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SALUS POPULI SUPREMA LEX ESTO

"The welfare of the people shall be the supreme law."



ROBIN CARNAHAN
SECRETARY OF STATE

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The rules are codified in the *Code of State Regulations* in this system—

Title	Code of State Regulations	Division	Chapter	Rule
1	CSR	10-	1.	010
Department		Agency, Division	General area regulated	Specific area regulated

They are properly cited by using the full citation, i.e., 1 CSR 10-1.010.

Each department of state government is assigned a title. Each agency or division within the department is assigned a division number. The agency then groups its rules into general subject matter areas called chapters and specific areas called rules. Within a rule, the first breakdown is called a section and is designated as (1). Subsection is (A) with further breakdown into paragraph 1., subparagraph A., part (I), subpart (a), item I. and subitem a.

RSMo—The most recent version of the statute containing the section number and the date.

Rules appearing under this heading are filed under the authority granted by section 536.025, RSMo 2000. An emergency rule may be adopted by an agency if the agency finds that an immediate danger to the public health, safety, or welfare, or a compelling governmental interest requires emergency action; follows procedures best calculated to assure fairness to all interested persons and parties under the circumstances; follows procedures which comply with the protections extended by the *Missouri* and the *United States Constitutions*; limits the scope of such rule to the circumstances creating an emergency and requiring emergency procedure, and at the time of or prior to the adoption of such rule files with the secretary of state the text of the rule together with the specific facts, reasons, and findings which support its conclusion that there is an immediate danger to the public health, safety, or welfare which can be met only through the adoption of such rule and its reasons for concluding that the procedure employed is fair to all interested persons and parties under the circumstances.

Rules filed as emergency rules may be effective not less than ten (10) days after filing or at such later date as may be specified in the rule and may be terminated at any time by the state agency by filing an order with the secretary of state fixing the date of such termination, which order shall be published by the secretary of state in the *Missouri Register* as soon as practicable.

All emergency rules must state the period during which they are in effect, and in no case can they be in effect more than one hundred eighty (180) calendar days or thirty (30) legislative days, whichever period is longer. Emergency rules are not renewable, although an agency may at any time adopt an identical rule under the normal rulemaking procedures.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—[State Funded Cost-Share Program]
State Soil and Water Assistance Program**

EMERGENCY AMENDMENT

10 CSR 70-5.010 Apportionment of Funds. The commission is amending the title of the chapter, the purpose statement, and sections (1) and (2).

PURPOSE: The amendment to the purpose statement will delete “Missouri State Soil and Water Conservation Cost-Share Program” and replace it with “program.” Amendments in sections (1) and (2) will delete “Cost-Share,” “cost-share,” “the purpose of cost-sharing,” and “the cost-sharing of.” These amendments will clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Amendments in section (1) will delete “landowner” and “landowners” and replace these terms with “landowner/operator” and “landowner/operators,” respectively, to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources. The amendment in subsection (2)(E) will revise the definition and purpose of the program based on new statutory requirements in H.B. 250.

EMERGENCY STATEMENT: The recent approval of S.C.S. H.C.S.

H.B. 250 (H.B. 250) changed the definition and purpose of the program from “the abatement of soil erosion and the controlling of sediment” to “saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land.” H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendments are necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendment to the purpose statement will delete “Missouri State Soil and Water Conservation Cost-Share Program” and replace it with “program.” Amendments in sections (1) and (2) will delete “Cost-Share,” “cost-share,” “the purpose of cost-sharing,” and “the cost-sharing of.” These amendments are necessary to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If this amendment is not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The amendments in section (1) will delete “landowner” and “landowners” and replace these terms with “landowner/operator” and “landowner/operators.” These amendments are necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If these amendments are not approved, it would be unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

The amendment in subsection (2)(E) will delete “the abatement of soil erosion and the controlling of sediment” and replace it with “saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land.” This amendment is necessary to revise the definition and purpose of the program in accordance with new statutory provisions in H.B. 250 and to provide justification for implementing additional cost-share or incentive practices designed to protect water resources. If the amendment in subsection (2)(E) is not approved, it would be unclear that the definition and purpose of the program had changed and that additional practices designed to protect water resources were eligible for cost-share or incentive payments.

The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the *Missouri* and *United States Constitutions*. The

commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.

PURPOSE: *This rule establishes commission guidelines for allocation of funds available for the [Missouri State Soil and Water Conservation Cost-Share Program] program.*

(1) General Availability of Funds. State [cost-share] funds shall be available only to [landowners] **landowner/operators** of land located in soil and water conservation districts which have agreed to locally administer the program and have executed a Memorandum of Understanding with the commission setting forth the terms of assistance. To be eligible, a [landowner] **landowner/operator** must have a conservation plan as approved by the district.

(2) Annual Apportionment of Funds. All funds apportioned to the [cost-share] program for any fiscal year shall be apportioned by the commission to the participating districts by considering the character of the districts' needs according to criteria developed by the commission.

(D) Use of Released Funds. Funds released by any district in accordance with subsections (2)(A)–(C) shall be returned to the [Cost-Share P]program and be reallocated by the commission considering the relative need basis or reserved by the commission for special allotment under subsection (2)(E).

(E) Special Allotments. The commission may withhold funds from the general apportionment under section (2) and may reserve funds released by the districts under subsections (2)(A)–(C) for [the purpose of cost-sharing] special projects which the commission considers necessary and of high priority for [the abatement of soil erosion and the controlling of sediment] **saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land.** The funds thus withheld for the general apportionment or returned to the commission shall be allotted to a district(s) specified by the commission for [the cost-sharing of] certain critical-needs projects. The special critical-needs projects shall be planned and designed by the commission incorporating the cooperative assistance of the local district(s) involved and with the technical assistance available to the district(s).

AUTHORITY: *section[s] 278.070, H.B. 250, First Regular Session, 95th General Assembly, 2009, [and] section 278.110, RSMo 2000, and section 278.080, RSMo Supp. [2007] 2008. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. Amended: Filed Sept. 26, 2007, effective May 30, 2008. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.*

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—[State Funded Cost-Share Program]
State Soil and Water Assistance Program

EMERGENCY AMENDMENT

10 CSR 70-5.020 Application and Eligibility for Funds. The commission is amending the title of the chapter, the purpose statement, and sections (1)–(9).

PURPOSE: *The amendment to the purpose statement will delete "Missouri State Soil and Water Conservation Cost-Share Program" and replace it with "program." Amendments in sections (1)–(4), (6)–(7), and (9) will delete "Cost-Share," "cost-share," "cost-sharing," "for cost-sharing," and "cost-shared," and, where necessary, replace these terms with "assistance," "funding," or "funded." These amendments will clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices*

designed to preserve the soil and protect water resources of the state. Amendments in sections (1)–(3) and (5)–(9) will delete "landowner," "landowners," "Landowners," and "landowner's," and replace these terms with "landowner/operator," "landowner/operators," "Landowner/Operators," and "landowner/operator's," respectively, to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources. Amendments in sections (2) and (8) will delete language pertaining to Special Area Land Treatment (SALT) program projects and cost-share practices that are no longer applicable following approval of H.B. 250. Amendments in section (2) will clarify which cost-share practices are eligible for saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land. An amendment in section (8) will clarify the termination dates for regular allocations and advance allocations.

EMERGENCY STATEMENT: *The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from "the abatement of soil erosion and the controlling of sediment" to "saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land." H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendments are necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.*

The amendment to the purpose statement will delete "Missouri State Soil and Water Conservation Cost-Share Program" and replace it with "program." Amendments in sections (1)–(4), (6)–(7), and (9) will delete "Cost-Share," "cost-share," "cost-sharing," "for cost-sharing," "of cost-sharing," and "cost-shared," and, where necessary, replace these terms with "assistance," "funding," or "funded." These amendments are necessary to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If these amendments are not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The amendments in sections (1)–(3) and (5)–(9) will delete "landowner," "landowners," "Landowners," and "landowner's," and replace these terms with "landowner/operator," "landowner/operators," "Landowner/Operators," and "landowner/operator's," respectively. These amendments are necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If this amendment is not approved, it would be

unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

Amendments in sections (2), (4), and (8) will delete language pertaining to Special Area Land Treatment (SALT) program projects and cost-share practices. These amendments are necessary because this language is no longer applicable as a result of the approval of H.B. 250. Additional amendments in section (2) are necessary to clarify which conservation practices are eligible for saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land. If these amendments are not approved, it would be unclear that both cost-share and incentive practices were eligible for assistance payments and mistakenly appear that only the listed cost-share practices were eligible for assistance payments if no excessive erosion was occurring. It would also be unclear how eligible erosion control and water resource practices were determined.

The amendment in section (8) pertaining to the termination date is necessary to clarify that a termination date not to exceed twelve (12) months will apply to regular allocations and a termination date not to exceed eighteen (18) months will apply to advance allocations. The inclusion of advance allocations is necessary to provide landowner/operators and soil and water conservation district staff (district staff) with an additional six (6) months to enter into contracts for up to twenty-four (24) additional conservation practices designed for protecting water resources, including practices (e.g., nutrient management, pest management, waste utilization) that typically take longer than twelve (12) months to establish and/or that must be obligated in a different fiscal year than the year when payments are made. If this amendment is not approved, it would create a hardship and delay the progress of the district staff in implementing the twenty-four (24) additional conservation practices for the protection of water resources, and it would result in delays in landowner/operator payments until the following fiscal year.

The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.

PURPOSE: This rule establishes criteria and methods of application for persons desiring funds from the [Missouri State Soil and Water Conservation Cost-Share Program] program.

(1) Establishing Practice Eligibility. The commission shall establish a list of eligible practices for which [cost-share] funds should be utilized and annually shall affirm or modify the list as it considers appropriate. The participating districts shall develop annual priority listings of preferred practices from the commission eligibility list upon which they will base their considerations for [cost-sharing] funding. [Landowners] Landowner/Operators shall be eligible for [cost-share] funds only for the types of practices designated as eligible for these purposes by the Soil and Water Districts Commission and by the participating districts. No eligible practices are available to treat flood scouring problems.

