Regulatory Analysis Form

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REVIEW COMMISSION

(1) Agency

Insurance Department

(2) I.D. Number (Governor's Office Use)

11-224

IRRC Number: 2462

(3) Short Title

Medicare Supplement Insurance Minimum Standards

(4) PA Code Cite

31 Pa. Code, Chapter 89, §§89.772, 89.773, 89.774, 89.775, 89.776, 89.777, 89.777a, 89.778, 89.780, 89.782, 89.781, 89.783, 89.784, 89.786, 89.787 and 89.790

(5) Agency Contacts & Telephone Numbers

Primary Contact: Peter J. Salvatore, Regulatory Coordinator, 1326 Strawberry Square, Harrisburg, PA 17120, (717) 787-4429
Secondary Contact:

(6) Type of Rulemaking (check one)

☐ Proposed Rulemaking
☐ Final Order Adopting Regulation
☒ Final Order, Proposed Rulemaking Omitted

(7) Is a 120-Day Emergency Certification Attached?

☒ No
☐ Yes: By the Attorney General
☐ Yes: By the Governor

(8) Briefly explain the regulation in clear and nontechnical language.

These amendments are necessary to maintain Pennsylvania's compliance with Federal requirements, which will ensure that Pennsylvania retains enforcement authority over Medicare Supplement policies. The Federal legislation establishes that those states adopting the language of the NAIC Medicare Supplement model regulation with Federal revisions will be considered to be in compliance with the Federal requirements. Pennsylvania needs to adopt these revisions to the Medicare Supplement regulations in order to avoid Federal intervention.

(9) State the statutory authority for the regulation and any relevant state or federal court decisions.

Sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411, and 412) provide the Insurance Commissioner with the authority and duty to promulgate regulations governing the enforcement of the laws relating to insurance. Other factors are the federal statutory requirements of the Social Security Act (42 U.S.C. §1395ss) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. No. 108-173, 117 Stat. 2066 (2003)).

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(10) Is the regulation mandated by any federal or state law or court order, or federal regulation? If yes, cite the specific law, case or regulation, and any deadlines for action.

Yes. The amendments will bring the Department's regulations for the approval of Medicare supplement policies into compliance with the federal statutory requirements of the Social Security Act (42 U.S.C. §1395ss) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. No. 108-173, 117 Stat. 2066 (2003)). This regulation needs to be in force in order to prevent Federal intervention.

(11) Explain the compelling public interest that justifies the regulation. What is the problem it addresses?

The Insurance Department seeks to amend 31 Pa. Code,Chapter 89 to be consistent with the authorizing statute and the Federal statute mentioned above. Moreover, it is in the public interest to amend the regulatory requirements in order to be consistent with other states and the Federal requirements for minimum standards.

(12) State the public health, safety, environmental or general welfare risks associated with nonregulation.

There are no public health, safety, environment or general welfare risks associated with this rulemaking.

(13) Describe who will benefit from the regulation. (Quantify the benefits as completely as possible and approximate the number of people who will benefit.)

The public will benefit from the regulation to the extent that it will be consistent with the Federal statute.

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(14) Describe who will be adversely affected by the regulation. (Quantify the adverse effects as completely as possible and approximate the number of people who will be adversely affected.)

There will be no adverse effects on any party as a result of the amendment of this regulation.

(15) List the persons, groups or entities that will be required to comply with the regulation. (Approximate the number of people who will be required to comply.)

The regulation applies to all insurers issuing Medicare supplement policies in the Commonwealth.

(16) Describe the communications with and input from the public in the development and drafting of the regulation. List the persons and/or groups who were involved, if applicable.

Comments regarding the amendment of this regulation were not solicited from the various trade associations representing the insurance industry. Comments from the various would not have altered the fact that the requirements found in the Federal statutes need to be followed by insurers issuing Medicare Supplement policies. These regulations allow Pennsylvania to maintain its jurisdictional oversight and does not in any way go against the Federal requirements.

(17) Provide a specific estimate of the costs and/or savings to the regulated community associated with compliance, including any legal, accounting or consulting procedures, which may be required.

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

Insurers are required to comply with the new Federal requirements in order to sell Medicare Supplement insurance. Therefore, the insurance industry will not incur additional costs due to the promulgation of this regulation.

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(18) Provide a specific estimate of the costs and/or savings to local governments associated with compliance, including any legal, accounting or consulting procedures, which may be required.

There are no costs or savings to local governments associated with this rulemaking.

