IDAPA 18 – IDAHO DEPARTMENT OF INSURANCE

Health & Disability Insurance

18.04.10 – Medicare Supplement Insurance Standards

Who does this rule apply to?
This rule applies to all Medicare supplement policies and certificates issued under group Medicare supplement policies delivered or issued for delivery in Idaho.

What is the purpose of this rule?
The purpose of this rule implements the NAIC Medicare Supplement Insurance Minimum Standards Model Act.

What is the legal authority for the agency to promulgate this rule?
This rule implements the following statutes passed by the Idaho Legislature:

- 41-02, et seq., Idaho Code – The Department of Insurance
- 41-44, et seq., Idaho Code – Medicare Supplement Insurance Minimum Standards

Who do I contact for more information on this rule?

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This rule chapter will be reviewed in compliance with Section 67-5292, Idaho Code, and in accordance with the 8-year rule review schedule linked here.

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000. LEGAL AUTHORITY.
Title 41, Chapters 2 and 44, Idaho Code. (3-31-22)

001. SCOPE.

a. Except as specifically provided in Sections 046, 051, 066, and 077, this chapter applies to: (3-31-22)

i. All Medicare supplement policies delivered or issued for delivery in this state; and (3-31-22)

ii. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state. (3-31-22)

b. This chapter does not apply to a policy or contract of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) 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 organization. (3-31-22)

002. INCORPORATION BY REFERENCE.
This chapter incorporates by reference Appendixes A (Refund Calculation and Calculation of Benchmark forms Model Regulation 651 pages 651-94 to 651-97), B (Form for Reporting Medicare Supplement Policies, page 651-98), and C (Disclosure Statements pages 651-99 to 651-108), and all other outlines of coverage and specific plan designs of the National Association of Insurance Commissioners (NAIC) Model Regulation 651 (pages 651-42 to 651-85) implementing the Medicare supplement insurance minimum standards (2018). The Model Regulation is available from the National Association of Insurance Commissioners and from the Idaho Department of Insurance. (3-31-22)

003. -- 009. (RESERVED)

010. DEFINITIONS.

01. Applicant. (3-31-22)

a. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and (3-31-22)

b. In the case of a group Medicare supplement policy, the proposed certificate holder. (3-31-22)

02. Bankruptcy. A Medicare Advantage 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. (3-31-22)

03. 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 sixty-three (63) days. (3-31-22)

04. Creditable Coverage. (3-31-22)

a. With respect to an individual, coverage of the individual provided under any of the following: (3-31-22)

i. A group health plan; (3-31-22)

ii. Health insurance coverage; (3-31-22)

iii. Part A or Part B of Title XVIII of the Social Security Act (Medicare); (3-31-22)

iv. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928; (3-31-22)

v. Title 10, Chapter 55, United States Code (CHAMPUS); (3-31-22)

vi. A medical care program of the Indian Health Service or of a tribal organization; (3-31-22)

vii. A state health benefits risk pool; (3-31-22)

viii. A health plan offered under Title 5, Chapter 89, United States Code (Federal Employees Health Benefits Program); (3-31-22)

ix. A public health plan as defined in federal regulation; and (3-31-22)

x. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)). (3-31-22)

b. Creditable coverage does not include one (1) or more, or any combination of, the following: (3-31-22)

i. Coverage only for accident or disability income insurance, or any combination thereof; (3-31-22)

ii. Coverage issued as a supplement to liability insurance; (3-31-22)

iii. Liability insurance, including general liability insurance and automobile liability insurance; (3-31-22)

iv. Workers' compensation or similar insurance; (3-31-22)

v. Automobile medical payment insurance; (3-31-22)

vi. Credit-only insurance; (3-31-22)

vii. Coverage for on-site medical clinics; and (3-31-22)

viii. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits. (3-31-22)

c. Creditable coverage does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are not an integral part of the plan: (3-31-22)

i. Limited scope dental or vision benefits; (3-31-22)

ii. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and (3-31-22)

iii. Such other similar, limited benefits as are specified in federal regulations. (3-31-22)

d. Creditable coverage does not include the following benefits if offered as independent, non-coordinated benefits: (3-31-22)

i. Coverage only for a specified disease or illness; and (3-31-22)

ii. Hospital indemnity or other fixed indemnity insurance. (3-31-22)

e. Creditable coverage does not include the following if it is offered as a separate policy, certificate, or contract of insurance: (3-31-22)

i. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act; (3-31-22)

ii. Coverage supplemental to the coverage provided under Title 10, Chapter 55, United States Code; and (3-31-22)

iii. Similar supplemental coverage provided to coverage under a group health plan. (3-31-22)

f. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifically addressed separate, noncoordinated benefits in the group market at PHSA Section 2721(d)(2) and the individual market at Section 2791(c)(3). HIPAA also references excepted benefits at PHSA Sections 2701(c)(1), 2721(d), 2763(b) and 2791(c). In addition, credible coverage has been addressed in an interim final rule (62 Fed. Reg. At 16960-16962 (April 8, 1997)) issued by the Secretary of Health and Human Services, pursuant to HIPAA, and may be addressed in subsequent regulations. (3-31-22)

05. Employee Welfare Benefit Plan. A plan, fund, or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act). (3-31-22)

06. Insolvency. When 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. (3-31-22)

07. Medicare Advantage Plan. A plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28 (b)(1), and includes: (3-31-22)

a. Coordinated care plans which provide health care services, including but not limited to managed care organization (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (3-31-22)

b. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and (3-31-22)

c. Medicare Advantage private fee-for-service plans. (3-31-22)

08. Medicare Supplement Policy. As defined in Section 41-4402 and in addition, "Medicare Supplement Policy" does not include Medicare Advantage plans established under Medicare Part C. Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act; provided, however, that under Section 104(c) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), policies that are advertised, marketed or designed primarily to cover out-of-pocket costs under Medicare Advantage Plans (established under Medicare Part C) need to comply with the Medicare supplement requirements of Section 1882(o) of the Social Security Act. (3-31-22)