(2) Application for Assistance. To be eligible for assistance from the [Cost-Share P] program, a [landowner] landowner/operator must make application on forms provided by the commission. Copies of these forms shall be available at district offices. The district's board will act upon only those applications [for cost-sharing] from [landowners] landowner/operators who have a conservation plan as approved by the district, except as provided in sections (7) and (8), and for eligible practices on which construction or implementation has not yet begun. [In commission-approved Special Area Land Treatment (SALT) program projects, the district board of supervisors may approve SALT cost-share applications at the date of the conservation plan approval or at the approval

date of the SALT project, whichever is later. However, g) Governmental agencies, political subdivisions and public institutions are excluded from participation in the [Cost-Share P] program. [As a further stipulation for receiving cost-sharing assistance,] For erosion control practices as determined by commission policy, the land upon which the practice is to be implemented or constructed must be eroding at rates greater than tolerable soil loss limits or be experiencing active gully erosion[.]. [except that cost-sharing a] Assistance [also may be] is also available [in the following instances when excessive erosion is not necessarily occurring:] to protect the water resources of the state.

[(A) For eligible practices to prevent gully erosion when needed to complete a water disposal system;

(B) For the establishment of permanent forest cover on marginal or riparian lands;

(C) For the exclusion of domestic livestock grazing from existing woodlands on marginal or riparian soils;

(D) For a no-till practice for forage conversions;

(E) For grade stabilization structures that are greater than ten (10) years old when the principal pipe has failed;

(F) For a no-till practice to improve the vegetative cover of pasture and rangeland to provide continued erosion prevention; and

(G) For a practice to demonstrate benefits of a planned grazing system.]

(3) Funding Determination and Limits. It shall be the responsibility and duty of the board of supervisors to determine the actual dollar amount [of cost-sharing] on individual applications. State [cost-share] rates shall not exceed the limits established in 10 CSR 70-5.040(1). In the event that the [landowner] landowner/operator wishes to construct or implement practices over and above the size or scope determined by a qualified technician to be of minimum and necessary need for soil and water conservation, the board shall provide [cost-share] assistance on only that part of the practice necessary for soil and water conservation purposes.

(4) Availability of Federal Funds. Applications for [cost-sharing] assistance may be approved by the district board of supervisors when it determines that federal funds are unavailable to that applicant for the proposed practice. State [cost-sharing] assistance also is available for practice units applied for but not approved by the federal program, if those additional units constitute a complete structure, conservation measure or operation in and of themselves. State [cost-sharing] assistance may supplement federal [cost-sharing] assistance on an individual practice, within limits set forth in section (3), and only upon practice components [cost-shared] funded by the federal program, when the estimated [cost-share] assistance portion of the practice exceeds the national program allowable dollar figure from the federal program. [Special area land treatment project areas approved by the commission are exempt from the provisions of this rule.]

(5) Compliance with Applicable Law. In the installation of any eligible practices, the [landowner] landowner/operator solely shall be responsible for assuring compliance with any applicable federal, state or local laws, ordinances and regulations. The [landowner] landowner/operator also is solely responsible for obtaining all permits, licenses or other instruments of permission required before the installation of the proposed practice.

(6) Group Projects. [Landowners] Landowner/Operators may cooperate with other [landowners] landowner/operators in the event that the most appropriate solution to the needs addressed in the Act requires eligible practices to be located on or across property lines of different [landowners] landowner/operators. In these cases, an agreement between or among cooperating [landowners] landowner/operators must be prepared by or on behalf of the group

stipulating and providing for, but not limited to, the divisions of unshared costs, maintenance, an easements as necessary to accomplish the installation, operation and maintenance of the practice and the sharing of rights and benefits over and above the public benefits which might accrue from the installation of the practice. This agreement and a group conservation plan shall be submitted to the district(s) within which the land included in the plan lies. Upon approval of the group conservation plan by the district, the individual *landowners/landowner/operators* are eligible to apply for *cost-sharing* assistance under this rule. The group conservation plan may serve in lieu of the individual *landowner/landowner/operator* conservation plan as stipulated in section (2). All other requirements for application and *cost-sharing* assistance remain in effect.

(7) Special Projects. Upon notification to a district(s) of a fund availability for special critical-needs projects so designated by the commission, the board shall make all reasonable efforts to contact *landowners/landowner/operators* of land within the special project area which lies within the district boundaries, to inform the *landowners/landowner/operators* of the availability of the special *cost-share* funds and to encourage the *landowners/landowner/operators* to cooperate in the special critical-needs projects. Each *landowner/landowner/operator* within the project boundaries shall then be eligible to apply for the special *cost-sharing* assistance on practices specified as eligible by the commission in its project plan. Application shall be made at the local district office in the manner of application for general state *cost-sharing* assistance to *landowners/landowner/operators*, but action on applications by the board as set forth in 10 CSR 70-5.050(2) shall not be taken unless applications from *landowners/landowner/operators* covering seventy-five percent (75%) of the land to be treated are made. In special critical-needs project cooperation, the *landowner/landowner/operator* requirement of a conservation plan as approved by the district, under section (2), is waived. All other *landowner/landowner/operator* requirements and obligations here named shall remain in effect. Cooperation in these special projects is entirely voluntary on the part of the *landowner/landowner/operator*.

(8) Termination Date. All applications shall specify a termination date which shall not exceed twelve (12) months for **regular allocations or eighteen (18) months for advance allocations** from the date the *landowner's/landowner/operator's* application is approved by the board. *In commission-approved SALT projects, the district board of supervisors may set the termination date to be anytime during the lifetime of the SALT project.* Claims for payment received after the termination date shall not be honored unless an amendment for an extension is approved by the board. Amendments for extensions can be authorized for an adequate period of time determined by the board to be reasonable and fair to the *landowner/landowner/operator*. An amendment for an extension must be approved prior to the termination date of the original application and only when the implementation or construction has begun on the practice.

(9) Application Amendments. A copy of any amendment will be furnished to each party receiving a copy of the original application and the board shall approve each amendment before it shall become effective. An amendment to an *cost-share* application shall not be appropriate in the event that the construction or implementation of a practice has begun, except as provided in subsections (10)(A), (C) and (F). An amendment to an application for *cost-sharing* assistance shall be appropriate for any of the following reasons:

(E) To increase the obligation to the *landowner/landowner/operator* for the proposed practice; or

(F) To reflect the added costs to the *landowner/landowner/operator* when physical conditions at the practice site which require design changes are encountered.

AUTHORITY: section[s] 278.070[.4], H.B. 250, First Regular Session, 95th General Assembly, 2009, [and] section 278.110.8, RSMo [1994] 2000, and sections 278.080.1 and 278.080.5(8), RSMo Supp. [1998] 2008. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the Code of State Regulations. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—[State Funded Cost-Share Program]
State Soil and Water Assistance Program**

EMERGENCY AMENDMENT

10 CSR 70-5.030 Design, Layout and Construction of Proposed Practices; Operation and Maintenance. The commission is amending the title of the chapter, the names of sections (3) and (5), and sections (3)–(6).

PURPOSE: The amendments to the name of section (5) and sections (3)–(6) will delete “Cost-Share,” “cost-share,” and “payment of cost-share assistance,” and, where necessary, replace these terms with “assistance” or “the assistance payment” to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Amendments to the name of section (3) and sections (3)–(6) will delete “Landowner” and “landowner” and replace these terms with “Landowner/Operator” and “landowner/operator,” respectively, to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources.

EMERGENCY STATEMENT: The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from “the abatement of soil erosion and the controlling of sediment” to “saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land.” H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendments are necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendments to the name of section (5) and sections (3)–(6) will delete “Cost-Share,” “cost-share,” and, where necessary, replace these terms with “assistance.” These amendments are necessary to clarify that following approval of H.B. 250, the program is no

longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If these amendments are not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The amendments to the name of section (3) and sections (3)–(6) will delete “Landowner” and “landowner” and replace these terms with “Landowner/Operator” and “landowner/operator,” respectively. These amendments are necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If this amendment is not approved, it would be unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.

(3) Operation and Maintenance by [Landowner] **Landowner/Operator**. Except as provided in section (4), the [landowner] **landowner/operator** shall be responsible for the operation and maintenance of all practices constructed with assistance from the [Cost-Share P]program and the [landowner] **landowner/operator** will be expected to maintain the same in good operating condition to assure their continued effectiveness for the purpose(s) for which they were installed.

(4) Operation and Maintenance by the District. If within the specified life span of the practice the district determines that [landowner] **landowner/operator** operation and maintenance responsibilities would constitute an undue burden upon the [landowner] **landowner/operator**, the district may assume responsibility for all or a part of the operation and maintenance and, prior to and as a condition for approval of a claim for payment for [cost-share] funds, as a condition of the [cost-share] assistance agreement under section (5), shall require the [landowner] **landowner/operator** to provide the district with the necessary easement or other land rights necessary to perform the operation or maintenance.

(5) [Cost-Share] Assistance Agreement. As a condition for receiving any [cost-share] funds for eligible practices, the [landowner] **landowner/operator**, before submission of a claim for reimbursement, shall enter into an agreement of maintenance on forms supplied by the commission. The provisions of the agreement shall state; if the practice is removed, altered or modified so as to lessen its effectiveness, without prior approval of the district, for a period of ten (10) years or the expected life span of the practice, whichever is the lesser, after the date of receiving payment, the [landowner] **landowner/operator** or his/her heirs, assignees or other transferees, shall refund to the [Cost-Share P]program the prorated amount of the state [cost-share] payment previously received for the practice or portion of the practice which has been removed, altered or modified; and that if the district assumes maintenance responsibilities, right of access will be granted by the [landowner] **landowner/operator**. A copy of the agreement shall be recorded by the commission in the county where the land upon which the practices are constructed is located if the commission concurs with a board’s determination that there is a need for recording.

(6) Requests for Removal, Alteration, Modification of Practices. A [landowner] **landowner/operator** may request the district’s approval of the removal, alteration or modification of the practice at

any time during the ten (10)-year or expected life span, whichever is lesser, following payment of [cost-share] assistance. In determining whether to approve or disapprove the action, the district shall consider—

AUTHORITY: section[s] 278.070, H.B. 250, First Regular Session, 95th General Assembly, 2009, section 278.080, RSMo Supp. 2008, and section 278.110, RSMo [1986] 2000. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. Amended: Filed Dec. 14, 1982, effective April 11, 1983. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—[State Funded Cost-Share Program]
State Soil and Water Assistance Program**

EMERGENCY AMENDMENT

10 CSR 70-5.040 [Cost-Share] Rates and Reimbursement Procedures. The commission is amending the title of the chapter, the title of the rule, the purpose statement, the name of section (1), and sections (1) and (4) and deleting sections (2) and (3).

