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**Rules of  
Department of Insurance  
Division 400—Life, Annuities and Health  
Chapter 3—Medicare Supplement Insurance**

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## Title 20—DEPARTMENT OF INSURANCE

### Division 400—Life, Annuities and Health Chapter 3—Medicare Supplement Insurance

#### 20 CSR 400-3.100 Rule to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions

*PURPOSE: This rule attempts to assure the orderly implementation and conversion of Medicare supplement insurance benefits and premiums due to changes in the federal Medicare program; provides for the reasonable standardization of the coverage, terms and benefits of Medicare supplement policies or contracts; facilitates public understanding of these policies or contracts; eliminates provisions contained in these policies or contracts which may be misleading or confusing in connection with the purchase of these policies or contracts to eliminate policy or contract provisions which may duplicate Medicare benefits; provides full disclosure of policy or contract benefits and benefit changes; and provides for refunds of premiums associated with benefits duplicating Medicare program benefits. This rule is promulgated pursuant to sections 376.850—376.890, RSMo.*

(1) Applicability and Scope. This regulation shall take precedence over other rules and requirements relating to Medicare supplement policies or contracts only to the extent necessary to assure that benefits are not duplicated, that applicants receive adequate notice and disclosure of changes in Medicare supplement policies and contracts, that appropriate premium adjustments are made in a timely manner and that premiums are reasonable in relation to benefits. Except as otherwise provided, this rule shall apply to—

(A) All Medicare supplement policies and contracts delivered, or issued for delivery, or which are otherwise subject to the jurisdiction of this state on or after October 27, 1988; and

(B) All certificates issued under group Medicare supplement policies as provided in subsection (1)(A).

(2) Definitions. For purposes of this rule—

(A) Applicant means—

1. In the case of an individual Medicare supplement policy or contract, the person

who seeks to contract for insurance benefits; and

2. In the case of a group Medicare policy or contract, the proposed certificate holder;

(B) Certificate means any certificate issued under a group Medicare supplement policy, which policy has been delivered, or issued for delivery, in this state; and

(C) Medicare supplement policy means a group or individual policy of accident and health insurance, or a subscriber contract of health service corporations, which is advertised, marketed or designed primarily to supplement coverage for hospital, medical or surgical expenses incurred by an insured person which are not covered by Medicare. This term does not include:

1. 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 of them, for employees or former employees, or combination of them, or for members or former members, or combination of them, of the labor organizations;

2. A policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination of them, if the association—

A. Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

B. Has been maintained in good faith for purposes other than obtaining insurance; and

C. Has been in existence for at least two (2) years prior to the date of its initial offering of the policy or plan to its members; or

3. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions which are inconsistent with the requirements of sections 376.850–376.885, RSMo nor to Medicare supplement policies being issued to employees or members as additions to franchise plans in existence on July 1, 1982.

(3) Benefit Conversion Requirements.

(A) Effective January 1, 1989, no Medicare supplement insurance policy, contract or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(B) General Requirements.

1. No later than thirty (30) days prior to the annual effective date of Medicare benefit changes mandated by the Medicare Catastrophic Coverage Act of 1988, every insurer,

health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts. This notice shall be in a format prescribed by the director or in a format adopted by the National Association of Insurance Commissioners (NAIC) in June of 1988 if no other format is prescribed by the director.

2. No modifications to any existing Medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this regulation, except to the extent necessary to eliminate duplication of Medicare benefits and any modifications necessary under the policy or contract to provide indexed benefit adjustment.

3. As soon as practicable, but no longer than forty-five (45) days after the effective date of the Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this state shall file with the division, in accordance with the applicable filing procedures of this state—

A. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Supporting documents as necessary to justify the adjustment shall accompany the filing; and

B. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

4. Upon satisfying the filing and approval requirements of this state, every insurer, health care service plan or other entity providing Medicare supplement insurance in this state shall provide each covered person with any rider, endorsement or policy form necessary to eliminate any benefit duplications under the policy or contract with benefits provided by Medicare. In the event a covered person must be issued a new policy, contract or certificate to eliminate benefit duplications, the insurer shall credit the covered person with all deductible amounts which have been incurred under the prior policy, contract or certificate and with all time periods for pre-existing condition satisfied under the prior coverage.

5. No insurer, health care service plan or other entity shall require any person cov-

ered under a Medicare supplement policy or contract which was in force prior to January 1, 1989 to purchase additional coverage under the policy or contract unless additional coverage was provided for in the policy or contract.

6. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state shall make the premium adjustments that are necessary to produce an expected loss ratio under the policy or contract as will conform with minimum loss ratio standards for Medicare supplement policies and which is expected to result in a loss ratio at least as great as that originally anticipated by the insurer, health care service plan or other entity for Medicare supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described in this rule should be made with respect to a policy at any time other than upon its renewal date. Premium adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within sixty (60) days of the renewal date if a refund is provided to the premium payer.

(4) Requirements for New Policies and Certificates.

(A) Effective January 1, 1989 no Medicare supplement insurance policy, contract or certificate shall be issued or issued for delivery in this state which provides benefits which duplicate benefits provided by Medicare. No Medicare supplement insurance policy, contract or certificate shall provide fewer benefits than those required under existing Medicare Supplement Minimum Standards Act or regulations except where duplication of Medicare benefits would result.

(B) General Requirements.

1. Within ninety (90) days (January 25, 1989) of the effective date of this rule (October 27, 1988), every insurer, health care service plan or other entity required to file its policies or contracts with this state shall file new Medicare supplement insurance policies or contracts which eliminate any duplication of Medicare supplement benefits with benefits provided by Medicare and which provide a clear description of the policy or contract benefit.

2. The filing required under paragraph (4)(B)1. shall provide for loss ratios which are in compliance with all minimum standards.

3. Every applicant for a Medicare supplement insurance policy, contract or certificate shall be provided with an outline of cov-

erage which simplifies and accurately describes benefits provided by Medicare and policy or contract benefits along with benefit limitations.

(5) Filing Requirements for Advertising.

Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any advertisement intended for use in this state whether through written, radio or television medium to the director of insurance of this state for review by the director. This advertisement shall be submitted to the director no later than the first day on which the advertisement is used. The department shall stamp each advertisement in a manner which indicates that it has been reviewed but that the review does not constitute approval by the department. All Medicare supplement advertisements will be retained for thirty (30) days before being returned to the company. The advertisement shall comply with all applicable laws and rules of this state.

(6) Buyer's Guide. No insurer, health care service plan or other entity shall make use of or otherwise disseminate any buyer's guide or informational brochure which does not accurately outline current Medicare benefits and which has not been adopted by the director.

(7) Separability. If any provision of this regulation or the application of it to any persons or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of that provision to other persons or circumstances shall not be affected by it.

*AUTHORITY: section 374.045, RSMo (1986). \* This rule was previously filed as 4 CSR 190-14.112. Original rule filed July 5, 1988, effective Oct. 27, 1988.*

*\*Original authority 1967.*

**20 CSR 400-3.200 Medicare Supplement Insurance Minimum Standards**

*PURPOSE: This rule provides for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; facilitates public understanding and comparison of these policies; eliminates provisions contained in the policies which may be misleading or confusing in connection with the purchase*

*of the policies or with the settlement of claims; and provides for full disclosure in the sale of accident and sickness insurance coverages to persons eligible for Medicare by reason of age.*

(1) Applicability and Scope. Except as otherwise specifically provided, this rule shall—

(A) Apply to all Medicare supplement policies and subscriber contracts delivered or issued for delivery in this state on or after November 1, 1989;

(B) Apply to all certificates issued under group Medicare supplement policies or subscriber contracts, which certificates have been delivered or issued for delivery in this state; and

(C) 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 of them, for employees or former employees or a combination of them, or for members or former members or combination of them of the labor organizations.