09. Pre-Standardized Benefit Plan. A group or individual policy of Medicare supplement insurance issued prior to July 1, 1992. (3-31-22)

10. 1990 Standardized Benefit Plan. A group or individual policy of Medicare supplement insurance issued on or after July 1, 1992 and with an effective date for coverage prior to June 1, 2010 and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured. (3-31-22)

11. 2010 Standardized Benefit Plan. A group or individual policy of Medicare supplement insurance with an effective date for coverage issued on or after June 1, 2010. (3-31-22)

12. Secretary. The Secretary of the United States Department of Health and Human Services. (3-31-22)

011. 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 the policy or certificate contains definitions or terms which conform to the requirements of this section. (3-31-22)

01. Accident, Accidental Injury, or Accidental Means. To employ "result" language and does not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization. (3-31-22)

a. The definition will 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." (3-31-22)

b. The definition may provide that injuries cannot 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 banned by law. (3-31-22)

02. Benefit Period or Medicare Benefit Period. Will not be defined more restrictively than as defined in the Medicare program. (3-31-22)

03. Convalescent Nursing Home, Extended Care Facility, or Skilled Nursing Facility. Will not be defined more restrictively than as defined in the Medicare program. (3-31-22)

04. Health Care Expenses. For purposes of Section 051, expenses of managed care organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. (3-31-22)

05. Hospital. 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. (3-31-22)

06. Medicare. Is defined in the policy and certificate, substantially 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 Public Law 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." (3-31-22)

07. Medicare Eligible Expenses. Expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare. (3-31-22)

08. Physician. Will not be defined more restrictively than as defined in the Medicare program. (3-31-22)

09. Sickness. Will 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. (3-31-22)

012. POLICY PROVISIONS.

01. Medicare Supplement Policy. Except for permitted preexisting condition clauses as described in Paragraph 022.01.a., no policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare. (3-31-22)

02. Waivers. 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. (3-31-22)

03. Duplicate Benefits. No Medicare supplement policy or certificate in force in this state may contain benefits which duplicate benefits provided by Medicare. (3-31-22)

013. -- 021. (RESERVED)

022. BENEFIT STANDARDS FOR 2010 STANDARDIZED BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY WITH AN EFFECTIVE DATE FOR COVERAGE ON OR AFTER JUNE 1, 2010.

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. 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. No issuer may offer any 1990 Standardized benefit plan for sale on or after June 1, 2010. Benefit standards applicable to policies and certificates issued with an effective date for coverage prior to June 1, 2010 remain in effect. (3-31-22)

01. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation. (3-31-22)

a. A Medicare supplement policy or certificate cannot exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate will 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 (6) months before the effective date of coverage. (3-31-22)

b. A Medicare supplement policy or certificate will not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents. (3-31-22)

c. A Medicare supplement policy or certificate provides that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes. (3-31-22)

d. No Medicare supplement policy or certificate may 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. (3-31-22)

e. Each Medicare supplement policy is guaranteed renewable. (3-31-22)

i. The issuer cannot cancel or nonrenew the policy solely on the ground of health status of the individual. (3-31-22)

ii. The issuer cannot cancel or nonrenew the policy for any reasons other than nonpayment of premium or material representation. (3-31-22)

iii. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subparagraph 022.01.e.v., the issuer offers certificateholders an individual Medicare supplement policy which (at the option of the certificateholder): (3-31-22)

(1) Provides for continuation of the benefits contained in the group policy; or (3-31-22)

(2) Provides for benefits that meet the requirements of this Subsection. (3-31-22)

iv. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer: (3-31-22)

(1) Offers the certificateholder the conversion opportunity described in Subparagraph 022.01.e.iii.; or (3-31-22)

(2) At the option of the group policyholder, offers the certificate holder continuation of coverage under the group policy. (3-31-22)

v. 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 offers coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy cannot exclude preexisting conditions that would have been covered under the group policy being replaced. (3-31-22)

f. Terminations of a Medicare supplement policy or certificate need to be without prejudice to any continuous loss that commenced while the policy was in force. Such 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. (3-31-22)

g. A Medicare supplement policy or certificate provides that benefits and premiums under the policy or certificate may be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (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, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance. (3-31-22)

i. If suspension occurs and if the policyholder or certificateholder loses entitlement to medical assistance, the policy or certificate is 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 ninety (90) days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement. (3-31-22)

ii. Each Medicare supplement policy provides that benefits and premiums under the policy may be suspended (for any period that may be 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 certificateholder loses coverage under the group health plan, the policy is 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 attributed to the period, effective as of the date of termination of enrollment in the group health plan. (3-31-22)

iii. Reinstitution of coverages as described in Subparagraphs 022.01.g.i. and 022.01.g.ii.; (3-31-22)

(1) Does not provide for any waiting period with respect to treatment of preexisting conditions; (3-31-22)

(2) Provides for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and (3-31-22)

(3) Provides 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 had the coverage not been suspended. (3-31-22)

h. An issuer makes available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic (core) benefits, as defined in Subsection 022.02. (3-31-22)

i. If an issuer makes available any of the additional benefits described in Subsection 022.03, or offers standardized benefit Plans K or L (as described in Paragraphs 022.04.h. and 022.04.i.), then the issuer makes available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic (core) benefits as described in Paragraph 022.01.h., a policy form or certificate form containing either standardized benefit Plan C (as described in Paragraph 022.04.c.) or standardized benefit Plan F (as described in Paragraph 022.04.e.). (3-31-22)

j. No groups, packages or combinations of Medicare supplement benefits other than those listed in

this section are offered for sale in this state, except as may be permitted in Subsection 022.05 and in Section 031. (3-31-22)

k. Benefit plans are uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in Section 010. Each benefit is structured in accordance with the format provided in Subsections 022.02 and 022.03; or, in the case of plans K or L, in Paragraphs 022.04.h. and 022.04.i. and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of benefit. (3-31-22)

l. In addition to the benefit plan designations prescribed in Paragraph 022.01.k., an issuer may use other designations to the extent permitted by law. (3-31-22)

02. Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans makes 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 of it. (3-31-22)

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; (3-31-22)

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; (3-31-22)

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (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 three hundred sixty-five (365) days. The provider will accept the issuer's payment as payment in full and will not bill the insured for any balance; (3-31-22)

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; (3-31-22)

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; (3-31-22)

f. Hospice Care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses. (3-31-22)

03. Standards for Additional Benefits. The following additional benefits are included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 024. (3-31-22)

a. Medicare Part A Deductible. Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period. (3-31-22)

b. Medicare Part A Deductible. Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period. (3-31-22)

c. 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. (3-31-22)

d. Medicare Part B Deductible. Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement. (3-31-22)

e. One Hundred Percent (100%) of the Medicare Part B Excess Charges. Coverage for all the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge. (3-31-22)

f. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (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 sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($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. (3-31-22)

04. Make-up of 2010 Standardized Benefit Plans. (3-31-22)

a. Standardized benefit Plan A includes only the following: The basic (core) benefits as defined in Subsection 022.02. (3-31-22)

b. Standardized benefit Plan B includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Paragraph 022.03.a. (3-31-22)

c. Standardized benefit Plan C includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., 022.03.d., and 022.03.f., respectively. (3-31-22)

d. Standardized benefit Plan D includes only the following: The basic (core) benefit (as defined in Subsection 022.02), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., and 022.03.f., respectively. (3-31-22)

e. Standardized [regular] Plan F includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., and 022.03.c., through 022.03.f., respectively. (3-31-22)

f. Standardized Plan F with High Deductible includes only the following: One hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph 022.04.f.ii. (3-31-22)

i. The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., and 022.03.c., through 022.03.f., respectively. (3-31-22)

ii. The annual deductible in Plan F with High Deductible consists of out-of-pocket expenses, other than premiums, for services covered by [regular] Plan F, and is in addition to any other specific benefit deductibles. The basis for the deductible is one thousand five hundred dollars ($1,500) and is adjusted annually from 1999 by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars ($10). (3-31-22)

g. Standardized benefit Plan G includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.a., 022.03.c., 022.03.e., and 022.03.f., respectively. Effective January 1, 2020, the standardized benefit plans described in Paragraph 025.01.d. (Redesignated Plan G High Deductible) may

be offered to any individual who was eligible for Medicare prior to January 1, 2020. (3-31-22)

h. Standardized Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and includes only the following: (3-31-22)

i. Part A Hospital Coinsurance sixty-first through ninetieth days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period. (3-31-22)

ii. Part A Hospital Coinsurance ninety-first through one hundred fiftieth day: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period; (3-31-22)

iii. Part A Hospitalization After One Hundred Fiftieth Day: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (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 three hundred sixty-five (365) days. The provider accepts the issuer's payment as payment in full and will not bill the insured for any balance; (3-31-22)

iv. Medicare Part A Deductible: Coverage for fifty percent (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 022.04.h.x. (3-31-22)

v. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used 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 until the out-of-pocket limitation is met as described in Subparagraph 022.04.h.x. (3-31-22)

vi. Hospice Care: Coverage for fifty percent (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 022.04.h.x.(3-31-22)

vii. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in Subparagraph 022.04.h.x. (3-31-22)

viii. Part B Cost Sharing: Except for coverage provided in Subparagraph 022.04.h.ix., coverage for fifty percent (50%) of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in Subparagraph 022.04.h.x. (3-31-22)

ix. Part B Preventive Services: Coverage of one hundred percent (100%) of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and (3-31-22)

x. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (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 four thousand dollars ($4,000) in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary. (3-31-22)

i. Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and includes only the following: (3-31-22)

i. The benefits described in Subparagraphs 022.04.h.i. through 022.04.h.iii., and 022.04.h.ix. (3-31-22)

ii. The benefits described in Subparagraphs 022.04.h.iv. through 022.04.h.viii. but substituting seventy-five percent (75%) for fifty percent (50%); and (3-31-22)

iii. The benefit described in Subparagraph 022.04.h.x. but substituting two thousand dollars ($2,000) for four thousand dollars ($4,000). (3-31-22)

j. Standardized Medicare supplement Plan M includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in Paragraphs 022.03.b., 022.03.c., and 022.03.f., respectively. (3-31-22)

k. Standardized Medicare supplement Plan N includes only the following: The basic (core) benefit as defined in Subsection 022.02, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in foreign country as defined in Paragraphs 022.03.a., 022.03.c., and 022.03.f., respectively, with copayments in the following amounts: (3-31-22)

i. The lesser of twenty dollars ($20) or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and (3-31-22)

ii. The lesser of fifty dollars ($50) or the Medicare Part B coinsurance or copayment for each covered emergency room visit, however, this copayment is waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense. (3-31-22)

05. New or Innovative Benefits. An issuer may, with the prior approval of the director, 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 include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits cannot adversely impact the goal of Medicare supplement simplification. New or innovative benefits cannot include an outpatient prescription drug benefit. New or innovative benefits cannot be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan. (3-31-22)

023. -- 024. (RESERVED)

025. STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS FOR 2020 STANDARDIZED BENEFIT PLAN POLICIES OR CERTIFICATES ISSUED FOR DELIVERY TO INDIVIDUALS NEWLY ELIGIBLE FOR MEDICARE ON OR AFTER JANUARY 1, 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires the following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. No policy or certificate that provides coverage of the Medicare Part B deductible may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies need to comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, remain subject to the requirements of Section 022. (3-31-22)