(19) Provide a specific estimate of the costs and/or savings to state government associated with the implementation of the regulation, including any legal, accounting, or consulting procedures, which may be required.

There are no costs or savings associated to state government associated with this rulemaking.

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(20) In the table below, provide an estimate of the fiscal savings and costs associated with implementation and compliance for the regulated community, local government, and state government for the current year and five subsequent years. N/A

	Current FY Year	FY +1 Year	FY +2 Year	FY +3 Year	FY +4 Year	FY +5 Year
SAVINGS:	**$**	**$**	**$**	**$**	**$**	**$**
Regulated Community						
Local Government						
State Government						
Total Savings						
COSTS:						
Regulated Community						
Local Government						
State Government						
Total Costs						
REVENUE LOSSES:						
Regulated Community						
Local Government						
State Government						
Total Revenue Losses						

(20a) Explain how the cost estimates listed above were derived.

N/A.

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(20b) Provide the past three-year expenditure history for programs affected by the regulation.
N/A.

Program	FY –3	FY -2	FY -1	Current FY

(21) Using the cost-benefit information provided above, explain how the benefits of the regulation outweigh the adverse effects and costs.

No costs or adverse effects are anticipated as a result of this regulation.

(22) Describe the nonregulatory alternatives considered and the costs associated with those alternatives. Provide the reasons for their dismissal.

Amending Chapter 31 Pa. Code, Chapter 89 is the most efficient method to achieve consistency with the authorizing statute. No other alternatives were considered.

(23) Describe alternative regulatory schemes considered and the costs associated with those schemes. Provide the reasons for their dismissal.

No other regulatory schemes were considered. The amendment of the regulation is the most efficient method of updating the regulatory requirements.

Regulatory Analysis Form

(24) Are there any provisions that are more stringent than federal standards? If yes, identify the specific provisions and the compelling Pennsylvania interest that demands stronger regulation.

No.

(25) How does this regulation compare with those of other states? Will the regulation put Pennsylvania at a competitive disadvantage with other states?

The rulemaking will not put Pennsylvania at a competitive disadvantage with other states. It merely provides for consistency with the statute.

(26) Will the regulation affect existing or proposed regulations of the promulgating agency or other state agencies? If yes, explain and provide specific citations.

No.

(27) Will any public hearings or informational meetings be scheduled? Please provide the dates, times, and locations, if available.

No public hearings or informational meetings are anticipated.

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(28) Will the regulation change existing reporting, record keeping, or other paperwork requirements? Describe the changes and attach copies of forms or reports, which will be required as a result of implementation, if available.

The amendment of the regulation imposes no additional paperwork requirements on the Department, insurers, or the general public then would be required by Federal statute.

(29) Please list any special provisions which have been developed to meet the particular needs of affected groups or persons including, but not limited to, minorities, elderly, small businesses, and farmers.

The rulemaking will have no effect on special needs of affected parties.

(30) What is the anticipated effective date of the regulation; the date by which compliance with the regulation will be required; and the date by which any required permits, licenses or other approvals must be obtained?

The rulemaking will take effect upon approval of the final form regulation by the legislative standing committees, the Office of the Attorney General, and the Independent Regulatory Review Commission and upon final publication in the *Pennsylvania Bulletin.*

(31) Provide the schedule for continual review of the regulation.

The Department reviews each of its regulations for continued effectiveness on a triennial basis.

CDL-1

FACE SHEET FOR FILING DOCUMENTS WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

#2462

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REVIEW COMMISSION

DO NOT WRITE IN THIS SPACE

Copy below is hereby approved as to form and legality. Attorney General

By _____
(Deputy Attorney General)

_____
Date of Approval

→ Check if applicable. Copy not approved. Objections attached.

Copy below is hereby certified to be a true and correct copy of a document issued, prescribed or promulgated by:

Insurance Department
(AGENCY)

DOCUMENT/FISCAL NOTE NO. 11-224

DATE OF ADOPTION: _____

BY: Diane Koken
M. Diane Koken
Insurance Commissioner

TITLE: _____
(EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)

Copy below is hereby approved as to form and legality. Executive ~~or~~ Independent Agencies

BY: _____

2.8.05
DATE OF APPROVAL

EXEC. (DEPUTY GENERAL COUNSEL)
~~(CHIEF COUNSEL, INDEPENDENT AGENCY)~~
(STRIKE INAPPLICABLE TITLE)

→ Check if applicable. No Attorney General approval or objection within 30 days after submission.

