

**Medigap Model Regulation – DRAFT with copays for specific services
11-6-11 Draft**

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Section 8. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued or Delivered on or After [insert effective date adopted by state] and Prior to June 1, 2010

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after [insert effective date] and prior to 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.

Drafting Note: This Section has been retained for transitional purposes. The purpose of this section is to govern policies issued subsequent to the adoption of 1990 Standardized benefit plans and prior to June 1, 2010. Standards for 2010 Standardized benefit plans issued for effective dates on or after June 1, 2010 are included in Section 8.1 of this regulation.

- A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.
- (1) A Medicare supplement policy or certificate shall not 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 may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

- (2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
- (3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Drafting Note: This provision was prepared so that premium changes can be made based on the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision to conform to their particular authority.

- (4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
- (5) Each Medicare supplement policy shall be guaranteed renewable.
 - (a) The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

- (b) The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.
- (c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8A(5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder)
 - (i) Provides for continuation of the benefits contained in the group policy, or
 - (ii) Provides for benefits that otherwise meet the requirements of this subsection.
- (d) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall
 - (i) Offer the certificate holder the conversion opportunity described in Section 8A(5)(c), or
 - (ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.
- (e) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
- (f) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

- (6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
- (7) (a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to

be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

- (b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder 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.
- (c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall 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 certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

Drafting Note: The Ticket to Work and Work Incentives Improvement Act failed to provide for payment of the policy premiums in order to reinstate coverage retroactively. States should consider adding the following language at the end of the last sentence in Subparagraph (c): “and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.” This addition will clarify that issuers are entitled to collect the premium in this situation, as they are under Subparagraph (b). Also, the Ticket to Work and Work Incentives Improvement Act of 1999 does not specify the period of time that a policy may be suspended under Section 8A(7)(c). In the event that the Centers for Medicare & Medicaid Services (CMS) provides states with guidance on this issue, the phrase “for any period that may be provided by federal law” has been inserted into this provision in parentheses so that any time period prescribed is incorporated by reference.

- (d) Reinstatement of coverages as described in Subparagraphs (b) and (c):
 - (i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
 - (ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and
 - (iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

- (8) If an issuer makes a written offer to the Medicare Supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her [1990 Standardized plan] (as described in Section 9 of this regulation) to a [2010 Standardized plan] (as described in Section 9.1 of this regulation), the offer and subsequent exchange shall comply with the following requirements:
- (a) An issuer need not provide justification to the [commissioner] if the insured replaces a [1990 Standardized] policy or certificate with an issue age rated [2010 Standardized] policy or certificate at the insured's original issue age [and duration]. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner [----- according to the state's rate filing procedure -----].
 - (b) The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.
 - (c) An issuer may not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged [1990 Standardized] policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new [2010 Standardized] policy or certificate not contained in the exchanged policy.
 - (d) The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

Drafting Note: The options an issuer may offer its policyholders or certificate holders may be (a) to only selected existing Plans or (b) to only certain new Plans for a particular existing Plan. For example, an exchange of a new Plan F for an old Plan F is an acceptable option. An offer to only policyholders with existing Plans with no reduction in benefits is also acceptable.

- B. Standards for Basic (Core) Benefits Common to Benefit Plans A to J. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer 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.
- (1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
 - (2) 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) 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 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

Drafting Note: The issuer is required to pay whatever amount Medicare would have paid as if Medicare was covering the hospitalization. The "or other appropriate Medicare standard of payment" provision means the manner in which Medicare would have paid. The issuer stands in the place of Medicare, and so the provider must accept the issuer's payment as payment in full. The Outline of Coverage specifies that the beneficiary will pay "\$0," and the provider cannot balance bill the insured.

- (4) 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;
- (5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;

Drafting Note: In all cases involving hospital outpatient department services paid under a prospective payment system, the issuer is required to pay the co-payment amount established by CMS, which will be either the amount established for the Ambulatory Payment Classification (APC) group, or a provider-elected reduced co-payment amount.

C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 9 of this regulation.