(2) Definitions. For the purposes of this rule—

(A) Applicant means—

1. In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder;

(B) Certificate means any certificate issued under a group Medicare supplement policy, which certificate had been delivered or issued for delivery in this state; and

(C) Medicare supplement policy means a group or individual policy of accident and sickness insurance or a subscriber contract of a health services corporation or health maintenance organization (HMO) which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

(3) Policy Definitions and Terms. No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy unless that policy or subscriber contract contains definitions or terms which substantially conform to the requirements of this section.

(A) Accident or accidental injury shall be defined to employ result language and shall not include words which establish an

accidental means test or use words such as external, violent, visible wounds or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: Injury(ies) for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force.

2. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any Workers' Compensation, employer's liability or similar law or motor vehicle no-fault plan, unless prohibited by law.

(B) Benefit period or Medicare benefit period shall not be defined as more restrictive than that defined in the Medicare program.

(C) Convalescent nursing home, extended care facility or skilled nursing facility shall be defined in relation to its status, facilities and available services.

1. A definition of such home or facility shall not be more restrictive than one requiring that it—

A. Be operated pursuant to law;

B. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

C. Provide continuous twenty-four (24) hour-a-day nursing service by care under the supervision of a registered graduate professional nurse (RN); and

D. Maintain a daily medical record of each patient.

2. The definition of such home or facility may provide that the term not be inclusive of—

A. Any home, facility or part of it used primarily for rest;

B. A home or facility used for the aged or for the care of drug addicts or alcoholics; or

C. A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(D) Health care expenses means expenses of HMOs associated with the delivery of health care services which are analogous to incurred losses of insurers. These expenses shall not include:

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

(E) Hospital may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

1. The definition of the term hospital shall not be more restrictive than one requiring that the hospital—

A. Be an institution operated pursuant to law;

B. Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and

C. Provide twenty-four (24) hour nursing service by or under the supervision of RNs.

2. The definition of the term hospital may state that the term shall not be inclusive of—

A. Convalescent homes or convalescent, rest or nursing facilities;

B. Facilities primarily affording custodial, educational or rehabilitative care;

C. Facilities for the aged, drug addicts or alcoholics; or

D. Any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or agency of it for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for those services.

(F) Medicare shall be defined in the policy. Medicare may be substantially defined as The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 or Title I, Part I of P.L. 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, or words of similar import.

(G) Medicare-eligible expenses shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare-eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims.

(H) Mental or nervous disorders shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder of any kind.

(I) Nurses may be defined so that the description of nurse is restricted to a type of nurse, such as an RN, a licensed practical nurse (LPN) or a licensed vocational nurse (LVN). If the words nurse, trained nurse or registered nurse are used without specific instruction, then the use of the terms requires the insurer to recognize the services of any individual who qualifies under the terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(J) Physician may be defined by including words such as duly qualified physician or duly licensed physician. The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when these services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(K) Sickness shall not be defined to be more restrictive than the following: sickness means sickness 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 sickness or diseases for which benefits are provided under any Workers' Compensation, occupational disease, employer's liability or similar law.

#### (4) Prohibited Policy Provisions.

(A) No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or subscriber contract limits or excludes coverage by type of illness, accident, treatment or medical condition, except as follows:

1. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

2. Mental or emotional disorders, alcoholism and drug addiction;

3. Illness, treatment or medical condition arising out of—

A. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; or service in the armed forces or auxiliary units of it;

B. Suicide or attempted suicide (while sane) or intentionally self-inflicted injury; and

C. Aviation;

4. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;

5. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effect of it, where that interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column;

6. Treatment provided in a governmental hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal Workers' Compensation, employer's liability or occupational disease law or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

7. Dental care or treatment;

8. Eyeglasses, hearing aids and examination for the prescription or fitting of these;

9. Rest cures, custodial care, transportation and routine physical examinations; and

10. Territorial limitations outside the United States. Provided, however, supplemental policies may not contain, when issued, limitations or exclusions of the type enumerated in paragraph (4)(A)1., 2., 5., 9. or 10. that are more restrictive than those of Medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

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

(C) The terms Medicare supplement, Medigap and words of similar import shall not be used unless the policy is issued in compliance with this rule.

(D) No Medicare supplement insurance policy, contract or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

(5) Minimum Benefit Standards. No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy which does not meet the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:

(A) General Standards. The following standards apply to Medicare supplement policies and are in addition to all other requirements of this rule:

1. A Medicare supplement policy may not deny a claim for losses incurred more than six (6) months from the effective date of coverage for a preexisting condition. The policy 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;

2. A Medicare supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

3. A Medicare supplement policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with these changes;

4. A noncancelable, guaranteed renewable or noncancelable and guaranteed renewable Medicare supplement policy shall not—

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

B. Be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health; and

5. Termination of a Medicare supplement policy 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 predicted 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;

(B) Minimum Benefit Standards.

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

2. Coverage for the daily copayment amount of Medicare Part A eligible expenses for the first eight (8) days per calendar year incurred for skilled nursing facility care.

3. Coverage 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) under Medicare Part A unless replaced in accordance with federal regulations.

4. Until January 1, 1990, coverage for twenty percent (20%) of the amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket

deductible of two hundred dollars (\$200) of expenses and to a maximum benefit of at least five thousand dollars (\$5000) per calendar year. Effective January 1, 1990 coverage for the copayment amount of Medicare-eligible expenses excluding outpatient prescription drugs under Medicare Part B regardless of hospital confinement up to the maximum out-of-pocket amount for Medicare Part B after the Medicare deductible amount.

5. Effective January 1, 1990, coverage under Medicare Part 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.

6. Effective January 1, 1990, coverage for the copayment amount of Medicare-eligible expenses for covered home intravenous (I.V.) therapy drugs (as determined by the secretary of Health and Human Services) subject to the Medicare outpatient prescription drug deductible amount, if applicable.

7. Effective January 1, 1990, coverage for the copayment amount of Medicare-eligible expenses for outpatient drugs used in immunosuppressive therapy subject to the Medicare outpatient prescription drug deductible if applicable; and

(C) Medicare-Eligible Expenses. Medicare-eligible expenses shall mean health care expenses of the kinds covered by Medicare to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare-eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims.

(6) Standards for Claims Payment.

(A) Every entity providing Medicare supplement policies or contracts shall comply with all provisions of Section 4081 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203).

(B) Compliance with the requirements set forth in subsection (6)(A) must be certified on the Medicare Supplement Insurance Experience exhibit attached to the annual statement.

(C) No policy or certificate may contain a provision reducing benefit payments due to the existence of other Medicare supplement coverage. Coverage must provide that insureds are entitled to a return of all premiums paid for duplicate coverage with the same insurer.

(7) Loss Ratio Standards.

(A) Medicare supplement policies shall return to policyholders in the form of aggregate benefits under the policy, for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience or incurred health care expenses where coverage is provided by an HMO on a service rather than reimbursement basis and earned premiums for that period and in accordance with accepted actuarial principles and practices—

1. At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies, or direct response policies issued on or after January 1, 1990; and

2. At least sixty percent (60%) of the aggregate amount of premiums earned in the case of individual policies.

(B) All filings of rates and rating schedules shall demonstrate that actual and expected losses in relation to premiums comply with the requirements of this section.

(C) Every entity providing Medicare supplement policies in this state annually shall file its rates, rating schedule and any supporting documentation requested by the director, including ratios of incurred losses to earned premiums by number of years of policy duration, demonstrating that it is in compliance with the previously mentioned applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience. For the purposes of this section, policy forms shall be deemed to comply with the loss ratio standards if—i) for the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for three (3) years or more is greater than or equal to the applicable percentages contained in this section and ii) the expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of this section. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

(D) In determining compliance with the loss ratio standards in subsections (7)(A)—(C) actual and expected incurred losses shall not include:

1. Loss adjustment expense incurred in settling claims; or

2. Claim reserves that would be found unreasonably excessive or unacceptable by actuarial standards, procedures and practices.