NOTICE OF FINAL-OMITTED RULEMAKING

INSURANCE DEPARTMENT

31 Pa. Code, Chapter 89
§§89.772, 89.773, 89.774, 89.775, 89.776, 89.777, 89.777a, 89.778, 89.780, 89.782, 89.781, 89.783, 89.784, 89.786, 89.787 and 89.790

Medicare Supplement Insurance Minimum Standards

PREAMBLE

By this notice the Insurance Department (Department) hereby amends 31 Pa. Code, Chapter 89, Subchapter K, Medicare Supplement Insurance Minimum Standards, §§89.772, 89.773, 89.774, 89.775, 89.776, 89.777, 89.777a, 89.778, 89.780, 89.781, 89.782, 89.783, 89.784, 89.786, 89.787, 89.790 to read as set forth in Annex A. Sections 206, 506, 1501 and 1502 of The Administrative Code of 1929 (71 P.S. §§ 66, 186, 411, and 412) provide the Insurance Commissioner with the authority and duty to promulgate regulations governing the enforcement of the laws relating to insurance. The amendments will also bring the Department's regulations for the approval of Medicare supplement policies into compliance with the Federal statutory requirements of the Social Security Act (42 U.S.C. §1395ss) and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. No. 108-173, 117 Stat. 2066 (2003)).

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 recent Federal legislation, specifically the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that was enacted December 8, 2003. Federal law requires that these changes be implemented by the states if they are to remain in compliance with the Federal requirements and maintain regulatory authority in this area. The revised National Association of Insurance Commissioners ("NAIC") Medicare Supplement model regulation was adopted September 8, 2004 and the Department's new regulations must be adopted within one year following the NAIC adoption of the model regulations in order for Pennsylvania to retain regulatory authority in this area. In order to comply with Federal statutory minimum requirements for Medicare supplement policies, the Insurance Commissioner finds that the proposed rulemaking procedures in Sections 201 and 202 of the CDL (45 P.S. §§1201 and 1202) are impracticable and unnecessary in this situation, and that the proposed rulemaking may be properly omitted under Section 204(3) of the CDL (45 P.S. §1204(3)).

Purpose

Subchapter K of Chapter 89 was initially promulgated to establish minimum standards for Medicare supplement insurance policies. Standardization of policies was Federally required under the Omnibus Budget Reconciliation Act of 1990. The Insurance Department currently seeks to modify Subchapter K to meet the new Federal mandates for Medicare supplement policies as required under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

These amendments are necessary to maintain Pennsylvania's compliance with Federal requirements, which will ensure that Pennsylvania retains enforcement authority over Medicare Supplement policies and these new requirements. These standards will be effective for Medicare Supplement issuers on January 1, 2006 under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The Federal legislation establishes that states that adopt the language of the NAIC Medicare Supplement model regulation that has been revised to address the Federal changes will be considered to be in compliance with the Federal requirements. Pennsylvania needs to adopt these revisions to the Medicare Supplement regulations by September 8, 2005 in order to avoid Federal intervention.

These amendments will protect the rights of Pennsylvania consumers purchasing Medicare supplement policies.

Explanation of Regulatory Requirements

Section 89.772 (relating to definitions) has been modified to reflect changes to definitions of the terms Bankruptcy, Employee Welfare Benefit Plan, Medicare+Choice, and Medicare Supplement Policy. The new language is based on the NAIC Medicare Supplement model regulation. The Department also defined the term producer to mean an insurance producer as defined in the act of December 6, 2002 (P.L. 1183, No. 147) (40 P.S. §310.1-310.99a), known as the Producer Licensing Modernization Act.

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

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

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

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

Section 89.775(1)(vii) (relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992) has been revised to clarify a Medicare supplement policy that has eliminated an outpatient prescription drug benefit to conform with the requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall be deemed to satisfy the guarantee renewal requirements of this subsection. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.776(1)(v)(F) (relating to benefit standards for policies or certificates issued or delivered on or after July 30, 1992) has been revised to clarify a Medicare supplement policy that has eliminated an outpatient prescription drug benefit to conform with the requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall be deemed to satisfy the guarantee renewal requirements of this subsection. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.776(1)(vi) (relating to benefit standards for policies or certificates issued or delivered on or after July 30, 1992) has been revised to clarify that receipt of Medicare Part D benefits will not be considered in determining a continuous loss. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.776(1)(vii)(D)(II) (relating to benefit standards for policies or certificates issued or delivered on or after July 30, 1992) has been revised to clarify that if the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, the reinstitution of the policy for Medicare Part D enrollees will be without coverage for outpatient prescription drugs and will otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.776(2)(iii) (relating to benefit standards for policies or certificates issued or delivered on or after July 30, 1992) has been revised to clarify specific Medicare supplement plans (A-J) and the change of payment method to applicable prospective payment system rate as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.776(3)(vi) (relating to benefit standards for policies or certificates issued or delivered on or after July 30, 1992) has been revised to clarify that for basic outpatient prescription drug benefit, the outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.776(3)(vii) (relating to benefit standards for policies or certificates issued or delivered on or after July 30, 1992) has been revised to clarify that for extended outpatient prescription drug benefit, the outpatient prescription drug benefit may be