- (1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.
- (2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
- (3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- (4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

- (5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.
- (6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a \$250 calendar year deductible, to a maximum of \$1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- (7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a \$250 calendar year deductible to a maximum of \$3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.
- (8) 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 \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.
- (9) (a) Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:
 - (i) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (b) and patient education to address preventive health care measures;
 - (ii) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.
- (b) Reimbursement shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of \$120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

- (10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.
- (a) For purposes of this benefit, the following definitions shall apply:
- (i) “Activities of daily living” include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.
 - (ii) “Care provider” means a duly qualified or licensed home health aide or homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.
 - (iii) “Home” shall mean any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured’s place of residence.
 - (iv) “At-home recovery visit” means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four-hour period of services provided by a care provider is one visit.
- (b) Coverage Requirements and Limitations.
- (i) At-home recovery services provided must be primarily services which assist in activities of daily living.
 - (ii) The insured’s attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.
 - (iii) Coverage is limited to:
 - (I) No more than the number and type of at-home recovery visits certified as necessary by the insured’s attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

- (II) The actual charges for each visit up to a maximum reimbursement of \$40 per visit;
- (III) \$1,600 per calendar year;
- (IV) Seven (7) visits in any one week;
- (V) Care furnished on a visiting basis in the insured's home;
- (VI) Services provided by a care provider as defined in this section;
- (VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;
- (VIII) At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(c) Coverage is excluded for:

- (i) Home care visits paid for by Medicare or other government programs; and
- (ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

Drafting Note: The Omnibus Budget Reconciliation Act 1990, 42 U.S.C. § 1395ss(p)(7), does not prohibit the issuers of Medicare supplement policies, through an arrangement with a vendor for discounts from the vendor, from making available discounts from the vendor to the policyholder or certificate holder for the purchase of items or services not covered under its Medicare supplement policies (for example: discounts on hearing aids or eyeglasses).

Drafting Note: The NAIC discussed including inflation protection for at-home recovery benefits, and preventive care benefits. However, because of the lack of an appropriate mechanism for indexing these benefits, NAIC has not included indexing at this point in time. However, NAIC is committed to evaluating the effectiveness of these benefits without inflation protection, and will revisit the issue. NAIC has determined that OBRA does not authorize NAIC to delegate the authority for indexing these benefits to a federal agency without an amendment to federal law.

D. Standards for Plans K and L.

- (1) Standardized Medicare supplement benefit plan "K" shall consist of the following:
 - (a) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

- (b) Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;
- (c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 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 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;
- (d) Medicare Part A Deductible: Coverage for 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 (j);
- (e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);
- (f) Hospice Care: Coverage for 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 (j);
- (g) 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 (j);
- (h) Except for coverage provided in Subparagraph (i) below, 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 (j) below;
- (i) 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

- (j) 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 \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.
- (2) Standardized Medicare supplement benefit plan “L” shall consist of the following:
 - (a) The benefits described in Paragraphs (1)(a), (b), (c) and (i);
 - (b) The benefit described in Paragraphs (1)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and
 - (c) The benefit described in Paragraph (1)(j), but substituting \$2000 for \$4000.

Section 8.1 Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery 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 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 Medicare supplement benefit plan] for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of [-insert proper citation-].

Drafting Note. Each state should insert the proper citation(s) to its statutes or rules that govern Medicare supplement insurance policies and certificates issued prior to the June 1, 2010 effective date of 2010 Standardized benefit plan standards found in Sections 8.1 and 9.1 of this regulation. It is recommended that each state’s applicable statutes or rules for Medicare supplement policies and certificates issued prior to June 1, 2010 be retained and that this section of the regulation be adopted in its entirety as a new section to govern policies issued on and after June 1, 2010.

- A. General Standards. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.
 - (1) A Medicare supplement policy or certificate shall not 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 may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

Drafting Note: States that have adopted the NAIC Individual Accident and Sickness Insurance Minimum Standards Model Act should recognize a conflict between Section 6B of that Act and this Subsection. It may be necessary to include additional language in the Minimum Standards Model Act that recognizes the applicability of this preexisting condition rule to Medicare supplement policies and certificates.