01. Benefit Requirements. The standards and requirements of Section 024 apply to all Medicare supplement policies or certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions: (3-31-22)

a. Standardized benefit Plan C is redesignated as Plan D and provides the benefits contained in Paragraph 022.04.c. but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible. (3-31-22)

b. Standardized benefit Plan F is redesignated as Plan G and provides the benefits contained in Paragraph 022.04.e. but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible. (3-31-22)

c. Standardized benefit plans C, F, and F with High Deductible will not be offered to individuals

newly eligible for Medicare on or after January 1, 2020. (3-31-22)

d. Standardized benefit Plan F With High Deductible is redesignated as Plan G With High Deductible and provides the benefits contained in Paragraph 022.04.f., but will not provide coverage for one hundred percent (100%) or any portion of the Medicare Part B deductible; provided further that, the Medicare Part B deductible paid by the beneficiary is considered an out-of-pocket expense in meeting the annual high deductible. (3-31-22)

e. The reference to Plans C or F contained in Paragraph 022.01.i. is deemed a reference to Plans D or G for purposes of this section. (3-31-22)

02. Applicability to Certain Individuals. This section applies only to individuals that are newly eligible for Medicare on or after January 1, 2020: (3-31-22)

a. By reason of attaining age sixty-five (65) on or after January 1, 2020; or (3-31-22)

b. By reason of entitlement to benefits under part A pursuant to section 226(b) or 226A of the Social Security Act, or who is deemed eligible for benefits under section 226(a) of the Social Security Act on or after January 1, 2020. (3-31-22)

03. Guaranteed Issue for Eligible Persons. For purposes of Subsection 041.05, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F With High Deductible) is deemed a reference to Medicare supplement policy D or G (including G With High Deductible) respectively that meet the requirements of Subsection 025.01. (3-31-22)

04. Offer of Redesignated Plans to Individuals Other Than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in Paragraph 025.01.d. may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in Subsection 022.04. (3-31-22)

026. -- 035. (RESERVED)

036. OPEN ENROLLMENT.

01. Offer of Coverage. (3-31-22)

a. An issuer cannot 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 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 (6) month period beginning with: (3-31-22)

i. The first day of the first month in which an individual is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B. (3-31-22)

ii. The first day of the first month of Medicare Part B eligibility due to disability or end stage renal disease, for an individual that is both under sixty-five (65) years of age and enrolled for benefits under Medicare Part B; or (3-31-22)

iii. The first day of the first month after the individual receives written notice of retroactive enrollment under Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration. (3-31-22)

b. Each Medicare supplement policy and certificate currently available from an issuer is made available to all applicants who qualify under Paragraph 036.01.a. without regard to age. (3-31-22)

02. Treatment of Preexisting Conditions. (3-31-22)

a. If an applicant qualifies under Subsection 036.01 and applies during the time period referenced in

Subsection 036.01 and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer cannot exclude benefits based on a preexisting condition. (3-31-22)

b. If the applicant qualifies under Subsection 036.01 and submits an application during the time period referenced in Subsection 036.01 and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer reduces 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 specifies the manner of the reduction under this Subsection. (3-31-22)

c. Except as provided in Paragraphs 036.02.a. and 02.b., and Sections 041 and 081, nothing in this chapter prevents the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was diagnosed during the six (6) months before the coverage became effective. (3-31-22)

037. -- 040. (RESERVED)

041. GUARANTEED ISSUE FOR ELIGIBLE PERSONS.

01. Guaranteed Issue. (3-31-22)

a. Eligible persons are those individuals described in Subsection 041.02 who seek to enroll under the policy during the period specified in Subsection 041.03, and who submit evidence of the date of termination or disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy. (3-31-22)

b. With respect to eligible persons, an issuer cannot deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection 041.05 that is offered and is available for issuance to new enrollees by the issuer, cannot discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and will not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy. (3-31-22)

02. Eligible Persons. An eligible person is an individual described here in any part of Subsection 041.02: (3-31-22)

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefits plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; (3-31-22)

b. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is sixty-five (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan: (3-31-22)

i. The certification of the organization or plan under this part has been terminated; (3-31-22)

ii. The organization has terminated or discontinued providing the plan in the area in which the individual resides; (3-31-22)

iii. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area; (3-31-22)

iv. The individual demonstrates, in accordance with guidelines established by the Secretary: (3-31-22)

(a) That the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (3-31-22)

(b) The organization, or agent, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or (3-31-22)

(c) The individual meets such other exceptional conditions as the Secretary may provide. (3-31-22)

c. The individual is enrolled with: (3-31-22)

i. An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); (3-31-22)

ii. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; (3-31-22)

iii. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or (3-31-22)

iv. An organization under a Medicare Select policy; and (3-31-22)

d. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Paragraph 041.02.b. (3-31-22)

e. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because: (3-31-22)

i. Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or (3-31-22)

ii. Of other involuntary termination of coverage or enrollment under the policy; (3-31-22)

iii. The issuer of the policy substantially violated a material provision of the policy; or (3-31-22)

iv. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual. (3-31-22)

f. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and (3-31-22)

g. The subsequent enrollment under Paragraph 041.02.f. is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or (3-31-22)

h. The individual, upon first becoming eligible for benefits under Part A of Medicare, enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment. (3-31-22)

i. The individual enrolls in a Medicare Part D plan during the initial enrollment period and at the time of enrollment in Part D, was enrolled under Medicare supplement policy that covers outpatient prescription drugs and

the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Paragraph 041.05.e. (3-31-22)

j. The individual is enrolled in a Medicare Supplement policy, and, on or after March 1, 2022, voluntarily terminates enrollment and enrolls in another Medicare Supplement policy. (3-31-22)