included for sale or issuance in a Medicare supplement policy until January 1, 2006. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.776(3)(ix) (relating to benefit standards for policies or certificates issued or delivered on or after July 30, 1992) has been revised to delete specific references to preventive screening tests or preventive services. This language has been replaced by general language to contemplate any future changes that Medicare may make in coverage to specific preventive services. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.776(3)(xi) (relating to new or innovative benefits for policies or certificates issued or delivered on or after July 30, 1992) has been revised and moved to section 89.777(g). This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.776(4) (relating to benefit standards for policies or certificates issued or delivered on or after July 30, 1992) has been added to set forth benefit standards for Medicare supplement plans K and L. This revision is based on the NAIC Medicare Supplement model regulation.

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

Section 89.777(c) (relating to standard Medicare supplement benefit plans) has been revised to include reference to the new Medicare supplement plans available as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

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

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

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

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

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

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

Section 89.777(g) (relating to new or innovative benefits for standard Medicare supplement benefit plans) has been added to set forth the requirements for new or innovative benefits (previously under section 89.776(3)(xi) (relating to new and innovative benefits for policies or certificates issued or delivered on or after July 30, 1992)). Effective December 31, 2005, the outpatient prescription drug program will not constitute an innovative benefit. This revision is based on the NAIC Medicare Supplement model regulation.

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

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

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

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

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

Section 89.780(b)(1)(relating to filing of refund or credit calculations) has been revised to delete the reference to Appendix E and to provide that such data shall be filed using an applicable Refund Calculation Form prescribed by the Department.

Section 89.781(b) (relating to filing and approval of policies and certificates and premium rates) has been revised to allow issuers to file riders or amendments to delete outpatient prescription drug benefits as required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.781(c)(2)(ii) (relating to filing and approval of policies and certificates and premium rates) has been renumbered as (d)(2)(ii) and revised to change agent to producer. This revision reflects the changes made by the act of December 6, 2002 (P.L. 1183, No. 147) (40 P.S. §310.1-310.99a), known as the Producer Licensing Modernization Act.

Section 89.782(a) (relating to permitted compensation agreements) has been revised to change agent to producer. This revision reflects the changes made by the act of December 6, 2002 (P.L. 1183, No. 147) (40 P.S. §310.1-310.99a), known as the Producer Licensing Modernization Act.

Section 89.782(b) (relating to permitted compensation agreements) has been revised to change agent to producer. This revision reflects the changes made by the act of December 6, 2002 (P.L. 1183, No. 147) (40 P.S. §310.1-310.99a), known as the Producer Licensing Modernization Act.

Section 89.783(a)(6) (relating to general rules) has been revised to change the Health Care Financing Administration to Centers for Medicare & Medicaid Services. This revision is based on the NAIC Medicare Supplement model regulation.

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

Section 89.783(c) (relating to MMA Notice Requirements) has been revised to reflect notice requirements for issuers as required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.783(c)(3) (relating to outline of coverage requirements for Medicare supplement policies) has been renumbered as 89.783(d)(3) and revised to reflect the availability of new Medicare supplement plans. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.783(c)(5) (relating to outline of coverage requirements for Medicare supplement policies) has been renumbered as 89.783(d)(5) and revised to change agent to producer. This revision reflects the changes made by the act of December 6, 2002 (P.L. 1183, No. 147) (40 P.S. §310.1-310.99a), known as the Producer Licensing Modernization Act.

Section 89.783(c)(6) (relating to outline of coverage requirements for Medicare supplement policies) has been renumbered as 89.783(d)(6) and revised to reflect the availability of new Medicare supplement plans. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.783(d)(2) (relating to disclosures in applications for policies or certificates which are not Medicare supplement policies) has been renumbered as 89.783(e)(2) and revised to delete the reference to Appendix I and to provide that the disclosure statement shall be on a form prescribed by the Department.

