**STATEMENT OF EMERGENCY**
**806 KAR 17:570E.**

This emergency regulation is being promulgated to meet an imminent threat to public health, safety, or welfare as prescribed in KRS 13A.190(1)(a). An ordinary administrative regulation would not be sufficient due to the timing of this imminent threat imposed. This administrative regulation will not be followed by an ordinary administrative regulation because it addresses a one-time Medicaid disenrollment action that is occurring due to the passage of the 2023 Consolidated Appropriations Act, which will not arise on a recurring basis. National analyses have estimated that up to 15 million current Medicaid enrollees will lose PHE-induced Medicaid coverage through this redetermination. In addition, data provided by the Kentucky Cabinet for Health and Family Services ("CHFS") indicates that approximately 17,986 Kentuckians will be negatively impacted if this emergency administrative regulation is not promulgated (Exhibit 1).

During the spring of 2020, CHFS received approval from the Centers for Medicare & Medicaid Services ("CMS") to stop disenrolling Kentucky Medicaid members. CHFS took this action to prevent persons enrolled in Medicaid from having a lapse in healthcare coverage during the Covid-19 pandemic. Accordingly, during the Public Health Emergency ("PHE"), CHFS did not disenroll Kentuckians whose Medicaid eligibility would have otherwise expired because they no longer met Medicaid eligibility standards. Typically, persons who become eligible for Medicare receive a Medicare supplement "open enrollment" period of six (6) months, pursuant to 806 KAR 17:570 Section 13. During this period, insurers are required to offer "guaranteed issue" rights to all applicants and are prohibited from discriminating in the pricing of Medicare supplement policies due to an applicant's health status. See 806 KAR 17:570 Section 14(1)(b). Insurers are also prohibited from selling Medicare supplement policies to individuals on Medicaid under Federal Law. See 42 U.S.C. § 1395ss(d)(3)(B)(iii).

The PHE will remain in place through May 11, 2023. Nevertheless, on December 29, 2022, the Consolidated Appropriations Act, 2023 (the "2023 CAA") was enacted by the federal government. The newly enacted 2023 CAA does not specifically address the end date of the COVID-19 PHE but does address the end of the continuous enrollment condition, the temporary Federal Medical Assistance Percentage (FMAP) increase, and the PHE Medicaid unwinding process. The continuous enrollment condition will end on March 31, 2023. Beginning April 1, 2023, states will be able to terminate Medicaid enrollment for individuals who are no longer eligible. As a result, CMS has begun a process known as "Medicaid Unwinding," through which it will conduct Medicaid and CHIP eligibility reviews and resume regular Medicaid eligibility operations for enrollees beginning on May 1, 2023. As part of Medicaid Unwinding, CMS is requiring CHFS to remove Medicaid members that no longer meet eligibility requirements. However, many Medicaid members who became eligible for Medicare during the PHE will have exhausted their six (6)-month Medicare supplement open enrollment period.

To help ensure low-income Kentucky seniors have access to affordable Medicare supplement policies, the Department is amending 806 KAR 17:570 by emergency regulation. The Department is requiring that guaranteed issue rights for Medicare supplement policies are offered to any applicants who have exhausted their initial Medicare supplement open enrollment period because of their continued enrollment in Medicaid during the PHE. These applicants will be required to provide verification of a Kentucky Medicaid disenrollment. CHFS plans to begin issuing verification of disenrollment to

persons 65 or older on May 1, 2023. After such verification, insurers will be required to: (1) treat such applicants as "eligible persons," pursuant to 806 KAR 17:570 Section 14(2); and (2) permit such applicants to enroll in a Medicare supplement policy with guaranteed issue rights and a new enrollment period starting on the date of the applicant's Medicaid disenrollment and continuing for sixty-three (63) days afterwards.

Without this emergency administrative regulation, insurers would not be required to provide open enrollment for these individuals to seek out the coverages they need. As a baseline, ensuring that eligible persons remain enrolled or can successfully transition to other coverage minimizes gaps in coverage. Elderly and ailed Kentuckians would be unable to enroll into the supplemental medical coverage they need to sustain life. Medicare supplement insurance provides seniors and those with an eligible disability supplemental coverage for hospitalizations, outpatient visits and diagnostic testing, and costs related to copays, coinsurance, or deductibles. Because there is only a one-time open enrollment into a Medicare Supplement plan, many Kentuckians were not afforded the opportunity to apply for a guaranteed issue Medicare Supplement plan when they would have first been eligible due to being enrolled in Medicaid during the PHE.

Without access to this mandated special open enrollment, seniors, and those with eligible disabilities, would have to apply for Medicare supplement coverage outside of their specified open enrollment period. This could result in individuals not being issued a Medicare supplement policy at all, or it could require them to pay significantly higher premiums. Medicare Supplement plans cover up to 20% of what standard Medicare plans (Parts A and B) do not cover. Requiring Kentuckians to incur out-of-pocket costs associated with that 20% would create a substantial burden. Late enrollment penalties can cause a 10% increase for premium payments. Based on the median of premiums presented in the attached chart for Part A Medicare supplement policies (Exhibit 2), this would mean an additional $28.05 a month for that coverage alone.

Furthermore, failure to provide an open enrollment period increases the possibility that these individuals avoid medical treatment altogether. By avoiding necessary medical treatment, these already vulnerable individuals exacerbate their vulnerabilities and have a high probability of becoming ill or experiencing a worsened condition. Lack of adequate coverage has been known to keep individuals from seeking the care they need. Without certain coverages provided by Medicare supplement policies, these individuals will be left to pay out-of-pocket cost for healthcare services that are vital to their physical and mental well-being. This is especially imperative for seniors and those with disabilities who have chronic health needs, and who therefore rely on this gap coverage to meet their daily needs. This emergency administrative regulation is imperative to protect vulnerable Kentuckians.

*SHARON P. CLARK, Commissioner*
*ANDY BESHEAR, Governor*

**PUBLIC PROTECTION CABINET**
**Department of Insurance**
**Division of Health, Life and Managed Care**
**(Emergency Amendment)**

## 806 KAR 17:570E. Minimum standards for Medicare supplement insurance policies and certificates.

RELATES TO: KRS 304.2-310, 304.2-320, 304.3-240, 304.12-020, 304.14-120, 304.14-500-304.14-550, 304.17-311, 304.17A-005, 304.18-034, 304.32-275, 304.33-030, 304.38-205, 42. C.F.R. 409.87, 45 C.F.R. Part 46, 74 F.R. 18808 (2009), 29 U.S.C. 1002, 42 U.S.C. 426, 42 U.S.C. 1320c-3, 1320d, 1320d-2, 42 U.S.C. 1395-1395ggg, 42 U.S.C. 1396, Pub. L. 108-173

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.14-510, 304.32-250, 304.38-150

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the commissioner of the Department of Insurance to promulgate administrative regulations necessary for or as an aid to the effectuation of any provision of the Kentucky Insurance Code, as defined in KRS 304.1-010. KRS 304.14-510 authorizes the commissioner of the Department of Insurance to promulgate administrative regulations establishing minimum standards for Medicare supplement insurance policies. KRS 304.32-250 authorizes the commissioner of the Department of Insurance to promulgate administrative regulations necessary for the proper administration of KRS 304.32. KRS 304.38-150 authorizes the commissioner of the Department of Insurance to promulgate administrative regulations necessary for the proper administration of KRS Chapter 304.38. This administrative regulation establishes minimum standards for Medicare supplement insurance policies and certificates.

Section 1. Definitions.

(1) "Applicant" is defined by KRS 304.14-500(1).

(2) "Bankruptcy" means a petition for declaration of bankruptcy filed by or filed against a Medicare Advantage organization that is not an insurer and has ceased doing business in the state.

(3) "Certificate" is defined by KRS 304.14-500(2).

(4) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the insurer.

(5) "Commissioner" means Commissioner of the Department of Insurance.

(6) "Compensation" means monetary or non-monetary remuneration of any kind relating to the sale or renewal of the policy or certificate including bonuses, gifts, prizes, awards, and finder's fees.

(7) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select insurer or its network providers.

(8) "Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than sixty-three (63) days.

(9) "Creditable coverage" is defined by KRS 304.17A-005(8).