03. Guaranteed Issue Time Periods. (3-31-22)

a. In the case of an individual described in Paragraph 041.02.a., the guaranteed issue period begins on the later of the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter; (3-31-22)

b. In the case of an individual described in Paragraphs 041.02.b., 041.02.c., 041.02.f., or 041.02.h., whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated; (3-31-22)

c. In the case of an individual described in Paragraph 041.02.e., the guaranteed issue period begins on the earlier of: (3-31-22)

i. The date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any; and (3-31-22)

ii. The date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated; (3-31-22)

d. In the case of an individual described in Paragraph 041.02.b. and Subparagraph 041.02.e.iii., and Subparagraph 041.02.e.iv., Paragraph 041.02.f., or 041.02.h., who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date; and (3-31-22)

e. In the case of an individual described in Paragraph 041.02.i., the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and (3-31-22)

f. In the case of an individual described in Subsection 041.02 but not described in the preceding provisions of Subsection 041.03, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date. (3-31-22)

g. In the case of an individual described in Paragraph 041.02.j., the guaranteed issue period begins on the individual's birthday and ends sixty-three (63) days thereafter. (3-31-22)

04. Extended Medigap Access for Interrupted Trial Periods. (3-31-22)

a. In the case of an individual described in Paragraph 041.02.f. (or so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Paragraph 041.02.f. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment is deemed an initial enrollment described in Paragraph 041.02.f.; (3-31-22)

b. In the case of an individual described in Paragraph 041.02.h. (or so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Paragraph 041.02.h. is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment is deemed an initial enrollment described in Paragraph 041.02.h.; and

(3-31-22)

c. For purposes of Paragraphs 041.02.f. and 041.02.h., no enrollment of an individual with an organization or provider described in Paragraph 041.02.f. or with a plan or in a program described in Paragraph 041.02.h. may be deemed an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program. (3-31-22)

05. Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under: (3-31-22)

a. Paragraphs 041.02.a. through 041.02.e. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F (including F with a high deductible), K or L offered by any issuer. (3-31-22)

b. Subject to Paragraph 041.05.c., Paragraph 041.02.g. is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Paragraph 041.05.a. (3-31-22)

c. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in Subsection 041.05 is: (3-31-22)

i. The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or (3-31-22)

ii. At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer; (3-31-22)

d. Paragraph 041.02.h. includes any Medicare supplement policy offered by any issuer. (3-31-22)

e. Paragraph 041.02.i. is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage. (3-31-22)

f. Paragraph 041.02.j. includes any comparable or lesser Medicare policy offered by any issuer. For the purposes of this Paragraph, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Supplement policy or certificate being replaced. (3-31-22)

06. Notification Provisions. (3-31-22)

a. At the time of an event described in Subsection 041.02 because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, notifies the individual of the individual's rights under this Section, and of the obligations of issuers of Medicare supplement policies under Subsection 041.01. Such notice is communicated contemporaneously with the notification of termination. (3-31-22)

b. At the time of an event described in Subsection 041.02 because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, notifies the individual of the individual's rights under this section, and of the obligations of issuers of Medicare supplement policies under Subsection 041.01. Such notice is communicated within ten (10) working days of the issuer receiving notification of disenrollment. (3-31-22)

042. -- 045. (RESERVED)

046. STANDARDS FOR CLAIMS PAYMENT.

01. Compliance. An issuer will 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: (3-31-22)

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 needed and making a payment determination on the basis of the information contained in that notice; (3-31-22)

b. Notifying the participating physician or supplier and the beneficiary of the payment determination; (3-31-22)

c. Paying the participating physician or supplier directly; (3-31-22)

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; (3-31-22)

e. Paying user fees for claim notices; and (3-31-22)

f. Providing to the Secretary, at least annually, a central mailing address to which all claims may be sent by Medicare carriers. (3-31-22)

02. Certification. Compliance with the requirements set forth in Subsection 046.01 is certified on the Medicare supplement insurance experience reporting form. (3-31-22)

047. -- 050. (RESERVED)

051. LOSS RATIO STANDARDS AND REFUND OR CREDIT OF PREMIUM.

01. Loss Ratio Standards. (3-31-22)

a. A Medicare supplement policy form or certificate form will not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form. (3-31-22)

i. At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or (3-31-22)

ii. At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies; (3-31-22)

b. Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a managed care organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a managed care organization will not include: (3-31-22)

i. Home office and overhead costs; (3-31-22)

ii. Advertising costs; (3-31-22)

iii. Commissions and other acquisition costs; (3-31-22)

iv. Taxes; (3-31-22)

v. Capital costs; (3-31-22)

vi. Administrative costs; and (3-31-22)

vii. Claims processing costs. (3-31-22)

c. All filings of rates and rating schedules demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards. Demonstrations, at a minimum, account for: (3-31-22)

i. Lapse rates; (3-31-22)

ii. Medical trend and rationale for trend; (3-31-22)

iii. Assumptions regarding future premium rate revisions; and (3-31-22)

iv. Interest rates for discounting and accumulating. (3-31-22)

d. For purposes of applying Paragraphs 051.01.a. and 056.05.b., only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) are individual policies. (3-31-22)

02. Refund or Credit Calculation. (3-31-22)

a. An issuer collects and files with the director by May 31 of each year the data contained in the applicable reporting form as defined by NAIC Model Regulation (Attachments) and accessible on the Department website for each type in a standard Medicare supplement benefit plan. (3-31-22)

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio one (1)) exceeds the adjusted experience ratio since inception (ratio three (3)), then a refund or credit calculation is needed. The refund calculation is done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year is excluded. (3-31-22)

c. For policies or certificates issued prior to July 1, 1992, the issuer makes the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after July 1, 1992. (3-31-22)

d. A refund or credit is made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credit exceeds a de minimis level. The refund includes interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary, but in no event less than the average rate of interest for thirteen (13) week Treasury notes. A refund or credit against premiums due is made by September 30 following the experience year upon which the refund or credit is based. (3-31-22)

03. Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates in this state annually files its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation demonstrates in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration excludes active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage is demonstrated for policies or certificates in force less than three (3) years. As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state files with the director, in accordance with the applicable filing procedures of this state: (3-31-22)

a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current

premium for the applicable policies or certificates. The supporting documents accompanying the filing need to justify the adjustment. (3-31-22)

i. An issuer's adjustments need to produce an expected loss ratio under the policy or certificate that conforms to minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein is made with respect to a policy at any time other than upon its renewal date or anniversary date. (3-31-22)

ii. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio prescribed by Section 051. (3-31-22)

b. Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. The riders, endorsements, or policy forms provides a clear description of the Medicare supplement benefits provided by the policy or certificate. (3-31-22)

052. -- 055. (RESERVED)

056. FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.

01. Filing of Policy Forms. (3-31-22)

a. An issuer cannot deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements and procedures prescribed by the director. (3-31-22)

b. An issuer would file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as prescribed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the director in the state in which the policy or certificate was issued. (3-31-22)

02. Filing of Premium Rates. (3-31-22)

a. An issuer cannot use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the director in accordance with the filing requirements and procedures prescribed by the director. (3-31-22)

b. Except as provided in Subsection 051.03, the insured cannot receive more than one (1) rate increase in any twelve (12) month period. (3-31-22)

03. Except as provided in Paragraph 056.03.a., an issuer will not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan. (3-31-22)

a. An issuer may offer, with the approval of the director, up to three (3) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) or each of the following cases: (3-31-22)

i. The inclusion of new or innovative benefits; (3-31-22)

ii. The addition of either direct response or agent marketing methods; (3-31-22)

iii. The addition of either guaranteed issue or underwritten coverage; (3-31-22)

b. For the purposes of Section 056, "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy. (3-31-22)

04. Availability of Policy Form or Certificate. Except as provided in Paragraph 056.04.a., an issuer continuously makes available for purchase any policy form or certificate form. A policy form or certificate form would not be considered available for purchase unless the issuer has actively offered it for sale continuously during the previous twelve (12) months. (3-31-22)

a. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the director in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of this notice by the director, the issuer no longer offers for sale the policy form or certificate form in this state. (3-31-22)

b. An issuer that discontinues the availability of a policy form or certificate form pursuant to Paragraph 056.04.a. will not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate. (3-31-22)

c. The sale or other transfer of Medicare supplement business to another issuer is considered a discontinuance for the purposes of Subsection 056.04. (3-31-22)

d. A change in the rating structure or methodology is considered a discontinuance under this Subsection 056.04 unless the issuer complies with the following requirements: (3-31-22)

i. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates. (3-31-22)

ii. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The director may approve a change to the differential which is in the public interest. (3-31-22)

05. Experience of Policy Forms. (3-31-22)

a. Except as provided in Paragraph 056.05.b., the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan is combined for purposes of the refund or credit calculation prescribed in Section 051. (3-31-22)

b. Forms assumed under an assumption reinsurance agreement are not combined with the experience of other forms for purposes of the refund or credit calculation. (3-31-22)

c. The experience of all policy forms or certificate forms for standardized benefit plans of the same type is combined for purposes of the rate change filing. Generally, any applicable percentage increase is filed and applied uniformly across all standardized plans within the same type, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type. (3-31-22)

06. Age Rating. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter: (3-31-22)

a. It is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age of an insured, subscriber or participant as the basis for increasing premiums or prepayment charges for policyholders who initially purchase a policy after January 1, 1995. For issue-age rated policies: (3-31-22)

i. For an individual who is sixty-five (65) years of age or older, the filed rate for any given age will not exceed the rate for any higher issue-age, similarly rated individual; and (3-31-22)

ii. For an individual who is under sixty-five (65) years of age, the premium is no greater than one

hundred fifty percent (150%) of the premium for an issue-age sixty-five (65) similarly rated individual, while the individual's attained age is less than sixty-five (65). Upon attaining age sixty-five (65), a policyholder with an issue-age less than sixty-five (65) is charged the same premium rate as an issue-age sixty-five (65), similarly rated individual. (3-31-22)

b. For policies issued after February 28, 2022, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use the increasing age or issue age of an insured, subscriber or participant as a basis for premiums. For such community-rated policies: (3-31-22)

i. For an individual who is eligible for Medicare Part B only due to disability or end stage renal disease, the premium is no greater than one hundred fifty percent (150%) of the premium for an enrollee otherwise eligible for Medicare Part B; and (3-31-22)

ii. Upon attaining Medicare Part B eligibility due to age, a policyholder who was previously eligible for Medicare Part B only due to disability or end stage renal disease is to be charged the same premium rate as an individual eligible for Medicare Part B due to age. (3-31-22)

07. Rating by Area and Gender. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter, it is an unfair practice and an unfair method of competition for any issuer, insurer, or licensee to use area or gender for rating purpose. (3-31-22)

08. Other Rating Requirements. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter, sold to residents of this State on or after January 1, 2018: (3-31-22)

a. Any rate adjustments are uniform between 1990 Standardized and later Standardized plans throughout the lifetime of the policies, unless doing so would violate the federal lifetime loss ratio standards for specific forms within the same type. (3-31-22)

b. The rating by the issuer does not differentiate on the basis of the reason for eligibility for Medicare Part B, except for an individual, at any given age, described at Subparagraph 056.06.b.i. (3-31-22)

