year, and all but one of the programs was in compliance with the 80% pass rate by the 2006-2007 examination year. Based on this historic data, it appears that virtually all RN programs will be able to reach the 80% standard within 2 years.

Of the LPN programs with pass rates below 80% over the 4 examination years considered, only one was unable to improve its pass rate to above 80% within 1 examination year; that program improved its pass rate to over 90% in the second year after initiating corrective measures. Based on this historic data, it appears that all LPN programs will be able to reach the 80% standard within 2 years.

Only three programs have had pass rates below 80% for 4 consecutive examination years. These programs include two baccalaureate degree programs (with rates of 60%—74.42%—74.24%—74.58% for a total of 183 students sitting for examination over the 4 year period, and 50%—76.92%—47.37%—47.52% for a total of 61 students sitting for examination over the four year period), and one diploma program (with rates of 75%—64.29%—64%—63.16% for a total of 101 students sitting for examination over the 4 year period). The Board anticipates that the second BSN program and the diploma program will need to make significant improvements across their programs to meet the 80% standard. Because programs have never been subject to the 80% pass rate or a timetable for coming into compliance with the new pass rate, it is impossible to anticipate whether all three of these programs would be able to reach the goal.

IRRC next noted that HAP recommended two additional approaches to meeting the 80% standard; first, phasing in the standard over a 3-year period and second, using a 3-year average to calculate the pass rate. As noted previously, the Board has notified programs for 10 years that a change would be coming to increase pass rates. The Board does not believe that programs need another year of notice that pass rate standards are increasing. The Board fully discussed the 3-year average suggestion in its response to HAP's comments. It is also interesting to note that two of the three programs identified previously would be placed on provisional approval status after 1 year under HAP's recommendation, and that all three of the programs would be placed on provisional approval status after 2 years under HAP's recommendation. The Board does not anticipate that its approach will be grossly over inclusive.

IRRC commented that it agreed with other commentators who had suggested that the Board consider examining the success rate of second time test takers and, if there were a question about the nexus between the program and a second time test taker's success, the Board could require that applicants report and document additional course work. The Board's statutory authority is to approve, and disapprove, nursing education programs. Even if the Board reviewed and analyzed information about the study habits of applicants for reexamination, it is not clear that the Board could distinguish what made an applicant successful or unsuccessful on reexamination. Moreover, it is important to note that all states base the determination of an educational program's effectiveness on the pass rate of first time test takers.

Regarding removal from the approved list, IRRC, following up on a question from HPLC, asked if in the past any programs had been removed from the approved list and later inquired about submitting an application for reinstatement. The Board has never removed a program from the approved list. Should a program be removed, it could reapply for initial approval by the Board.

IRRC next questioned the responsibility of the controlling institution to students set forth in §§ 21.34(b) and 21.166(b). This provision requires the controlling institutions to maintain support from the program until currently enrolled students have graduated or been placed in other programs. The provisions that make the controlling institution responsible for students in the institution's program are found in § 21.41(c) (relating to notification; completion of program; records) for professional nursing education programs and in § 21.173(c) (relating to discontinuance or interruption of a program of a practical nursing education programs).

Finally, IRRC suggested that the Board include in its regulation a reference to section 6.2(a) of the RN Law (63 P. S. § 216.2(a)). Section 6.2(a) of the RN Law provides that a students who obtained part of the nursing education from a program that was removed from the proposed list shall be granted credit for that course work by another program into which the student transfers. The Board has referenced this section of the RN Law in § 21.34(d). The LPN Act does not include a parallel provision for practical nursing students because practical nursing programs take less than a year to complete.

Fiscal Impact and Paperwork Requirements

The final-form regulations will have no adverse fiscal impact on the Commonwealth or its political subdivisions. The final-form regulations will impose only minimal additional paperwork requirements upon the Board, and none upon any political subdivisions. Nursing education programs may incur additional costs in conforming to the regulations.