- (2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
- (3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, co-payment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

Drafting Note: This provision was prepared so that premium changes can be made based on the changes in policy benefits that will be necessary because of changes in Medicare benefits. States may wish to redraft this provision to conform to their particular authority.

- (4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
- (5) Each Medicare supplement policy shall be guaranteed renewable.
 - (a) The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.
 - (b) The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.
 - (c) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 8.1A(5)(e) of this regulation, the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):
 - (i) Provides for continuation of the benefits contained in the group policy; or
 - (ii) Provides for benefits that otherwise meet the requirements of this Subsection.
 - (d) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall
 - (i) Offer the certificate holder the conversion opportunity described in Section 8.1A(5)(c) of this regulation; or
 - (ii) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

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

Drafting Note: Rate increases otherwise authorized by law are not prohibited by this Paragraph (5).

- (6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.
- (7)
 - (a) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.
 - (b) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstated (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder 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.
 - (c) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall 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 certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss.

Drafting Note: The Ticket to Work and Work Incentives Improvement Act failed to provide for payment of the policy premiums in order to reinstitute coverage retroactively. States should consider adding the following language at the end of the last sentence in Subparagraph (c): “and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.” This addition will clarify that issuers are entitled to collect the premium in this situation, as they are under Subparagraph (b). Also, the Ticket to Work and Work Incentives Improvement Act of 1999 does not specify the period of time that a policy may be suspended under Section 8A(7)(c). In the period that may event that the Centers for Medicare & Medicaid Services (CMS) provides states with guidance on this issue, the phrase “for any be provided by federal law” has been inserted into this provision in parentheses so that any time period prescribed is incorporated by reference.

- (d) Reinstitution of coverages as described in Subparagraphs (b) and (c):
 - (i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;
 - (ii) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and
 - (iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

B. 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 shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

- (1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;
- (2) 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) 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 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;

Drafting Note: The issuer is required to pay whatever amount Medicare would have paid as if Medicare was covering the hospitalization. The “or other appropriate Medicare standard of payment” provision means the manner in which Medicare would have paid. The issuer stands in the place of Medicare, and so the provider must accept the issuer’s payment as payment in full. The Outline of Coverage specifies that the beneficiary will pay “\$0,” and the provider cannot balance bill the insured.

- (4) 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;
- (5) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the co-payment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible;
- (6) Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

Drafting Note: In all cases involving hospital outpatient department services paid under a prospective payment system, the issuer is required to pay the co-payment amount established by CMS, which will be either the amount established for the Ambulatory Payment Classification (APC) group, or a provider-elected reduced co-payment amount.

- C. Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by Section 9.1 of this regulation.

Drafting Note: Benefits for Plans K and L are set by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and can be found in Sections 9.1E(8) and (9) of this regulation

- (1) Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.
- (2) Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period.
- (3) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.
- (4) Medicare Part B Deductible: Coverage for one hundred percent (100%) of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.
- (5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of 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.

- (6) 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 \$250, and a lifetime maximum benefit of \$50,000. For purposes of this benefit, “emergency care” shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

Drafting Note: The Omnibus Budget Reconciliation Act 1990, 42 U.S.C. § 1395ss(p)(7), does not prohibit the issuers of Medicare supplement policies, through an arrangement with a vendor for discounts from the vendor, from making available discounts from the vendor to the policyholder or certificate holder for the purchase of items or services not covered under its Medicare supplement policies (for example: discounts on hearing aids or eyeglasses).

Drafting Note: The descriptions of Plans K and L are contained in Section 9.1E(8) and (9) of this regulation.

Section 9. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After [insert effective date adopted by state] and Prior to June 1, 2010

Drafting Note: This section has been retained for transitional purposes. The purpose of this Section is to govern policies issued subsequent to the adoption of 1990 Standardized benefit plans and prior to June 1, 2010. Standards for 2010 Standardized benefit plans issued for effective dates on or after June 1, 2010 are included in Section 9.1 of this regulation.

