Regulatory Analysis Form

(Completed by Promulgating Agency)

IRRC

Independent Regulatory Review Commission

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INDEPENDENT REGULATORY REVIEW COMMISSION

SECTION I: PROFILE

(1) Agency:

Insurance Department

(2) Agency Number:

Identification Number: 11-242

IRRC Number: 2752.

(3) Short Title:

Medicare Supplement Insurance Minimum Standards

(4) PA Code Cite:

31 Pa. Code, Chapter 89, §§89.772, 89.774, 89.775, 89.776, 89.776a, 89.777, 89.777b, 89.783, 89.784 and 89.791

(5) Agency Contacts (List Telephone Number, Address, Fax Number and Email Address):

Primary Contact:

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

Secondary Contact:

Jodi A. Frantz, Department Counsel, 1341 Strawberry Square, Harrisburg, PA 17120, (717)787-2567.

(6) Primary Contact for Public Comments (List Telephone Number, Address, Fax Number and Email Address) – Complete if different from #5:
(All Comments will appear on IRRC'S website)

(7) Type of Rulemaking (check applicable box):

- ☐ Proposed Regulation
- ☐ Final Regulation
- ☒ Final Omitted Regulation
- ☐ Emergency Certification Regulation;
  - ☐ Certification by the Governor
  - ☐ Certification by the Attorney General

(8) Briefly explain the regulation in clear and nontechnical language. (100 words or less)

The Insurance Department currently seeks to modify Subchapter K to meet the new federal mandates for Medicare Supplement Insurance (Medigap) policies as required by the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 100-275, 122 Stat. 2494 (MIPAA) and the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881 (GINA), as reflected in amendments to the National Association of Insurance Commissioners (NAIC) model regulation adopted by the NAIC September 24, 2008. Currently there are 17 different standardized Medigap plans in force. After the modernization revisions are implemented, there will be 11 plans available, including two new plans designed to give beneficiaries new options for higher beneficiary cost-sharing with a lower premium. Additionally, all Medigap plans will conform to the requirements set forth in GINA.

(9) Include a schedule for review of the regulation including:

A. The date by which the agency must receive public comments: _____

B. The date or dates on which public meetings or hearings will be held: _____

C. The expected date of promulgation of the proposed regulation as a final-form regulation: _____

D. The expected effective date of the final-form regulation: _____

E. The date by which compliance with the final-form regulation will be required: _____

F. The date by which required permits, licenses or other approvals must be obtained: _____

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

The Department continues to monitor the effectiveness of regulations on a triennial basis.

SECTION II: STATEMENT OF NEED

(11) State the statutory authority for the regulation. Include specific statutory citation.

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.

(12) Is the regulation mandated by any federal or state law or court order, or federal regulation? Are there any relevant state or federal court decisions? If yes, cite the specific law, case or regulation as well as, any deadlines for action.

The amendments include changes to Medigap plans and benefits established by federal law. Specifically, the amendments include changes mandated by MIPPA and GINA. In order to continue to regulate the Medigap market, Pennsylvania must adopt the revisions required by GINA by July 1, 2009, and the revisions required by MIPPA by September 24, 2009.

(13) State why the regulation is needed. Explain the compelling public interest that justifies the regulation. Describe who will benefit from the regulation. Quantify the benefits as completely as possible and approximate the number of people who will benefit.

The Insurance Department seeks to amend 31 Pa. Code, Chapter 89 to be consistent with the authorizing statute and the Federal statutes mentioned above. Moreover, it is in the public interest that Pennsylvania will retain its authority to regulate Medigap insurance.

(14) If scientific data, studies, references are used to justify this regulation, please submit material with the regulatory package. Please provide full citation and/or links to internet source.

N/A

(15) Describe who and how many will be adversely affected by the regulation. How are they affected?

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

(16) 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 Medigap policies in the Commonwealth. Approximately 65 issuers are authorized.

