CHAPTER 37
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

191—37.1(514D) Purpose. The purpose of this chapter is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

191—37.2(514D) Applicability and scope. Except as otherwise specifically provided in rules 37.6(514D), 37.11(514D), 37.12(514D), 37.15(514D) and 37.20(514D), this chapter shall apply to:

All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date hereof, and

All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

This chapter shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof; for employees or former employees, or a combination thereof; or for members or former members, or a combination thereof, of the labor organizations.

191—37.3(514D) Definitions. For purposes of this chapter:

"Applicant" means:

1. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and
2. In the case of a group Medicare supplement policy, the proposed certificate holder.

"Bankruptcy" means a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

"Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

"Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Continuous period of creditable coverage" means 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" means, with respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;
5. Chapter 55 of Title 10, United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

9. A public health plan as defined in federal regulation; and

10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

11. A organized delivery system.

12. Short-term limited durational policy.

"Creditable coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;
2. Coverage issued as a supplement to liability insurance;
3. Liability insurance, including general liability insurance and automobile liability insurance;
4. Workers' compensation or similar insurance;
5. Automobile medical payment insurance;
6. Credit-only insurance;
7. Coverage for on-site medical clinics; and
8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

"Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;
2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and
3. Such other similar, limited benefits as are specified in federal regulations.

"Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness; and
2. Hospital indemnity or other fixed indemnity insurance.

"Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and
3. Similar supplemental coverage provided to coverage under a group health plan.

"Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

"Insolvency" means that an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

"Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

"Medicare" means the "Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as Then Constituted or Later Amended."

"Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C (as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33), and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;
2. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and
3. Medicare+Choice private fee-for-service plans.

"Medicare supplement policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 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.

"Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

"Secretary" means the Secretary of the United States Department of Health and Human Services.

191—37.4(514D) Policy definitions and terms. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this rule.

"Accident," "accidental injury," or *"accidental means"* shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."
2. Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

"Benefit period" or *"Medicare benefit period"* shall not be defined more restrictively than as defined in the Medicare program.

"Convalescent nursing home," "extended care facility," or *"skilled nursing facility"* shall not be defined more restrictively than as defined in the Medicare program.

"Health care expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

Such expenses shall not include:

1. Home office and overhead costs;
2. Advertising costs;
3. Commissions and other acquisition costs;
4. Taxes;
5. Capital costs;
6. Administrative costs; and
7. Claims processing costs.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

"Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Pub. L. No. 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

"Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

"Physician" shall not be defined more restrictively than as defined in the Medicare program.

"Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

191—37.5(514D) Policy provisions.

37.5(1) Except for permitted preexisting condition clauses as described in 37.6(1)*"a"* and 37.7(1)*"a,"* no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

37.5(2) No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

37.5(3) No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

191—37.6(514D) Minimum benefit standards for policies or certificates issued for delivery prior to January 1, 1992. No policy or certificate may be advertised, solicited or issued for delivery in this state 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 not inconsistent with these standards.

37.6(1) *General standards.* The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall 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 six months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. 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 amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

d. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" Medicare supplement policy shall not:

(1) 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; or

(2) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e. (1) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(2) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subparagraph *"e"*(4) below, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

1. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

2. An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in 37.7(2).

(3) If membership in a group is terminated, the issuer shall:

1. Offer the certificate holder such conversion opportunities as are described in 37.6(1)*"e"*(2); or

2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(4) 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 shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any 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.

37.6(2) *Minimum benefit standards.*

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

c. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

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

e. 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;

f. Coverage for the coinsurance 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 ($100);

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

191—37.7(514D) Benefit standards for policies or certificates issued or delivered on or after January 1, 1992. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

37.7(1) *General standards.* The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six 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 six months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. 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 amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

d. No Medicare supplement policy or certificate shall 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.

e. Each Medicare supplement policy shall be guaranteed renewable and

(1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(2) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under 37.7(1)*"e"*(5), the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

1. Provides for continuation of the benefits contained in the group policy, or
2. Provides for such benefits as otherwise meets the requirements of this subrule.

(4) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

1. Offer the certificate holder the conversion opportunity described in 37.7(1)*"e"*(3), or
2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) 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 shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any 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, if any, or payment of the maximum benefits.

g. (1) 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 certificate holder 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, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance.

(2) If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(3) Reinstitution of such coverages:

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;
2. Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and
3. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(4) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for the period provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder 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 such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

37.7(2) *Standards for Basic ("Core") Benefits Common to All Benefit Plans.* Every issuer shall make available a policy or certificate including only the following basic "Core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "Core" package, but not in lieu thereof.

a. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. 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;

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A Eligible Expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

d. 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;

e. 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.

37.7(3) *Standards for Additional Benefits.* The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by 37.8(514D).

a. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

b. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

c. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the Medicare Part B Excess Charges: Coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

e. 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 any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

f. Basic Outpatient Prescription Drug Benefit: Coverage for 50 percent 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.

g. Extended Outpatient Prescription Drug Benefit: Coverage for 50 percent 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.

h. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent 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" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive Medical Care Benefit: Coverage for the following preventive health services:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (2) and patient education to address preventive health care measures.

(2) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

1. Digital rectal examination;
2. Dipstick urinalysis for hematuria, bacteriuria and proteinuria;
3. Pure tone (air only) hearing screening test, administered or ordered by a physician;
4. Serum cholesterol screening (every five years);
5. Thyroid function test;
6. Diabetes screening;
7. Tetanus and diphtheria booster (every ten years).

(3) Any other tests or preventive measures determined appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent 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 shall not include payment for any procedure covered by Medicare.

j. 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.

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

1. "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
2. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.
3. "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

4. "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(2) Coverage requirements and limitations.