PURPOSE: The amendments to the name of 10 CSR 70-5.040, the purpose statement, the name of section (1), and section (1) will delete “Cost-Share,” “Cost-share,” and “cost-share” to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Sections (2) and (3) will be deleted to clarify that cost-share payments to landowner/operators will be based solely on existing language in section (1) and establishment of rates and payments will be based on “estimated approved costs” established annually by the commission rather than “documented costs” provided by individual landowner/operators. With the deletion of sections (2) and (3), existing section (4) is proposed to be renumbered to section (2). Amendments in existing section (4) (proposed section (2)) will delete “landowner” and replace this term with “landowner/operator” to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources. An additional amendment in existing section (4) (proposed section (2)) will delete the sentence, “A copy of the certification worksheet of costs incurred by the landowner or the current farm operator and of the vendor(s) receipts, both required by section (3), shall be attached to the claim for payment before submission to the district,” which is no longer applicable if sections (2) and (3) are deleted.

EMERGENCY STATEMENT: The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from “the abatement of soil erosion and the controlling of sediment” to “saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land.” H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion

abatment and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendments are necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendments to the name of 10 CSR 70-5.040, the purpose statement, the name of section (1), and section (1) will delete "Cost-Share," "Cost-share," and "cost-share." These amendments are necessary to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If these amendments are not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The deletion of sections (2) and (3) is necessary to—

1. Clarify that payments to landowner/operators will be based solely on existing language in section (1);

2. Change the procedures used in establishing rates and payments from "documented costs" provided by individual landowner/operators to "estimated approved costs" established annually by the commission; and

3. Reduce district staff time spent administering assistance payments so more time can be devoted to providing technical assistance to landowner/operators and implementing the additional twenty-four (24) conservation practices needed to protect water resources.

If deletion of sections (2) and (3) is not approved, it would be unclear that payments were based on "estimated approved costs" established annually by the commission and mistakenly appear that landowner/operators needed to provide receipts with all payment requests.

In addition, if deletion of sections (2) and (3) is not approved, this would place a significant, unnecessary administrative burden on district staff and landowner/operators to obtain, record, and verify receipts for every conservation practice designed for protecting water resources. If so, time spent by district staff in recording and verifying receipts would significantly reduce the technical assistance provided to landowner/operators, adversely affect progress in installing or applying conservation practices designed to protect water resources, delay cost-share payments, and jeopardize water resources of the state.

If the proposed deletion of sections (2) and (3) is approved, existing section (4) will be amended to section (2). If deletion of sections (2) and (3) is not approved, section (4) will remain unchanged and the consequences noted above will likely occur.

An amendment in existing section (4) (proposed section (2)) will delete "landowner" and replace this term with "landowner/operator." This amendment is necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If this amendment is not approved, it would be unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

An amendment in existing section (4) (proposed section (2)) will delete the sentence "A copy of the certification worksheet of costs incurred by the landowner or the current farm operator and of the vendor(s) receipts, both required by section (3), shall be attached to the claim for payment before submission to the district." This amendment is necessary because this sentence will no longer be applicable if sections (2) and (3) are deleted. In addition, several conservation

practices designed to protect water resources use incentive payments rather than cost-share payments. Management incentives involve a one-time or annual payment to landowner/operators to encourage them to change farming techniques as opposed to cost-share payments, which are based on seventy-five percent (75%) of the estimated approved costs for installing or applying conservation practices. If deletion of this sentence is not approved, it would be unclear that practices involving management incentives were eligible to be included in claims for payment.

The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the *Missouri and United States Constitutions*. The commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.

PURPOSE: This rule establishes [cost-share] rates and reimbursement procedures.

(1) [Cost-Share] Rates. [Cost-share r]Rates shall not exceed seventy-five percent (75%) of the estimated approved costs of eligible practices or the incentive rates established annually by the commission for certain management practices which have proven to be effective soil and water conservation methods.

[(2) Eligible Costs. Eligible costs will be determined by the district and shall include all necessary and reasonable costs incurred by the landowner in installing or applying an approved practice. The costs include machine hire or the costs of the use of his/her own equipment, needed materials delivered to and used at the site and labor required to construct the practice.]

[(3) Documenting Costs. All authorized items or costs for which the landowner desires cost-sharing assistance shall be supported by receipts of payments from the vendor(s). Receipts of payments from the vendor(s) shall show the name of the vendor(s), the materials, labor or equipment used on the practice, the component(s) cost, the total amount paid for the component(s), the date payment was received and the vendor's verification of payment received. Should receipts include components which were not needed on the approved practice, the bill shall be adjusted to reflect the actual cost of minimum and necessary components. Costs for labor, materials or equipment incurred by the landowner or by the current farm operator when no vendor receipts for payment are obtainable should be listed on a certification worksheet showing the component(s) cost, amount or number of each component and the total amount for which payment is claimed.]

[(4)](2) Claim for Payment. After the practice has been completed and certified by the responsible technician, the [landowner] landowner/operator shall complete a claim for payment on forms provided by the commission and available at the location where the application form was obtained. [A copy of the certification worksheet of costs incurred by the landowner or the current farm operator and of the vendor(s) receipts, both required by section (3), shall be attached to the claim for payment before submission to the district.] The [landowner] landowner/operator at the same time shall complete and sign the agreement form required by 10 CSR 70-5.030(5), a copy of which shall be submitted to the district for processing along with the claim for payment.

AUTHORITY: section 278.070, H.B. 250, First Regular Session, 95th General Assembly, 2009 and section 278.080, RSMo Supp. [2007] 2008. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the *Code of State Regulations*. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.

Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—[State Funded Cost-Share Program]
State Soil and Water Assistance Program

EMERGENCY AMENDMENT

10 CSR 70-5.050 District Administration of the [Cost-Share] Program. The commission is amending the title of the chapter, the title of the rule, the purpose statement, the name of section (5), and sections (1)–(8).

PURPOSE: The amendments to the title of the rule, the purpose statement, and sections (1)–(3) and (5)–(8) will delete “Cost-Share,” “cost-share,” and “cost-sharing” to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Amendments to the name of section (5) and sections (2) and (4)–(6) will delete “landowner,” “landowners,” and “Landowner” and replace these terms with “landowner/operator,” “landowner/operators,” and “Landowner/Operator,” respectively, to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources.

EMERGENCY STATEMENT: The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from “the abatement of soil erosion and the controlling of sediment” to “saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land.” H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendments are necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendments to the title of the rule, the purpose statement, and sections (1)–(3) and (5)–(8) will delete “Cost-Share,” “cost-share,” and “cost-sharing.” These amendments are necessary to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If these amendments are not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The amendments to the name of section (5) and sections (2) and (4)–(6) will delete “landowner,” “landowners,” and “Landowner” and replace these terms with “landowner/operator,” “landowner/oper-

ators,” and “Landowner/Operator,” respectively. These amendments are necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If this amendment is not approved, it would be unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the *Missouri* and *United States Constitutions*. The commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.

PURPOSE: This rule establishes guidelines for the administration of the [Cost-Share P]program by the participating districts.

(1) Application. This rule shall apply only to districts which have entered into a Memorandum of Understanding with the commission agreeing to assist the commission in the administration of the [Cost-Share P]program and to applicants having active conservation plans as required by 10 CSR 70-5.010(1) as approved by the district and to eligible practices covered by the conservation plan.

(2) Board Action on Applications. The board of supervisors shall review the [cost-share] assistance application and any amendments and shall approve or disapprove each application or amendment. The action shall be recorded in the official minutes of the district meeting and the [landowners] landowner/operators shall be notified of the action within ten (10) days. The board at this time also shall determine the amount of funding under 10 CSR 70-5.020(3). Special circumstances may arise where board approval for [cost-share] assistance is needed before the next monthly board meeting. In those cases, the board shall establish specific criteria by which any board member may approve that action. All those approvals shall be reviewed at the next board meeting and recorded in the official minutes of the district meeting. Applications for [cost-share] assistance may be approved by the board only when there is a sufficient unobligated fund balance to provide the estimated [cost-share] amount based upon the actual cost information available to the district. The board shall not approve any application for [cost-share] assistance on which the construction or implementation of projects or practices has begun.

(3) Record Keeping. The district shall maintain a record of funds obligated as applications for [cost-share] assistance are approved based upon estimated costs. A [cost-share] ledger will be kept current showing the balance of unobligated funds and other information as the commission determines is necessary to provide for proper documentation of all expenditures from the [Cost-Share P]program.

(4) District Review of Claim for Payment. Upon completion of an approved practice, the district shall review the claim for payment prepared by the [landowner] landowner/operator in accordance with 10 CSR 70-5.040(4) and, if it finds that the practice was installed properly, that all other conditions have been satisfied and that the claim has been completed properly and is accompanied by all required supporting documentation, shall approve the claim for payment. If the district determines that the claim is prepared improperly, or that other deficiencies exist, it shall so notify the [landowner] landowner/operator and shall provide the [landowner] landowner/operator with a reasonable opportunity to correct the deficiencies and to resubmit the claim for payment.

(5) District Assistance to [Landowner] Landowner/Operator. The district shall provide assistance as it considers appropriate to the

[landowner] **landowner/operator** in the completion of necessary forms and any other *[Cost-Share P]* program matters.

(6) Filing System. To provide for efficient processing of requests for *[cost-sharing]* assistance and for maintenance of necessary documentation of matters relating to the administration of the *[Cost-Share P]* program, the district shall develop and maintain with the assistance of the commission, a filing system which includes copies of all forms completed by the *[landowner]* **landowner/operator** and all other information considered relevant to the construction of the eligible practices and to the *[cost-sharing]* assistance provided. The files shall be available for inspection by the personnel of the commission and by representatives of the state auditor's office during normal business hours of the district.

(7) Quarterly Reports. The district, no later than the tenth day of October, January, April and July of each state fiscal year, shall submit a report to the commission indicating the status of *[cost-share]* funds as shown on each district *[cost-share]* ledger required by section (3) at the close of the last day of the preceding month.