SECTION III: COST AND IMPACT ANALYSIS

(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. Explain how the dollar estimates were derived.

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.

(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. Explain how the dollar estimates were derived.

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. Explain how the dollar estimates were derived.

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

(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.

	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) Provide the past three year expenditure history for programs affected by the regulation.

Program	FY -3	FY -2	FY -1	Current FY

(21) Explain how the benefits of the regulation outweigh any cost and adverse effects.

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

(22) Describe the communications with and input from the public and any advisory council/group in the development and drafting of the regulation. List the specific persons and/or groups who were involved.

Comments regarding the amendment of this regulation were not solicited from the various trade associations representing the insurance industry. Because the amendments are mandated by federal law, the requirements therein cannot be modified by public comment. Because the changes mandated by federal law will go into effect regardless of Pennsylvania regulatory action, public comment is unnecessary. However, if the amendments are not implemented by the deadlines established by the federal law, regulatory oversight of Medigap policies will be assumed by CMS.

(23) Include a description of any alternative regulatory provisions which have been considered and rejected and a statement that the least burdensome acceptable alternative has been selected.

Amending Chapter 31 Pa. Code, Chapter 89 is the most efficient method to achieve consistency with the authorizing statute and maintain regulatory authority of Medigap policies. No other alternatives were considered.

(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 regulations.

No.

(25) How does this regulation compare with those of other states? How will this affect Pennsylvania's ability to compete with other states?

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

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

No.

(27) Submit a statement of legal, accounting or consulting procedures and additional reporting, recordkeeping or other paperwork, including copies of forms or reports, which will be required for implementation of the regulation and an explanation of measures which have been taken to minimize these requirements.

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

(28) 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.

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INDEPENDENT REGULATORY REVIEW COMMISSION

FACE SHEET FOR FILING DOCUMENTS WITH THE LEGISLATIVE REFERENCE BUREAU

(Pursuant to Commonwealth Documents Law)

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. 11-242

DATE OF ADOPTION: _____

BY: _____
Joel Ario
Insurance Commissioner

TITLE: _____
(EXECUTIVE OFFICER, CHAIRMAN OR SECRETARY)

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

BY: _____
Andrew C. Clark

FEB 25 2009
DATE OF APPROVAL

(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. Sections 89.772-89.791.
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, 89.774, 89.775, 89.776, 89.776a, 89.777, 89.777b, 89.783, 89.784, 89.791 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 include changes to Medicare Supplement Insurance (Medigap) plans and benefits established by federal law. Specifically, the amendments include changes mandated by the Medicare Improvements for Patients and Providers Act of 2008, Pub. L. No. 100-275, 122 Stat. 2494 (MIPPA) and the Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881 (GINA).

Notice of the proposed rulemaking is omitted in accordance with section 204(3) of the act of July 31, 1968 (P.L. 769, No. 240) known as the Commonwealth Documents Law (CDL) (45 P.S. § 1204(3)). Under Section 204(3) of the CDL, notice of proposed rulemaking may be omitted when the agency for good cause finds that public notice of its intention to amend an administrative regulation is, under the circumstances, impracticable and unnecessary. The changes indicated to Subchapter K are federally mandated under MIPAA and GINA, which established strict deadlines for state adoption of these revisions. In order to continue to regulate the Medigap market, Pennsylvania must adopt the revisions required by GINA by July 1, 2009, and the revisions required by MIPPA by September 24, 2009. Medigap plans must conform to the new requirements by the effective dates, regardless of Pennsylvania action. However, if the revisions to this Subchapter are not adopted by the respective deadlines, Pennsylvania will be considered out of compliance with federal requirements, and Centers for Medicaid and Medicare Services would regulate Medigap business instead of the Pennsylvania Insurance Department.