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

(11) "Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of the individual.

(12) "Genetic information" means except for information relating to the sex or age:

(a) With respect to any individual:

1. Information about the individual's genetic tests, the genetic tests of family members of the individual, and the manifestation of a disease or disorder in family members of the individual; or

2. Any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by the individual or any family member of the individual.

(b) Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman, including:

1. Genetic information of any fetus carried by a pregnant woman; or

2. With respect to an individual or family member utilizing reproductive technology, genetic information of any embryo legally held by an individual or family member.

(13) "Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

(14) "Genetic test":

(a) Means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes;

(b) Except for an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that may reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

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

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

(17) "Insolvency" is defined by KRS 304.33-030(18).

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

(19) "Insurer of a Medicare supplement policy or certificate" means an insurer or third-party administrator, or other person acting for or on behalf of the insurer.

(20) "Medicare" is defined by KRS 304.14-500(4).

(21) "Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. 1395w-28(b)(1), including:

(a) A coordinated care plan, which provides health care services, including the following:

1. A health maintenance organization plan, with or without a point-of-service option;

2. A plan offered by provider-sponsored organization; and

3. A preferred provider organization plan;

(b) A medical savings account plan coupled with a contribution into a Medicare Advantage plan medical savings account; and

(c) A Medicare Advantage private fee-for-service plan.

(22) "Medicare Select insurer" means an insurer offering, or seeking to offer, a Medicare Select policy or certificate.

(23) "Medicare Select policy" or "Medicare Select certificate" means, respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

(24) "Medicare supplement policy" is defined by KRS 304.14-500(3).

(25) "Network provider" means a provider of health care, or a group of providers of health care, that has entered into a written agreement with the insurer to provide benefits insured under a Medicare Select policy.

(26) "Policy form" means the form on which the policy is delivered or issued for delivery by the insurer.

(27) "Pre-Standardized Medicare supplement benefit plan," "Pre-Standardized benefit plan," or "Pre-Standardized plan" means a group or individual policy of Medicare supplement insurance issued prior to January 1, 1992.

(28) "Restricted network provision" means any provision that conditions the payment of benefits, in whole or in part, on the use of network providers.

(29) "Secretary" means the Secretary of the U.S. Department of Health and Human Services.

(30) "Service area" means the geographic area approved by the commissioner within which an insurer is authorized to offer a Medicare Select policy.

(31) "Structure, language, designation, and format" means style, arrangement, and overall content of a benefit.

(32) "Underwriting purposes" means:

(a) Rules for, or determination of, eligibility, including enrollment and continued eligibility, for benefits under the policy;

(b) The computation of premium or contribution amounts under the policy;

(c) The application of any pre-existing condition exclusion under the policy; and

(d) Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

(33) "1990 Standardized Medicare supplement benefit plan," "1990 Standardized benefit plan," or "1990 plan" means a group or individual policy of Medicare supplement insurance issued on or after January 1, 1992, with an effective date for coverage prior to June 1, 2010 including Medicare supplement insurance policies and certificates renewed on or after that date that are not replaced by the insurer at the request of the insured.

(34) "2010 Standardized Medicare supplement benefit plan," "2010 Standardized benefit plan," or "2010 plan" means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

Section 2. Purpose. The purpose of this administrative regulation shall be to:

(1) Provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies;

(2) Facilitate public understanding and comparison of the policies;

(3) Eliminate provisions contained in the policies that may be misleading or confusing in connection with the purchase of the policies or with the settlement of claims; and

(4) Provide for full disclosures in the sale of accident and sickness insurance coverage to persons eligible for Medicare.

Section 3. Applicability and Scope.

(1) Except as provided in Sections 6, 15, 16, 19, and 24, the requirements of this administrative regulation shall apply to:

(a) All Medicare supplement policies delivered or issued for delivery in Kentucky on or after January 4, 2010; and

(b) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in Kentucky.

(2) This administrative regulation shall not apply to a policy or contract:

(a) Of one (1) or more employers or labor organizations, or of the trustees of a fund established by one (1) or more employers or labor organizations, or combination thereof;

(b) For employees or former employees, or a combination thereof; or

(c) For members or former members, or a combination thereof, of the labor organizations.

Section 4. Policy Definitions and Terms. A policy or certificate shall not be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless the policy or certificate contains definitions or terms that conform to this section.

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

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

(b) 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 the definition is prohibited by law.

(2) "Activities of daily living" shall include bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(3) "At-home recovery visit" shall mean the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four (4) hours in a twenty-four (24) hour period of services provided by a care provider shall be one (1) visit.

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

(5) "Care provider" shall mean a duly qualified or licensed home health aide or homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

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

(7) "Emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(8) "Home" shall mean any place used by the insured as a place of residence, if the place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

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

(10) "Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended", or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

(11) "Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

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

(13) "Preexisting condition" shall not be defined 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.

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

Section 5. Policy Provisions.

(1) Except for permitted preexisting condition clauses as described in Sections 6(2)(a), 7(1)(a), and 8(1) of this administrative regulation, a policy or certificate shall not be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(2) A Medicare supplement policy or certificate shall not:

(a) Contain a probationary or elimination period; or

(b) Use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(3) A Medicare supplement policy or certificate in force in the state shall not contain benefits that duplicate benefits provided by Medicare.

(4)

(a) Subject to Sections 6(2)(d), (e), and (g), and 7(1)(d) and (e) of this administrative regulation, a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(b) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(c) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs shall not be renewed after the policyholder enrolls in Medicare Part D unless:

1. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Part D plan; and

2. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at Medicare Part D enrollment, accounting for any claims paid, if applicable.

Section 6. Minimum Benefit Standards for Pre-Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery Prior to January 1, 1992.

(1) A policy or certificate shall not be advertised, solicited, or issued for delivery in Kentucky as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards, which shall not preclude the inclusion of other provisions or benefits that are not inconsistent with these standards.

(2) General standards. The following standards shall apply to Medicare supplement policies and certificates and are in addition to all other requirements of this administrative regulation.

(a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition and the policy or certificate shall not define a preexisting condition more restrictively than Section 4(13) of this administrative regulation.

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

(c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide

with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with the changes.

(d) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

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

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

(e)

1. An insurer shall not cancel or nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

2. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in paragraph (e)4 of this subsection, the insurer shall offer certificate holders an individual Medicare supplement policy with at least the following choices:

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

b. An individual Medicare supplement policy that provides the benefits as are required to meet the minimum standards as defined in Section 8(2) of this administrative regulation.

3. If membership in a group is terminated, the insurer shall:

a. Offer the certificate holder the conversion opportunities described in subparagraph 2 of this paragraph; or

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

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

(f) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

(g) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173, the modified policy shall satisfy the guaranteed renewal requirements of this subsection.

(3) Minimum benefit standards. The following minimum benefit standards shall apply to Medicare supplement policies and certificates and are in addition to all other requirements of this administrative regulation.

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

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

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

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

(e) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood, or equivalent quantities of packed red blood cells, pursuant to 42 C.F.R. 409.87(a)(2), unless replaced in accordance with 42 C.F.R. 409.87(c)(2) or already paid for under Part B;

(f) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible; and

(g) 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, pursuant to 42 C.F.R. 409.87(a)(2), unless replaced in accordance with 42 C.F.R. 409.87(c)(2) or already paid for under Part A, subject to the Medicare deductible amount.

Section 7. Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan and Policies or Certificates Issued or Delivered on or After January 1, 1992, and With an Effective Date for Coverage Prior to June 1, 2010. The following standards shall apply to all Medicare supplement policies or certificates delivered or issued for delivery in Kentucky on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. A policy or certificate shall not be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

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

(a) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition and the policy or certificate shall not define a preexisting condition more restrictively than Section 4(13) of this administrative regulation.

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

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

(d) A Medicare supplement policy or certificate shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(e) Each Medicare supplement policy shall be guaranteed renewable.

1. The insurer shall not cancel or nonrenew the policy solely on health status of the individual.

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

3. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph 5 of this paragraph, the insurer shall offer certificate holders an option to choose an individual Medicare supplement policy which, at the option of the certificate holder:

a. Provides for continuation of the benefits contained in the group policy; or

b. Provides for benefits that meet the requirements of this subsection.