- A. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in Section 8B of this regulation.
- B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in Section 9G and in Section 10 of this regulation.
- C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans “A” through “L” listed in this subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8B and 8C, or 8D and list the benefits in the order shown in this subsection. For purposes of this section, “structure, language, and format” means style, arrangement and overall content of a benefit.
- D. An issuer may use, in addition to the benefit plan designations required in Subsection C, other designations to the extent permitted by law.

Drafting Note: It is anticipated that if a state determines that it will authorize the sale of only some of these benefit plans, the letter codes used in this regulation will be preserved. The *Guide to Health Insurance for People with Medicare* published jointly by the NAIC and CMS will contain a chart comparing the possible combinations. In order for consumers to compare specific policy choices, it will be important that a uniform “naming” system be used. Thus, if only plans “A,” “B,” “D,” “F (including F with a high deductible)” and “H” (for example) are authorized in a state, these plans should retain these alphabetical designations. However, an issuer may use, in addition to these alphabetical designations, other designations as provided in Section 9D of this regulation.

E. Make-up of benefit plans:

- (1) Standardized Medicare supplement benefit plan “A” shall be limited to the basic (core) benefits common to all benefit plans, as defined in Section 8B of this regulation.
- (2) Standardized Medicare supplement benefit plan “B” shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible as defined in Section 8C(1).
- (3) Standardized Medicare supplement benefit plan “C” shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (3) and (8) respectively.
- (4) Standardized Medicare supplement benefit plan “D” shall include only the following: The core benefit (as defined in Section 8B of this regulation), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in Sections 8C(1), (2), (8) and (10) respectively.
- (5) Standardized Medicare supplement benefit plan “E” shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in Sections 8C(1), (2), (8) and (9) respectively.
- (6) Standardized Medicare supplement benefit plan “F” shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the 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 Sections 8C(1), (2), (3), (5) and (8) respectively.
- (7) Standardized Medicare supplement benefit high deductible plan “F” shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan “F” deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, 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 Sections 8C(1), (2), (3), (5) and (8) respectively. The annual high deductible plan “F” deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan “F” policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan “F” deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

- (8) Standardized Medicare supplement benefit plan “G” shall include only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in Sections 8C(1), (2), (4), (8) and (10) respectively.
- (9) Standardized Medicare supplement benefit plan “H” shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as defined in Sections 8C(1), (2), (6) and (8) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
- (10) Standardized Medicare supplement benefit plan “I” shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit as defined in Sections 8C(1), (2), (5), (6), (8) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
- (11) Standardized Medicare supplement benefit plan “J” shall consist of only the following: The core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.
- (12) Standardized Medicare supplement benefit high deductible plan “J” shall consist of only the following: 100% of covered expenses following the payment of the annual high deductible plan “J” deductible. The covered expenses include the core benefit as defined in Section 8B of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in Sections 8C(1), (2), (3), (5), (7), (8), (9) and (10) respectively. The annual high deductible plan “J” deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan “J” policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10. The

outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

- F. Make-up of two Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA);
- (1) Standardized Medicare supplement benefit plan “K” shall consist of only those benefits described in Section 8 D(1).
 - (2) Standardized Medicare supplement benefit plan “L” shall consist of only those benefits described in Section 8 D(2).
- G. New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

Drafting Note: Use of new or innovative benefits may be appropriate to add coverage or access if they offer uniquely different or significantly expanded coverage.

Drafting Note: A state may determine by statute or regulation which of the above benefit plans may be sold in that state. The core benefit plan must be made available by all issuers. Therefore, the core benefit plan must be one of the authorized benefit plans adopted by a state. In no event, however, may a state authorize the sale of more than 10 standardized Medicare supplement benefit plans (that is, 9 plus the core policy), plus the two (2) high deductible plans, and the two (2) benefit plans K and L, mandated by MMA at the same time. Further, the modified versions of plans H, I, J as required by MMA after December 31, 2005 will not count as additional plans toward the limitations on the total number of plans discussed above.