In order to comply with federal statutory minimum requirements for Medigap 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, unnecessary and not contrary to the public interest 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 Medigap 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 Medigap policies as required by MIPAA and GINA, as reflected in amendments to the National Association of Insurance Commissioners (NAIC) model regulation adopted by the NAIC September 24, 2008. Currently there are 17 different standardized Medigap plans in force. After the

modernization revisions are implemented, there will be 11 plans available, including two new plans designed to give beneficiaries new options for higher beneficiary cost-sharing with a lower premium. Additionally, all Medigap plans will conform to the requirements set forth in GINA.

These amendments will protect the rights of Pennsylvania consumers by allowing Pennsylvania to retain its authority to regulate Medigap policies.

Explanation of Regulatory Requirements

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

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

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

Section 89.776 (relating to benefits standards for policies or certificates issued or delivered on or after July 30, 1992 and prior to June 1, 2010) is retained for transitional purposes. This section has been amended to add a reference to "copayment" or "coinsurance," mirroring the language in 89.775 and 89.776a, and to specify requirements for offers and subsequent exchanges involving 1990 Standardized Medicare supplement benefit plan for 2010 Standardized Medicare supplement benefit plans.

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

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

Section 89.777b (relating to Standard Medicare supplement benefit plans for 2010 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after June 1, 2010) has been added to specify standards for policies effective on or

after June 1, 2010. Specifically, this provision: contains a full description of the benefits contained in Plans K and L; specifies that if a carrier wishes to offer any plan in addition to Plan A, the carrier must also offer Plan C or Plan F; sets forth the make-up of plans D and G; adds requirements for plans M and N; adds language describing new or innovative benefits; and deletes reference to prescription drug benefits while reinforcing the principle that these benefits should not impact the goal of simplification and should not be used to change or reduce benefits in any standardized plan.

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

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

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

Fiscal Impact

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

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

Effectiveness/Sunset Date

The rulemaking will become effective upon final adoption and publication in the *Pennsylvania Bulletin* as final-form rulemaking. Although the regulation is effective upon publication, the GINA requirements are applicable to all Medicare supplement policies with policy years beginning on or after May 21, 2009. The benefit standards established by MIPAA apply to all policies or certificates issued or delivered on or after June 1, 2010. The Department continues to monitor the effectiveness of 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 27, 2009 to the Independent Regulatory Review Commission (IRRC) and to the Chairpersons of the House Committee on Insurance and the Senate Committee on Banking and Insurance. On the same date, the regulations were submitted to the Office of Attorney General for review and approval under the Commonwealth Attorneys Act (71 P.S. §§ 732-101 - 732-506).

In accordance with section 5 (c) of the Regulatory Review Act, the 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 the amendments is impracticable or contrary to the public interest. These effective dates 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, impractical, and not contrary to the public interest (45 P.S. §1204(3)) for the following reasons:

(i) The changes mandated by federal law will go into effect regardless of Pennsylvania regulatory action;

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

(iii) If the amendments are not implemented by the deadlines established by the federal law, regulatory oversight will be assumed by the federal government. This would negatively impact 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.

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*.

Joel S. Ario
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.

§ 89.772. Definitions.

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

1990 Standardized Medicare supplement benefit plan **-- A group or individual policy of Medicare supplement insurance issued on or after July 20, 1992 and prior to June 1, 2010. This term includes Medicare supplement insurance policies and certificates renewed on or after July 20, 1992 which are not replaced by the issuer at the request of the insured.**

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

Applicant—

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

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

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

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

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

Commissioner—The Insurance Commissioner of the Commonwealth.

Continuous period of creditable coverage—The period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

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

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

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

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

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

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

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

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

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

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

Medicare supplement policy—

(i) A group or individual policy of insurance or a subscriber contract other than a policy issued under a contract under section 1876 of the Social Security Act (42 U.S.C.A. § § 1395—1395mm) or a policy issued under a demonstration project specified in section 1882 of the SSA (42 U.S.C.A. § 1395ss(g)(1)), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

(ii) The term does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug Plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under section 1833 (a)(1)(A) of the Social Security Act (42 U.S.C.A. 13951 (a)(1)(A)).