(8) Delegation of Responsibilities by the Board. The commission shall be notified in writing of any delegation of responsibilities. The board of supervisors may delegate any of the authorities and responsibilities assigned to it by these rules to a member or subcommittee of the board, except—

(B) Establishment of *[cost-sharing]* dollar amounts under 10 CSR 70-5.020(3);

AUTHORITY: section[s] 278.070, **H.B. 250, First Regular Session, 95th General Assembly, 2009, section 278.080, RSMo Supp. 2008, and section 278.110, RSMo [1986] 2000. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the Code of State Regulations. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.**

**Title 10—DEPARTMENT OF NATURAL RESOURCES
Division 70—Soil and Water Districts Commission
Chapter 5—[State Funded Cost-Share Program]
State Soil and Water Assistance Program**

EMERGENCY AMENDMENT

10 CSR 70-5.060 Commission Administration of the [Cost-Share] Program. The commission is amending the title of the chapter, the title of the rule, the purpose statement, the names of sections (3) and (5), and sections (1)–(7).

PURPOSE: *The amendments to the title of the rule, the purpose statement, the names of sections (3) and (5), and sections (1) and (3)–(7) will delete “Cost-Share,” “cost-share,” “Cost-Sharing,” “Cost-sharing,” and “cost-sharing” to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. Amendments to the name of section (3) and sections (2)–(5) will delete “Landowner,” “landowner,” and “landowner’s” and replace these terms with “Landowner/Operator,” “landowner/operator,” and “landowner/operator’s,” respectively, to clarify that landowners or operators, as appropriate, may be eligible for conservation practices designed to protect water resources.*

EMERGENCY STATEMENT: *The recent approval of S.C.S. H.C.S. H.B. 250 (H.B. 250) changed the definition and purpose of the program from “the abatement of soil erosion and the controlling of sediment” to “saving the soil and protecting the water resources of the state to preserve the productive power of Missouri agricultural land.”*

H.B. 250 was declared an emergency act within the meaning of the constitution, and as such, it was in full force and effect upon its approval on June 26, 2009. The repeal and reenactment of section 278.070 of this act by H.B. 250 was deemed necessary for the immediate preservation of the public health, welfare, peace, and safety because of the need to preserve the productive power of Missouri agricultural land. Prior to approval of H.B. 250, only traditional cost-share payments to landowners were available under this program. Consistent with H.B. 250, the commission approved additional conservation practices for financial assistance that were designed for protecting water resources. The commission further authorized financial assistance for these additional practices in the form of both cost-share payments for installing structural practices for soil erosion abatement and other financial incentives for changing management techniques. In addition, landowners as well as operators are eligible for several of these additional practices. The following emergency amendment is necessary to fully effectuate the intent of H.B. 250 to ensure that state assistance is properly provided during this transitional year and to provide interim regulatory guidance for implementing the provisions of H.B. 250 to the public, DNR staff, and staff of the one hundred fourteen (114) soil and water conservation district offices in the state that will be independently implementing these provisions until the regular rulemaking process is completed, which might take one hundred eighty (180) days or longer.

The amendments to the title of the rule, the purpose statement, the names of sections (3) and (5), and sections (1) and (3)–(7) will delete “Cost-Share,” “cost-share,” “Cost-Sharing,” “Cost-sharing,” and “cost-sharing.” These amendments are necessary to clarify that following approval of H.B. 250, the program is no longer limited solely to traditional cost-share practices, but now also includes other types of incentives for practices designed to preserve the soil and protect water resources of the state. If these amendments are not approved, it would be unclear that incentive payments were available for conservation practices designed to protect water resources and mistakenly appear that only cost-share practices were eligible for financial assistance.

The amendments to the name of section (3) and sections (2)–(5) will delete “Landowner,” “landowner,” and “landowner’s” and replace these terms with “Landowner/Operator,” “landowner/operator,” and “landowner/operator’s,” respectively. These amendments are necessary to clarify that following approval of H.B. 250, several conservation practices designed to protect water resources (e.g., nutrient management, pest management, and waste utilization) are eligible for either operators or landowners. If these amendments are not approved, it would be unclear that operators were eligible for conservation practices designed to protect water resources and mistakenly appear that only landowners were eligible for financial assistance.

The scope of this emergency amendment is limited to the circumstances creating the emergency and complies with the protections extended in the Missouri and United States Constitutions. The commission believes this emergency amendment is fair to all interested persons and parties under the circumstances.

PURPOSE: *This rule establishes guidelines for the administration of the [Cost-Share P] program by the commission.*

(1) Forms. The commission shall prepare and make available to participating districts, sufficient copies of all forms necessary for district administration and shall further prepare and keep updated a handbook for district use in assisting in the administration of the *[Cost-Share P]* program.

(2) Commission Review of Claims for Payment. Upon receipt from a district-approved claim for payment, a commission representative shall review the claim and the supporting documentation which is attached. If the claim is determined to be complete and properly documented, the commission shall prepare a voucher for transmittal to

the Office of Administration for preparation of a warrant payable to the *landowner/landowner/operator*.

(3) Payment to *Landowner/Landowner/Operator* and Recording Agreement. Upon receipt of the warrant from the Office of Administration, the commission shall transmit the same by mail to the *landowner/landowner/operator*. The district shall be notified monthly of any transmission at which time the commission shall complete all necessary portions of the *cost-sharing* assistance agreement prepared by the *landowner/landowner/operator* at the time the claim for payment was prepared. Costs incurred in the recording and indexing of the agreements shall be paid by the commission.

(4) Incomplete or Inaccurate Claims for Payments. If, in reviewing the claim for payment, the commission or its agent determines that the information contained in the claim is incomplete or inaccurate, that an error exists in the final computations or that proper documentation has not been supplied, it shall notify the district of the deficiency. The district then shall request the *landowner/landowner/operator* to complete a claim for payment and if necessary a new *cost-sharing* assistance agreement required by 10 CSR 70-5.030(5). No payment will be authorized until the commission has determined that the claim for payment and necessary supporting documentations are complete and accurate in all respects. *Cost-sharing a*) Assistance agreements shall not be recorded until the payment in fact has been authorized by the commission and received by the *landowner/landowner/operator*.

(5) Violations of *Cost-Sharing* Assistance Agreement. In the event the commission is notified of an alleged violation of the *cost-sharing* assistance agreement, a representative of the commission, or a representative of the district, or both, shall investigate the alleged violation and report the results of the investigation to the commission. If, following the investigation, it appears as though a violation has occurred, the district board of supervisors shall notify the *landowner/landowner/operator* by certified mail, return receipt requested, and shall make demand for repayment of the appropriate amount to the state *Cost-Share P*)program within thirty (30) days after receipt of the demand for repayment. Within that thirty (30)-day period, the *landowner/landowner/operator* may request the commission review the demand for repayment. The request for a review must be in writing. The review shall be conducted at a regularly scheduled commission meeting, allowing adequate opportunity for the *landowner/landowner/operator* to present arguments in support of the claim. The *landowner's/landowner/operator's* arguments may be presented by the *landowner/landowner/operator*, by a representative or in writing. If, following the review, the commission determines that no violation has occurred or that extenuating circumstances justify the *landowner's/landowner/operator's* position, the demand for repayment shall be withdrawn and the commission shall so notify the *landowner/landowner/operator* of its decision. If, however, following the review, the commission determines the violation did occur, it shall so notify the *landowner/landowner/operator* by certified mail, return receipt requested, and shall renew the demand for repayment. If the repayment is not received within thirty (30) days of receipt of the commission's request for repayment or if all deficiencies are not corrected at the *landowner's/landowner/operator's* expense within the time specified, by the commission, the commission may refer the matter to the Office of the Attorney General for recovery of the state *cost-share* funds.

(6) Report to Districts. The commission shall prepare on a monthly basis a report to each participating district indicating the payments which have been made from the *Cost-Share P*)program during the preceding month and any other information determined by the com-

mission to be of value to the districts regarding the administration of the program.

(7) New Practices. The commission shall have authority to conduct a pilot project for the purpose of testing development and implementation of new *cost-share* practices appropriate for future soil and water conservation resource needs. A pilot project will be conducted for a specified period of time in a limited area determined by the commission.

AUTHORITY: section[s] 278.070(4)], H.B. 250, First Regular Session, 95th General Assembly, 2009, section 278.080(8), RSMo Supp. 2008, and section 278.110.8, RSMo [Supp. 1995] 2000. Original rule filed Aug. 12, 1980, effective Jan. 1, 1981. For intervening history, please consult the Code of State Regulations. Emergency amendment filed July 29, 2009, effective Aug. 8, 2009, expires Feb. 25, 2010.

Under this heading will appear the text of proposed rules and changes. The notice of proposed rulemaking is required to contain an explanation of any new rule or any change in an existing rule and the reasons therefor. This is set out in the Purpose section with each rule. Also required is a citation to the legal authority to make rules. This appears following the text of the rule, after the word "Authority."

Entirely new rules are printed without any special symbolology under the heading of the proposed rule. If an existing rule is to be amended or rescinded, it will have a heading of proposed amendment or proposed rescission. Rules which are proposed to be amended will have new matter printed in boldface type and matter to be deleted placed in brackets.

An important function of the *Missouri Register* is to solicit and encourage public participation in the rulemaking process. The law provides that for every proposed rule, amendment, or rescission there must be a notice that anyone may comment on the proposed action. This comment may take different forms.

If an agency is required by statute to hold a public hearing before making any new rules, then a Notice of Public Hearing will appear following the text of the rule. Hearing dates must be at least thirty (30) days after publication of the notice in the *Missouri Register*. If no hearing is planned or required, the agency must give a Notice to Submit Comments. This allows anyone to file statements in support of or in opposition to the proposed action with the agency within a specified time, no less than thirty (30) days after publication of the notice in the *Missouri Register*.

An agency may hold a public hearing on a rule even though not required by law to hold one. If an agency allows comments to be received following the hearing date, the close of comments date will be used as the beginning day in the ninety (90)-day-count necessary for the filing of the order of rulemaking.

If an agency decides to hold a public hearing after planning not to, it must withdraw the earlier notice and file a new notice of proposed rulemaking and schedule a hearing for a date not less than thirty (30) days from the date of publication of the new notice.

(1) The following definitions shall apply to the interpretations and enforcement of sections 196.931–196.959, RSMo:

(A) Milk is the product defined in 21 CFR section 131.110. Note: Applicable sections of parts 131–133 are included in Appendix L of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)*.

1. Goat milk is the lacteal secretion, practically free from colostrum, obtained by the complete milking of healthy goats. The word milk shall be interpreted to include goat milk.