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

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

Section 89.784 (relating to requirements for application forms and replacement coverage) has been revised to require application forms to inquire whether the applicant currently has Medicare Advantage or Medicaid coverage. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.784(1) (relating to requirements for application forms and replacement coverage) has been revised to inform the applicant of important rights and modified the questions to be asked by the issuer to reflect those changes required by The Medicare

Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.784(1)(iv) (relating to requirements for application forms and replacement coverage) has been revised to inform the applicant of important rights regarding suspension of coverage as it relates to the changes required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.784(1)(v) (relating to requirements for application forms and replacement coverage) has been revised to inform the application of important rights regarding suspension of coverage in circumstances where, by reason of disability, an individual later becomes covered by an employer or union-based group health plan as it relates to the changes required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.784(1)(vi) (relating to requirements for application forms and replacement coverage) has been renumbered to accommodate changes required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003.

Section 89.784(2) has been revised to add questions designed to elicit whether an applicant is eligible for guaranteed issue of a Medicare supplement insurance policy. This revision reflects changes required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.784(3) (relating to requirements for application forms and replacement coverage) has been revised to move the requirement formerly located at 89.784(d). This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.784(4) (relating to replacement notice) has been revised to add Medicare Advantage insurance. Revisions were made to clarify reasons for replacement of Medicare supplement policies. This revision reflects changes required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.786(a)(1) (relating to standards for marketing) has been revised to change agent to producer. This revision reflects the changes made by the act of December 6, 2002 (P.L. 1183, No. 147) (40 P.S. §310.1-310.99a), known as the Producer Licensing Modernization Act.

Section 89.786(b)(3) (relating to standards for marketing) has been revised to change agent to producer. This revision reflects the changes made by the act of December 6,

2002 (P.L. 1183, No. 147) (40 P.S. §310.1-310.99a), known as the Producer Licensing Modernization Act.

Section 89.787(a) (relating to appropriateness of recommended purchase and excessive insurance) has been revised to change agent to producer. This revision reflects the changes made by the act of December 6, 2002 (P.L. 1183, No. 147) (40 P.S. §310.1-310.99a), known as the Producer Licensing Modernization Act.

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

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

Section 89.790(b)(2) (relating to eligible persons) has been revised to change Medicare+Choice to Medicare Advantage. This revision reflects changes required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.790(b)(2)(iv)(B) (relating to eligible persons) has been revised to change agent to producer. This revision reflects the changes made by the act of December 6, 2002 (P.L. 1183, No. 147) (40 P.S. §310.1-310.99a), known as the Producer Licensing Modernization Act.

Section 89.790(b)(4)(iii)(relating to eligible persons) has been revised to change agent to producer. This revision reflects the changes made by the act of December 6, 2002 (P.L. 1183, No. 147) (40 P.S. §310.1-310.99a), known as the Producer Licensing Modernization Act.

Section 89.790(b)(5) (relating to eligible persons) has been revised to change Medicare+Choice to Medicare Advantage. This revision reflects changes required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.790(b)(6) (relating to eligible persons) has been revised to change Medicare+Choice to Medicare Advantage. This revision reflects changes required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

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

Section 89.790(c)(1) (relating to guaranteed issue time periods) has been revise to clarify time frame for the guarantee issue period. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.790(c)(4) (relating to guaranteed issue time periods) has been revised to correct the reference term from "section" to "subsection". This revision was made to clarify and maintain consistency within the regulation.

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

Section 89.790(e)(1) (relating to products to which eligible persons are entitled) has been added to provide clarification regarding products to which an eligible person may be entitled as required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.790(e)(2) (relating to products to which eligible persons are entitled) has been added to provide clarification regarding products to which an eligible person may be entitled as required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Section 89.790(e)(4) (relating to products to which eligible persons are entitled) has been added to provide clarification regarding products to which an eligible person may be entitled as required by The Medicare Prescription Drug, Improvement and Modernization Act of 2003. This revision is based on the NAIC Medicare Supplement model regulation.

Fiscal Impact

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

Insurers are required to comply with the new Federal requirements in order to sell Medicare Supplement insurance. Therefore, the insurance industry will not incur additional costs due to the promulgation of this regulation.

Effectiveness/Sunset Date

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

Contact Person

Questions regarding the final omitted rulemaking may be addressed to Peter J. Salvatore, Regulatory Coordinator, Pennsylvania Insurance Department, 1326 Strawberry Square, Harrisburg, Pennsylvania 17120, phone number (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, Act 24 of 1997, the agency submitted a copy of the regulations with the proposed rulemaking omitted on February 11, 2005 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 regulations were (deemed) approved by the Senate Banking and Insurance Committee on _____, and (deemed) approved by the House Insurance Committee on _____. The Attorney General approved the regulation on _____. IRRC met on _____ and approved the regulation.