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

Pre-Standardized Medicare supplement benefit plan **-- a group or individual policy of Medicare supplement insurance issued prior to July 30, 1992.**

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

§ 89.774. Exclusions and limitations.

(a) Except for permitted preexisting condition clauses as described in § § 89.775(1)(i)**,** [and] 89.776(1)(i), **and 89.776a(1)(i)**(relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992; [and] benefit[s] standards for policies or certificates issued or delivered on or after July 30, 1992 **and prior to June 1, 2010; and benefit standards for policies or certificates issued or delivered on or after June 1, 2010**), a policy or certificate may not be advertised, solicited or issued for delivery in this Commonwealth as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

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

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

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

(1) Subject to § § 89.775 (1)(iv), (v) and (vii) and 89.776 (1)(iv) and (v) (relating to minimum benefit standards for policies or certificates issued for delivery prior to July 30, 1992; and benefits standards for policies or certificates issued or delivered on or after July 30, 1992 **and prior to June 1, 2010**) a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

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

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

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

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

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

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

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

(i) *Exclusion/limitation of benefits.* A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

(ii) *Indemnification of sickness and accidents.* A Medicare supplement policy or

certificate may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

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

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

(A) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

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

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

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

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

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

(II) An individual Medicare supplement policy which provides only benefits that are required to meet the minimum standards as defined in [§ 89.776(2)] **§ 89.776a(2)** (relating to benefits standards for policies or certificates issued or delivered on or after [July 30, 1992] **June 1, 2010**)**.**

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

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

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

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

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

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

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

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

(i) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

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

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

(iv) Upon exhaustion of Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days.

(v) Coverage under Medicare Part A for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells, as defined under Federal regulations, unless replaced in accordance with Federal regulations or already paid for under Part B.

(vi) Coverage for the coinsurance amount, or in the case of hospital outpatient

department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible.

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

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

§ 89.776. Benefits standards for policies or certificates issued or delivered on or after July 30, 1992 and prior to June 1, 2010.

The following standards apply to [Medicare supplement policies or certificates delivered or issued for delivery in this Commonwealth on or after July 30, 1992] **1990 Standardized Medicare supplement benefit plans.** A policy or certificate may not be advertised, solicited, delivered or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it complies with these benefit standards.

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

(i) *Exclusions and limitations.* A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.

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

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

(iv) *Termination of coverage.* A Medicare supplement policy or certificate may not provide for termination of coverage of a spouse solely because of the occurrence of an event

specified for termination of coverage of the insured, other than the nonpayment of premium.

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

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

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

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

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

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

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

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

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

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

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

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

(vii) *Suspension by policyholder.*

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificateholder has applied for and is determined to be entitled to Medical Assistance under Title XIX of the Social Security Act (42 U.S.C.A. § § 1396—1396u), but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to this assistance.

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

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act (42 U.S.C.A. § 426(b)) and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act (42 U.S.C.A. § 1395y(b)(1)(A)(v)). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

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

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

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

(III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder if the coverage had not been suspended.

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

supplement benefit plan, the offer and subsequent exchange shall comply with the following requirements:

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

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

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

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

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

(i) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period.

(ii) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

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

(iv) Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood (or equivalent quantities of packed red blood cells, as defined under Federal regulations), unless replaced in accordance with Federal regulations.

(v) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

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

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

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

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

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

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

(vi) *Basic outpatient prescription drug benefit.* Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(vii) *Extended outpatient prescription drug benefit.* Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(viii) *Medically necessary emergency care in a foreign country.* Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, ''emergency care'' means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(ix) *Preventive medical care benefit.* Reimbursement shall be for the actual charges up to 100% of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit may not include payment for a procedure covered by Medicare. Coverage for the preventive health services not covered by Medicare is as follows:

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

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

(x) *At-home recovery benefit.* Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(A) For purposes of this benefit, the following definitions apply:

(I) *Activities of daily living*—The term includes bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered and changing bandages or other dressings.