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

a. Offer the certificate holder the conversion opportunity described in subparagraph 3 of this paragraph; or

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

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

6. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173, the modified policy shall satisfy the guaranteed renewal requirements of this paragraph.

(f) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss that commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits shall not be considered in determining a continuous loss.

(g)

1. A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period, not to exceed twenty-four (24) months, in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., but only if the policyholder or certificate holder notifies the insurer of the policy or certificate within ninety (90) days after the date the individual becomes entitled to assistance.

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

3. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended, for any period that may be provided by 42 U.S.C. 1395ss(q)(5), at the request of the policyholder if the policyholder is entitled to benefits under Section 226 (b) of the Social Security Act, 42 U.S.C. 426(b), and is covered under a group health plan, as defined in Section 1862 (b)(1)(A)(v) of the Social Security Act, 42 U.S.C. 1395y(b)(1)(A)(v). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted, effective as of the date of loss of coverage, if the policyholder provides notice of loss of coverage within ninety (90) days after

the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

4. Reinstitution of coverages as described in subparagraphs 2 and 3 of this paragraph:

a. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

b. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

c. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(h) If an insurer makes a written offer to the Medicare Supplement policyholders or certificate holders of one or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan, as described in Section 9 of this administrative regulation, to a 2010 Standardized plan, as described in Section 10 of this administrative regulation, the offer and subsequent exchange shall comply with the following requirements:

1. An insurer shall not be required to provide justification to the commissioner if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an insurer shall be filed with the commissioner in accordance with KRS 304.14-120 and 806 KAR 14:007.

2. The rating class of the new policy or certificate shall be the class closest to the insured's class of the replaced coverage.

3. An insurer shall not apply new pre-existing condition limitations or a new incontestability period to the new policy for those benefits contained in the exchanged 1990 Standardized policy or certificate of the insured, but may apply pre-existing condition limitations of no more than six (6) months to any added benefits contained in the new 2010 Standardized policy or certificate not contained in the exchanged policy.

4. The new policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except if the offer or issue would be in violation of state or federal law.

5. An insurer may offer its policyholders or certificate holders the following exchange options:

a. Selected existing plans; or

b. Certain new plans for a particular existing plan.

(2) Standards for basic (core) benefits common to benefit plans A to J. Every insurer shall make available a policy or certificate including at a minimum the following basic "core" package of benefits to each prospective insured. An insurer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(b) Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

(d) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood, or equivalent quantities of packed red blood cells, pursuant to 42 C.F.R. 409.87(a)(2), unless replaced in accordance with 42 C.F.R. 409.87(c)(2); and

(e) Coverage for the coinsurance amount or for hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

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

(a) Medicare Part A Deductible, which is coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(b) Skilled Nursing Facility Care, which is coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(c) Medicare Part B Deductible, which is coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty (80) Percent of the Medicare Part B Excess Charges, which is coverage for eighty (80) percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program, and the Medicare-approved Part B charge.

(e) 100 Percent of the Medicare Part B Excess Charges, which is coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare Program or state law, and the Medicare-approved Part B charge.

(f) Basic Outpatient Prescription Drug Benefit which is coverage for fifty (50) percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(g) Extended Outpatient Prescription Drug Benefit, which is coverage for fifty (50) percent of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(h) Medically Necessary Emergency Care in a Foreign Country, which is coverage to the extent not covered by Medicare for eighty (80) percent of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.

(i)

1. Preventive Medical Care Benefit, which is coverage for the following preventive health services not covered by Medicare:

a. An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph 2 of this paragraph and patient education to address preventive health care measures; and

b. Preventive screening tests or preventive services, the selection and frequency of which are determined to be medically appropriate by the attending physician.

2. Reimbursement shall be for the actual charges up to 100 percent of the Medicare approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(j) At-Home Recovery Benefit, which is coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

1. Coverage requirements and limitations.

a. At-home recovery services provided shall be primarily services that assist in activities of daily living.

b. The insured's attending physician shall certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

c. Coverage shall be limited to:

(i) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment;

(ii) The actual charges for each visit up to a maximum reimbursement of forty (40) dollars per visit;

(iii) $1,600 per calendar year;

(iv) Seven (7) visits in any one (1) week;

(v) Care furnished on a visiting basis in the insured's home;

(vi) Services provided by a care provider as described in Section 4(5) of this administrative regulation;

(vii) At-home recovery visits while the insured is covered under the policy or certificate and not excluded; and

(viii) At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight (8) weeks after the service date of the last Medicare-approved home health care visit.

2. Coverage shall be excluded for:

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

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

(4) Standards for Plans K and L.

(a) Standardized Medicare supplement benefit plan "K" shall consist of the following:

1. Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

2. Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

4. Medicare Part A Deductible, which is coverage for fifty (50) percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 10 of this paragraph;

5. Skilled Nursing Facility Care, which is coverage for fifty (50) percent of the coinsurance amount for each day used from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 10 of this paragraph;

6. Hospice Care, which is coverage for fifty (50) percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 10 of this paragraph;

7. Coverage for fifty (50) percent, under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, pursuant to 42 C.F.R. 409.87(a)(2)), unless replaced in accordance with 42 C.F.R. 409.87(c)(2), until the out-of-pocket limitation is met as described in subparagraph 10 of this paragraph;

8. Except for coverage provided in subparagraph 9 of this paragraph, coverage for fifty (50) percent of the cost sharing applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 10 of this paragraph;

9. Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

10. Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the secretary.

(b) Standardized Medicare supplement benefit plan "L" shall consist of the following:

1. The benefits described in paragraph (a)1, 2, 3, and 9 of this section;

2. The benefit described in paragraph (a)4, 5, 6, 7, and 8 of this section, but substituting seventy-five (75) percent for fifty (50) percent; and

3. The benefit described in paragraph (a)10 of this section, but substituting $2,000 for $4,000.

Section 8. Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date for Coverage on or After June 1, 2010. The following standards shall apply to all Medicare supplement policies or certificates delivered or issued for delivery in Kentucky with an effective date for coverage on or after June 1, 2010. A policy or certificate shall not be advertised, solicited, delivered, or issued for delivery in Kentucky as a Medicare supplement policy or certificate unless it complies with these benefit standards. An insurer shall not offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of Sections 7 and 9 of this administrative regulation.

(1) General Standards. The general standards of Section 7(1)(a) through (g), except 7(1)(e)6, shall apply to all policies under Section 8 of this administrative regulation.

(2) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, High Deductible F, G, M and N. Every insurer of Medicare

supplement insurance benefit plans shall make available a policy or certificate including, at a minimum, the following basic "core" package of benefits to each prospective insured. An insurer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

(a) The basic core benefits included within Section 7(2)(a) through (e) of this administrative regulation shall be applied to plans under this section; and

(b) Hospice Care, which is coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(3) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, High Deductible F, G, M, and N as provided by Section 10 of this administrative regulation.

(a) Medicare Part A Deductible, which is coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(b) Medicare Part A Deductible, which is coverage for fifty (50) percent of the Medicare Part A inpatient hospital deductible amount per benefit period.

(c) Skilled Nursing Facility Care, which is coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

(d) Medicare Part B Deductible, which is coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(e) 100 percent of the Medicare Part B Excess Charges, which is coverage for the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program, and the Medicare-approved Part B charge.

(f) Medically Necessary Emergency Care in a Foreign Country, which is coverage to the extent not covered by Medicare for eighty (80) percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000.

Section 9. Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After January 1, 1992, and with an Effective Date for Coverage Prior to June 1, 2010.

(1) An insurer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in Section 7(2) of this administrative regulation.

(2) Groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall not be offered for sale in Kentucky, except as may be permitted in subsection (7) of this section and Section 11 of this administrative regulation.

(3) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans "A" through "L" listed in this section and conform to the definitions in Section 1 of this administrative regulation. Each benefit shall be structured in accordance with the format provided in Sections 7(2) and 7(3) or 7(4) of this administrative regulation and shall list the benefits in the order shown in this section.