(E) As soon as practicable, but no later than sixty (60) days prior to the effective date of Medicare benefit changes required by the Medicare Catastrophic Coverage Act of 1988, every insurer, health care service plan or

other entity providing Medicare supplement insurance or contracts in this state (except employers subject to the requirements of Section 421 of the Medicare Catastrophic Coverage Act of 1988) shall file with the director in accordance with the applicable filing procedures of this state—

1. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. These supporting documents, as necessary to justify the adjustment, shall accompany the filing. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state pursuant to Section 2 of the Medicare Supplement Insurance Minimum Standards Model Act shall make whatever premium adjustments are necessary to produce an expected loss ratio under the policy or contract that will conform with 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 insurer, health care service plan or other entity for those Medicare supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described in this rule should be made with respect to a policy at any time other than upon its renewal date or anniversary date. Premium adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within sixty (60) days of the renewal date or anniversary date if a refund is provided to the premium payer. Premium adjustments shall be calculated for the period commencing with Medicare benefit changes; and

2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

(8) Filing Requirements for Out-of-State Group Policies. Every insurer providing group Medicare supplement insurance benefits to a resident of this state pursuant to Section 2 of the Medicare Supplement Insurance Minimum Standards Model Act shall file a copy of the master policy and any certificate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state; provided, however, that no insurer shall be required to make a filing earlier than thirty (30) days after insurance was pro-

vided to a resident of this state under a master policy issued for delivery outside this state.

(9) Prohibited Compensation for Replacement with the Same Company. No entity shall provide compensation to its agents or other producers which is greater than the renewal compensation which would have been paid on an existing policy if the existing policy is replaced by another policy with the same company where the new policy benefits are substantially similar to the benefits under the old policy and the old policy was issued by the same insurer or insurer group.

(10) Required Disclosure Provisions.

(A) General Rules.

1. Medicare supplement policies shall include a renewal, continuation or nonrenewal provision. The language or specifications of the provision must be consistent with the type of contract to be issued. The provision shall be appropriately captioned, shall appear on the first page of the policy and clearly shall state the duration, where limited or renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

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

3. A Medicare supplement policy which provides for the payment of benefits based on standards described as usual and customary, reasonable and customary or words of similar import shall include definitions and explanations of the terms in its accompanying outline of coverage.

4. If a Medicare supplement policy contains any limitations with respect to pre-existing conditions, the limitations must appear as

a separate paragraph of the policy and be labeled as preexisting condition limitations.

5. Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached to it stating in substance that the policyholder or certificate holder shall have 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.

6. Insurers issuing accident and sickness policies, certificates or subscriber contracts which provide hospital or medical expense coverage on an expense-incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to all applicants a Medicare supplement Buyer's Guide in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration. Delivery of the Buyer's Guide shall be made whether or not the policies, certificates or subscriber contracts are advertised, solicited or issued as Medicare supplement policies as defined in this regulation. Except in the case of direct response insurers, delivery of the Buyer's Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Buyer's Guide shall be obtained by the insurer. Direct response insurers shall deliver the Buyer's Guide to the applicant upon request but not later than at the time the policy is delivered.

(B) Notice Requirements.

1. As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts in a format acceptable to the director. For the years 1989 and 1990, and if prescription drugs are covered in 1991, the notice shall be in a format prescribed by the director or in the format prescribed in Appendices A, B and C if no other format is prescribed by the director. In addition, the notice shall—

A. Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy or contract; and

B. Inform each covered person as to when any premium adjustment is to be made due to changes in Medicare.

2. The notice of benefit modifications and any premium adjustments shall be in out-

line form and in clear and simple terms to facilitate comprehension.

3. The notices shall not contain or be accompanied by any solicitation.

(C) Outline of Coverage Requirements for Medicare Supplement Policies.

1. Insurers issuing Medicare supplement policies or certificates for delivery in this state shall provide an outline of coverage to all applicants at the time application is made and, except for direct response policies, shall obtain an acknowledgment of receipt of the outline from the applicant.

2. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered, and contain 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.

(D) Notice Regarding Policies or Subscriber Contracts Which Are Not Medicare Supplement Policies. Any accident and sickness insurance policy or subscriber contract other than a Medicare supplement policy, disability income policy, basic, catastrophic or major medical expense policy, single premium nonrenewable policy or other policy identified in subsection (1)(B) of this rule, issued for delivery in this state to persons eligible for Medicare by reason of age shall notify insureds under the policy or subscriber contract that the policy or subscriber contract is not a Medicare supplement policy. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or subscriber contract or, if no outline of coverage is delivered, to the first page of the policy, certificate or subscriber contract delivered to insureds. The notice shall be in no less than twelve (12)-point type and shall contain the following language: "THIS (POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company."

(11) Requirements for Replacement.

(A) Application forms shall include a question designed to elicit information as to whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary applica-

tion or other form to be signed by the applicant containing such a question may be used.

(B) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One (1) copy of the notice shall be provided to the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage. In no event, however, will this notice be required in the solicitation of accident-only and single premium nonrenewable policies.

(C) The notice required by subsection (11)(B) for an insurer, other than a direct response insurer, shall be provided in substantially the form as indicated in Appendix B.

(D) The notice required by subsection (11)(B) for a direct response shall be as indicated in Appendix C.

(12) Filing Requirements for Advertising. Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the (director) of insurance of this state for review or approval by the (director) to the extent it may be required under state law.

(13) Separability. If any provision of this rule or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of that provision to other persons or circumstances shall not be affected by it.

(14) Effective Date. This rule shall be effective on November 1, 1989.

*AUTHORITY: sections 376.864, 376.869, 376.874 and 376.879, RSMo (Cum. Supp. 1989). This rule was previously filed as 4 CSR 190-14.113. Emergency rule filed July 18, 1989, effective Sept. 1, 1989, expired Oct. 31, 1989. Original rule filed July 18, 1989, effective Nov. 1, 1989.*

*\*Original authority: 376.864, RSMo (1989), amended 1992; 376.869 and 376.874, RSMo (1989); and 376.879, RSMo (1989), amended 1992.*

## APPENDIX A

(COMPANY NAME)  
OUTLINE OF MEDICARE  
SUPPLEMENT COVERAGE

1. Read your policy carefully—This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**
2. Medicare Supplement Coverage—Policies of this category are designed to supplement Medicare by covering some hospital, medical and surgical services which are partially covered by Medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any deductibles and copayment provisions which may be in addition to those provided by Medicare and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).
3. A. (for agents): Neither (*insert company's name*) nor its agents are connected with Medicare.  
B. (for direct responses): (*insert company's name*) is not connected with Medicare.
4. (A brief summary of the major medical benefit gaps in Medicare Parts A & B with a parallel description of supplemental benefits, including dollar amounts (and indexed copayments or deductibles, as appropriate) provided by the Medicare supplement coverage in the following order:)

DESCRIPTION	THIS POLICY PAYS	YOU PAY
<u>SERVICE</u>		
<u>PART A</u>		
INPATIENT HOSPITAL SERVICES:		
Semiprivate Room & Board		
Miscellaneous Hospital Services & Supplies, such as Drugs, X rays, Lab Tests & Operating Room		
SKILLED NURSING FACILITY CARE		
BLOOD		
<u>PARTS A &amp; B</u>		
Home Health Services		
<u>PART B</u>		
MEDICAL EXPENSE:		
Services of a Physician/ Outpatient Services		
Medical Supplies Other Than Prescribed Drugs		
BLOOD		



DESCRIPTION	THIS POLICY PAYS	YOU PAY
SERVICE		
MAMMOGRAPHY SCREENING		
OUT-OF-POCKET MAXIMUM		
PRESCRIPTION DRUGS		
<u>MISCELLANEOUS</u>		
Home I.V.-Drug Therapy		
Immunosuppressive Drugs		
Respite Care Benefits		

IN ADDITION TO THIS OUTLINE OF COVERAGE, (INSURANCE COMPANY NAME) WILL SEND AN ANNUAL NOTICE TO YOU 30 DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGES WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.

