191—37.20(514D) Medicare Select policies and certificates.

37.20(1) *Applicability of this rule.*

a. Rule 191—37.20(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.

37.20(2) *Definitions.* For the purposes of this rule, in addition to the definitions of Iowa Code section 514D.2, and of rules 191—37.3(514D) and 191—37.4(514D), the following definitions shall apply:

"Complaint" means any dissatisfaction expressed by a covered individual concerning a Medicare Select issuer or a Medicare Select network provider.

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

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

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

"Medicare Select policy" means a Medicare supplement individual policy that contains a restricted network provision; *"Medicare Select certificate"* means an individual's certificate of coverage under a group Medicare supplement policy that contains restricted network provisions; and *"Medicare Select policy or certificate"* means either a Medicare Select policy or a Medicare Select certificate.

"Restricted network provision" means any provision in a Medicare Select policy or certificate which conditions the payment of benefits, in whole or in part, on the use of Medicare Select network providers belonging to a network specified by the Medicare Select policy or certificate.

"Service area" means the geographic area, approved by the commissioner as part of the Medicare Select issuer's plan of operation, within which the Medicare Select issuer is authorized to offer a Medicare Select policy or certificate.

37.20(3) *Authorization to offer Medicare Select policies or certificates.* 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, upon review and approval of the plan of operation filed in accordance with subrule 37.20(5), that the issuer has satisfied all of the requirements of this chapter.

37.20(4) *Prohibition against offering Medicare Select policies or certificates without approved plan of operation.* 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, and the commissioner has authorized the issuer to offer Medicare Select policies or certificates, pursuant to subrule 37.20(3).

37.20(5) *Medicare Select issuer shall file a proposed plan of operation.* An issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner and receive approval of the proposed plan from the commissioner prior to offering Medicare Select policies or certificates. The plan of operation shall contain at a minimum all of the information required by paragraphs 37.20(5)*"a"* through *"g"* as follows:

a. Evidence that all services covered under the Medicare Select policies or certificates that are subject to restricted network provisions are available and accessible through Medicare Select network providers, including a demonstration that the issuer has met all of the conditions in subparagraphs 37.20(5)*"a"*(1) through (5) as follows:

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

(2) The number of Medicare Select network providers in the service area is sufficient, with respect to current and expected covered individuals, 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 Medicare Select 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 Medicare Select network providers prohibiting such Medicare Select network providers from billing or otherwise seeking reimbursement from or recourse against any covered individual 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, that is compliant with subrule 37.20(11).

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

(1) The formal organizational structure;

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

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

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

f. Copies of the written information proposed to be used by the Medicare Select issuer to comply with subrule 37.20(9).

g. Any other information requested by the commissioner.

37.20(6) *Filing of changes and updates to Medicare Select issuer's plan of operations.*

a. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of Medicare Select 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 Medicare Select network providers shall be filed with the commissioner at least quarterly.

37.20(7) *Use of restricted network provision prohibited under certain circumstances.* A Medicare Select policy or certificate issuer shall not apply a restricted network provision to limit a payment amount for covered services provided by providers that are not restricted network 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 Medicare Select network provider.

37.20(8) *Full coverage for services required under certain circumstances.* A Medicare Select policy or certificate shall provide payment for full coverage under the Medicare Select policy for covered services that are not available through Medicare Select network providers.

37.20(9) *Content of required disclosure.* 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 a minimum all of the information described in paragraphs 37.20(9)*"a"* through *"g"* as follows:

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 Medicare Select issuer; and

(2) Other Medicare Select policies or certificates.

b. A description (including address, telephone number and hours of operation) of the Medicare Select 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 Medicare Select network providers are utilized. Except to the

extent specified in the Medicare Select policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in Medicare Select Plans K and L.

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 Medicare Select network providers and to other providers.

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

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

37.20(10) *Acknowledgment.* 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 subrule 37.20(9) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

37.20(11) *Complaint and grievance procedures.* A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the covered individuals. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

a. The grievance procedure shall be described in the Medicare Select policy or certificate and in the outline of coverage.

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

c. The Medicare Select issuer shall consider grievances in a timely manner and shall transmit them 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 by the Medicare Select issuer about the results of a grievance.

f. The Medicare Select 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 prior calendar year and a summary of the subject, nature and resolution of such grievances.

37.20(12) *Opportunity to purchase another policy at time of purchase.* 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 Medicare Select issuer.

37.20(13) *Opportunity to purchase another policy after issue.*

a. At the request of a covered individual under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the covered individual the opportunity to purchase a Medicare supplement policy or certificate offered by the Medicare Select issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The Medicare Select 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 at-home recovery services or coverage for Medicare Part B excess charges.

37.20(14) *Continuation of coverage.* Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary determines that Medicare Select policies and certificates issued pursuant to this rule should be discontinued due to either the failure of the Medicare

Select program to be reauthorized under law or the substantial amendment of the Medicare Select program.

a. Each Medicare Select issuer shall make available to each insured individual under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the Medicare Select issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The Medicare Select 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 at-home recovery services or coverage for Medicare Part B excess charges.

37.20(15) *Compliance with data requests.* A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the U.S. Department of Health and Human Services, for the purpose of evaluating the Medicare Select program.

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