(4) An insurer may use, in addition to the benefit plan designations required in subsection (3) of this section, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized Medicare supplement benefit Plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as described in Section 7(2) of this

administrative regulation.
(b) Standardized Medicare supplement benefit Plan "B" shall include only the following: The core benefit as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible as described in Section 7(3)(a).
(c) Standardized Medicare supplement benefit Plan "C" shall include only the following: The core benefit as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible and medically necessary emergency care in a foreign country as described in Sections 7(3)(a), (b), (c), and (h) respectively.
(d) Standardized Medicare supplement benefit Plan "D" shall include only the following: The core benefit, as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in an foreign country and the at-home recovery benefit as described in Sections 7(3)(a), (b), (h), and (j) respectively.
(e) Standardized Medicare supplement benefit Plan "E" shall include only the following: The core benefit as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as described in Sections 7(3)(a), (b), (h), and (i) respectively.
(f) Standardized Medicare supplement benefit Plan "F" shall include only the following: The core benefit as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible, the skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in Section 7(3)(a), (b), (c), (e), and (h) respectively.
(g) Standardized Medicare supplement benefit high deductible Plan "F" shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible Plan "F" deductible. The covered expenses shall include the core benefits as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in Section 7(3)(a), (b), (c), (e), and (h) respectively. The annual high deductible Plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1,500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten (10) dollars.
(h) Standardized Medicare supplement benefit Plan "G" shall include only the following: The core benefit as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible, skilled nursing facility care, eighty (80) percent of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as described in Section 7(3)(a), (b), (d), (h), and (j) respectively.
(i) Standardized Medicare supplement benefit Plan "H" shall consist of only the following: The core benefit as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit and medically necessary emergency care in a foreign country as described in Section 7(3)(a), (b), (f), and (h) respectively. The outpatient

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

(j) Standardized Medicare supplement benefit Plan "I" shall consist of only the following: The core benefit as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country and at-home recovery benefit as described in Section 7(3)(a), (b), (e), (f), (h), and (j) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(k) Standardized Medicare supplement benefit Plan "J" shall consist of only the following: The core benefit as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care and at-home recovery benefit as described in Section 7(3)(a), (b), (c), (e), (g), (h), (i), and (j) respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(l) Standardized Medicare supplement benefit high deductible Plan "J" shall consist of only the following: 100 percent of covered expenses following the payment of the annual high deductible Plan "J" deductible. The covered expenses shall include the core benefits as described in Section 7(2) of this administrative regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as described in Section 7(3)(a), (b), (c), (e), (g), (h), (i) and (j) respectively. The annual high deductible Plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement Plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten (10) dollars. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(6) Design of two (2) Medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), Pub. L. 108-173.

(a) Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in Section 7(4)(a) of this administrative regulation.

(b) Standardized Medicare supplement benefit plan "L" shall consist of only those benefits described in Section 7(4)(b) of this administrative regulation.

(7) New or Innovative Benefits: An insurer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not available, cost-effective, and offered in a manner that is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2005, the innovative benefit shall not include an outpatient prescription drug benefit.

Section 10. Standard Medicare Supplement Benefit Plans for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates with an Effective Date for Coverage on or After June 1, 2010. The following standards shall apply to all Medicare supplement policies or certificates with an effective date for coverage in this state on or after June 1, 2010. A policy or certificate shall not be advertised, solicited, delivered, or issued for delivery in Kentucky as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued before June 1, 2010, shall remain subject to the requirements of Section 7 and 9 of this administrative regulation.

(1)

(a) An insurer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as described in Section 8(2) of this administrative regulation.

(b) If an insurer makes available any of the additional benefits described in Section 8(3), or offers standardized benefit Plans K or L, as described in Sections 10(5)(h) and (i) of this administrative regulation, then the insurer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in paragraph (a) of this subsection of this section, a policy form or certificate form containing either standardized benefit Plan C, as described in Section 10(5)(c) of this administrative regulation, or standardized benefit Plan F, as described in 10(5)(e) of this administrative regulation.

(2) Groups, packages or combinations of Medicare supplement benefits other than those listed in this Section shall not be offered for sale in this state, except as may be permitted in Section 10(6) and in Section 12 of this administrative regulation.

(3) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in this subsection and conform to the definitions in Section 1 of this administrative regulation. Each benefit shall be structured in accordance with the format provided in Sections 8(2) and 8(3) of this administrative regulation; or, in the case of plans K or L, in subsection(5)(h) or (i) of this section and list the benefits in the order shown.

(4) In addition to the benefit plan designations required in subsection (3) of this section, an insurer may use other designations if approved by the commissioner in accordance with subsection (6) of this section.

(5) 2010 Standardized Benefit Plans:

(a) Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as described in Section 8(2) of this administrative regulation.

(b) Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as described in Section 8(2) of this administrative regulation, plus 100 percent of the Medicare Part A deductible as described in Section 8(3)(a) of this administrative regulation.

(c) Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as described in Section 8(2) of this administrative regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as described in Section 8(3)(a), (c), (d), and (f) of this administrative regulation, respectively.

(d) Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit, as described in Section 8(2) of this administrative regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in an foreign country as described in Sections 8(3)(a), (c), and (f) of this administrative regulation, respectively.

(e) Standardized Medicare supplement Plan F shall include only the following: The basic (core) benefit as described in Section 8(2) of this administrative regulation, plus 100 percent of the Medicare Part A deductible, the skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in Sections 8(3)(a), (c), (d), (e), and (f), respectively.

(f) Standardized Medicare supplement Plan High Deductible F shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph 2 of this paragraph of this subsection.

1. The basic (core) benefit as described in Section 8(2) of this administrative regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in Sections 8(3)(a), (c), (d), (e), and (f) of this administrative regulation, respectively.

2. The annual deductible in High Deductible Plan F shall consist of out-of-pocket expenses, other than premiums, for services covered by Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve (12) month period ending with August of the preceding year, and rounded to the nearest multiple of ten (10) dollars.

(g)

1. Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as described in Section 8(2) of this administrative regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as described in Sections 8(3)(a), (c), (e), and (f), respectively.

2. Beginning January 1, 2020, the standardized benefit plans described in Section (11)(1)(d) of this administrative regulation (Redesignated Plan G High Deductible) may be offered to any individual who was eligible for Medicare prior to January 1, 2020.

(h) Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173, and shall include only the following:

1. Part A Hospital Coinsurance 61st through 90th days: Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any Medicare benefit period;

2. Part A Hospital Coinsurance, 91st through 150th days: Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the 91st through the 150th day in any Medicare benefit period;

3. Part A Hospitalization After 150 Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

4. Medicare Part A Deductible: Coverage for fifty (50) percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 10 of this paragraph;

5. Skilled Nursing Facility Care: Coverage for fifty (50) percent of the coinsurance amount for each day used from the twenty-first (21) day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 10 of this paragraph;

6. Hospice Care: Coverage for fifty (50) percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 10 of this paragraph;

7. Blood: Coverage for fifty (50) percent, under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood, or equivalent quantities of packed red blood cells, as described under 42 C.F.R. 409.87(a)(2) unless replaced in accordance with 42 C.F.R. 409.87(c)(2) until the out-of-pocket limitation is met as described in subparagraph 10 of this paragraph;

8. Part B Cost Sharing: Except for coverage provided in subparagraph 9 of this paragraph, coverage for fifty (50) percent of the cost sharing applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 10 of this paragraph;

9. Part B Preventive Services: Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

10. Cost Sharing After Out-of-Pocket Limits: Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(i) Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. 108-173, and shall include only the following:

1. The benefits described in paragraph(h)1, 2, 3, and 9 of this subsection;

2. The benefit described in paragraph(h)4, 5, 6, 7, and 8 of this subsection, but substituting seventy-five (75) percent for fifty (50) percent; and

3. The benefit described in paragraph(h)10 of this subsection, but substituting $2,000 for $4,000.

(j) Standardized Medicare supplement Plan M shall include only the following: The basic core benefit as described in Section 8(2) of this administrative regulation, plus fifty (50) percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as described in Sections 8(3)(a), (c) and (f) of this administrative regulation, respectively.