09. Discriminatory Discount or Other Payment Practices. With respect to Medicare supplement policies that conform to the Standard Benefit Plans under this chapter: (3-31-22)

a. No discount or underwriting factor of less than 1.0 will be available to policies issued outside of open enrollment, per Section 036, or guaranteed issue, per Section 041, unless the greatest discount or lowest underwriting factor is automatically applied to all policies issued under open enrollment and guaranteed issue. (3-31-22)

b. For policies issued after February 28, 2022, it is an unfair practice and an unfair method of competition for any issuer to require application or policy fees or to vary premium rates based on payment terms including, without limitation, payment method or frequency of payment. (3-31-22)

c. Nothing in this Subsection is construed to limit the ability of an issuer of a Medicare supplement policy or certificate to apply a discount or underwriting factor for: (3-31-22)

i. Multiple Medicare Supplement policies issued to individuals residing within the same household, or; (3-31-22)

ii. Non-smoking or non-tobacco use. (3-31-22)

057. -- 060. (RESERVED)

061. PERMITTED COMPENSATION ARRANGEMENTS.

01. Commissions. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first-year

commission or other first-year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period. An issuer or other entity may not vary commission or otherwise pay commission differentials based upon variables such as age, guarantee issue status, or on any other basis. (3-31-22)

02. Compensation in Subsequent Years. The commission or other compensation provided in subsequent renewal years needs to be the same as that provided in the second year or period and be provided for no fewer than five (5) renewal years. (3-31-22)

03. Renewal Compensation. No issuer or other entity provides compensation to its agent or other producers and no agent or producer receives compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced. (3-31-22)

04. Compensation. For purposes of Section 061, compensation includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate, including but not limited to bonuses, gifts, prizes, awards, and finder's fees. (3-31-22)

062. -- 065. (RESERVED)

066. DISCLOSURE PROVISIONS.

01. General Rules. (3-31-22)

a. Medicare supplement policies and certificates includes a renewal or continuation provision. The language or specifications of the provision is consistent with the type of contract issued. The provision is appropriately captioned and appears on the first page of the policy, and includes any reservation by the issuer of the right to change premiums. (3-31-22)

b. 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 needed to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy requires a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term is agreed to in writing and signed by the insured, unless the benefits are prescribed by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is prescribed by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge is set forth in the policy. (3-31-22)

c. Medicare supplement policies or certificates do not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import. (3-31-22)

d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations." (3-31-22)

e. Medicare supplement policies and certificates 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 thirty (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 for any reason. (3-31-22)

f. Issuers of accident and sickness policies or certificates that provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare provide to those applicants a "Guide to Health Insurance for People with Medicare" in the form developed jointly by the National Association of Insurance Commissions and the Centers for Medicare & Medicaid Services and in a type size no smaller than twelve (12) point type. Delivery of the Guide is made whether or not the policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates. Except in the case of direct response issuers, delivery of the

Guide will be made to the applicant at the time of application and acknowledgment of receipt of the Guide is obtained by the issuer. Direct response issuers deliver the Guide to the applicant upon request but not later than at the time the policy is delivered. (3-31-22)

g. For the purposes of Section 066, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing. (3-31-22)

02. Notice Requirements. (3-31-22)

a. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer notifies its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the director. The notice will: (3-31-22)

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, and (3-31-22)

ii. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare. (3-31-22)

b. The notice of benefit modifications and any premium adjustments is in outline form and in clear and simple terms so as to facilitate comprehension. (3-31-22)

c. The notices cannot contain or be accompanied by any solicitation. (3-31-22)

03. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 Notice Requirements. Issuers comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. (3-31-22)

04. Outline of Coverage Requirements for Medicare Supplement Policies. (3-31-22)

a. Issuers provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, obtain an acknowledgment of receipt of the outline from the applicant; and (3-31-22)

b. 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 accompanies the policy or certificate when it is delivered and contains the following statement, in no less than twelve (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." (3-31-22)

c. The outline of coverage provided to applicants pursuant to this section consists of four (4) 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 is in the language and format prescribed below in no less than twelve (12) point type. All plans are shown on the cover page, and the plans that are offered by the issuer are prominently identified. Premium information for plans that are offered are shown on the cover page or immediately following the cover page and is prominently displayed. The premium and mode is stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant are illustrated. (3-31-22)

05. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies. (3-31-22)

a. Any accident and sickness insurance policy or certificate other than Medicare supplement policy and policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy; or other policy identified in Paragraph 001.02.b., issued for delivery in this state to persons eligible for Medicare notifies insureds under the policy that the policy is not a Medicare supplement

policy or certificate. The notice is either 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 is no less than twelve (12) point type and contains 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." (3-31-22)

b. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Paragraph 066.04.a. disclose, using the applicable NAIC Model Regulation as incorporated by reference in Section 002 and referenced as Appendix C. The disclosure statement is provided as a part of, or together with, the application for the policy or certificate. (3-31-22)

067. -- 070. (RESERVED)

071. REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE.

01. Application Forms. Application forms include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another 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 agent containing such questions and statements may be used. (3-31-22)

02. Statements. (3-31-22)

a. You do not need more than one (1) Medicare supplement policy. (3-31-22)

b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (3-31-22)

c. You may be eligible for benefits under Medicaid and not need a Medicare supplement policy. (3-31-22)

d. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You need to request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (3-31-22)

e. If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (3-31-22)

f. Counseling services are available through the Senior Health Insurance Benefit Advisors program (SHIBA), to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a

Specified Low-Income Medicare Beneficiary (SLMB). (3-31-22)

03. **Agents**. Agents will list any other health insurance policies they have sold to the applicant. (3-31-22)

a. List policies sold which are still in force. (3-31-22)

b. List policies sold in the past five (5) years which are no longer in force. (3-31-22)

04. **Direct Response Issuer**. 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, is returned to the applicant by the insurer upon delivery of the policy. (3-31-22)

05. **Notice Regarding Replacement of Medicare Supplement Coverage**. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, furnishes the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, is provided to the applicant and an additional signed copy is retained by the issuer. A direct response issuer delivers to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage. (3-31-22)