Drafting Note: The Omnibus Budget Reconciliation Act of 1990 preempts state mandated benefits in Medicare supplement policies or certificates, except for those states which have been granted a waiver for non-standardized plans.

Drafting Note: After December 31, 2005, MMA prohibits Medicare supplement issuers from offering policies with outpatient prescription drug coverage, and from renewing outpatient prescription drug coverage for insureds enrolled in Medicare Part D. Consequently, plans with an outpatient prescription drug benefit will not be offered to new enrollees after that time.

Drafting Note: Pursuant to the enactment of MMA, two new benefit packages, called K and L, were added to plans A through J. The two new packages have higher co-payments and coinsurance contributions from the Medicare beneficiary.

Section 9.1 Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery 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 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 plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010 remain subject to the requirements of [-insert proper citation-].

Drafting Note. Each state should insert the proper citation(s) to its statutes or rules that govern Medicare supplement insurance policies and certificates issued prior to the June 1, 2010 effective date of the 2010 Standardized benefit plan standards found in Sections 8.1 and 9.1 of this regulation. It is recommended that each state's applicable statutes or rules for Medicare supplement benefit plans for policies and certificates issued prior to June 1, 2010 be retained and that this section of the Model be adopted in its entirety as a new section to govern policies and certificates issued on and after June 1, 2010. (The benefit plan standards of the Medicare Supplement Model Regulation for policies issued prior to June 1, 2010 are found in Section 9 of this regulation.)

- A. (1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in Section 8.1B of this regulation.
- (2) If an issuer makes available any of the additional benefits described in Section 8.1C, or offers standardized benefit Plans K or L (as described in Sections 9.1E(8) and (9) of this regulation), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in subsection A(1) above, a policy form or certificate form containing either standardized benefit Plan C (as described in Section 9.1E(3) of this regulation) or standardized benefit Plan F (as described in 9.1E(5) of this regulation).
- B. No groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall be offered for sale in this state, except as may be permitted in Section 9.1F and in Section 10 of this regulation.
- C. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in this Subsection and conform to the definitions in Section 4 of this regulation. Each benefit shall be structured in accordance with the format provided in Sections 8.1B and 8.1C of this regulation; or, in the case of plans K or L, in Sections 9.1E(8) or (9) of this regulation and list the benefits in the order shown. For purposes of this Section, "structure, language, and format" means style, arrangement and overall content of a benefit.
- D. In addition to the benefit plan designations required in Subsection C of this section, an issuer may use other designations to the extent permitted by law.

Drafting Note: It is anticipated that if a state determines that it will authorize the sale of only some of these benefit plans, the letter codes used in this regulation will be preserved. The *Guide to Health Insurance for People with Medicare* published jointly by the NAIC and CMS will contain a chart comparing the possible combinations. In order for consumers to compare specific policy choices, it will be important that a uniform "naming" system be used. Thus, if only Plans A, B, D, F, F with High Deductible, and K (for example) are authorized in a state, these plans must retain their alphabetical designations. An issuer may use, in addition to these alphabetical designations, other designations as provided in Section 9.1D of this regulation.

- E. Make-up of 2010 Standardized Benefit Plans:
 - (1) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in Section 8.1B of this regulation.
 - (2) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in Section 8.1C(1) of this regulation.

- (3) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, 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 Sections 8.1C(1), (3), (4), and (6) of this regulation, respectively.

Effective [XX/XX/2015], Standardized Medicare supplement benefit Plan C shall include co-payments in the following amounts:-

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(a) the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and

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(b) the lesser of [XXXX] dollars [(\$XX)] or the Medicare Part B coinsurance or co-payment for each covered [XXXXXXXX service]; and

(c) the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

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- (4) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in Section 8.1B of this regulation), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as defined in Sections 8.1C(1), (3), and (6) of this regulation, respectively.

- (5) Standardized Medicare supplement [regular] Plan F shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, 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 Sections 8.1C(1), (3), (4), (5), and (6), respectively.