Regulatory Review

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on January 9, 2008, the Board submitted a copy of the notice of proposed rulemaking, published at 38 Pa.B. 344 to IRRC and the Chairpersons of the HPLC and the SCP/PLC for review and comment.

Under section 5(c) of the Regulatory Review Act, IRRC, the HPLC and the SCP/PLC were provided with copies of the comments received during the public comment period, as well as other documents when requested. In preparing the final-form rulemaking, the Board has considered all comments from IRRC, the HPLC, the SCP/PLC and the public.

Under section 5.1(j.2) of the Regulatory Review Act (71 P. S. § 745.5a(j.2)), on March 18, 2009, the final-form rulemaking was deemed approved by the HPLC. On March 18, 2009, the final-form rulemaking was deemed approved by the SCP/PLC. Under section 5.1(e) of the Regulatory Review Act, IRRC met on March 19, 2009, and approved the final-form rulemaking.

Additional Information

Additional information may be obtained by writing to Ann Steffanic, Board Administrator, State Board of Nursing, P. O. Box 2649, Harrisburg, PA 17105-2649.

Findings

The Board finds that:

(1) Public notice of intention to adopt the administrative amendments adopted by this order was given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations promulgated thereunder 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law and all comments were considered in drafting this final-form rulemaking.

(3) The amendments made to the final-form rulemaking do not enlarge the original purpose of the proposed rulemaking as published at 38 Pa.B. 344.

(4) These amendments to the regulations of the Board are necessary and appropriate for the regulation of the practice of RNs and LPNs in this Commonwealth.

Order

The Board therefore orders that:

(a) The regulations of the Board, 49 Pa. Code Chapter 21, are amended by amending §§ 21.1, 21.31, 21.33, 21.34, 21.141, 21.162; by adding §§ 21.33a, 21.33b, 21.162a, 21.162b and 21.166; and by deleting § 21.26 to read as set forth in Annex A, with ellipses referring to the existing text of the regulation.

(b) The Board shall submit a copy of Annex A to the Office of the Attorney General and the Office of General Counsel for approval 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) The regulations shall take effect immediately upon publication in the *Pennsylvania Bulletin*.

ANN L. O'SULLIVAN, Ph.D., FAAN, CRNP,
Chairperson

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission relating to this document, see 39 Pa.B. 1770 (April 4, 2009).)

Fiscal Note: Fiscal Note 16A-5123 remains valid for the final adoption of the subject regulations.

Annex A

TITLE 49. PROFESSIONAL AND VOCATIONAL STANDARDS

PART I. DEPARTMENT OF STATE

Subpart A. PROFESSIONAL AND OCCUPATIONAL AFFAIRS

CHAPTER 21. STATE BOARD OF NURSING

Subchapter A. REGISTERED NURSES

GENERAL PROVISIONS

§ 21.1. Definitions.

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

* * * * *

Examination year—The period beginning on October 1st of a year through September 30th of the following year.

* * * * *

LICENSES

§ 21.26. (Reserved).

APPROVAL OF NURSING EDUCATION PROGRAMS

§ 21.31. Surveys; list of approved nursing education programs.

(a) Survey visits are made of basic nursing programs conducted in hospitals, colleges or universities of exchange visitor programs and of cooperating agencies. In this section, "cooperating agency" means an educational institution or health care delivery system which cooperates with the controlling institution. The survey report is presented to the Board and a written report of recommendations or requirements, or both, is sent to the school, college or university.

(b) Classified lists of approved schools of nursing and of exchange visitor programs are compiled and published annually and are made available for distribution.

(c) A list of approved cooperating agencies that provide educational programs for schools of nursing is compiled and published annually and is made available for distribution.

(d) For purposes of activities relating to the approval and status of nursing education programs, the term "Board" used in this subchapter may mean the Board's educational advisors appointed under section 2.1(i) of the act (63 P. S. § 212.2(i)). Only the Board may, by a majority vote, confer initial approval status on a proposed nursing education program, extend the maximum 2-year period for correction of deficiencies or remove a program from the approved list.

§ 21.33. Types of approval.