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 these regulations would be impractical and not serve the public interest. Under Section 204(3) of the CDL there is no purpose to be served by deferring the effective date. An immediate effective date will best serve the public interest by ensuring Pennsylvania'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 amendment under the circumstances is unnecessary and impractical (45 P.S. §1204(3)) for the following reasons:

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

(ii) If the amendments are not implemented as established by the Federal law, regulatory oversight of these requirements will be assumed by the Federal

government. If this were to occur it would split regulation of Medicare supplement policies between Pennsylvania and the Federal government. Such dual regulation would negatively impact Pennsylvania consumers due to a shortage in Federal enforcement staffing. Accordingly, it would be more difficult for Pennsylvania consumers to have complaints concerning the new requirements addressed by the Federal government in a timely manner; and

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

Order

The Insurance 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 at 31 Pa Code, Chapter 89, Subchapter K, are amended as set forth in Annex A, with ellipses referring to the existing text of the regulations.

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

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

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

M. Diane Koken
Insurance Commissioner

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

Sec.

Section

§ 89.772. Definitions.

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

* * * * *

Bankruptcy—The condition under which a [Medicare+Choice plan] 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.

* * * * *

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).

* * * * *

[*Medicare + Choice*] *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 plan.

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

(iii) [Medicare+Choice] Medicare Advantage private fee-for-service plans.

Medicare supplement policy - A group or individual policy of insurance or a subscriber contract other than a policy issued under a contract under section 1876 of the Social Security Act (42 U.S.C.A. §§ 1395—1395mm or a policy issued under a demonstration project specified in section 1882 of the SSA (42 U.S.C.A. § 1395ss(g)(1)), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug Plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under section 1833 (a)(1)(A) of the Social Security Act (42 U.S.C.A. 13951 (a)(1)(A).

* * * * *

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

* * * * *

§ 89.773. Policy definitions and terms.

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

* * * * *

(4) The term ''health care expenses'' for purposes of § 89.780, shall be defined to mean expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. [The expenses may not include:

(i) Home office and overhead costs.

(ii) Advertising costs.

(iii) Commissions and other acquisition costs.

(iv) Taxes.

(v) Capital costs.

(vi) Administrative costs.

(vii) Claims processing costs.]

* * * * *

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

* * * * *

§ 89.774. Exclusions and limitations.

* * * * *

(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) *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), 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 shall not be issued after December 31, 2005.

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

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

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

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

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

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

* * * * *

(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 modified policy shall be deemed to satisfy the guaranteed renewal requirement of this subsection.

(viii) [(vii)]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.

* * * * *

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

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

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

* * * * *

(v) *Cancellation or nonrenewal of policy.* Each Medicare supplement policy shall be guaranteed renewable.

* * * * *

(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 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.*

* * * * *

(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 [which] 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.

* * * * *

(2) *Standards for basic (core) benefits common to[all] 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:

* * * * *

(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 [Diagnostic Related Group (DRG) day outlier per diem] 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.

* * * * *

(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.

* * * * *

(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.

* * * * *

(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 [from] described in clause (B) and patient education to address preventive health care measures.

(B) [One or a combination of the following p] Preventive screening tests or preventive services, the selection and frequency of which is determined to be [considered] medically appropriate by the attending physician.[:]

[(I) Digital rectal examination.

(II) Dipstick urinalysis for hematuria, bacteriuria and proteinuria.

(III) Pure tone (air only) hearing screening test, administered or ordered by a physician.

(IV) Serum cholesterol screening every 5 years.

(V) Thyroid function test.

(VI) Diabetes screening.

(C) Tetanus and Diphtheria booster every 10 years.

(D) Other tests or preventive measures determined appropriate by the attending physician.]

* * * * *

[(xi) *New or innovative benefits.* 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.]

(4) Standards for Plans K and L

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

(A) Coverage of 100% of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

(B) Coverage of 100% of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

(C) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of the 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(D) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (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 post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (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 Subparagraph (j);

(G) Coverage for 50%, under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph (j);

(H) Except for coverage provided in subparagraph (i) below, 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 Subparagraph (j) below;

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

(J) Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

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

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

(B) The benefits described in subparagraphs (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 $4000.

§ 89.777. Standard Medicare supplement benefit plans.