Effective [XX/XX/2015], Standardized Medicare supplement benefit Plan F shall include co-payments in the following amounts:

(a) the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and

(b) the lesser of [XXXX] dollars [(\$XX)] or the Medicare Part B coinsurance or co-payment for each covered [XXXXXXXX service]; and

(c) the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital

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and the emergency visit is subsequently covered as a Medicare Part A expense.

- (6) Standardized Medicare supplement Plan F With High Deductible shall include only the following: one hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in Subparagraph (b).
- (a) The basic (core) benefit as defined in Section 8.1B of this regulation, 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 Sections 8.1C(1), (3), (4), (5), and (6) of this regulation, respectively.
 - (b) The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by [regular] Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be \$1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services 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).
- (7) Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, 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 Sections 8.1C(1), (3), (5), and (6), respectively.
- (8) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:
- (a) Part A Hospital Coinsurance 61st through 90th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;
 - (b) Part A Hospital Coinsurance, 91st through 150th days: Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;
 - (c) Part A Hospitalization After Lifetime Reserve Days are Exhausted: 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 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

- (d) Medicare Part A Deductible: Coverage for 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 (j);
 - (e) Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in Subparagraph (j);
 - (f) Hospice Care: Coverage for 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 (j);
 - (g) 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 (j);
 - (h) Part B Cost Sharing: Except for coverage provided in Subparagraph (i), 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 (j);
 - (i) 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
 - (j) 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 \$4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.
- (9) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:
- (a) The benefits described in Paragraphs 9.1E(8)(a), (b), (c) and (i);
 - (b) The benefit described in Paragraphs 9.1E(8)(d), (e), (f), (g) and (h), but substituting seventy-five percent (75%) for fifty percent (50%); and

- (c) The benefit described in Paragraph 9.1E(8)(j), but substituting \$2000 for \$4000.
- (10) Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, 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 Sections 8.1C(2), (3) and (6) of this regulation, respectively.
- (11) Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in Section 8.1B of this regulation, 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 Sections 8.1C(1), (3) and (6) of this regulation, respectively, with co-payments in the following amounts:
 - (a) the lesser of twenty dollars (\$20) or the Medicare Part B coinsurance or co-payment for each covered health care provider office visit (including visits to medical specialists); and
 - (b) the lesser of fifty dollars (\$50) or the Medicare Part B coinsurance or co-payment for each covered emergency room visit, however, this co-payment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

Drafting Note: The NAIC expects to periodically review the co-payment levels for Medicare supplement Plan N and make adjustments to this regulation as necessary.

- F. **New or Innovative Benefits:** An issuer may, with the prior approval of the [commissioner], offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall 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 must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Drafting Note: Recognizing the challenge in maintaining standardization while ensuring availability of new or innovative benefits, the drafters have included additional guidance to states in the NAIC Medicare Supplement Insurance Model Regulation Compliance Manual. This guidance includes a recommendation that states consider making publicly available all approved new or innovative benefits, and requests states to report the approval of all new or innovative benefits to the NAIC Senior Issues Task Force, who will maintain a record of these benefits for use by regulators and others. The Senior Issues Task Force will periodically review state approved benefits and consider whether to recommend that they be made part of standard benefit plan designs in this regulation.

Drafting Note: A state may determine by statute or regulation which of the above benefit plans may be sold in that state. Plan A, which consists of the basic (core) benefits must be made available by all issuers. Therefore, Plan A must be one of the authorized benefit plans adopted by a state. If an issuer offers any benefit plan in addition to Plan A, then the issuer must also offer either Plan C or Plan F. Therefore, if any benefit plan is authorized by a state other than Plan A, then either Plan C or Plan F must be among the authorized benefit plans adopted by a state. Except where a new or innovative benefit is approved by the [commissioner] for sale in a state, a state may not authorize the sale of any Medicare supplement plan other

than the standardized Medicare supplement benefit plans (that is, Plans A, B, C, D, F, F With High Deductible, G, K, L, M and N) set forth in this regulation.

Drafting Note: The Omnibus Budget Reconciliation Act of 1990 preempts state mandated benefits in Medicare supplement policies or certificates, except for those states which have been granted a waiver for non-standardized plans.