5. (The following charts shall accompany the outline of coverage:)

APPENDIX A  
Part A  
MEDICARE BENEFITS IN

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
PART A				
Inpatient Hospital Services	All but \$540 for first 60 days/benefit period	All but \$564 deductible for an unlimited number of days/calendar year	All but Part A deductible for an unlimited number of days/calendar year	All but Part A deductible for an unlimited number of days/calendar year
Semiprivate Room & Board	All but \$135 a day for 61st—90th day/benefit period			
Miscellaneous Hospital Services & Supplies, such as Drugs, X rays, Lab Tests & Operating Room	All but \$270 a day for 91st—150th day (if the individual chooses to use 60 nonrenewable lifetime reserve days)			
	Nothing beyond 150 days			
*****				
Skilled Nursing Facility Care	100% of costs for 1st 20 days (after a 3 day prior hospital confinement)  All but \$67.50 a day for 1st—100th days  Nothing beyond 100 days	80% of Medicare reasonable costs for first 8 days per calendar year w/out prior hospitalization requirement  100% of costs thereafter up to 150 days/calendar year	80% for 1st 8 days/calendar year  100% for 9th—150th day/calendar year	80% for 1st 8 days/calendar year  100% for 9th—150th day/calendar year
*****				
Blood	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in <u>each benefit period</u>	Pays all costs except payment of deductible (equal to costs for first 3 pints) <u>each calendar year</u> . Part A blood deductible reduced to the extent paid under Part B	All but blood deductible (equal to costs for first 3 pints)	All but blood deductible (equal to costs for first 3 pints)
*****				

APPENDIX A

Part B  
MEDICARE BENEFITS IN

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<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
PARTS A & B				
Home Health Services	Intermittent skilled nursing care and other services in the home (daily skilled nursing care for up to 21 days or longer in some cases)—100% of covered services and 80% of durable medical equipment under both Parts A & B	Same as 1988	Intermittent skilled nursing care for up to 7 days a week for up to 38 days allowing for continuation of services under unusual circumstances; other services, —100% of covered services and 80% of durable medical equipment under both Parts A & B	Same as 1990

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PART B

Medical Expense: Services of a Physician/Outpatient Services	80% of reasonable charges after an annual \$75 deductible	80% after annual \$75 deductible	80% of reasonable charges after \$75 annual deductible until out-of-pocket maximum is reached. 100% of reasonable charges are covered for remainder of calendar year	Same as 1990
Medical Supplies Other than Prescribed Drugs				

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Blood	80% of costs except nonreplacement fees (blood deductible) for 1st 3 pints in each benefit period after \$75 deductible	Pays 80% of all costs except payment of deductible (equal to costs for first 3 pints) <u>each calendar year</u>	Same as 1989	Same as 1989
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Mammography Screening			80% of approved charge for elderly and disabled Medicare beneficiaries— exams available every other year for women 65 & over	Same as 1990
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APPENDIX A

Part B  
MEDICARE BENEFITS IN

Service	1988	1989	1990	1991
Out-of-Pocket Maximum			\$1370 consisting of Part B \$75 deductible, Part B blood deductible and 20% coinsurance	\$1370—will be adjusted annually by secretary of Health and Human Services
Outpatient Prescription Drugs			There is a \$550 total deductible applicable to home I.V. drug and immunosuppressive drug therapies as noted below	Covered after \$600 deductible subject to 50% coinsurance
PART B				
Home I.V. Drug Therapy			80% of I.V. therapy drugs subject to \$550 deductible (deductible waived if home therapy is a continuation of therapy initiated in a hospital)	80% of I.V. therapy drugs subject to standard drug deductible (deductible waived if home therapy is a continuation of therapy drugs initiated in a hospital)
Immunosuppressive Drug Therapy	80% of costs during 1st year following a covered organ transplant (no special drug deductible; only the regular Part B deductible)	Same as 1988	Same as 1988 for 1st year following covered transplant; 50% of costs during 2nd and following years (subject to \$550 deductible)	Same as 1990 (subject to \$600 deductible)
Respite Care Benefit			In-home care for chronically dependent individual covered for up to 80 hours after either the out-of-pocket limit or the outpatient drug deductible has been met	Same as 1990

## APPENDIX A

6. Statement that the policy does or does not cover the following:
- (a) Private duty nursing;
  - (b) Skilled nursing home care costs (beyond what is covered by Medicare);
  - (c) Custodial nursing home care costs;
  - (d) Intermediate nursing home care costs;
  - (e) Home health care above number of visits covered by Medicare;
  - (f) Physician charges (above Medicare's reasonable charges);
  - (g) Drugs (other than prescription drugs furnished during a hospital or skilled nursing facility stay);
  - (h) Care received outside the United States of America; and
  - (i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care and examinations for the cost of eyeglasses or hearing aids.
7. A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay or in any other manner operate to qualify payments of the benefits described in paragraph 4., including conspicuous statements—
- (a) That the chart summarizing Medicare benefits only briefly describes the benefits; and
  - (b) That the Health Care Financing Administration or its Medicare publications should be consulted for further details and limitations.
8. A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.
9. The amount of premium for this policy.

DRAFTING NOTE: The term "certificate" should be substituted for the word "policy" throughout the outline of coverage, where appropriate.

## APPENDIX B

NOTICE OF APPLICANT REGARDING  
REPLACEMENT OF ACCIDENT  
AND SICKNESS INSURANCE

According to *(your application) (information you have furnished)*, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by *(Company Name)* Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. If an insurer, health services corporation or health maintenance organization replaces a Medicare supplement policy, it may not deny benefits under the replacing policy to an insured on the basis that the benefits would be excluded as a preexisting condition, except to the extent that the replaced policy would have excluded the benefits as a preexisting condition.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded. The above Notice to Applicant was delivered to me on:

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Applicant's Signature)

## APPENDIX C

**NOTICE OF APPLICANT REGARDING  
REPLACEMENT OF ACCIDENT  
AND SICKNESS INSURANCE**

According to *(your application) (information you have furnished)* you intended to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by *(Company Name)* Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. If an insurer, health services corporation or health maintenance organization replaces a Medicare supplement policy, it may not deny benefits under the replacing policy to be an insured on the basis that the benefits would be excluded as a preexisting condition, except to the extent that the replaced policy would have excluded the benefits as a preexisting condition.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. *(To be included only if the application is attached to the policy.)* If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to *(Company Name and Address)* within ten (10) days if any information is not correct and complete, or if any past medical history has been left out of the application.

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*(Company Name)*

## APPENDIX D

(COMPANY NAME)

## NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE—1989

YOUR HEALTH CARE BENEFITS PROVIDED BY THE FEDERAL MEDICARE PROGRAM WILL CHANGE BEGINNING JANUARY 1, 1989. ADDITIONAL CHANGES WILL OCCUR ON MEDICAL BENEFITS IN FOLLOWING YEARS. THE MAJOR CHANGES ARE SUMMARIZED BELOW. THESE CHANGES WILL AFFECT HOSPITAL, MEDICAL AND OTHER SERVICES AND SUPPLIES PROVIDED UNDER MEDICARE. BECAUSE OF THESE CHANGES, YOUR MEDICARE SUPPLEMENT COVERAGE PROVIDED BY (COMPANY NAME) WILL CHANGE. ALSO, THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ CAREFULLY!