* * * * *

(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 §§ [89.776(3)(xi)] 89.777 (g) and 89.777a of this chapter.

(c) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans A[, B, C, D, E, F, G, H, I and J] through 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:

* * * * *

(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 shall 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 shall 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 shall 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 shall 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 Section 89.776 (4)(i).

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

(g) New or Innovative Benefits: 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 shall not include an outpatient prescription drug program.

§ 89.777a. Medicare Select policies and certificates.

* * * * *

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

* * * * *

(3) A description of the restricted network provisions, including payments for coinsurance

and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-pocket providers do not count toward the out-of-pocket annual limit contained in plans K and L.

* * * * *

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

* * * * *

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

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

* * * * *

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

coverage for Part B excess charges.

* * * * *

§ 89.778. Open enrollment.

* * * * *

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

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

(a) *Loss ratio standards.*

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

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

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

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

(i) Home office and overhead costs.

(ii) Advertising costs.

(iii) Commissions and other acquisition costs.

(iv) Taxes.

(v) Capital costs.

(vi) Administrative costs.

(vii) Claims processing costs.

[(2)](3) Filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

[3](4) For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet the following:

* * * * *

(b) *Refund or credit calculation.*

(1) An issuer shall collect data for each standard Medicare supplement benefit plan and file

such data with Commissioner on or by May 31 of each year [the data contained in the applicable reporting form contained in Appendix E for each type in a standard Medicare supplement benefit plan] using an applicable Refund Calculation Form, as prescribed by the Department.

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

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

(b) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

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

([c]d) *Exceptions.*

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

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

(i) The inclusion of new or innovative benefits.

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

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

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

([d]e) *Availability of policy form.*

* * * * *

([e]f) *Combination of forms.*

* * * * *

§ 89.782. Permitted compensation arrangements.

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

* * * * *

(c) An issuer or other entity may not provide compensation to its [agents or other] producers or its other representatives and [an agent or] a producer may not receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

* * * * *

§ 89.783. Required disclosure provisions.

(a) *General rules.*

* * * * *

(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 [the Health Care Financing Administration] 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.

* * * * *

[(8) Medicare supplement policies or certificates shall be issued to insureds by direct mailing from the insurer and not issued through an agent or broker to these insureds. Except in the case of a direct response insurer, a copy of the completed application shall be a part of or affixed to the policy or certificate issued to the insured.]

* * * * *

(c) MMA Notice Requirements – Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

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

* * * * *

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

* * * * *

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

* * * * *

NOTICE (Boldface Type)

This policy may not fully cover all of your medical costs. (for [agents] producers:)

Neither (insert company's name) nor its [agents] producers are connected with Medicare.

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

* * * * *

(6) The cover page and the accompanying charts for Plan A to Plan [J] L of the Outlines of Coverage are available upon request from the Department in printed and electronic formats. In addition, notice will be published, in the *Pennsylvania Bulletin*, of the availability of the amended outlines when revisions are made available to the Department by the United States Department of Health and Human Services as published in the *Federal Register*. The Outlines of Coverages will be

made available on the Department's website at http://www.insurance.state.pa.us.

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

* * * * *

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

(f) All applicable forms relating to Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare, Refund Calculations and Reporting of Duplicate Medicare Policies for Medicare Supplement Chapter 89 are available upon request from the Department in printed and electronic formats. In addition, notice will be published, in the *Pennsylvania Bulletin*, of the availability of amended Medicare Supplement forms when revisions are made. These Medicare Supplement forms will be made available on the Department's website at http://www.insurance.state.pa.us.

§ 89.784. Requirements for application forms and replacement coverage.

[(a)] 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 [another] Medicare supplement, [or] 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 [agent] producer containing these questions and statements may be used.

(1) [(Statements)] Statements.

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

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

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

[(4)](iv) If, after purchasing this policy, you become eligible for Medicaid, [The] 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.

[5](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*)] *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____/____/____

[''To the best of your knowledge:

(1) Do you have another Medicare supplement policy or certificate in force?

(a) If so, with which company?

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

(2) Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

(a) If so, with which company?

(b) What kind of policy?

(3) Are you covered for Medical Assistance through the state Medicaid program?

(a) As a Specified Low Income Medicare Beneficiary (SLMB)?

(b) As a Qualified Medicare Beneficiary (QMB)?

(c) For other Medicaid medical benefits?]

[(d) Agents shall list other health insurance policies they have sold to the applicant.]

[(e) The notice required by subsection (d) for an issuer shall be provided in substantially the following form in no less than twelve (12) point type:]

(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 five (5) years which are no longer in force.