2. Breed milk is milk from a herd of cows where at least ten percent (10%) of the herd is registered purebred and the remainder at least high grade individuals of the same breed. The word milk shall be interpreted to include breed milk;

(P) Grade A dry milk and whey products are products which have been produced for use in Grade A pasteurized milk products and which have been manufactured under the provisions of the [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administration Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Services, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO)./;

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

Proposed Amendment Text Reminder:

Boldface text indicates new matter.

[Bracketed text indicates matter being deleted.]

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.010 Definitions. The board is amending the purpose section and subsections (1)(A) and (P).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule defines terms used in the regulations of the State Milk Board. This rule corresponds with Part II, Section 1 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.020 Sale of Adulterated, Misbranded Milk or Milk Products. The board is amending the purpose and section (2).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule provides for the control of adulterated, misbranded Grade A milk or milk products, or any combination of these. This rule corresponds with Part II, Section 2 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(2) Any adulterated or misbranded milk or milk product may be impounded under proper authority by the regulatory agency and disposed of in accordance with applicable laws or regulations. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.030 Permits. The board is amending the purpose section and section (5).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 *Grade A Pasteurized Milk Ordinance with Administrative Procedures*.

PURPOSE: This rule provides for the issuance of permits to persons involved in the production, transporting, and processing of Grade A milk and milk products. This rule corresponds with Part II, Section 3 of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)*.

(5) Upon repeated violation(s), the regulatory agency may revoke the permit following reasonable notice to the permit holder and an opportunity for a hearing. This rule is not intended to preclude the institution of court action as provided in 2 CSR 80-2.050 (Section 5 of the PMO) and 2 CSR 80-2.060 (Section 6 of the PMO). The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1,

1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.040 Labeling. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 *Grade A Pasteurized Milk Ordinance with Administrative Procedures*.

PURPOSE: This rule provides regulations for the proper labeling of Grade A milk or milk products. This rule corresponds with Part II, Section 4 of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO)*.

(1) All bottles, containers, and packages enclosing milk or milk products defined in 2 CSR 80-2.010 (Section 1 of the PMO) of these rules shall be labeled in substantial compliance with the applicable requirements of the Federal Food, Drug and Cosmetic Act, the Fair Packaging and Labeling Act and regulations developed thereunder and in addition shall comply with the applicable requirements of this rule as follows. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.050 Inspection Frequency and Procedure. The board is amending the purpose and section (4).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule is for the purpose of providing requirements concerning inspection frequency and procedures. This rule corresponds with Part II, Section 5 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(4) It shall be unlawful for any person who, in an official capacity, obtains any information, which is entitled to protection as a trade secret (including information as to quantity, quality, source, or disposition of milk or milk products, or results of inspections or tests of milk or milk products), under the provisions of these rules, to use this information to his/her own advantage or to reveal it to any unauthorized person. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.060 The Examination of Milk and Milk Products. The board is amending the purpose section and section (6).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule specifies sampling frequency and required chemical and bacteriological tests to be conducted both on raw and pasteurized Grade A dairy products. This rule corresponds with Part II, Section 6 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(6) Samples shall be analyzed at an official or appropriate officially designated laboratory. All sampling procedures and required laboratory examinations shall be in substantial compliance with the current edition of *Standard Methods for the Examination of Dairy Products of the American Public Health Association*, and the current edition of *Official Methods of Analysis of the Association of Official Analytical Chemists*. These procedures, including the certification of sample collectors and examinations shall be evaluated in accordance with 2005 *Evaluation of Milk Laboratories, Recommendations of the U.S. Public Health Service/Food and Drug Administration*. Examinations and tests to detect adulterants, including pesticides, shall be conducted as the regulatory agency requires. Assays of milk and milk products to which vitamin(s) A, D, or both have been added, shall be made at least annually in a laboratory acceptable to the regulatory agency. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.070 Standards for Milk and Milk Products. The

board is amending the purpose section and sections (1) and (2).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule provides standards which Grade A raw or pasteurized milk or milk products must meet with regard to cooling temperatures, bacterial limits, somatic cell counts, antibiotics, coliform limits, phosphatase determinations, and sanitation requirements for dairy farms, milk haulers, transfer stations, receiving stations, and milk plants. This rule corresponds with Part II, Section 7 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(1) All Grade A raw milk for pasteurization and all Grade A pasteurized milk and milk products shall be produced, processed, and pasteurized to conform with the following chemical, bacteriological, and temperature standards and the sanitation requirements of this rule. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

(2) No process or manipulation other than pasteurization, processing methods integral to pasteurization, and appropriate refrigeration shall be applied to milk and milk products for the purpose of removing or deactivating microorganisms. Provided that in the bulk shipment of raw cream, skim milk, or lowfat milk, the heating of the raw milk to temperatures no greater than one hundred twenty-five degrees Fahrenheit (125 °F) (52 °C) for separation purposes is permitted when the resulting bulk shipments of cream, skim milk, and lowfat milk are labeled heat-treated.

Table 1—Chemical, Bacteriological, and Temperature Standards

Grade A raw milk for pasteurization	Temperature	Cooled to 45 °F (7 °C) or less within two (2) hours after milking, provided that the blend temperature first and subsequent milkings does not exceed 50 °F (10 °C).
	Bacterial limits	Individual producer milk not to exceed 100,000 per milliliter (ml) prior to commingling with other producer milk. Not to exceed 300,000 per ml as commingled milk prior to pasteurization.
	Antibiotics	Tests and methodology as required by the <i>[current] 2009 Grade A Pasteurized Milk Ordinance</i> . Commingled milk: Tests and methodology as required by the <i>[2005] 2009 Grade A Pasteurized Milk Ordinance</i> .
	Somatic cell count	Individual producer milk: Not to exceed 750,000 per ml
Grade A pasteurized milk and milk products	Temperature	Cooled to 45 °F (7 °C) or less and maintained thereat.
	Bacterial limits*	20,000 per ml
	Coliform	Not to exceed 10 per ml: Provided that, in case of bulk milk transport tank shipments, shall not exceed 100 per ml
	Phosphatase	Less than one (1) microgram per ml by the Schrarer Rapid Method or Methods approved in the <i>[2005] 2009</i> edition of the <i>Pasteurized Milk Ordinance</i> .
	Antibiotics	Test and methodology required by the <i>[current] 2009 Grade A Pasteurized Milk Ordinance</i> .

*Not applicable to cultured products.

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.080 Animal Health. The board is amending the purpose section and section (3).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule provides requirements regarding animal health for Grade A dairy farms. This rule corresponds with Part II, Section 8 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(3) For diseases other than brucellosis and tuberculosis, the regulatory agency shall require physical, chemical, or bacteriological tests as it deems necessary. The diagnosis of other diseases in dairy cattle shall be based upon the findings of a licensed veterinarian or a veterinarian in the employ of an official agency. Any diseased animal disclosed by these test(s) shall be disposed of as the regulatory agency directs. The [2005] 2009 edition of the Grade A Pasteurized Milk Ordinance with Administrative Procedures is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.091 Milk and Milk Products Which May Be Sold. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule specifies milk and milk products which may be sold. This rule corresponds with Part II, Section 9 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Services/Food and Drug Administration (PMO).

(1) From and after the date on which this rule is adopted, except as provided by law (section 196.935, RSMo), only Grade A pasteurized milk and milk products shall be sold to the final consumer, or to restaurants, soda fountains, grocery stores, or similar establishments. Provided that in an emergency, the sale of pasteurized milk and milk products which have not been graded or the grade of which is unknown, may be authorized by the regulatory agency; in which case, the milk and milk products shall be labeled ungraded. The [2005] 2009 edition of the Grade A Pasteurized Milk Ordinance with Administrative Procedures is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.101 Transferring; Delivery Containers; Cooling. The board is amending the purpose section and section (3).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule provides standards relating to transferring; delivery containers; and cooling of milk, milk products, or both. This rule corresponds with Part II, Section 10 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(3) It shall be unlawful to sell or serve any pasteurized milk or milk products which have not been maintained at the temperature set forth in 2 CSR 80-2.070. If containers of pasteurized milk or milk products are stored in ice, the storage container shall be properly drained. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.110 Milk and Milk Products from Points Beyond the Limits of Routine Inspection. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule provides for requirements for milk and milk products from points beyond the limits of routine inspection. This rule corresponds with Part II, Section 11 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(1) Milk and milk products from points beyond the limits of routine inspection of the State Milk Board of Missouri or its jurisdiction may

be sold in Missouri or its jurisdiction provided they are produced, pasteurized, or both, under rules which are substantially equivalent to the *Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the U. S. Public Health Service/Food and Drug Administration* and have been awarded an acceptable milk sanitation compliance and enforcement rating made by a state milk sanitation rating officer certified by the Food and Drug Administration. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.121 Future Dairy Farms and Milk Plants. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule provides requirements for construction or reconstruction of future dairy farms and milk plants. This rule corresponds with Part II, Section 12 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(1) Properly prepared plans shall be submitted to the regulatory agency for written approval before work is begun on all milkhouses, milking barns, stables and parlors, transfer stations, receiving stations, and milk plants regulated under these rules which are constructed, reconstructed, or extensively altered after July 1, 1980. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.130 Personnel Health. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule establishes requirements relating to personnel health. This rule corresponds with Part II, Section 13 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(1) No person affected with any disease in a communicable form, or while a carrier of that disease, shall work at any dairy farm or milk plant in any capacity which brings him/her into contact with the production, handling, storage, or transportation of milk, milk products, containers, equipment, and utensils; and no dairy farm or milk plant operator shall employ in any capacity any person or any person suspected of having any disease in a communicable form or of being a carrier of disease. Any producer or distributor of milk or milk products, upon whose dairy farm or in whose milk plant any communicable disease occurs, or who suspects that any employee has contracted any disease in a communicable form, or has become a carrier of the disease, shall notify the regulatory agency immediately. The [2005] 2009 edition of the Grade A Pasteurized Milk Ordinance with Administrative Procedures is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed April 20, 1973, effective April 30, 1973. Rescinded and readopted: Filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.141 Procedure When Infection is Suspected. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule provides the procedure to follow when infection is suspected. This rule corresponds with Part II, Section 14 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(1) When reasonable cause exists to suspect the possibility of transmission of infection from any person concerned with the handling of milk, milk products, or both, the regulatory agency is authorized to require any of the following measures:

(C) Adequate medical and bacteriological examination of the person, his/her associates, and of his/her and their body discharges. The [2005] 2009 edition of the Grade A Pasteurized Milk Ordinance with Administrative Procedures is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.151 Enforcement. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule provides for regulatory enforcement methods. This rule corresponds with Part II, Section 15 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(1) These rules shall be enforced by the regulatory agency in accordance with the *Grade A Pasteurized Milk Ordinance with Administrative Procedures—Recommendations of the United States Public Health Service/Food and Drug Administration*, a copy of which shall be on file at the State Milk Board office. Where the mandatory compliance with provisions of the appendices is specified, provisions shall be deemed a requirement of these rules. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.161 Penalty. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule provides for the penalty for violation of any of the provisions of these rules. This rule corresponds with Part II, Section 16 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(1) Any person(s) who shall violate any of the provisions of these

rules shall be guilty of a misdemeanor and, upon conviction, shall be punished by a fine of not more than that established by the statutes of Missouri, or the person(s) may be enjoined from continuing the violations, or both. Each day upon which the violations occur shall constitute a separate violation. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 2—DEPARTMENT OF AGRICULTURE
Division 80—State Milk Board
Chapter 2—Grade A Pasteurized Milk Regulations**

PROPOSED AMENDMENT

2 CSR 80-2.170 Separability Clause. The board is amending the purpose section and section (1).

PURPOSE: This amendment changes the incorporated by reference materials to the 2009 Grade A Pasteurized Milk Ordinance with Administrative Procedures.