(A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.)

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	Medicare Now Pays Per Benefit Period	Medicare Will Pay Per Calendar Year	Your 1988 Coverage Per Benefit Period	Your Coverage Will Pay Per Calendar Year
		Effective January 1, 1989		Effective January 1, 1989
MEDICARE PART A SERVICES AND SUPPLIES	First 60 days— All but \$540	Unlimited number of hospital days after \$( ) deductible		
	61st to 90th day— All but \$135 a day			
	91st to 150th day— All but \$270 a day (if individual chooses to use 60 nonrenewable lifetime reserve days)			
	Beyond 150th day— Nothing			
SKILLED NURSING FACILITY CARE	Requires a 3-day prior stay and enter the facility generally within 30 days after hospital discharge	There is no prior confinement require- ment for this benefit		
	First 20 days— 100% of costs	First 8 days— All but \$( ) a day		
	21st through 100th day— All but \$67.50 a day	9th through 150th day— 100% of costs		
	Beyond 100 days— Nothing	Beyond 150 days— Nothing		

APPENDIX D

Services	Medicare Benefits		Your Medical Supplement Coverage	
	Medicare Now Pays Per Calendar Year	In 1989 Medicare Part B Pays The Same As In 1988	Your Policy Now Pays	Effective January 1, 1989 Your Policy Will Pay
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible)	NOTE: Medicare benefits. change on January 1, 1990 as follows: 80% of allowable charges (after \$( ) deductible) until an annual Medicare Catastrophic limit is met. 100% of allowable charges for the remainder of the calendar year. The limit in 1990 is \$1370* and will be adjusted on an annual basis		
PRESCRIPTION DRUGS	Inpatient prescription drugs only	In 1989 Medicare covers inpatient prescription drugs only.  Effective January 1, 1990 Per Calendar Year 80% of allowable charges for home intravenous (I.V.) therapy drugs and 50% of allowable charges for immunosuppressive drugs after (\$550 in 1990) calendar year deductible is met.  Effective January 1, 1991 Per Calendar Year inpatient prescription drugs: 50% of allowable charges for all other outpatient prescription drugs after a \$600 calendar year deductible is met (the deductible will change). Coverage will increase to 60% of allowable charges in 1992 and to 80% of allowable charges from 1993 on.		

## APPENDIX D

**\*Expenses that count toward the Part B Medicare Catastrophic Limit include: the Part B deductible and copayment charges and the Part B blood deductible charges.**

*(ANY ADDITIONAL BENEFITS)*

*(Describe any coverage provisions changing due to Medicare modifications.)*

*(Include information about premium adjustments that may be necessary due to changes in Medicare benefits, or when premium changes, information will be sent.)*

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT (POLICY) CONTACT:

*(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT) (ADDRESS/PHONE NUMBER)*

APPENDIX E

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE—1990

YOUR HEALTH CARE BENEFITS PROVIDED BY THE FEDERAL MEDICARE PROGRAM WILL CHANGE BEGINNING JANUARY 1, 1990. ADDITIONAL CHANGES WILL OCCUR IN MEDICAL BENEFITS IN FOLLOWING YEARS. THE MAJOR CHANGES ARE SUMMARIZED BELOW. THESE CHANGES WILL AFFECT HOSPITAL, MEDICAL AND OTHER SERVICES AND SUPPLIES PROVIDED UNDER MEDICARE. BECAUSE OF THESE CHANGES YOUR MEDICARE SUPPLEMENT COVERAGE PROVIDED BY (COMPANY NAME) WILL CHANGE. ALSO, THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

(A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.)

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	Medicare Now Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay Per Calendar Year	Your Coverage Now Pays Per Calendar Year	Effective January 1, 1990 Your Coverage Will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES	Unlimited number of hospital days after \$564 deductible			
SKILLED NURSING FACILITY CARE	There is no prior confinement require- ment for this benefit First 8 days— All but \$( ) a day 9th through 150th day— 100% of costs Beyond 150 days— Nothing			

## APPENDIX E

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	Medicare Now Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay Per Calendar Year	Your Coverage Pays Per Now Calendar Year	Effective January 1, 1990 Your Coverage Will Pay Per Calendar Year
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible) until an annual Medicare Catastrophic Limit * is met. 100% of allowable charges for the remainder of the calendar year. The limit in 1990 is \$1370 and will be adjusted on an annual basis.			
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for home intravenous (I.V.) therapy drugs and 50% of allowable charges for immunosuppressive drugs after (\$550 in 1990) calendar year deductible is met.			

\*Expenses that count toward the Part B Medicare Catastrophic Limit include: the Part B deductible and copayment charges and the Part B blood deductible charges.

(ANY ADDITIONAL BENEFITS)

(Describe any coverage provisions changing due to Medicare modifications.)

(Include information about premium adjustments that may be necessary due to changes in Medicare benefits, or when premium changes, information will be sent.)

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS, CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT (POLICY) CONTACT:

(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT) (ADDRESS/PHONE NUMBER)

APPENDIX F

(COMPANY NAME)

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE—1991

YOUR HEALTH CARE BENEFITS PROVIDED BY THE FEDERAL MEDICARE PROGRAM WILL CHANGE BEGINNING JANUARY 1, 1991. ADDITIONAL CHANGES WILL OCCUR IN MEDICAL BENEFITS IN FOLLOWING YEARS. THE MAJOR CHANGES ARE SUMMARIZED BELOW. THESE CHANGES WILL AFFECT HOSPITAL, MEDICAL AND OTHER SERVICES AND SUPPLIES PROVIDED UNDER MEDICARE. BECAUSE OF THESE CHANGES YOUR MEDICARE SUPPLEMENT COVERAGE PROVIDED BY (COMPANY NAME) WILL CHANGE. ALSO, THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

*(A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.)*

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	Medicare Now Pays Per Calendar Year	Effective January 1, 1991 Medicare Will Pay Per Calendar Year	Your Coverage Now Pays Per Calendar Year	Effective January 1, 1991 Your Coverage Will Pay Per Calendar Year
MEDICARE PART A SERVICES AND SUPPLIES	Unlimited number of hospital days after \$( ) deductible			
SKILLED NURSING FACILITY CARE	There is no prior confinement require- ment for this benefit First 8 days— All but \$( ) a day 9th through 150th day— 100% of costs Beyond 150 days— Nothing			

## APPENDIX F

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	Medicare Now Pays Per Calendar Year	Effective January 1, 1991 Medicare Will Pay Per Calendar Year	Your Coverage Now Pays Per Calendar Year	Effective January 1, 1991 Your Coverage Will Pay Per Calendar Year
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible) until an annual Medicare Catastrophic Limit * is met. 100% of allowable charges for the remainder of the calendar year. The limit in 1991 is \$( ) and will be adjusted on an annual basis.			
PRESCRIPTION DRUGS	Inpatient prescription drugs. 50% of allowable charges for all other outpatient prescription drugs, until \$600 calendar year deductible is met.	Inpatient prescription drugs 60% of allowable charges for all other outpatient prescription drugs, until \$652 calendar year deductible is met. Coverage will increase to 80% of allowable charges from 1993 on, and deductible will be adjusted on an annual basis.		

\*Expenses that count toward the Part B Medicare Catastrophic Limit include: the Part B deductible and copayment charges and the Part B blood deductible charges.

(ANY ADDITIONAL BENEFITS)

(Describe any coverage provisions changing due to Medicare modifications.)

(Include information about premium adjustments that may be necessary due to changes in Medicare benefits, or when premium changes information will be sent.)

THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS, CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT (POLICY), CONTACT:

(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT) (ADDRESS/PHONE NUMBER)

**20 CSR 400-3.300 Medicare Supplement Loss Ratio Standards**

(Rescinded August 28, 1994)

**20 CSR 400-3.400 Model Rule to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of Medicare Catastrophic Coverage Act**

*PURPOSE: This rule assures the orderly implementation and conversion of Medicare supplement insurance benefits, coverage and premiums due to changes in the federal Medicare program.*

*Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.*

(1) This rule shall apply to all Medicare supplement coverage delivered or issued for delivery in this state. The provisions of this rule shall have precedence over the provisions of any other regulation of this state to the extent necessary to assure that—

(A) Benefits do not duplicate benefits payable by Medicare;

(B) Benefits are adjusted to reflect changes in Medicare benefits;

(C) Applicants receive adequate notice and disclosure of changes in their Medicare supplement coverage; and

(D) Appropriate premium adjustments are made in a timely manner.

(2) Definitions. For the purposes of this rule—

(A) Applicant means—

1. In the case of an individual Medicare supplement policy or contract, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy or contract, the proposed certificate holder;

(B) Certificate means any certificate issued under a group Medicare supplement policy which has been delivered or issued for delivery in this state; and

(C) Medicare supplement policy means a group or individual policy of accident and

health insurance, or a subscriber contract of health service corporations, which is advertised, marketed or designed primarily to supplement coverage for hospital, medical or surgical expenses incurred by an insured person which are not covered by Medicare. This term does not include:

1. 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 a combination of them for employees or former employees or a combination of them, or for members or former members or a combination of them of the labor organization;

2. A policy or contract of any professional, trade or occupational association for its members, former or retired members or a combination of them if the association—

A. Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;

B. Has been maintained in good faith for purposes other than obtaining insurance; and

C. Has been in existence for at least two (2) years prior to the date of its initial offering of the policy or plan to its members; or

3. Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when the group or individual policy or contract includes provisions which are inconsistent with the requirements of sections 376.850—376.885, RSMo nor to Medicare supplement policies being issued to employees or members as additions to franchise plans in existence on July 1, 1982.

(3) Benefit Conversion Requirements.

(A) Effective January 1, 1990 no Medicare supplement insurance policy, contract or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(B) Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

(C) For Medicare supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be—

1. 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;

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

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

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

5. Coverage under Medicare Part A 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 or already paid for under Part B;

6. Coverage for coinsurance amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (seventy-five dollars (\$75)); and

7. Effective January 1, 1990 coverage under Medicare Part 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 or already paid for under Part A, subject to the Medicare deductible amount.

(D) General Requirements.

1. No later than January 31, 1990, every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts. This notice shall be in the format prescribed in Appendix A.

A. The notice shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy or contract.

B. The notice shall inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be effective.

C. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

D. The notice shall not contain or be accompanied by any solicitation.

2. No modifications to an existing Medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this regulation except

to the extent necessary to accomplish the purpose of this regulation.

(4) Form and Rate Filing Requirements.

(A) As soon as practicable, but no longer than forty-five (45) days after the effective date of the Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this state shall file with the Department of Insurance, in accordance with the applicable filing procedures of this state—

1. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Supporting documents as necessary to justify the adjustment shall accompany the filing; and

2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare and to provide the benefits required by section (3). These riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

(B) Upon satisfying the filing and approval requirements of this state, every insurer, health care service plan or other entity providing Medicare supplement insurance in this state shall provide each covered person with any rider, endorsement or policy form necessary to make the adjustments outlined in section (4).

(C) Any premium adjustments shall produce an expected loss ratio under the policy or contract as will conform with minimum loss ratio standards for Medicare supplement policies and shall result in an expected loss ratio at least as great as that originally anticipated by the insurer, health care service plan or other entity for the Medicare supplement insurance policies or contracts. Premium adjustments may be calculated for the period commencing with Medicare benefits changes.

(5) Offer of Reinstatement of Coverage.

(A) Except as provided in subsection (5)(B), in the case of an individual who had in effect, as of December 31, 1988, a Medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under this policy before the date of the enactment of the repeal of the Medicare Catastrophic Coverage Act of 1988, the insurer shall—

1. Provide written notice no earlier than December 15, 1989 and no later than January 30, 1990 to the policyholder or certificate

holder (at the most recent available address) of the offer described in this rule; and

2. Offer the individual, during a period of at least sixty (60) days beginning not later than February 1, 1990, reinstatement of coverage (with coverage effective as of January 1, 1990) under terms which—

A. Do not provide for any waiting period with respect to treatment of preexisting conditions;

B. Provide for coverage which is substantially equivalent to coverage in effect before the date of the termination; and

C. Provide for classification of premiums which are 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 never terminated.

(B) An insurer is not required to make the offer under paragraph (5)(A)2. in the case of an individual who is a policyholder or certificate holder in another Medicare supplement policy as of January 1, 1990 if the individual is not subject to a waiting period with respect to treatment of a preexisting condition under the other policy.

(6) Requirements for New Policies and Certificates.

(A) Effective January 1, 1990 no Medicare supplement insurance policy, contract or certificate shall be delivered or issued for delivery in this state which provides benefits which duplicate benefits provided by Medicare. No Medicare supplement insurance policy, contract or certificate shall provide less benefits than those required under the existing Medicare Supplement Insurance Minimum Standards Model Act or Regulation except where duplication of Medicare benefits would result and except as required by transition provisions.

(B) General Requirements.

1. Within ninety (90) days of April 16, 1990, every insurer, health care service plan or other entity required to file its policies or contracts with this state shall file new Medicare supplement insurance policies or contracts which eliminate any duplication of Medicare supplement benefits with benefits provided by Medicare, which adjust minimum required benefits to changes in Medicare benefits and which provide a clear description of the policy or contract benefit.

2. The filing required under paragraph (6)(B)1. shall provide for loss ratios which are in compliance with all minimum standards.

3. Every applicant for a Medicare supplement insurance policy, contract or certificate shall be provided with an outline of cov-

erage which simplifies and accurately describes benefits provided by Medicare and policy or contract benefits along with benefit limitations.

(7) Filing Requirements for Advertising. Every insurer, health service plan or other entity providing Medicare supplement insurance or benefits in this state shall provide a copy of any advertisement intended for use in this state whether through written, radio or television medium to the director of insurance of this state for review or approval by the director to the extent it may be required under state law. This advertisement shall comply with all applicable laws of this state.

(8) Buyer's Guide. No insurer, health care service plan or other entity shall make use of or otherwise disseminate any buyer's guide or informational brochure which does not accurately outline current Medicare benefits and which has not been adopted by the director.

(9) Separability. If any provision of this rule or the application of it to any person or circumstance is for any reason held to be invalid, the remainder of the regulation and the application of that provision to other persons or circumstances shall not be affected by it.

*AUTHORITY: sections 374.045 and 376.850—376.890, RSMo (1986).\**  
*This rule was previously filed as 4 CSR 190-14.620. Emergency rule filed Dec. 22, 1989, effective Jan. 1, 1990, expired April 15, 1990. Original rule filed Jan. 17, 1990, effective April 16, 1990.*

*\*Original authority: 374.045, RSMo (1967); 376.850, RSMo (1981), amended 1989; 376—376.864, RSMo (1989), amended 1992; 376.869—376.874, RSMo (1989), amended 1990, 1992; 376.879—376.889, RSMo (1989), amended 1992; and 376.890, RSMo (1981), amended 1988.*

**APPENDIX A**  
*(COMPANY NAME)*

**NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE—1990**

THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS CAREFULLY!