(k) Standardized Medicare supplement Plan N shall include only the following: The basic core benefit as described in Section 8(2) of this administrative regulation, plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as described in Sections 8(3)(a), (c) and (f) of this administrative regulation, respectively, with copayments in the following amounts:

1. The lesser of twenty (20) dollars or the Medicare Part B coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists; and

2. The lesser of fifty (50) dollars or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

(6) New or Innovative Benefits: An insurer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that complies with the applicable standards of this section. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not available, and are cost-effective. Approval of new or innovative benefits shall not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

Section 11. Standard Medicare Supplement Benefit Plans for 2020 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery to individuals Newly Eligible for Medicare on or After January 1, 2020. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), Pub. L. 114-10, requires the following standards to be applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state to individuals newly eligible for Medicare on or after January 1, 2020. A policy or certificate providing coverage of the Medicare Part B deductible shall not be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate to individuals newly eligible for Medicare on or after January 1, 2020. All policies shall comply with the following benefit standards. Benefit plan standards applicable to Medicare supplement policies and certificates issued to individuals eligible for Medicare before January 1, 2020, shall remain subject to the requirements of Sections 9 and 10 of this administrative regulation.

(1) Benefit Requirements. The standards and requirements of Section 10 shall apply to all Medicare supplement policies and certificates delivered or issued for delivery to individuals newly eligible for Medicare on or after January 1, 2020, with the following exceptions:

(a) Standardized Medicare supplement benefit Plan C is redesignated as Plan D and shall provide the benefits contained in Section (10)(5)(c) of this administrative regulation but shall not provide coverage for any portion of the Medicare Part B deductible.

(b) Standardized Medicare supplement benefit Plan F is redesignated as Plan G and shall provide the benefits contained in Section (10)(5)(e) of this administrative regulation but shall not provide coverage for 100 percent or any portion of the Medicare Part B deductible.

(c) Standardized Medicare supplement benefit plans C, F, and F with High Deductible shall not be offered to individuals newly eligible for Medicare on or after January 1, 2020.

(d)

1. Standardized Medicare supplement benefit Plan F with High Deductible is redesignated as Plan G with High Deductible and shall provide the benefits contained in Section (10)(5)(f) of this administrative regulation but shall not provide coverage for any portion of the Medicare Part B deductible.

2. The Medicare Part B deductible paid by the beneficiary shall be considered an out of pocket expense in meeting the annual high deductible.

(2) Applicability to Certain Individuals. This section shall apply only to individuals that are newly eligible for Medicare on or after January 1, 2020:

(a) By reason of attaining age 65 on or after January 1, 2020; or

(b) By reason of entitlement to benefits under Part A pursuant to section 226(b) or 226A of the Social Security Act, 42 U.S.C. 426(b) or 426-1, or who is deemed eligible

for benefits under section 226(a) of the Social Security Act, 42 U.S.C. 426(a), on or after January 1, 2020.

(3) Guaranteed Issue for Eligible Persons. For purposes of Section 14(5) of this administrative regulation, in the case of any individual newly eligible for Medicare on or after January 1, 2020, any reference to a Medicare supplement policy C or F (including F with High Deductible) shall be deemed to be a reference to Medicare supplement policy D or G (including G with High Deductible) respectively that meet the requirements of this section.

(4) Offer of Redesignated Plans to Individuals Other than Newly Eligible. On or after January 1, 2020, the standardized benefit plans described in subsection (1)(d) of this section may be offered to any individual who was eligible for Medicare prior to January 1, 2020 in addition to the standardized plans described in Section 10(5) of this administrative regulation.

Section 12. Medicare Select Policies and Certificates.

(1)

(a) This section shall apply to Medicare Select policies and certificates, as described in this section.

(b) A policy or certificate shall not be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(2) The commissioner may authorize an insurer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, 42 U.S.C. 1395ss and 42 U.S.C. 1320c-3, if the commissioner finds that the insurer has satisfied all of the requirements of this administrative regulation.

(3) A Medicare Select insurer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner pursuant to this section and KRS 304.14-120.

(4) A Medicare Select insurer shall file a proposed plan of operation with the commissioner. The plan of operation shall contain at least the following information:

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

1. Covered services may be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall not be more than sixty (60) miles from the insured's place of residence.

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

a. To deliver adequately all services that are subject to a restricted network provision; or

b. To make appropriate referrals.

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

4. Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

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

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

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

(d) A description of the quality assurance program, including:

1. The formal organizational structure;

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

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

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

(f) Copies of the written information proposed to be used by the insurer to comply with subsection (8) of this section.

(g) Any other information requested by the commissioner in accordance with this section, KRS 304.14-120, and KRS 304.14-130.

(5)

(a) A Medicare Select insurer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing the changes. Changes shall be considered approved by the commissioner after sixty (60) days unless specifically disapproved.

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

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

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

(b) It is not reasonable to obtain services through a network provider; or

(c) There are no network providers available within sixty (60) miles of the insured's place of residence.

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

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

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

1. Other Medicare supplement policies or certificates offered by the insurer; and

2. Other Medicare Select policies or certificates.

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

(c) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers shall not count toward the out-of-pocket annual limit contained in plans K and L.

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

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

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

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

(9) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select insurer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (8) of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

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

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

(b) Upon issuance of the policy or certificate, the insurer shall provide detailed information to the policyholder describing how a grievance may be registered with the insurer.

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

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

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

(f) The insurer shall report no later than each March 31st to the commissioner regarding its grievance procedure, including the number of grievances filed in the past year and a summary of the subject, nature, and resolution of grievances.

(11) Upon initial purchase, a Medicare Select insurer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the insurer.

(12)

(a) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select insurer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the insurer that has comparable or lesser benefits and that does not contain a restricted network provision. The insurer shall make the policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

(b) For the purposes of this subsection, a Medicare supplement policy or certificate shall be considered to have comparable or lesser benefits unless it contains one (1) or more of the following significant benefits not included in the Medicare Select policy or certificate being replaced, coverage for:

1. The Medicare Part A deductible;
2. At-home recovery services; or
3. Part B excess charges.

(13) Medicare Select policies and certificates shall provide for continuation of coverage if the secretary determines that Medicare Select policies and certificates issued pursuant to this section shall be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

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

(b) For the purposes of this subsection, a Medicare supplement policy or certificate shall be considered to have comparable or lesser benefits unless it contains one (1) or more of the following significant benefits not included in the Medicare Select policy or certificate being replaced, coverage for:

1. The Medicare Part A deductible;
2. At-home recovery services; or
3. Part B excess charges.

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

Section 13. Open Enrollment.

(1)

(a) An insurer shall not deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in Kentucky, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant if:

1. An application for a policy or certificate is submitted prior to or during the six (6) month period beginning with the first day of the first month in which an individual is sixty-five (65) years of age or older; and
2. The applicant is enrolled for benefits under Medicare Part B.

(b) Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

(2)

(a) If an applicant qualifies under subsection (1) of this section and submits an application during the time period referenced in subsection (1) of this section and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the insurer shall not exclude benefits based on a preexisting condition.

(b) If the applicant qualifies under subsection (1) of this section and submits an application during the time period referenced in subsection (1) of this section and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the insurer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subsection.

(3) Except as provided in subsection (2) and Sections 14 and 25 of this administrative regulation, subsection (1) of this section shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was diagnosed during the six (6) months before the coverage became effective.

Section 14. Guaranteed Issue for Eligible Persons.

(1) Guaranteed Issue:

(a) Eligible persons are those individuals described in subsection (2) of this section who seek to enroll under the policy during the period specified in subsection (3) of this section, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(b) With respect to eligible persons, an insurer shall not:

1. Deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (5) of this section that is offered and is available for issuance to new enrollees by the insurer;
2. Discriminate in the pricing of a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition; and
3. Impose an exclusion of benefits based on a preexisting condition under a Medicare supplement policy.