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

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

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

(B) Coverage requirements and limitations are as follows:

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

(II) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(III) Coverage is limited to:

(-a-) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment.

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

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

(-d-) Seven visits in 1 week.

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

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

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

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

(C) Coverage is excluded for:

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

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

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

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

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

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

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

(D) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (J).

(E) Skilled nursing facility care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in clause (J).

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

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

(H) Except for coverage provided in clause (I), coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in clause (J).

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

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

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

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

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

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

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

The following standards apply to 2010 Standardized Medicare supplement benefit plans. An issuer may not offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. A policy or certificate may not be advertised, solicited, delivered or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it complies with these benefit standards.

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

(i) ***Exclusions or limitations.*** **A Medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than 6 months after the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within 6 months before the effective date of coverage.**

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

(iii) ***Cost sharing amounts under Medicare.*** **A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment or coinsurance amounts. Premiums may be modified to correspond with these changes.**

(iv) ***Termination of coverage.*** **A Medicare supplement policy or certificate may not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.**

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

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

(B) The issuer may not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

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

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

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

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

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

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

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

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

(vii) Suspension by policyholder.

(A) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to Medical Assistance under Title XIX of the Social Security Act (42 U.S.C.A. § § 1396—1396u), but only if the

policyholder or certificateholder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to this assistance.

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

(C) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act (42 U.S.C.A. § 426(b)) and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act (42 U.S.C.A. § 1395y(b)(1)(A)(v)). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within 90 days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

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

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

(II) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension.

(III) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder if the coverage had not been suspended.

(2) *Standards for basic (core) benefits common to benefit Plans A-D, F, F with high deductible, G, M and N.* Every issuer shall make available a policy or certificate, including only the following basic (core) package of benefits to each prospective insured. An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan. An issuer may also make available to prospective insureds any Medicare Supplement Insurance Benefit Plan in addition to the basic core package, but not instead of it. The core packages are as follows:

(i) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from day 61 through day 90 in any Medicare benefit period.

(ii) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

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

(iv) Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood, or equivalent quantities of packed red blood cells as defined under Federal regulations, unless replaced in accordance with Federal regulations.

(v) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

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

(3) *Standards for additional benefits.* The following additional benefits shall be included in Medicare supplement benefit Plans B-D, F, F with High Deductible, G, M, and N as provided by § 89.777b .

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

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

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

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

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

(vi) *Medically necessary emergency care in a foreign country.* Coverage to the extent not covered by Medicare for 80% of the billed charges for Medicare-eligible expenses

for medically necessary emergency hospital, physician and medical care received in a foreign country which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

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

(a) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in § 89.776(2) (relating to benefits standards for policies or certificates issued for delivery on or after July 30, 1992 and prior to June 1, 2010). An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan.

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

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

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

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

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

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

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

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

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

(6) Standardized Medicare supplement benefit Plan F shall consist of only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges and medically necessary emergency care in a foreign country as defined in § 89.776(3)(i)—(iii), (v) and (viii).

(7) Standardized Medicare supplement benefit high deductible Plan **["F"]** **F** shall include only the following: 100% of covered expenses following the payment of the annual high deductible Plan **["F"]** **F** deductible. The covered expenses include the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100% of the Medicare Part B excess charges and medically necessary emergency care in a foreign country as defined in § 89.776(3)(i)—(iii), (v) and (viii) respectively. The annual high deductible Plan **["F"]** **F** deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan **["F"]** **F** policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan **["F"]** **F** deductible shall be $1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the HHS Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

(8) Standardized Medicare supplemental benefit Plan G shall include only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, 80% of the Medicare Part B excess charges, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in § 89.776(3)(i), (ii), (iv), (viii) and (x).