(a) The Board grants the following types of approval to nursing education programs:

(1) *Initial.* The Board may grant initial approval to a new nursing education program, with evidence that the standards of this subchapter are being met, for a period of time necessary to evaluate the results of the licensing examination taken by the first cohort of graduates. A program will not be placed on full approval status until it

has graduated its first class and the class has achieved an acceptable rate of passing the National licensure examination, as set forth in § 21.33b (relating to minimum rate for graduates of nursing education programs to pass the National licensure examination). A program on initial approval status that fails to achieve an acceptable rate of passing the National licensure examination upon graduation of its first class will be placed on provisional approval status.

(2) *Full.* The Board will place on full approval a nursing education program which attains and maintains the standards of this subchapter.

(3) *Provisional.* The Board may place on provisional approval a nursing education program not meeting the standards of this subchapter. A nursing education program on full approval status will be placed on provisional approval status if the program fails to meet the provisions of § 21.33b.

(b) A nursing education program shall notify applicants for admission of the program's approval status and, within 30 days of a change of status, shall notify applicants and students by electronic mail or first class mail that the program's approval status has changed. The program shall provide the Board with a copy of the notice sent to applicants and students. A program shall provide additional notice to applicants and students at the direction of the Board.

§ 21.33a. Failure to comply with standards.

(a) If the Board receives information suggesting that a nursing education program has not maintained the standards of this subchapter, the Board will validate the information and will notify the program, in writing, of the alleged deficiency. The Board may request information from the program or conduct an announced or unannounced site visit before notifying the program of the alleged deficiency. The Board may informally resolve any deficiency.

(b) The Board will notify a program, in writing, that the program will be placed on provisional approval status.

(c) The Board will notify a program on provisional approval status, in writing, of the deficiencies and the amount of time that will be allowed for correction of the deficiencies that resulted in the program's placement on provisional approval status. The Board may extend the time period for correction of deficiencies at its discretion if the program is making demonstrable progress toward the correction of deficiencies. If additional deficiencies are identified, the existing provisional period may be extended at the discretion of the Board.

(d) The Board may place restrictions on a nursing education program on provisional approval status as deemed necessary by the Board to bring the program into compliance with this subchapter and will notify the program, in writing, of the restrictions.

(e) The Board may require that a nursing education program on provisional approval status prepare and submit additional reports and will notify the program, in writing, of the reports required.

(f) The Board may make announced or unannounced site visits to a nursing education program on provisional approval status.

(g) A period of 2 years will be the maximum time period allowed for the correction of deficiencies that returns the program to compliance with the regulations. A program may petition the Board for extension of the maximum period and the Board may, by majority vote, extend the period for good cause demonstrated by the program.

(h) If the standards of this subchapter are met within the designated time, the nursing education program will be removed from provisional approval status. The Board will notify the program in writing of this action.

(i) If the standards of this subchapter are not met within the designated time, the nursing education program will be removed from the approved list as provided in § 21.34 (relating to removal from approved list).

(j) Within 10 days of service of a request under subsection (a) or (e) or notice of the imposition of a restriction under subsection (d), a nursing education program may appeal the action of the staff as provided in 1 Pa. Code § 35.20 (relating to appeals from actions of the staff).

(k) The failure of a program to cooperate with the Board by failing to provide requested information or reports, by refusing or limiting a site visit, or by refusing to adhere to restrictions mandated by the Board will be considered a violation of the standards for nursing education programs and may result in immediate referral of the program to the prosecution division to consider formal action to remove the program from the approved list as provided in § 21.34.

§ 21.33b. Minimum rate for graduates of nursing education programs to pass the National licensure examination.

A nursing education program shall prepare its graduates to pass the National licensure examination at a rate at least equal to the minimum rate set by the Board. The minimum rate for graduates to pass the National licensure examination are as follows:

(1) A nursing education program shall achieve and maintain a minimum pass rate of 60% or more of its first-time examinees during an examination year.