(2) An eligible person shall include the following:

(a) An individual that is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all the supplemental health benefits to the individual;
(b) An individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and:
1. The individual is sixty (65) years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, 42 U.S.C 1395eee, and there are circumstances similar to those described in subparagraph 2 of this paragraph that would permit discontinuance of the individual's enrollment with the provider if the individual were enrolled in a Medicare Advantage plan; or
2. Any of the following circumstances apply:
a. The certification of the organization or plan has been terminated;
b. The organization has terminated or discontinued providing the plan in the area in which the individual resides;
c. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act, 42 U.S.C 1395w-21(g)(3)(B), if the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856, 42 U.S.C. 1395w-26, or the plan is terminated for all individuals within a residence area; or
d. The individual demonstrates, in accordance with guidelines established by the secretary, that:
(i) The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide the covered care in accordance with applicable quality standards;
(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
(iii) The individual meets the other exceptional conditions as the secretary may provide;
(c)
1. An individual is enrolled with:
a. An eligible organization under a contract under Section 1876 of the Social Security Act, 42 U.S.C. 1395mm regarding Medicare cost;
b. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
c. An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act, 42 U.S.C. 1395l(a)(1)(A), regarding health care prepayment plan; or
d. An organization under a Medicare Select policy; and
2. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (b) of this subsection;
(d) The individual is enrolled under a Medicare supplement policy and the enrollment ceases due to any of the following reasons:
1.
a. The insolvency of the insurer or bankruptcy of the non-insurer organization; or
b. The involuntary termination of coverage or enrollment under the policy;

2. The insurer of the policy substantially violated a material provision of the policy; or

3. The insurer, or an agent or other entity acting on the insurer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(e)

1. An individual that was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any of the following:

a. A Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare;

b. An eligible organization under a contract under Section 1876 of the Social Security Act, 42 U.S.C. 1395mm regarding Medicare cost;

c. A similar organization operating under demonstration project authority;

d. A PACE provider under Section 1894 of the Social Security Act, 42 U.S.C. 1395eee; or

e. A Medicare Select policy; and

2. The subsequent enrollment under subparagraph 1 of this paragraph is terminated by the enrollee during any period within the first twelve (12) months of subsequent enrollment during which the enrollee is permitted to terminate the subsequent enrollment under Section 1851(e) of the federal Social Security Act, 42 U.S.C. 1395w-21(e);

(f) An individual who, upon first becoming eligible for benefits under part A of Medicare at age 65, enrolls in:

1. A Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, 42 U.S.C. 1395eee; and

2. Disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment; or

(g) An individual that:

1. Enrolls in a Medicare Part D plan during the initial enrollment period;

2. Upon enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs; and

3. Terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (5)(d) of this section.

(h) An individual who:

1. Is sixty five (65) years or older;

2. Has exhausted their options for open enrollment as a result of their continued enrollment in Medicaid under Section 6008 of the Families First Coronavirus Response Act, 42 U.S.C. 1396d(cc)); and

3. Has received verification from the Kentucky Cabinet of Health and Family Services, Department of Medicaid Services of their Medicaid disenrollment as permitted under Section 6008 of the Families First Coronavirus Response Act, 42 U.S.C. 1396d(cc)).

(3) Guaranteed Issue Time Periods.

(a) For an individual described in subsection (2)(a) of this section, the guaranteed issue period shall:

1. Begin on the later of the date:

a. The individual receives a notice of termination or cessation of all supplemental health benefits, or, if a notice is not received, notice that a claim has been denied because of a termination or cessation; or

b. That the applicable coverage terminates or ceases; and

2. End sixty-three (63) days thereafter;

(b) For an individual described in subsection (2)(b), (c), (e),(f), or (h) of this section whose enrollment is terminated involuntarily, the guaranteed issue period shall begin on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(c) For an individual described in subsection (2)(d)1 of this section, the guaranteed issue period shall end on the date that is sixty-three (63) days after the date the coverage is terminated and shall begin on the earlier of the date that:

1. The individual receives a notice of termination, a notice of the insurer's bankruptcy or insolvency, or other the similar notice if any; or

2. The applicable coverage is terminated;

(d) For an individual described in subsection (2)(b), (d)2, (d)3, (e), or (f) of this section who disenrolls voluntarily, the guaranteed issue period shall begin on the date that is sixty (60) days before the effective date of the disenrollment and shall end on the date that is sixty-three (63) days after the effective date;

(e) For an individual described in subsection (2)(g) of this section, the guaranteed issue period shall begin on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act, 42 U.S.C. 1395ss(v)(2)(B), from the Medicare supplement insurer during the sixty (60) day period immediately preceding the initial Part D enrollment period and shall end on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(f) For an individual described in subsection (2) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period shall begin on the effective date of disenrollment and shall end on the date that is sixty-three (63) days after the effective date.

(4) Extended Medigap Access for Interrupted Trial Periods.

(a) For an individual described in subsection (2)(e) of this section whose enrollment with an organization or provider described in Subsection (2)(e)1 of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in subsection(2)(e)of this section;

(b) For an individual described in subsection (2)(f) of this section whose enrollment with a plan or in a program described in Subsection (2)(f) of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in subsection (2)(f) of this section; and

(c) For purposes of subsection (2)(e) and (f) of this section, enrollment of an individual with an organization or provider described in subsection (2)(e)1 of this section, or with a plan or in a program described in subsection (2)(f) of this section, shall not be deemed to be an initial enrollment under this paragraph after the two (2) year period beginning on the date on which the individual first enrolled with an organization, provider, plan, or program.

(5) Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons shall be entitled under:

(a) Section 14(2)(a), (b), (c) and (d) of this administrative regulation is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F, high deductible F, K, or L offered by any insurer;

(b)

1. Subject to subparagraph 2 of this paragraph, a person eligible pursuant to subsection (2)(e) of this section is the same Medicare supplement policy in which

the individual was most recently previously enrolled, if available from the same insurer, or, if not so available, a policy described in paragraph (a) of this subsection;

2. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is:

a. The policy available from the same insurer but modified to remove outpatient prescription drug coverage; or

b. At the election of the policyholder, an A, B, C, F, high deductible F, K, or L policy that is offered by any insurer;

(c) Subsection (2)(f) of this section shall include any Medicare supplement policy offered by any insurer;

(d) Subsection (2)(g) of this section is a Medicare supplement policy that:

1. Has a benefit package classified as Plan A, B, C, F, high deductible F, K, or L; and

2. Is offered and available for issuance to new enrollees by the same insurer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(6) Notification provisions.

(a) Upon an event described in subsection (2) of this section resulting in a loss of coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the insurer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of the individual's rights under this section, and of the obligations of insurers of Medicare supplement policies under subsection (1) of this section. This notice shall be communicated simultaneously with the notification of termination.

(b) Upon an event described in subsection (2) of this section resulting in an individual ceasing enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this section, and of the obligations of insurer of Medicare supplement policies under subsection (1) of this section. The notice shall be communicated within ten (10) working days of the insurer receiving notification of disenrollment.

Section 15. Standards for Claims Payment.

(1) An insurer shall comply with 42 U.S.C. 1395ss, section 1882(c)(3) of the Social Security Act, by:

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

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

(c) Paying the participating physician or supplier;

(d) Upon enrollment, furnishing each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(e) Paying user fees for claim notices that are transmitted electronically or in another manner; and

(f) Providing to the secretary of, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

(2) Compliance with the requirements established in subsection (1) of this section shall be certified to the commissioner as part of the insurer's annual filing pursuant to KRS 304.3-240.

Section 16. Loss Ratio Standards and Refund or Credit of Premium.

(1) Loss Ratio Standards.

(a)

1. Pursuant to KRS 304.14-530, a Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery in Kentucky unless it is expected to return to policyholders and certificate holders in the form of aggregate benefits, not including anticipated refunds or credits, provided under the policy form or certificate form which total:

a. At least seventy-five (75) percent of the aggregate amount of premiums earned in the case of group policies; or

b. At least sixty-five (65) percent of the aggregate amount of premiums earned in the case of individual policies.

2. The calculation shall be in accordance with accepted actuarial principles and practices; and

a. Based on:

(i) Incurred claims experience or incurred health care expenses if coverage is provided by a health maintenance organization on a service rather than reimbursement basis; and

(ii) Earned premiums for the period; and

b. Incurred health care expenses if coverage is provided by a health maintenance organization shall not include:

(i) Home office and overhead costs;

(ii) Advertising costs;

(iii) Commissions and other acquisition costs;

(iv) Taxes;

(v) Capital costs;

(vi) Administrative costs; and

(vii) Claims processing costs.