[(3)](4) *Notice.* The notice for an issuer shall be provided in substantially the following form in no less than twelve (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, [AGENT (BROKER] PRODUCER (OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

_____ Additional benefits.

_____ No change in benefits, but lower premium.

_____ Fewer benefits and lower premiums.

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment (optional only for Direct Mailers.)

_____

_____

_____

_____ Other. (please specify)

---

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and

health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

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

(Signature of [Agent, Broker] producer or [Other]other [Representative]representative)*

(Typed Name and Address of [Issuer]issuer, [Agent or Broker]producer or other representative)

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

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

§ 89.786. Standards for marketing.

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

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

* * * * *

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

* * * * *

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

* * * * *

§ 89.787. Appropriateness of recommended purchase and excessive insurance.

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

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

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

§ 89.790. Guaranteed issue for eligible persons.

(a) *Guaranteed issue.*

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

* * * * *

(b) *Eligible persons.* An eligible person is an individual described in paragraphs (1)—([6]7):

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

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

* * * * *

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

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

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

* * * * *

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

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

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

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

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

(6) The individual, upon first becoming eligible for benefits under Part A and enrolled in Part B, if eligible, of Medicare, enrolls in a [Medicare + Choice] Medicare Advantage plan

under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program within 12 months after the effective date of enrollment.

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

(c) *Guaranteed issue time periods.*

(1) In the case of an individual described in subsection (b)(1), the guaranteed issue period begins on the later of (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of [such] a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends 63 days thereafter [the date of the applicable notice].

(2) In the case of an individual described in subsection (b)(2), (3), (5) or (6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

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

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

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

days after the date the coverage is terminated.

(4) In the case of an individual described in subsection (b)(2), (4)(ii), (4)(iii), (5) or (6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

(5) In the case of an individual described in Subsection b (7), the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty (60) day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

([5]6) In the case of an individual described in subsection (b) but not described in subsections (d) - (f), the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

* * * * *

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

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

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

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

(ii) After December 31, 2005, if the individual was most recently enrolled in a Medicare

supplement policy with an outpatient prescription drug benefit, one of the following:

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

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

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

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

* * * * *

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
SPECIAL PROJECTS OFFICE
1326 Strawberry Square
Harrisburg, PA 17120

Phone: (717) 787-4429
Fax: (717) 772-1969
E-Mail: psalvatore@state.pa.us

February 11, 2005

Ms. Mary S. Wyatte, Esq.
Acting Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17101

Re: Insurance Department Final-Omitted Regulation No. 11-224, Medicare Supplement Insurance Minimum Standards

Dear Ms. Wyatte:

Pursuant to Section 5a(c) of the Regulatory Review Act, enclosed for your information and review is final-omitted regulation 31 Pa. Code, Chapter 89, Medicare Supplement Insurance Minimum Standards.

The changes indicated to Subchapter K are Federally mandated under recent Federal legislation, specifically the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 that was enacted December 8, 2003. Federal law requires that these changes be implemented by the states if they are to remain in compliance with the Federal requirements and maintain regulatory authority in this area. The revised National Association of Insurance Commissioners ("NAIC") Medicare Supplement model regulation was adopted September 8, 2004 and the Department's new regulations must be adopted within one year following the NAIC adoption of the model regulations in order for Pennsylvania to retain regulatory authority in this area.

If you have any questions regarding this matter, please contact me at (717) 787-4429.

Sincerely yours,

Peter J. Salvatore
Regulatory Coordinator

TRANSMITTAL SHEET FOR REGULATIONS SUBJECT TO THE REGULATORY REVIEW ACT

I.D. NUMBER:	11-224
SUBJECT:	Medicare Supplement Insurance Minimum Standards
AGENCY:	DEPARTMENT OF INSURANCE

TYPE OF REGULATION

Proposed Regulation

Final Regulation

X Final Regulation with Notice of Proposed Rulemaking Omitted

120-day Emergency Certification of the Attorney General

120-day Emergency Certification of the Governor

Delivery of Tolled Regulation
a. With Revisions b. Without Revisions

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
2/11/05		HOUSE COMMITTEE ON INSURANCE
2/11/05		
2/11/05		SENATE COMMITTEE ON BANKING & INSURANCE
2-11-05		
2/11/05		INDEPENDENT REGULATORY REVIEW COMMISSION
2/11/05		ATTORNEY GENERAL (for Final Omitted only)
		LEGISLATIVE REFERENCE BUREAU (for Proposed only)