*(A BRIEF DESCRIPTION OF THE REVISIONS TO MEDICARE PARTS A & B WITH A PARALLEL DESCRIPTION OF SUPPLEMENTAL BENEFITS WITH SUBSEQUENT CHANGES, INCLUDING DOLLAR AMOUNTS, PROVIDED BY THE MEDICARE SUPPLEMENT COVERAGE IN SUBSTANTIALLY THE FOLLOWING FORMAT.)*

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	<u>In 1989 Medicare Pays Per Calendar Year</u>	<u>Effective January 1, 1990 Medicare Will Pay</u>	<u>In 1989 Your Coverage Pays</u>	<u>Effective January 1, 1990 Your Coverage Will Pay</u>
<b>MEDICARE PART A SERVICES AND SUPPLIES</b>				
Inpatient Hospital Services	Unlimited number of hospital days after \$560 deductible	All but \$592 for first 60 days/benefit period		
Semiprivate Room & Board		All but \$148 a day for 61st—90th day/benefit period		
Misc. Hospital Services & Supplies, such as Drugs, X rays, Lab Tests & Operating Room		All but \$296 a day for 91st—150th day (if individual chooses to use 60 nonrenewable lifetime reserve days)		
<b>BLOOD</b>	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period		
<b>SKILLED NURSING FACILITY CARE</b>	There is no prior confinement requirement for this benefit	100% of costs for first 20 days (after a 3-day prior hospital confinement)/benefit period		
	First 8 days— All but \$25.50 a day	All but \$74.00 a day for 21st—100th day/benefit period		

## APPENDIX A

Services	Medicare Benefits		Your Medicare Supplement Coverage	
	<u>In 1989 Medicare Pays Per Calendar Year</u>	<u>Effective January 1, 1990 Medicare Will Pay</u>	<u>In 1989 Your Coverage Pays</u>	<u>Effective January 1, 1990 Your Coverage Will Pay</u>
	9th through 150th day— 100% of costs	Beyond 100 days Nothing/benefit period		
	Beyond 150 days— Nothing			
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible)	80% of allowable charges (after \$75 deductible/ calendar year)		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immunosup- pressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)		
BLOOD	80% of all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after \$75 deductible/ calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period (after \$75 deductible/ calendar year)		

*(Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.)*

*(Describe any coverage provisions changing due to Medicare modifications.)*

*(Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.)*

**THIS CHART SUMMARIZING THE CHANGES IN YOUR MEDICARE BENEFITS AND IN YOUR MEDICARE SUPPLEMENT PROVIDED BY (COMPANY) ONLY BRIEFLY DESCRIBES SUCH BENEFITS. FOR INFORMATION ON YOUR MEDICARE BENEFITS, CONTACT YOUR SOCIAL SECURITY OFFICE OR THE HEALTH CARE FINANCING ADMINISTRATION. FOR INFORMATION ON YOUR MEDICARE SUPPLEMENT (POLICY) CONTACT:**

**(COMPANY OR FOR AN INDIVIDUAL POLICY—NAME OF AGENT) (ADDRESS/PHONE NUMBER)**

**20 CSR 400-3.500 Medicare Supplement Insurance Minimum Standards—December 31, 1990 to July 29, 1992**

*PURPOSE: This rule provides for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; facilitates public understanding and comparison of these policies; eliminates provisions contained in the policies which may be misleading or confusing in connection with the purchase of the policies or with the settlement of claims; and provides for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare by reason of age.*

*Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.*

(1) Applicability and Scope. Except as otherwise specifically provided in sections (8) and (9), this rule shall—

(A) Apply to all Medicare supplement policies and subscriber contracts delivered or issued for delivery in this state on or after the effective date of this rule, December 31, 1990 and before July 30, 1992 except to the extent modified by 20 CSR 400-3.600(5);

(B) Apply to all certificates delivered or issued for delivery in this state under group Medicare supplement policies or subscriber contracts; and

(C) 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 a combination of them, for employees or former employees or a combination of them, or for members or former members, or a combination of them, of the labor organizations.

(2) Definitions. For the purposes of this rule—

(A) Applicant means—

1. In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits; and

2. In the case of a group Medicare supplement policy or subscriber contract, the proposed certificate holder;

(B) Certificate means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy or subscriber contract; and

(C) Medicare supplement policy means a group or individual policy of accident and sickness insurance or a subscriber contract of a health service corporation or health maintenance organization (HMO) which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age. A contract or certificate of an HMO which provides coverage to Medicare enrollees in connection with the HMO's contract with the Health Care Financing Administration (HCFA) is not considered a Medicare supplement policy for the purposes of this regulation.

(3) Policy Definitions and Terms. No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy unless the policy or subscriber contract contains definitions or terms which conform to the requirements of this section.

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

1. The definition shall not be more restrictive than the following: Injury(ies) for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause and occurs while insurance coverage is in force.

2. The definition may provide that injuries shall not include injuries for which benefits are provided or available under any Workers' Compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(B) Benefit period or Medicare benefit period shall not be defined more restrictively than it is defined in the Medicare program.

(C) Convalescent nursing home, extended care facility or skilled nursing facility shall be defined in relation to its status, facilities and available services.

1. No definition shall be more restrictive than one requiring that it—

A. Be operated pursuant to law;

B. Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

C. Provide continuous twenty-four (24)-hour-a-day nursing service by or under the supervision of a registered graduate professional nurse (RN); and

D. Maintain a daily medical record of each patient.

2. The definition may exclude—

A. Any home, facility or any part of a home or facility used primarily for rest;

B. A home or facility for the aged or for the care of drug addicts or alcoholics; or

C. A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(D) Health care expenses means expenses of HMOs associated with the delivery of health care services which are analogous to incurred losses of insurers. These expenses shall not include:

1. Home office or overhead costs;

2. Advertising costs;

3. Commissions and other acquisition costs;

4. Taxes;

5. Capital costs;

6. Administrative costs; or

7. Claims processing costs.

(E) Hospital may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

1. The definition of the term hospital shall not be more restrictive than one requiring that the hospital—

A. Operate pursuant to law;

B. Primarily and continuously engage in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and

C. Provide twenty-four (24)-hour nursing service by or under the supervision of RNs.

2. The definition of the term hospital may state that the term shall not include:

A. Convalescent homes, convalescent, rest or nursing facilities;

B. Facilities primarily affording custodial, educational or rehabilitative care;

C. Facilities for the aged, drug addicts or alcoholics; or

D. Any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or its agency for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis

where a legal liability exists for charges made to the individual for those services.

(F) Medicare shall be defined in the policy. Medicare may be substantially defined as The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 or Title I, Part I of P.L. 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.

(G) Medicare-eligible expenses shall mean health care expenses of the kinds covered by Medicare, to the extent recognized as reasonable by Medicare. Payment of benefits by insurers for Medicare-eligible expenses may be conditioned upon the same or less restrictive payment conditions, including determinations of medical necessity as are applicable to Medicare claims.

(H) Mental or nervous disorders shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease, or disorder of any kind.

(I) Nurses may be defined so that the description of nurse is restricted to a type of nurse, such as an RN, a licensed practical nurse (LPN) or a licensed vocational nurse (LVN). If the words nurse, trained nurse or registered nurse are used without specific instruction, then the use of those terms requires the insurer to recognize the services of any individual who qualified under the terminology in accordance with the applicable statutes or administrative rules of the State Board of Nursing.

(J) Physician may be defined by including words such as duly qualified physician or duly licensed physician. The use of these terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when those services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(K) Sickness shall not be defined to be more restrictive than the following: Sickness means sickness 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.