PURPOSE: This rule provides a separability clause. This rule corresponds with Part II, Section 17 of the Grade A Pasteurized Milk Ordinance with Administrative Procedures—[2005] 2009 Recommendations of the United States Public Health Service/Food and Drug Administration (PMO).

(1) Should any section, paragraph, sentence, clause, or phrase of these rules be declared unconstitutional or invalid for any reason, the remainder of these rules shall not be affected. The [2005] 2009 edition of the *Grade A Pasteurized Milk Ordinance with Administrative Procedures* is hereby incorporated by reference as published by the Department of Health and Human Services, Public Health Service, Food and Drug Administration, Milk Safety Branch (HFS-626), 5100 Paint Branch Parkway, College Park, MD 20740-3835. This rule does not incorporate any subsequent amendments or additions to the Pasteurized Milk Ordinance (PMO).

AUTHORITY: section 196.939, RSMo 2000. Original rule filed March 11, 1980, effective July 1, 1980. Amended: Filed Feb. 1, 1990, effective April 26, 1990. Amended: Filed Feb. 15, 2007, effective July 30, 2007. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri State Milk Board, 1616 Missouri Blvd., PO Box 630, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. No public hearing is scheduled.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses**

PROPOSED AMENDMENT

11 CSR 45-4.020 Licenses, Restrictions on Licenses, Licensing Authority of the Executive Director and Other Definitions. The commission is amending subsections (7)(B) and (C) and adding subsection (7)(D).

PURPOSE: This amendment clarifies the entities required to possess a supplier's license.

- (7) Supplier license is a license issued to a person or entity that—
- (B) Provides gaming equipment maintenance or repair; *[or]*
 - (C) Provides testing services on gaming related equipment, components, peripherals, systems, or other items directed by the commission to a Class A or Class B licensee or the commission~~./~~; **or**
 - (D) Provides junket services, as defined in this chapter, to Class A or Class B licensees.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the Code of State Regulations. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses**

PROPOSED AMENDMENT

11 CSR 45-4.190 License Renewal. The commission is amending section (2).

PURPOSE: This amendment removes the mandate to conduct a complete reinvestigation of Class A, Class B, supplier, and key licensees each sixth year from the original license.

(2) *[Each sixth year from the original license a comprehensive investigation for the period since the last comprehensive investigation shall be conducted on the Class A, Class B, supplier and key licensees in the same manner as the initial investigation.]* Class A, Class B, supplier, and affiliate supplier licensees and the key person, key person business entity, and occupational licensees thereof shall have a continuing obligation to demonstrate suitability to hold a license. The commission may reopen the investigation of a licensee at any time. The licensee shall be assessed fees, if any, to cover the additional costs of the investigation.

AUTHORITY: section[s] 313.004, RSMo 2000 and sections 313.800–313.850, RSMo 2000 and Supp. [2007] 2008. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the Code of State Regulations. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses**

PROPOSED AMENDMENT

11 CSR 45-4.200 Supplier's License. The commission is amending section (1).

PURPOSE: This amendment clarifies the entities required to possess a supplier's license.

(1) A supplier's license is required of persons who or entities which manufacture, sell, or lease gaming equipment, gaming supplies, or both; or provide gaming equipment maintenance or repair; or provide testing services on gaming related equipment, components, peripherals, systems~~./~~; or provide services on the gaming floor that relate to gaming equipment of a Class A or Class B licensee, or other items directed by the commission; **or provide junket services, as defined in this chapter, to Class A or Class B licensees;** unless exempted by the executive director. Additionally the executive director may waive or modify licensing fees and requirements. Such waiver, modification, or exemption shall not be applicable for testing laboratories.

AUTHORITY: section[s] 313.004, RSMo 2000 and sections 313.805 and 313.810, RSMo Supp. [2007] 2008. Emergency rule filed Sept. 1, 1993, effective Sept. 20, 1993, expired Jan. 17, 1994. Emergency rule filed Jan. 5, 1994, effective Jan. 18, 1994, expired Jan. 30, 1994. Original rule filed Sept. 1, 1993, effective Jan. 31, 1994. For intervening history, please consult the Code of State Regulations. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses**

PROPOSED RULE

11 CSR 45-4.500 Junket, Junket Enterprises, Junket Representatives—Definitions

PURPOSE: This rule establishes terms and definitions applicable to junkets.

(1) The following words and terms, when used in this chapter, shall have the following meanings unless the context clearly indicates otherwise.

(A) "Agent" means any person, including a junket representative, junket enterprise, or employee of a Class A or Class B licensee acting as a junket representative, acting directly or indirectly on behalf of a Class A or Class B licensee or its affiliate.

(B) "Applicable laws" means all those applicable existing and future statutes, laws, rules, regulations, orders, permits, codes, authorizations, building regulations, zoning laws, ordinances, and all other requirements of any governmental authority.

(C) "Business day" means Monday through Friday, excluding federal and state holidays.

(D) "Compensation" means any form of remuneration whatsoever, including, but not limited to, the payment of cash, the forgiveness or forbearance of a debt, or the direct or indirect provision of a product, service, or item without charge or for less than full value.

(E) "Complimentary" means a service, item, or accommodation provided to a person at no cost, or at a reduced price not generally available to the public under similar circumstances; provided, however, that the term shall include any service, item, or accommodation provided to a person at a reduced price due to the anticipated or actual gambling activities of that person.

(F) "Governmental authority" means any federal, state, county, and/or municipal government or quasi-governmental entity or agency, whether now in existence or enacted hereafter, which maintains jurisdiction over the subject matter of any agreement executed by and between a Class A or Class B licensee and a junket enterprise or junket representative or the parties thereto.

(G) "Junket" means an arrangement the purpose of which is to

induce any person, selected or approved for participation therein on the basis of the person's ability to satisfy a financial qualification obligation related to the person's ability or willingness to gamble or on any other basis related to the person's propensity to gamble to come to a Class B licensee's premises for the purpose of gambling and pursuant to which, and as consideration for which, any or all of the cost of transportation, food, lodging, and entertainment for said person is directly or indirectly paid by a licensee or employee or agent thereof.

(H) "Junket enterprise" means any person or entity, other than the holder of a Class A or Class B license, who employs or otherwise engages the services of a junket representative in connection with a junket to a Class B licensee's premises.

(I) "Junket representative" means any person who negotiates the terms of, engages in the referral, procurement, or selection of persons who may participate in a junket to a Class B licensee's premises. A Class B licensee's employee who holds a commission-issued occupational license and who performs the functions of a junket representative for the Class A licensee by whom employed is not deemed a junket representative.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000 and section 313.805, RSMo Supp. 2008. Original rule filed Aug. 3, 2009.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses**

PROPOSED RULE

11 CSR 45-4.510 Junket Enterprise; Junket Representative—Licensing Requirements

PURPOSE: This rule establishes general requirements applicable to junket enterprises.

(1) A junket enterprise shall have applied for and been granted a commission-issued supplier's license prior to a Class B licensee permitting a junket involving that junket enterprise to arrive at its licensed premises. A junket enterprise shall be considered "involved" in a junket to a Class B licensee's premises if it receives any compensation whatsoever from any person as a result of the conduct of the junket. A Class B licensee may not engage the services of any junket enterprise which is not the holder of a commission-issued supplier's license.

(2) A junket enterprise supplier licensee shall not employ or otherwise engage the services of a junket representative unless said representative holds a commission-issued occupational license.

(3) A person may not act as a junket representative in connection with a junket to a Class B licensee unless the person holds a commission-issued occupational license and is employed by a junket enterprise that is the holder of a commission-issued supplier's license.

(4) Junket enterprise employees and junket representatives required to hold commission-issued key person or occupational licenses shall, at all times when on the premises of a Class B licensee performing the duties and functions for which licensed, display in a clearly visible manner, a valid, commission-issued occupational license badge.

(5) Junket enterprises, their employees, and junket representatives required to hold a commission-issued supplier's, key person, or occupational license shall comply with all requirements of section 313.800, et seq. RSMo, as amended from time-to-time, and 11 CSR 45-1, et seq., as amended from time-to-time, hereinafter known as the Riverboat Gaming Act, unless the context of such clearly indicates otherwise.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000 and section 313.805, RSMo Supp. 2008. Original rule filed Aug. 3, 2009.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will cost: each junket enterprise supplier fifteen thousand dollars (\$15,000) for the first year and five thousand dollars (\$5,000) for each year thereafter; key persons eleven hundred dollars (\$1,100) for the first year and one hundred dollars (\$100) for each year thereafter; junket enterprise employees one hundred twenty-five dollars (\$125) for the first year and fifty dollars (\$50) for each year thereafter. The costs of the background investigation will range from ten thousand dollars to fifty thousand dollars (\$10,000 to \$50,000).