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

(10) Standardized Medicare supplement benefit Plan I shall consist of only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as defined in

§ 89.776(3)(i), (ii), (v), (vi), (viii) and (x). The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(11) Standardized Medicare supplement benefit Plan J shall consist of only the following: the core benefit as defined in § 89.776(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100% of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in § 89.776(3)(i)—(iii), (v) and (vii)—(x). The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

(12) Standardized Medicare supplement benefit high deductible Plan [''J''] J shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible Plan [''J''] 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''] J deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan [''J''] J policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the HHS Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit may not be included in a Medicare supplement policy sold after December 31, 2005.

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

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

(f) New or innovative benefits must conform to this subsection. An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit may not include an outpatient prescription drug program.

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

(a) *Applicability.* The following standards apply to 2010 Standardized Medicare

supplement benefit plan policies or certificates. A policy or certificate may not be advertised, solicited, delivered or issued for delivery in this Commonwealth as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of §89.777 (relating to Standard Medicare supplement benefit plans for 1990 Standardized Medicare supplement benefit plan policies or certificates issued or delivered on or after July 30, 1992 and prior to June 1, 2010.).

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

(1) An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in § 89.776a(2). An issuer shall also offer a policy or certificate to prospective insureds meeting the Plan B benefit plan.

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

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

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

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

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

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

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

deductible as defined in§ 89.776a(3)(i).

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

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

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

(6) Standardized Medicare supplement high deductible Plan F shall include only the following: 100% of covered expenses following the payment of the annual high deductible Plan F deductible. The covered expenses include the basic (core) benefit as defined in § 89.776a(2), plus 100% of the Medicare Part A deductible, skilled nursing facility care, 100% of the Medicare Part B deductible, 100% of the Medicare Part B excess charges, and medically necessary emergency care in a foreign county as defined in § 89.776a(3)(i), (iii) and (iv)-(vi). The annual high deductible Plan F deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan F policy, and shall be in addition to any other specific benefit deductibles. The basis of the deductible shall be $1,500 and shall be adjusted annually from 1999 by the HHS Secretary to reflect the change in the Consumer Price Index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

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

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

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

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

from day 91 through day 150 in any Medicare benefit period.

(iii) *Part A hospitalization after 150 days.* On exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100% of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(iv)*Medicare Part A deductible.* Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (x).

(v) *Skilled nursing facility care.* Coverage for 50% of the coinsurance amount for each day used from day 21 through the day 100 in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (x).

(vi) *Hospice care.* Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (x).

(vii) *Blood.* Coverage for 50% under Medicare Part A or B, of the reasonable cost of the first 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 (x).

(viii) *Part B cost sharing.* Except for coverage provided in subparagraph (ix), coverage for 50% of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in clause (J).

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

(x)*Cost sharing after out-of-pocket limits.* Coverage of 100% of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the HHS Secretary.

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

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

(ii) The benefit described in subparagraphs (f)(8)(iv), (v), (vi), (vii) and (viii), but

substituting 75% for 50%.

(iii) The benefit described in subparagraph (f)(8)(x), but substituting $2000 for $4000.

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

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

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

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

(g) *New or innovative benefits.* New or innovative benefits must conform to this subsection. An issuer may, with the prior approval of the Commissioner, offer policies or certificates with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include only benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

§ 89.783. Required disclosure provisions.

(a) *General rules.*

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

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

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

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

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied. The notice shall contain a company mailing address to which the policyholder or certificateholder should direct the return policy or certificate. Upon receipt of a request for a refund, the company shall promptly refund the total premium amount paid directly to the policyholder or certificateholder. When an insurer asks questions in the application concerning the medical history of an individual applying for ''coverage,'' a notice shall be given to the individual urging them to verify the accuracy and completeness of the medical history information on the application and warning them that erroneous or incomplete application data could jeopardize their claim.

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

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

(b) *Notice requirements.*

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

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

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

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

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

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

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

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

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

(2) If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany the policy or certificate when it is delivered and contain the following statement, in no less than 12 point type, immediately above the company name:

''NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.''