(2) Beginning on October 1, 2009, a nursing education program shall achieve and maintain a minimum pass rate of 70% or more of its first-time examinees during an examination year.

(3) Beginning on October 1, 2010, a nursing education program shall achieve and maintain a minimum pass rate of 80% or more of its first-time examinees during an examination year.

§ 21.34. Removal from approved list.

(a) The Board may remove a nursing education program from the approved list in accordance with the following procedures if the program fails to meet and maintain minimum standards, including the minimum passing rates on the National licensure examination, as established by this subchapter.

(1) The Board will give a nursing education program notice of its intent to remove the program from the approved list.

(2) The notice of intent to remove a program from the approved list will set forth the alleged violations of the standards for nursing education programs.

(3) A program served with notice of intent to remove will be given 45 days in which to file a written answer to the notice.

(4) The nursing education program will be provided an opportunity to appear at a hearing to demonstrate why approval should not be withdrawn.

(5) The nursing education program and the Commonwealth will be provided an opportunity to file post-hearing briefs.

(6) The Board will issue a written decision which will set forth findings of fact and conclusions of law.

(7) The Board's written decision is a final decision of a governmental agency subject to review under 2 Pa.C.S. § 702 (relating to appeals).

(b) If a nursing education program is removed from the approved list, the controlling institution shall provide for the completion of the program for students currently enrolled by placing the students in an approved program.

(c) If a nursing education program is removed from the approved list, the controlling institution shall make provision for permanent retention of student and graduate records in conformance with §§ 21.123 and 21.125 (relating to access and use of records; and custody of records).

(d) If a nursing education program is removed from the approved list, the program shall give students notice of the protection granted under section 6.2(a) of the act (63 P. S. § 216.2(a)).

Subchapter B. PRACTICAL NURSES

GENERAL PROVISIONS

§ 21.141. Definitions.

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

* * * * *

Examination year—The period beginning on October 1st of a year through September 30th of the following year.

* * * * *

APPROVAL OF PRACTICAL NURSING PROGRAMS

§ 21.162. Types of approval.

(a) The Board grants the following types of approval to nursing education programs:

(1) *Initial.* The Board may grant initial approval to a new nursing education program, with evidence that the standards of this subchapter are being met, for a period of time necessary to evaluate the results of the licensing examination by the first cohort of graduates. A program will not be placed on full approval status until it has graduated its first class and the class has achieved an acceptable rate of passing the National licensure examination, as set forth in § 21.162b (relating to minimum rate for graduates of nursing education programs to pass the national licensure examination). A program on initial approval status that fails to achieve an acceptable rate of passing the National licensure examination upon graduation of its first class will be placed on provisional approval status.

(2) *Full.* The Board will place those nursing education programs on full approval status which attain and maintain the standards of this subchapter.

(3) *Provisional.* The Board may place on provisional approval a nursing education program not meeting the standards of this subchapter. A nursing education program on full approval status will be placed on provisional approval status if the program fails to meet the provisions of § 21.162b.

(b) A nursing education program shall notify applicants for admission of the program's approval status and, within 30 days of a change of status, shall notify applicants and students by electronic mail or first class mail that the program's approval status has changed. The program shall provide the Board a copy of the notice sent to applicants and students. A program shall provide additional notice to applicants and students at the direction of the Board.

(c) For purposes of activities relating to the approval and status of nursing education programs, the term "Board" as used in this subchapter may mean the Board's educational advisors appointed under section 2.1(i) of the act (63 P. S. § 212.2(i)). Only the Board may, by a majority vote of a quorum, confer initial approval status on a proposed nursing education program, extend the maximum 2-year period for correction of deficiencies or remove a program from the approved list.

§ 21.162a. Failure to comply with standards.

(a) If the Board receives information suggesting that a nursing education program has not maintained the standards of this subchapter, the Board will validate the information and notify the program, in writing, of the alleged deficiency. The Board may request information from the program or conduct an announced or unannounced site visit before notifying the program of the alleged deficiency. The Board may informally resolve any deficiency.