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**FISCAL NOTE
PRIVATE COST**

**I. Department Title: 11 – Department of Public Safety
Division Title: 45 – Missouri Gaming Commission
Chapter Title: 4 – Licenses**

Rule Number and Title:	11 CSR 45-4.510 Junket Enterprise; Junket Representative— Licensing Requirements
Type of Rulemaking:	Proposed Rule

II. SUMMARY OF FISCAL IMPACT

Estimate of the number of entities by class which would likely be affected by the adoption of the rule:	Classification by types of the business entities which would likely be affected:	Estimated cost of compliance with the rule by the affected entities:
Each Supplier	Junket Enterprise Supplier	\$15,000 initial fees* \$5,000 annual renewal fee
Each Key Person	Key Person	\$1,100 initial fees* \$100 annual renewal fee
Each Representative	Junket Representative	\$125 initial fees \$50 annual license renewal fee

* Those applying for a license will be assessed fees for the background investigation as required by section 313.810.4, RSMo. An Actual Cost of the Suitability Investigation will range from \$10,000 to \$50,000 per applicant to cover the actual costs incurred. Key Persons investigated as part of the Junket Enterprise Supplier's license investigation typically have no additional investigation costs.

III. WORKSHEET

Junket Enterprise Supplier—

Application fee + license fee = Total first year cost

\$10,000 + \$5,000 = \$15,000

Renewal fee \$5,000 annually

Key Person—

Application fee + license fee = Total first year cost

\$1,000 + \$100 = \$1,100

Renewal fee \$100 annually

Junket Representative—

Application fee + license fee = Total first year cost

\$75 + \$50 = \$125

Renewal fee \$50 annually

IV. ASSUMPTIONS

It is unknown how many applicants will apply.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses**

PROPOSED RULE

11 CSR 45-4.520 Junket Arrangements—Patron Selection

PURPOSE: This rule establishes general requirements relating to patron selection by junket enterprises.

(1) A person may be selected or approved to participate as a junket patron on the basis of one (1) or more of the following:

(A) The ability to satisfy a financial qualification obligation related to the person's ability or willingness to gamble, which shall be deemed to occur whenever a person, as an element of the arrangement, is required to perform one (1) or more of the following:

1. Establish a customer deposit with a Class B licensee;
2. Demonstrate to a Class B licensee the availability of a specified amount of cash or cash equivalent;
3. Gamble to a predetermined level at the Class B licensee's facility; or
4. Comply with any similar obligation; and/or

(B) The propensity to gamble, which shall be deemed to occur whenever a person has been selected or approved on the basis of one (1) or more of the following:

1. The previous satisfaction of a financial obligation in accordance with the provisions of subsection (1)(A) of this rule;
2. An evaluation that the person has a tendency to participate in gambling activities as the result of—

A. An inquiry concerning the person's tendency to gamble;

or
B. Use of other means of determining that the person has a tendency to participate in gambling activities.

(2) A rebuttable presumption that a person has been selected or approved for participation in an arrangement on a basis related to the person's propensity to gamble shall be created whenever the person is provided, as part of the arrangement, with one (1) or more of the following:

(A) Complimentary accommodations; or

(B) Complimentary food, entertainment, or transportation which has a value of two hundred dollars (\$200) or more.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000 and section 313.805, RSMo Supp. 2008. Original rule filed Aug. 3, 2009.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses**

PROPOSED RULE

11 CSR 45-4.530 Junket Enterprise; Junket Representative; Agents; Employees—Policies and Prohibited Activities

PURPOSE: This rule establishes prohibited activities applicable to junket enterprises, junket representatives, and the agents and employees thereof.

(1) A junket enterprise, junket representative, or agent or employee thereof shall not—

(A) Be compensated based upon the actual gaming activity (casino win) of a patron;

(B) Engage in collection efforts;

(C) Solicit, receive, or accept any fee, service charge, or gratuity from a patron for the privilege of participating in a junket or for the performance of the functions for which licensed;

(D) Pay for services, including transportation or other items of value, provided to or for the benefit of any patron participating in a junket, unless otherwise disclosed to and approved in writing by the commission;

(E) Extend credit to or grant credit on behalf of a Class A or Class B licensee to a patron participating in a junket;

(F) Accept an advance of money or a loan from any patron participating in a junket;

(G) Conduct themselves in a manner that compromises the integrity of gaming in Missouri, tarnishes the image and reputation of the state of Missouri, or reflects poorly on the Missouri Gaming Commission or any licensee thereof;

(H) Conduct advertising and public relations activities in a manner other than with decency, dignity, good taste, and honest and fair representation;

(I) Cater to, assist, employ, or associate with, either socially or in business affairs, persons of notorious or unsavory reputation or who have felony police records or the employing either directly through a contract or other means, of any firm or individual in any capacity where the repute of the state of Missouri or the gaming industry is liable to be damaged because of the unsuitability of the firm or individual; or

(J) Play or be permitted to play any gambling game in the establishment where the junket enterprise, junket representative, agent or employee thereof is engaged in a junket arrangement.

(2) A junket representative may not be employed by more than one (1) junket enterprise at a time. For the purposes of this chapter, to qualify as an employee of a junket enterprise, a junket representative shall—

(A) Receive all compensation for services as a junket representative within this state through the payroll account of the junket enterprise; and

(B) Exhibit other appropriate indicia of genuine employment, including federal and state tax withholdings.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000 and section 313.805, RSMo Supp. 2008. Original rule filed Aug. 3, 2009.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for October 22,

2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 11—DEPARTMENT OF PUBLIC SAFETY
Division 45—Missouri Gaming Commission
Chapter 4—Licenses**

PROPOSED RULE

11 CSR 45-4.540 Junket—Agreements, Schedules, and Reports

PURPOSE: This rule establishes requirements for junket agreements, schedules, and reports to be filed and maintained by Class B licensees.

(1) Junket Agreements.

(A) Every agreement entered into by and between a Class A or Class B licensee and a junket enterprise or junket representative for junket services shall be in writing, a signed and executed copy of which shall be filed with the commission prior to any junket being scheduled to arrive at a Class B licensee's premises.

(B) Every agreement shall include the following conditions:

1. If, at any time, either prior to or subsequent to the initiation of the agreement, the commission disapproves the terms and conditions of the agreement, denies the license application of the junket enterprise or junket representative for any applicable license, or otherwise determines the junket enterprise or junket representative to be unsuitable for any reason, the agreement shall be deemed terminated as of the date of such disapproval, denial, or determination as though such date were the date originally fixed for termination of the agreement;

2. The junket enterprise or junket representative shall at all times maintain in good standing and effect all necessary and proper business licenses and other licenses and permits relating to its business operations; and

3. Junket enterprise or junket representative represents and warrants that its services will comply with all applicable laws.

(2) Junket schedules shall be—

(A) Prepared by a Class B licensee for each junket that is arranged through a junket enterprise or its junket representative;

(B) Filed with the commission by a Class B licensee by the fifteenth day of the month preceding the month in which the junket is scheduled to arrive at the Class B licensee's premises. If a junket is arranged after the fifteenth day of the month preceding the arrival of the junket, an amended schedule shall be filed by the Class B licensee by the close of the next business day after the junket is so arranged;

(C) Certified by an employee of the Class B licensee and shall include the following:

1. The origin of the junket;
2. The number of participants in the junket;
3. The arrival time and date of the junket;
4. The departure time and date of the junket; and
5. The name and license number of all junket representatives and the name and license number of all junket enterprises involved in the junket; and

(D) Changes in the information which occur after the filing of a junket schedule or amended junket schedule shall be reported in writing to the commission by the Class B licensee by the close of the next business day. These changes, plus any other material change in the information provided in a junket schedule, shall also be noted on the arrival report maintained pursuant to this chapter.

(3) Arrival reports shall—

(A) Be prepared by a Class B licensee for each junket arranged through a junket enterprise or its junket representative with whom the Class B licensee conducts business;

(B) Include a junket manifest listing the names and addresses of the junket participants;

(C) Include information required under "Junket Schedules" that has not been previously provided to the commission in a junket schedule pertaining to a particular junket, or an amendment thereto;

(D) Be certified by an employee of the Class B licensee; and

(E) Maintained on the premises of the Class B licensee and made immediately available to the commission upon request.

(4) Junket final reports shall—

(A) Be prepared by a Class B licensee for each junket engaged in or on its premises for which the Class B licensee was required to prepare either a junket schedule or junket arrival report;

(B) Be prepared within seven (7) days of the completion of the junket, maintained on the premises of the Class B licensee, and made immediately available to the commission upon request; and

(C) Include the actual amount of complimentary services, accommodations, and items provided to each junket participant.

AUTHORITY: sections 313.004 and 313.807, RSMo 2000 and section 313.805, RSMo Supp. 2008. Original rule filed Aug. 3, 2009.

PUBLIC COST: This proposed rule will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed rule will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE OF PUBLIC HEARING AND NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed rule with the Missouri Gaming Commission, PO Box 1847, Jefferson City, MO 65102. To be considered, comments must be received within thirty (30) days after publication of this notice in the Missouri Register. A public hearing is scheduled for October 22, 2009, at 10:00 a.m., in the Missouri Gaming Commission's Hearing Room, 3417 Knipp Drive, Jefferson City, Missouri.

**Title 13—DEPARTMENT OF SOCIAL SERVICES
Division 70—MO HealthNet Division
Chapter 15—Hospital Program**

PROPOSED AMENDMENT

13 CSR 70-15.010 Inpatient Hospital Services Reimbursement Plan; Outpatient Hospital Services Reimbursement Methodology. The division is amending sections (3), (15), (16), (18), and (20).

PURPOSE: This amendment provides for the State Fiscal Year (SFY) 2010 trend factor, reduces better of days calculation by seventy-five percent (75%) for all hospitals, eliminates the utilization adjustment for all hospitals except for safety net hospitals and children's hospitals, clarifies disproportionate share hospital (DSH) calculation to allow for payment up to one hundred percent (100%) of DSH allotment, defines DSH cap, and adds language regarding merger of state hospitals.

(3) Per Diem Reimbursement Rate Computation. Each hospital shall receive a MO HealthNet per diem rate based on the following computation.

(B) Trend Indices (TI). Trend indices are determined based on the four (4)-quarter average DRI Index for DRI-Type Hospital Market Basket as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY) 1995 to 1998. Trend indices starting in SFY 1999 will be determined based on CPI Hospital indexed as published in *Health Care Costs* by DRI/McGraw-Hill for each State Fiscal Year (SFY).