1. At-home recovery services provided must be primarily services which assist in activities of daily living.

2. 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.

3. Coverage is limited to:

- 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 shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.
- The actual charges for each visit up to a maximum reimbursement of $40 per visit.
- One thousand six hundred dollars per calendar year.
- Seven visits in any one week.
- Care furnished on a visiting basis in the insured's home.
- Services provided by a care provider as defined in this paragraph *"j."*
- At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.
- At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(3) Coverage is excluded for:

1. Home care visits paid for by Medicare or other government programs; and

2. Care provided by family members, unpaid volunteers or providers who are not care providers.

k. New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such 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.

191—37.8(514D) Standard Medicare supplement benefit plans.

37.8(1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "Core" benefits as defined in 37.7(2).

37.8(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in 37.7(3)*"k"* and in 37.9(514D).

37.8(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this subrule and conform to the definitions in 37.3(514D). Each benefit shall be structured in accordance with the format provided in 37.7(2) and 37.7(3) and list the benefits in the order shown in this subrule. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.

37.8(4) An issuer may use, in addition to the benefit plan designations required in 37.8(3), other designations to the extent permitted by law.

37.8(5) Makeup of benefit plans:

a. Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in 37.7(2).

b. Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in 37.7(2), plus the Medicare Part A Deductible as defined in 37.7 (3)*"a."*

c. Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in 37.7(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 37.7(3) *"a," "b," "c,"* and *"h,"* respectively.

d. Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit, as defined in 37.7(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 37.7(3) *"a," "b," "h,"* and *"j,"* respectively.

e. Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit, as defined in 37.7(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 37.7(3) *"a," "b," "h,"* and *"i,"* respectively.

f. Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3) *"a," "b," "c," "e,"* and *"h,"* respectively.

g. Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80 Percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in 37.7(3) *"a," "b," "d," "h,"* and *"j,"* respectively.

h. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit, as defined in 37.7(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 37.7(3) *"a," "b," "f,"* and *"h,"* respectively.

i. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 Percent 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 37.7(3)*"a," "b," "e," "f," "h,"* and *"j,"* respectively.

j. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 Percent 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 37.7(3) *"a," "b," "c," "e," "g," "h," "i,"* and *"j,"* respectively.

k. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the Core Benefit as defined in subrule 37.7(2), plus the Medicare Part A Deductible Skilled Nursing Facility Care, the Medicare Part B Deductible, 100 percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3)*"a," "b," "c," "e,"* and *"h,"* respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the 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.

l. Standardized Medicare supplement benefit high deductible plan "J" shall consist only of the following: 100 percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the Core Benefit as defined in 37.7(2), plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent 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 37.7(3)*"a," "b," "c," "e," "g," "h," "i,"* and *"j,"* respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the 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.

191—37.9(514D) Medicare Select policies and certificates.

37.9(1) *a.* Rule 37.9(514D) shall apply to Medicare Select policies and certificates, as defined in this rule.

b. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this rule.

37.9(2) For the purposes of this rule:

a. *"Complaint"* means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

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

c. *"Medicare Select Issuer"* means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

d. *"Medicare Select Policy"* or *"Medicare Select Certificate"* means respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

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

f. *"Restricted Network Provision"* means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

g. *"Service Area"* means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

37.9(3) The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this rule and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner finds that the issuer has satisfied all of the requirements.

37.9(4) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

37.9(5) A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

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

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

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

1. To adequately deliver all services that are subject to a restricted network provision; or
2. To make appropriate referrals.

(3) There are written agreements with network providers describing specific responsibilities.

(4) Emergency care is available 24 hours per day and seven days per week.

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

b. A statement or map providing a clear description of the service area.

c. A description of the grievance procedure to be utilized.

d. A description of the quality assurance program, including:

(1) The formal organizational structure;

(2) The written criteria for selection, retention and removal of network providers; and

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

e. A list and description, by specialty, of the network providers.

f. Copies of the written information proposed to be used by the issuer to comply with 37.9(9).

g. Any other information requested by the commissioner.

37.9(6) *a.* A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

b. An updated list of network providers shall be filed with the commissioner at least quarterly.

37.9(7) A Medicare Select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

a. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

b. It is not reasonable to obtain such services through a network provider.

37.9(8) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

37.9(9) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

a. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(1) Other Medicare supplement policies or certificates offered by the issuer; and

(2) Other Medicare Select policies or certificates.

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

c. A description of the restricted network provisions, including payments for coinsurance and deductibles, when providers other than network providers are utilized.

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

e. A description of limitations on referrals to restricted network providers and to other providers.

f. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

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

37.9(10) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to 37.9(9) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

37.9(11) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

a. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

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

c. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

d. If a grievance is found to be valid, corrective action shall be taken promptly.

e. All concerned parties shall be notified about the results of a grievance.

f. The issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

37.9(12) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

37.9(13) *a.* At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

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

37.9(14) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

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

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

37.9(15) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select program.

191—37.10(514D) Open enrollment.

37.10(1) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subrule without regard to age.

37.10(2) If an applicant under subrule 37.10(1) submits an application during the time period referenced in subrule 37.10(1) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

If the applicant qualifies under subrule 37.10(1) and submits an application during the time period referenced in subrule 37.10(1) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subrule.

37.10(3) Except as provided in 37.21(514D), subrule 37.10(1) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

191—37.11(514D) Standards for claims payment.

37.11(1) An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

a. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

b. Notifying the participating physician or supplier and the beneficiary of the payment determination;

c. Paying the participating physician or supplier directly;

d. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

e. Paying user fees for claim notices that are transmitted electronically or otherwise; and

f. Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

37.11(2) Compliance with the requirements set forth in 37.11(1) shall be certified on the Medicare supplement insurance experience reporting form.