06. **SHIBA and Consumer Assistance Link**. The notice prescribed in Subsection 071.05 for an issuer is provided in the NAIC Model Regulation as incorporated by reference in Section 002 of this rule, which includes NAIC Appendixes A, B, and C and all other outlines of coverage and specific plan designs which can be accessed on the Idaho Department of Insurance website. To obtain a copy of the NAIC Model Regulation, contact SHIBA at the Idaho Department of Insurance. (3-31-22)

072. FILING REQUIREMENTS FOR ADVERTISING.

An issuer provides a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio, or television medium to the director for review or approval by the director. (3-31-22)

073. STANDARDS FOR MARKETING.

01. **Issuer**. An issuer, directly or through its producers: (3-31-22)

a. Establishes marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate. (3-31-22)

b. Establishes marketing procedures to assure excessive insurance is not sold or issued. (3-31-22)

c. Displays prominently by type, stamp, or other appropriate means, on the first page of the policy the following: **"Notice to buyer: This policy may not cover all of your medical expenses."** (3-31-22)

d. Inquires and makes every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance. (3-31-22)

e. Establishes auditable procedures for verifying compliance with this Subsection 073.01. (3-31-22)

02. **Banned Acts and Practices**. In addition to the practices banned in Title 41, Chapter 13,Idaho Code, the following acts and practices are banned: (3-31-22)

a. High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance. (3-31-22)

b. Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to

disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company. (3-31-22)

03. Banned Terms. The terms "Medicare supplement," "Medigap," "Medicare wrap-around," and words of similar import cannot be used unless the policy is issued in compliance with this chapter. (3-31-22)

074. -- 075. (RESERVED)

076. APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE.
In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent makes reasonable efforts to determine the appropriateness of a recommended purchase or replacement. Any sale of Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is banned. An issuer cannot issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage. (3-31-22)

077. REPORTING OF MULTIPLE POLICIES.

01. Reporting. On or before March 1 of each year, an issuer reports the following information for every individual resident of this state for which the issuer has in force more than one (1) Medicare supplement policy or certificate: (3-31-22)

a. Policy and certificate number, and (3-31-22)

b. Date of issuance. (3-31-22)

02. Grouping by Individual Policyholder. The items set forth above need to be grouped by individual policyholder. (3-31-22)

078. -- 080. (RESERVED)

081. PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

01. Waiving of Time Periods. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer waives any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy. (3-31-22)

02. Replacing Policy. If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy does not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods for benefits similar to those contained in the original policy or certificate. (3-31-22)

082. PROHIBITION AGAINST USE OF GENETIC INFORMATION AND REQUESTS FOR GENETIC TESTING.

01. Banned Provisions. An issuer of a Medicare supplement policy or certificate: (3-31-22)

a. Does not deny or condition the issuance of effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) on the basis of the genetic information with respect to such individual; and (3-31-22)

b. Does not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual. (3-31-22)

02. Denial of Coverage. Nothing in Subsection 082.01 is construed to limit the ability of an issuer, to

the extent otherwise permitted by law, from: (3-31-22)

a. 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; or (3-31-22)

b. 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 the policy (in such case, the manifestation of a disease or disorder in one individual will not also be used as genetic information about other group members and to further increase the premium for the group). (3-31-22)

03. Genetic Testing. An issuer of a Medicare supplement policy or certificate cannot request or require an individual or a family member of such individual to undergo a genetic test. (3-31-22)

04. Payment. Subsection 082.03 does not preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under part C of title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with Subsection 082.01. (3-31-22)

05. Information. For purposes of carrying out Subsection 082.04, an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose. (3-31-22)

06. Allowed Genetic Testing. Notwithstanding Subsection 082.03, an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met: (3-31-22)

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 rules for the protection of human subjects in research. (3-31-22)

b. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that: (3-31-22)

i. Compliance with the request is voluntary; and (3-31-22)

ii. Non-compliance will have no effect on enrollment status or premium or contribution amounts. (3-31-22)

c. No genetic information collected or acquired under Subsection 082.06 is used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate. (3-31-22)

d. The issuer notifies the Secretary in writing that the issuer is conducting activities pursuant to the exception provided for under Subsection 082.06, including a description of the activities conducted. (3-31-22)

e. The issuer complies with such other conditions as the Secretary may by regulation require for activities conducted under Subsection 082.06. (3-31-22)

f. An issuer of a Medicare supplement policy or certificate cannot request, require, or purchase genetic information for underwriting purposes. (3-31-22)

g. An issuer of a Medicare supplement policy or certificate cannot request, require or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment. (3-31-22)

h. If an issuer of Medicare supplement policy or certificate obtains genetic information incidental to

the requesting, requiring, or purchasing of other information concerning an individual, such request, requirement, or purchase is not considered a violation of Paragraph 082.06.g. if such request, requirement, or purchase is not in violation of Paragraph 082.06.f. (3-31-22)

07. Definitions. For the purposes of this section only; (3-31-22)

a. "Issuer of a Medicare supplement policy or certificate" includes third-party administrator, or other person acting for or on behalf of such issuer. (3-31-22)

b. "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual. (3-31-22)

c. "Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. Such term includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, includes genetic information of any fetus carried by such pregnant woman, or with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual. (3-31-22)

d. "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education. (3-31-22)

e. "Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. (3-31-22)

f. "Underwriting purposes" means: (3-31-22)

i. Rules for, or determination of, eligibility (including enrollment and continued eligibility) for benefits under the policy; (3-31-22)

ii. The computation of premium or contribution amounts under the policy; (3-31-22)

iii. The application of any preexisting condition exclusion under the policy; and (3-31-22)

iv. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits. (3-31-22)

083. -- 999. (RESERVED)