#### (4) Prohibited Policy Provisions.

(A) No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if that policy or subscriber contract limits or excludes coverage by type

of illness, accident, treatment or medical condition, except as follows:

1. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet;

2. Mental or emotional disorders, alcoholism and drug addiction;

3. Illness, treatment or medical condition arising out of—

A. War or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or their auxiliary units;

B. Suicide or attempted suicide, while sane, or intentionally self-inflicted injury; or

C. Aviation;

4. Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when that service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;

5. Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and its effect, where that interference is the result of or related to distortion, misalignment or subluxation of, or in, the vertebral column;

6. Treatment provided in a governmental hospital; benefits provided under Medicare or other governmental program (except Medicaid), any state or federal Workers' Compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

7. Dental care or treatment;

8. Eye glasses, hearing aids and examination for prescribing or fitting them;

9. Rest cures, custodial care, transportation and routine physical examinations; and

10. Territorial limitations outside the United States.

(B) Medicare supplement policies may not contain limitations or exclusions of the type enumerated in paragraph (4)(A)1., 2., 5., 7. or 10. that are more restrictive than those of Medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under Medicare.

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

(D) The terms Medicare supplement, Medigap and words of similar import shall not be used unless the policy is issued in compliance with this rule.

#### (5) Benefit Conversion Requirements.

(A) Effective January 1, 1990 no Medicare supplement insurance policy, contract or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(B) Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

(C) For Medicare supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be—

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

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

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

4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, of ninety percent (90%) of all Medicare Part A-eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days;

5. Coverage under Medicare Part A 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 or already paid for under Part A;

6. Coverage for the coinsurance amount of Medicare-eligible expenses under Part B regardless of hospital confinement subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (seventy-five dollars (\$75)); and

7. Effective January 1, 1990, under Medicare Part 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 or already paid for under Part A, subject to the Medicare deductible amount.

(6) Minimum Standards. No insurance policy or subscriber contract may be advertised,

solicited or issued for delivery in this state as a Medicare supplement policy which does not meet the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards:

(A) General Standards. The following standards apply to Medicare supplement policies and are in addition to all other requirements of this rule:

1. A Medicare supplement policy may not deny a claim for losses incurred more than six (6) months from the effective date of coverage for a preexisting condition. The policy 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;

2. A Medicare supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents;

3. A Medicare supplement policy may not contain a provision which reduces benefit payments due to the existence of other Medicare supplement coverage. Coverage must provide that insureds are entitled to a return of all premiums paid for duplicate coverage with the same insurer;

4. A Medicare supplement policy shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with the changes;

5. A noncancelable, guaranteed renewable or noncancelable and guaranteed renewable Medicare supplement policy shall not—

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

B. Be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health;

6. An insurer shall neither cancel nor nonrenew an individual Medicare supplement policy or group certificate for any reason other than nonpayment of premium or material misrepresentation. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection (5)(D), the insurer shall offer certificate holders an individual Medicare supplement policy. The insurer shall

offer the certificate holder at least the following choices:

A. An individual Medicare supplement policy which provides for continuation of the benefits contained in the group policy;

B. An individual Medicare supplement policy which provides only benefits required to meet the minimum standards;

C. If membership in a group is terminated, the insurer shall offer—

(I) The certificate holder conversion opportunities such as those described in subsections (6)(A) and (B); or

(II) The certificate holder continuation of coverage under the group policy, at the option of the group policyholder; and

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

7. Termination of a Medicare supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits; and

(B) Minimum Benefit Standards.

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

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

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

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

5. Coverage under Medicare Part A 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 or already paid for under Part B.

6. Coverage for the coinsurance amount of Medicare-eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible (seventy-five dollars (\$75)) maximum benefit.

7. Effective January 1, 1990 coverage under Medicare Part 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 or already paid for under Part A, subject to the Medicare deductible amount.

(7) Standards for Claims Payment.

(A) Every entity providing Medicare supplement policies or contracts shall comply with all provisions of Section 4081 of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203).

(B) Compliance with the requirements set forth in subsection (7)(A) must be certified on the Medicare supplement insurance experience reporting form.

(8) Loss Ratio Standards.

(A) For the purposes of this section, policy forms shall be deemed to comply with the loss ratio standards if—

1. For the most recent year, the ratio of the incurred losses to earned premiums for policies or certificates which have been in force for three (3) years or more is greater than or equal to the applicable percentages contained in this section; and

2. The expected losses in relation to premiums over the entire period for which the policy is rated comply with the requirements of this section. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

(B) Medicare supplement policies shall return to policyholders in the form of aggregate benefits under the policy, for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience or incurred health care expenses where coverage is provided by an HMO on a service rather than reimbursement basis, and earned premiums for the period and in accordance with accepted actuarial principles and practices at least—

1. Seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; and

2. Sixty percent (60%) of the aggregate amount of premiums earned in the case of individual policies.

(C) All filings of rates and rating schedules shall demonstrate that actual and expected losses in relation to premiums comply with the requirements of this section. In determining compliance with the loss ratio standards in section (8), the actual and expected incurred losses shall not include:

1. Loss adjustment expenses;
2. Active life reserves; and
3. Other claim reserves that would be found excessive or inconsistent with accepted actuarial standards.

(D) Every entity providing Medicare supplement policies in this state annually shall file its rates, rating schedules and supporting documentation on a form prescribed by the director including ratios of incurred losses-to-earned premiums by number of years of policy duration demonstrating that it is in compliance with the foregoing applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience.

(E) Any change to a rate schedule must be filed and approved by the director. The rate change request must be accompanied by supporting documentation as set forth in subsection (8)(D).

(F) As soon as practicable, but prior to the effective date of Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this state shall file with the director—

1. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Supporting documents necessary to justify the adjustment shall accompany the filing, and every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this state pursuant to sections 376.850—376.890, RSMo shall make the premium adjustments necessary to produce an expected loss ratio under the 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 insurer, health care service plan or other entity for the Medicare supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described in this rule should be made with respect to a policy at any time other than upon its renewal date or anniversary date; and

2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare. Any riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

- (9) Filing Requirements for Out-of-State Group Policies. Every insurer providing group Medicare supplement insurance benefits to a resident of this state pursuant to sections 376.850—376.890, RSMo shall file a copy of the master policy and any certificate used in this state in accordance with the filing requirements and procedures applicable to group Medicare supplement policies issued in this state; however, no insurer shall be required to make a filing earlier than thirty (30) days after insurance was provided to a resident of this state under a master policy issued for delivery outside this state.

- (10) Permitted Compensation Arrangements.

- (A) An insurer 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.

- (B) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no less than three (3) renewal years.

- (C) No entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing insurer on renewal policies or certificates if an existing policy or certificate is replaced unless benefits of the new policy or certificate are clearly and substantially greater than the benefits under the replaced policy.

- (D) An agent writing a replacement policy shall complete a form substantially similar to that attached as Appendix B at the time of solicitation. The form shall be maintained in the company's underwriting file.



APPENDIX B
Medicare Supplement Comparison

This comparison is to be used when you are soliciting a Medicare supplement policy to replace a Medicare supplement policy previously issued. It is for use by you and by the Home Office and should not be left with the insured:

Insured: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy Being Replaced: \_\_\_\_\_

Name of Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Plan Name or Policy Form: \_\_\_\_\_

Table with 3 columns: Policy Being Replaced, Replacing Policy, and a descriptive column. Rows include: Guaranteed Renewable, Pays Part A Deductible, Pays for Skilled Nursing Facility Stays Beyond 100 Days Per Benefit Period, Pays Even Though Nursing Facility Is Not Medicare-Approved, Pays for Intermediate Care Facility Stays, Pays for Levels of Care Other Than Skilled Care, Pays Part B Deductible, Pays Part B Benefit In Excess of 20% of Medicare-Approved Charges, If "Yes", Describe, Pays for Some Care Outside U.S.A., Annual Premium, Other Items.

Agent's Name: \_\_\_\_\_ Date: \_\_\_\_\_