(b) A filing of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

(c) For policies issued prior to October 14, 1990, expected claims in relation to premiums shall meet:

1. The originally filed anticipated loss ratio when combined with the actual experience since inception;

2. The appropriate loss ratio requirement from paragraph (a)1a and b of this subsection when combined with actual experience beginning with July 5, 1996, to date; and

3. The appropriate loss ratio requirement from paragraph (a)1a and b of this subsection over the entire future period for which the rates are computed to provide coverage.

(2) Refund or Credit Calculation.

(a) An insurer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in HL-MS-1 for each type in a standard Medicare supplement benefit plan.

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

(c) For policies or certificates issued prior to October 14, 1990, the insurer shall make the refund or credit calculation separately for all individual policies, including all group policies subject to an individual loss ratio standard when issued, combined and all other group policies combined for experience after July 5, 1996.

(d) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds the level as identified on the annual refund calculation form HL-MS-1. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but it shall not be less than the average rate of interest for thirteen (13) week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(3) Annual filing of Premium Rates.

(a) An insurer of Medicare supplement policies and certificates issued before or after January 14, 1992, in this state shall file annually for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner in KRS 304-14-120:

1. Rates;
2. Rating schedule; and
3. Supporting documentation, including ratios of incurred losses to earned premiums by policy duration.

(b) The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. The demonstration shall exclude active life reserves.

(c) An expected third-year loss ratio that is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

(d) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every insurer of Medicare supplement policies or certificates in this state shall file with the commissioner, in accordance with KRS 304-14.120:

1.

a. Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. The supporting documents necessary to justify the adjustment shall accompany the filing.

b. Appropriate premium adjustments necessary to produce an expected loss ratio under the policy or certificate to conform to minimum loss ratio standards for Medicare supplement policies and that 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 for the Medicare supplement policies or certificates. A premium adjustment that would modify the loss ratio experience under the policy other than the adjustments described in this subsection shall not be made with respect to a policy at any time other than upon its renewal date or anniversary date.

c. If an insurer fails to make premium adjustments acceptable to the commissioner in accordance with this section, the commissioner may order premium adjustments, refunds or premium credits necessary to achieve the loss ratio required by this section.

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

(4) Public Hearings. The commissioner may conduct a public hearing pursuant to KRS 304.2-310, to gather information concerning a request by an insurer for an increase in a rate for a policy form or certificate form issued before or after January 1, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance shall be made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in accordance with KRS 304.2-320.

Section 17. Filing and Approval of Policies and Certificates and Premium Rates.

(1) An insurer shall not deliver or issue for delivery a policy or certificate to a resident of Kentucky unless the policy form or certificate form has been filed with and approved by the commissioner in accordance with filing requirements and procedures in KRS 304.14-120.

(2) An insurer shall file, with the commissioner, any riders or amendments to policy or certificate forms, issued in Kentucky, to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173.

(3) An insurer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner in accordance with KRS 304.14-120.

(4)

(a) Except as provided in paragraph (b) of this subsection, an insurer shall not file for approval more than one (1) form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(b) An insurer may offer, with the approval of the commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one (1) for each of the following cases:

1. The inclusion of new or innovative benefits;
2. The addition of either direct response or agent marketing methods;
3. The addition of either guaranteed issue or underwritten coverage; and
4. The offering of coverage to individuals eligible for Medicare by reason of disability.

(c) A type of a policy or certificate form shall include:

1. An individual policy;
2. A group policy;
3. An individual Medicare Select policy; or
4. A group Medicare Select policy.

(5)

(a) Except as provided in subparagraph 1 of this paragraph, an insurer shall continue to make available for purchase any policy form or certificate form issued after January 1, 1992, that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the insurer has actively offered it for sale in the previous twelve (12) months.

1. An insurer may discontinue the availability of a policy form or certificate form if the insurer provides to the commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the insurer shall not offer for sale the policy form or certificate form in Kentucky.

2. An insurer that discontinues the availability of a policy form or certificate form pursuant to subparagraph 1 of this paragraph shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the insurer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(b) The sale or other transfer of Medicare supplement business to another insurer shall be considered a discontinuance for the purposes of this subsection.

(c) A change in the rating structure or methodology shall be considered a discontinuance under paragraph (a) of this subsection unless the insurer complies with the following requirements:

1. The insurer provides an actuarial memorandum, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

2. The insurer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

(6)

(a) Except as provided in paragraph (b) of this subsection, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 16 of this administrative regulation.

(b) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(7) An insurer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after October 4, 2005, based upon a structure or methodology with any groupings of attained ages greater than one (1) year. The ratio between rates for successive ages shall increase smoothly as age increases.

Section 18. Permitted Compensation Arrangements.

(1) 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 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

(2) The commission or other compensation provided in subsequent (renewal) years shall be the same as that provided in the second year or period and shall be provided for no fewer than five (5) renewal years.

(3) An insurer or other entity shall not provide compensation to its agents or other producers and an agent or producer shall not 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.

Section 19. Required Disclosure Provisions.

(1) General Rules.

(a)

1. Medicare supplement policies and certificates shall include a renewal or continuation provision.

2. The language or specifications of a renewal or continuation provision shall be consistent with the type of contract issued.

3. The renewal or continuation provision shall:

a. Be appropriately captioned;

b. Appear on the first page of the policy; and

c. Include any reservation by the insurer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

(b)

1. A rider or endorsement added to a Medicare supplement policy after date of issue or at reinstatement or renewal that reduces or eliminates benefits or coverage in the policy shall require a signed acceptance by the insured, except for a rider or endorsement by which an insurer:

a. Effectuates a request made in writing by the insured;

b. Exercises a specifically reserved right under a Medicare supplement policy; or

c. Is required to reduce or eliminate benefits to avoid duplication of Medicare benefits.

2. After the date of policy or certificate issue, any rider or endorsement that increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless:

a. The benefits are required by the minimum standards for Medicare supplement policies; or

b. If the increased benefits or coverage is required by law.

3. If 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.

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

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

(e) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached thereto, 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.

(f)

1. Insurers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to persons eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the language, format, type size, type proportional spacing, bold character, and line spacing developed jointly by the National Association of Insurance Commissioners and Centers for Medicare and Medicaid Services and in a type size no smaller than twelve (12) point type.

2. Delivery of the guide described in subparagraph 1 of this paragraph shall be made:

a. Whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as described in this administrative regulation.

b. To the applicant upon application and acknowledgement of receipt of the guide shall be obtained by the insurer, except that direct response insurer shall deliver the guide to the applicant upon request but not later than at policy delivery.

(2) Notice requirements.

(a) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an insurer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates. The notice shall:

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

2. Inform each policyholder or certificate holder as to if any premium adjustment is to be made due to changes in Medicare.

(b) 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.

(c) The notices shall not contain or be accompanied by any solicitation.

(3) Insurers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub.L. 108-173.

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

(a) An insurer shall provide an outline of coverage to all applicants when an application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgement of receipt of the outline from the applicant.

(b) If an outline of coverage is provided at application and the Medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall 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."

(c) The outline of coverage provided to applicants pursuant to this section shall consist of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the insurer. The outline of coverage shall be in the language and format prescribed in the HL-MS-4 or the Plan Benefit Chart in no less than twelve (12) point type. All plans shall be shown on the cover page, and the plans that are offered by the insurer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(5) Notice Regarding Policies or Certificates That Are Not Medicare Supplement Policies.

(a)

1. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act, 42 U.S.C. 1395 et seq., disability income policy, or other policy identified in Section 3(2) of this administrative regulation, issued for delivery in Kentucky to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate.

2. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is

delivered, to the first page of the policy, or certificate delivered to insureds.

3. The notice shall be in no less than twelve (12) point type and shall contain the following language: "THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CONTRACT). If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

(b) Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in paragraph (a) of this subsection shall disclose, using the applicable statement in HL-MS-3 the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

Section 20. Requirements for Application Forms and Replacement Coverage.

(1) Comparison statement.

(a) If a Medicare Advantage or Medicare supplement policy or certificate is to replace another Medicare supplement or Medicare Advantage policy or certificate, there shall be presented to the applicant, no later than the application date, HL-MS-5.

(b) Direct response insurers shall present the comparison statement to the applicant not later than when the policy is delivered.