(b) The Board will notify a program, in writing, that the program will be placed on provisional approval status.

(c) If the Board places a nursing education program on provisional approval status, the Board will notify the program, in writing, of the deficiencies and the amount of time that will be allowed for correction of the deficiencies that resulted in the program's placement on provisional approval status. The Board may extend the time period for correction of deficiencies at its discretion if the program is making demonstrable progress toward the correction of deficiencies. If additional deficiencies are identified, the existing provisional period may be extended at the discretion of the Board.

(d) The Board may place restrictions on a nursing education program on provisional approval status as deemed necessary by the Board to bring the program into compliance with this subchapter and will notify the program, in writing, of the restrictions.

(e) The Board may require that a nursing education program on provisional approval status prepare and submit additional reports and will notify the program, in writing, of the reports required.

(f) The Board may make announced or unannounced site visits to a nursing education program on provisional approval status.

(g) A period of 2 years will be the maximum time period allowed for the correction of deficiencies that returns the program to compliance with the Board's regulations. A program may petition the Board for extension of the maximum period and the Board may, by majority vote, extend the period for good cause demonstrated by the program.

(h) If the standards of this subchapter are met within the designated time, the nursing education program will be removed from provisional approval status. The Board will notify the program in writing of this action.

(i) If the standards of this subchapter are not met within the designated time, the nursing education pro-

gram will be removed from the approved list as provided in § 21.166 (relating to removal from approved list).

(j) Within 10 days of service of a request under subsection (a) or (e) or notice of the imposition of a restriction under subsection (d), a nursing education program may appeal the action of the staff as provided in 1 Pa. Code § 35.20 (relating to appeals from actions of the staff).

(k) The failure of a program to cooperate with the Board by failing to provide requested information or reports, by refusing or limiting a site visit, or by refusing to adhere to restrictions mandated by the Board will be considered a violation of the standards for nursing education programs and may result in immediate referral of the program to the prosecution division to consider formal action to remove the program from the approved list as provided in § 21.166 (relating to removal from approved list).

§ 21.162b. Minimum rate for graduates of nursing education programs to pass the National licensure examination.

A nursing education program shall prepare its graduates to pass the National licensure examination at a rate at least equal to the minimum rate set by the Board. The minimum rate for graduates to pass the National licensure examination are as follows:

(1) A nursing education program shall achieve and maintain a minimum pass rate of 60% or more of its first-time examinees during an examination year.

(2) Beginning on October 1, 2009, a nursing education program shall achieve and maintain a minimum pass rate of 70% or more of its first-time examinees during an examination year.

(3) Beginning on October 1, 2010, a nursing education program shall achieve and maintain a minimum pass rate of 80% or more of its first-time examinees during an examination year.

§ 21.166. Removal from approved list.

(a) The Board may remove a nursing education program from the approved list in accordance with the following procedures if the program fails to meet and maintain minimum standards, including the minimum passing rates on the National licensure examination, as established by this subchapter.

(1) The Board will give a nursing education program notice of its intent to remove the program from the approved list.

(2) The notice of intent to remove a program from the approved list will set forth the alleged violations of the standards for nursing education programs.

(3) A program served with notice of intent to remove will be given 45 days in which to file a written answer to the notice.

(4) The nursing education program will be provided an opportunity to appear at a hearing to demonstrate why approval should not be withdrawn.

(5) The nursing education program and the Commonwealth will be provided an opportunity to file posthearing briefs.

(6) The Board will issue a written decision which will set forth findings of fact and conclusions of law.

(7) The Board's written decision will be a final decision of a governmental agency subject to review under 2 Pa.C.S. § 702 (relating to appeals).

(b) If a nursing education program is removed from the approved list, the controlling institution shall provide for the completion of the program for students currently enrolled by placing the students in an approved program.

(c) If a nursing education program is removed from the approved list, the controlling institution shall make provision for permanent retention of student and graduate records in conformity with §§ 21.233 and 21.234 (relating to custody of records; and access and use of records).

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