(3) The outline of coverage provided to applicants under this section consists of four parts: a cover page, premium information, disclosure pages and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format **[**prescribed**]** **required** in this paragraph in no less than 12 point type. All Plans **[A—L]** shall be

shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

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

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

PREMIUM INFORMATION
(Boldface Type)

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

DISCLOSURES
(Boldface Type)

Use this outline to compare benefits and premiums among policies.

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

READ YOUR POLICY VERY CAREFULLY
(Boldface Type)

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

RIGHT TO RETURN POLICY
(Boldface Type)

If you find that you are not satisfied with your policy, you may return it to (insert issuer's

address). If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT
(Boldface Type)

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

NOTICE
(Boldface Type)

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

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

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

COMPLETE ANSWERS ARE VERY IMPORTANT
(Boldface Type)

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

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

(Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts **[below]** **as provided in paragraph (6).** No more than four plans may be shown on one chart. [For purposes of illustration, charts for each plan are included in this subchapter.] An issuer may use additional benefit plan designations on these charts pursuant to § **[89.777(d)]** **89.777b(e)**).

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

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

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

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

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

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

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

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

§ 89.784. Requirements for application forms and replacement coverage.

Application forms shall include the following requirements and questions designed to elicit information as to whether, as of the date of application, the applicant currently has Medicare

supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing these questions and statements may be used. **In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.**

(1) *Statements.*

* * * * *

(4) *Notice.*

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

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

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF MEDICARE SUPPLEMENT
INSURANCE OR MEDICARE ADVANTAGE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU
IN THE FUTURE.

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement or Medicare Advantage and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

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

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

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

__
Additional benefits.

__
No change in benefits, but lower premium.

__
Fewer benefits and lower premiums.

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

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

—
Other. (please specify)

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

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

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

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

(Signature of producer or other representative)*

(Typed Name and Address of issuer, producer or other representative)

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

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

(A) 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.

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

(C) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all

information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

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

[(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.]

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

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

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

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

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

Genetic counseling **--Obtaining, interpreting, or assessing genetic information.**

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) Obtain and use the results of a genetic test in making a determination regarding payment, as defined for the purposes of applying regulations promulgated under Part C of title XI and section 264 of the Health Insurance Portability and Accountability Act of 1996, consistent with paragraphs (1) and (2) if the issuer requests only the minimum amount of information necessary to accomplish the intended purpose.

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

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

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

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

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

description of the activities conducted.

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

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

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

(ii) Compute premium contribution amounts under a policy.

(ii) Apply any pre-existing condition exclusion under a policy.

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

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

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

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

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

pennsylvania
INSURANCE DEPARTMENT

February 27, 2009

Mr. Kim Kaufman
Executive Director
Independent Regulatory Review Comm.
333 Market Street
Harrisburg, PA 17101

Re: Insurance Department Final- Omitted Regulation No. 11-242, Medicare Supplement Insurance Minimum Standards

Dear Mr. Kaufman:

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, Subchapter K, Medicare Supplement Insurance Minimum Standards.

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

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:	11-242
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

RECEIVED
2009 MAR 27 PM 2:21
INDEPENDENT REGULATORY REVIEW COMMISSION

FILING OF REGULATION

DATE	SIGNATURE	DESIGNATION
2-27-09	Sheila Eckhart	HOUSE COMMITTEE ON INSURANCE
2/27/09	Arthur F. McGinley	MAJORITY CHAIRMAN **REP. ANTHONY DELUCA**
2/27/09	Ronnie Jacobs	SENATE COMMITTEE ON BANKING & INSURANCE
2/27/09	Mikie Sowers	MAJORITY CHAIRMAN **SEN. DONALD C. WHITE**
2/27/09	Kathy Cooper	INDEPENDENT REGULATORY REVIEW COMMISSION
2-27-09	Mary Mummert	ATTORNEY GENERAL
		LEGISLATIVE REFERENCE BUREAU