(c) Agents shall:

1. Obtain the signature of the applicant on the comparison statement;

2. Sign the comparison statement; and

3. Send the comparison statement to the insurer and attach a copy of the comparison statement to the replacement policy.

(2)

(a) Application forms shall include the questions on HL-MS-6 designed to elicit information as to whether, as of the date of the application:

1. The applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force; or

2. A Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force.

(b) An agent shall provide the HL-MS-07 to the applicant.

(c) A supplementary application or other form to be signed by the applicant and agent containing the questions as found on the HL-MS-06 and statements on HL-MS-07 may be used.

(3) Agents shall list, on HL-MS-06 or on the supplementary form as identified in subsection (2)(c) of this section, any other health insurance policies they have sold to the applicant including:

(a) Policies sold that are still in force; and

(b) Policies sold in the past five (5) years that are no longer in force.

(4) For an insurer that uses direct response, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(5) Upon determining that a sale will involve replacement of Medicare supplement coverage, any insurer, other than an insurer that uses direct response, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of the notice signed by the applicant and the agent, except if the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the insurer. An insurer that uses direct response shall deliver to the applicant at issuance of the policy, the notice regarding replacement of Medicare supplement coverage. Upon receipt of the notice, the applicant or the applicant's designee shall notify

the insurer who previously provided Medicare supplement coverage of the replacement coverage.

(6) The notice required by subsection (5) of this section for an insurer shall be provided as specified in HL-MS-08, in no less than twelve (12) point type or in a form developed by the insurer, which shall:

(a) Meet the requirements of this section; and

(b) Be filed with and approved by the commissioner prior to use.

Section 21. Filing Requirements for Advertising and Policy Delivery.

(1) An insurer shall provide a copy of any Medicare supplement advertisement intended for use in Kentucky whether through written, electronic, radio, or television, or any other medium to the commissioner for review prior to use. Advertisements shall not require approval prior to use, but an advertisement shall not be used if it has been disapproved by the commissioner and notice of the disapproval has been given to the insurer.

(2) Insurers and agents shall not use the names and addresses of persons purchased as "leads" unless the solicitation material used to obtain the names and addresses of the "leads" are filed as advertisement as required by this section. Insurers and agents shall not use "leads" if the solicitation materials have been disapproved by the commissioner.

(3) If a Medicare supplement policy is not delivered by mail, the agent or insurer shall obtain a signed and dated delivery receipt from the insured. If the delivery receipt is obtained by an agent, the agent shall forward the delivery receipts to the insurer.

Section 22. Standards for Marketing.

(1) An insurer, directly or through its agents or other representatives, shall:

(a) Establish marketing procedures to assure that any comparison of policies by its agents or other representatives will be fair and accurate.

(b) Establish marketing procedures to assure excessive insurance is not sold or issued.

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

(d) Inquire and make every reasonable effort to identify if a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any insurance.

(e) Establish auditable procedures for verifying compliance with this subsection.

(2) In addition to the practices prohibited in KRS Chapter 304.12 and 806 KAR 12:092, the following acts and practices shall be prohibited:

(a) Twisting. Making any unfair or deceptive representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert an insurance policy or to take out a policy of insurance with another insurer.

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

(c) Cold lead advertising. Making use of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

(3) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and similar words shall not be used unless the policy is issued in compliance with this administrative regulation.

Section 23. Appropriateness of Recommended Purchase and Excessive Insurance.

(1) In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(2) Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate shall be prohibited.

(3) An insurer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

Section 24. Reporting of Multiple Policies.

(1) On or before March 1 of each year, an insurer shall report to the commissioner the following information, using HL-MS-2, for every individual resident of Kentucky for which the insurer has in force more than one Medicare supplement policy or certificate:

(a) Policy and certificate number; and

(b) Date of issuance.

(2) The items set forth in subsection (1) of this section shall be grouped by individual policyholder.

Section 25. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods, and Probationary Periods in Replacement Policies or Certificates.

(1) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing insurer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate to the extent time was spent under the original policy.

(2) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods, and probationary periods.

Section 26. Prohibition Against Use of Genetic Information and Requests for Genetic Testing. This Section shall apply to all policies with policy years beginning on or after the effective date of this administrative regulation.

(1) An insurer of a Medicare supplement policy or certificate shall not:

(a) Deny or condition the issuance or effectiveness of the policy or certificate, including the imposition of any exclusion of benefits under the policy based on a pre-existing condition, on the basis of the genetic information with respect to any individual; and

(b) Discriminate in the pricing of the policy or certificate, including the adjustment of premium rates, of an individual on the basis of the genetic information with respect to any individual.

(2) Subsection (1) of this section shall not be construed to limit the ability of an insurer, to the extent permitted by law, from:

(a) Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

(b) Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of an individual who is covered under the policy, and the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

(3) Except as provided by subsection (6) of this section, an insurer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of an individual to undergo a genetic test.

(4) Subsection (3) of this section shall not be construed to prohibit an insurer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment, as described for the purposes of applying the regulations promulgated under part C of title XI of the Social Security Act, 42 U.S.C. 1320d et seq., and section 264 of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. 1320d-2, and consistent with subsection (1) of this section.

(5) For purposes of carrying out subsection (4) of this section, an insurer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

(6) Notwithstanding subsection (3) of this section, an insurer of a Medicare supplement policy may request, but shall not require, that an individual or a family member of the individual undergo a genetic test if each of the following conditions is met:

(a) The request shall be made pursuant to research that complies with 45 C.F.R. part 46, or equivalent federal regulations, and any applicable state or local law, or administrative regulations, for the protection of human subjects in research.

(b) The insurer clearly indicates to each individual, or if a minor child, to the legal guardian of the child, to whom the request is made that:

1. Compliance with the request shall be voluntary; and

2. Noncompliance shall have no effect on enrollment status or premium or contribution amounts.

(c) Genetic information collected or acquired under this subsection shall not be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

(d) The insurer notifies the secretary in writing that the insurer is conducting activities pursuant to the exception provided for under this subsection, including a description of the activities conducted.

(e) The insurer complies with other conditions as the secretary may by federal regulation require for activities conducted under this subsection.

(7) An insurer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

(8) An insurer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to an individual's enrollment under the policy in connection with enrollment.

(9) If an insurer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, the request, requirement, or purchase shall not be considered a violation of subsection (8) of this section if the request, requirement, or purchase is not in violation of subsection (7) of this section.

Section 27. Incorporated by Reference.

(1) The following material is corporate by reference:

(a) "HL-MS-1", July 2009 edition;

(b) "HL-MS-2", July 2009 edition;

(c) "HL-MS-3", July 2009 edition;

(d) "HL-MS-4", October 2009 edition;

(e) "HL-MS-5", May 2018 edition;

(f) "HL-MS-06", July 2009 edition;

(g) "HL-MS-07", July 2009 edition;

(h) "HL-MS-08", October 2009 edition; and

(i) "Plan Benefit Chart", April 2018 edition.

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m.

*SHARON P. CLARK, Commissioner*
*RAY A. PERRY, Secretary*

APPROVED BY AGENCY: April 26, 2023

FILED WITH LRC: April 28, 2023 at 3:30 p.m.

PUBLIC HEARING AND COMMENT PERIOD: A public hearing on this administrative regulation shall be held at 9:00 a.m. on June 21st, 2023 at 500 Mero Street, Frankfort, Kentucky 40601. Individuals interested in being heard at this hearing shall notify this agency in writing by five workdays prior to the hearing, of their intent to attend. If no notification of intent to attend the hearing is received by that date, the hearing may be canceled. This hearing is open to the public. Any person who wishes to be heard will be given an opportunity to comment on the proposed administrative regulation. A transcript of the public hearing will not be made unless a written request for a transcript is made. If you do not wish to be heard at the public hearing, you may submit written comments on the proposed administrative regulation. Written comments shall be accepted through 11:59 PM on June 30th, 2023. Send written notification of intent to be heard at the public hearing or written comments on the proposed administrative regulation to the contact person below.

CONTACT PERSON: Abigail Gall, Executive Advisor, 500 Mero Street, Frankfort, Kentucky 40601, phone +1 (502) 564-6026, fax +1 (502) 564-1453, email abigail.gall@ky.gov.