1. The TI are—
 - A. SFY 1994—4.6%
 - B. SFY 1995—4.45%
 - C. SFY 1996—4.575%
 - D. SFY 1997—4.05%
 - E. SFY 1998—3.1%
 - F. SFY 1999—3.8%
 - G. SFY 2000—4.0%
 - H. SFY 2001—4.6%
 - I. SFY 2002—4.8%
 - J. SFY 2003—5.0%
 - K. SFY 2004—6.2%
 - L. SFY 2005—6.7%
 - M. SFY 2006—5.7%
 - N. SFY 2007—5.9%
 - O. SFY 2008—5.5%
 - P. SFY 2009—5.5%
 - Q. SFY 2010—3.9%**

2. The TI for SFY 1996 through SFY 1998 are applied as a full percentage to the OC of the per diem rate and for SFY 1999 the OC of the June 30, 1998 rate shall be trended by 1.2% and for SFY 2000 the OC of the June 30, 1999 rate shall be trended by 2.4%. The OC of the June 30, 2000 rate shall be trended by 1.95% for SFY 2001.

3. The per diem rate shall be reduced as necessary to avoid any negative Direct Medicaid Payments computed in accordance with subsection (15)(B).

(15) Direct Medicaid Payments.

(B) Direct Medicaid payment will be computed as follows:

1. The MO HealthNet share of the inpatient FRA assessment will be calculated by dividing the hospital's inpatient Medicaid patient days by the total inpatient hospital patient days from the hospital's base cost report to arrive at the inpatient Medicaid utilization percentage. This percentage is then multiplied by the inpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the inpatient FRA assessment. The MO HealthNet share of the outpatient FRA assessment will be calculated by dividing the hospital's outpatient MO HealthNet charges by the total outpatient hospital charges from the base cost report to arrive at the MO HealthNet utilization percentage. This percentage is then multiplied by the outpatient FRA assessment for the current SFY to arrive at the increased allowable MO HealthNet costs for the outpatient FRA assessment;

2. The unreimbursed MO HealthNet costs are determined by subtracting the hospital's per diem rate from its trended per diem costs. The difference is multiplied by the estimated MO HealthNet patient days for the current SFY plus the out-of-state days from the fourth prior year cost report trended to the current SFY. The estimated MO HealthNet patient days for the current SFY shall be the better of the sum of the Fee-for-Service (FFS) days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation. The FFS days are determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior SFY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

A. Effective January 1, 2010, the estimated MO HealthNet patient days shall be the better of the sum of the FFS days plus managed care days or the days used in the prior SFY's Direct Medicaid payment calculation (i.e., for SFY 2010, prior SFY would be SFY 2009) adjusted downward by seventy-five percent (75%).

(I) The FFS days plus managed care days are determined as follows: The FFS days are determined by applying a

trend to the second prior Calendar Year (CY) days (i.e., for SFY 2010, second prior CY would be 2008) as determined from the state's Medicaid Management Information System (MMIS). The trend is determined from a regression analysis of the hospital's FFS days from February 1999 through December of the second prior CY. The managed care days are based on the FFS days determined from the regression analysis, as follows: The FFS days are factored up by the percentage of FFS days to the total of FFS days plus managed care days from the hospital's fourth prior year cost report. The difference between the FFS days and the FFS days factored up by the FFS days' percentage are the managed care days.

(II) The days used in the prior SFY's Direct Medicaid payment calculation adjusted downward by seventy-five percent (75%) are determined as follows: The days used in the prior SFY's Direct Medicaid payment calculation were compared to the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I). If the hospital had greater estimated days as used in the prior SFY's Direct Medicaid payment calculation then the sum of the FFS days plus managed care days as determined in part (15)(B)2.A.(I), the difference between the days were reduced by seventy-five percent (75%). This difference was removed from the estimated days as used in the prior SFY's Direct Medicaid payment calculation to arrive at the current year's estimated days.

A./B. The trended cost per day is calculated by trending the base year costs per day by the trend indices listed in paragraph (3)(B)1., using the rate calculation in subsection (3)(A). In addition to the trend indices applied to inflate base period costs to the current fiscal year, base year costs will be further adjusted by a Missouri Specific Trend. The Missouri Specific Trend will be used to address the fact that costs for Missouri inpatient care of MO HealthNet residents have historically exceeded the compounded inflation rates estimated using national hospital indices for a significant number of hospitals. The Missouri Specific Trend will be applied at one and one-half percent (1.5%) per year to the hospital's base year. For example, hospitals with a 1998 base year will receive an additional six percent (6%) trend, and hospitals with a 1999 base year will receive an additional four and one-half percent (4.5%) trend.

B./C. For hospitals that meet the requirements in paragraphs (6)(A)1., (6)(A)2., and (6)(A)4. of this rule (safety net hospitals), the base year cost report may be from the third prior year, the fourth prior year, or the fifth prior year. For hospitals that meet the requirements in paragraphs (6)(A)1. and (6)(A)3. of this rule (first tier Disproportionate Share Hospitals), the base year operating costs may be the third or fourth prior year cost report. The MO HealthNet Division shall exercise its sole discretion as to which report is most representative of costs. For all other hospitals, the base year operating costs are based on the fourth prior year cost report. For any hospital that has both a twelve (12)-month cost report and a partial year cost report, its base period cost report for that year will be the twelve (12)-month cost report.

C./D. The trended cost per day does not include the costs associated with the FRA assessment, the application of minimum utilization, the utilization adjustment, and the poison control costs computed in paragraphs (15)(B)1., 3., 4., and 5.;

3. The minimum utilization costs for capital and medical education is calculated by determining the difference in the hospital's cost per day when applying the minimum utilization as identified in paragraph (5)(C)4., and without applying the minimum utilization. The difference in the cost per day is multiplied by the estimated MO HealthNet patient days for the SFY;

4. The utilization adjustment cost is determined by estimating the number of MO HealthNet inpatient days the hospital will not provide as a result of the managed care health plans limiting inpatient hospital services. These days are multiplied by the hospital's cost per day to determine the total cost associated with these days. This cost is divided by the remaining total patient days from its base period cost report to arrive at the increased cost per day. This increased cost

per day is multiplied by the estimated MO HealthNet days for the current SFY to arrive at the MO HealthNet utilization adjustment.

A. Effective January 1, 2010, the utilization adjustment will no longer apply to any hospital other than safety net hospitals as defined in subsection (6)(B) and children's hospitals as defined in subsection (2)(S). Safety net hospitals will continue to receive one hundred percent (100%) of the adjustment and children's hospitals as defined in subsection (2)(S) shall receive fifty percent (50%) of the adjustment as calculated in accordance with paragraph (15)(B)4.

5. The poison control cost shall reimburse the hospital for the prorated MO HealthNet managed care cost. It will be calculated by multiplying the estimated MO HealthNet share of the poison control costs by the percentage of managed care participants to total MO HealthNet participants; and

6. Prior to July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days from the base year cost report. Effective July 1, 2006, the costs for including out-of-state Medicaid days is calculated by subtracting the hospital's per diem rate from its trended per diem cost and multiplying this difference by the out-of-state Medicaid days as determined from the regression analysis performed using the out-of-state days from the fourth, fifth, and sixth prior year cost reports.

(16) Safety Net Adjustment. A safety net adjustment, in lieu of the Direct Medicaid Payments and Uninsured Add-Ons, shall be provided for each hospital which qualified as disproportionate share under the provision of paragraph (6)(A)4. The safety net adjustment payment shall be made prior to the end of each federal fiscal year.

(A) The safety net adjustment for facilities which qualify under subparagraph (6)(A)4.B. or (6)(A)4.C. of this regulation shall be computed in accordance with the Direct Medicaid Payment calculation described in section (15) and the uninsured costs calculation described in subsection (18)(D) of this regulation. *[The safety net adjustment for the facilities that qualify under this subsection shall be calculated by adding an additional ten percent (10%) to the percentage that will be used to distribute either the total annual projected cost of the uninsured population that is related to hospital services, or the DSH cap for hospitals, whichever is lower (i.e., if ninety percent (90%) is used to distribute the annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals, whichever is lower, then one hundred percent (100%) would be used for the facilities that qualify under this subsection.]* The safety net adjustment will include the last three (3) quarters of the SFY ending June 30 and the first quarter of the next SFY beginning July 1 to correspond with the FFY of October 1 to September 30.

(18) In accordance with state and federal laws regarding reimbursement of unreimbursed costs and the costs of services provided to uninsured patients, reimbursement for each State Fiscal Year (SFY) (July 1–June 30) shall be determined as follows:

(E) Uninsured Add-Ons effective July 1, 2009, for all facilities except Department of Mental Health (DMH) safety net facilities as defined in subparagraph (6)(A)4.D. DMH safety net facilities will continue to be calculated in accordance with subsection (18)(B). The Uninsured Add-On for all facilities except DMH safety net facilities will be based on the following:

1. Determination of the cost of the uninsured—

A. Allocate the uninsured population as determined from the Current Population Survey (CPS), Annual Social and Economic Supplement (Table HI05) as published by the U.S. Census Bureau, to the same categories of age (COA) and age groups as the managed care rate cells as determined by the Managed Care Unit of the MO HealthNet Division;

B. Determine the total annual projected cost of the uninsured population by multiplying the number of uninsured for each rate cell by the average contract per member per month (PMPM) for that individual managed care rate cell multiplied by twelve (12); and

C. Determine the amount of the total annual projected cost of the uninsured population that is related to hospital services by multiplying the total annual projected cost of the uninsured population as calculated in paragraph (18)(E)1. above by the percentage of the contract PMPM for each individual rate cell that is related to hospital services. This would be the maximum amount of uninsured add-on payments that could be made to hospitals. This amount is also subject to the DSH cap; and

2. Proration to individual hospitals of the cost of the uninsured calculated in paragraph (18)(E)1.—

A. Determine each individual hospital's Uninsured Add-On payment by dividing the individual hospital's uninsured cost as determined from the three (3)-year average of the fourth, fifth, and sixth prior base-year cost reports by the total uninsured cost for all hospitals as determined from the three (3)-year average of the fourth, fifth, and sixth prior base-year cost reports, multiplied by either the total annual projected cost of the uninsured population that is related to hospital services or the DSH cap for hospitals whichever is lower. The DSH cap for hospitals is the federal DSH allotment less the IMD allotment less any redirections of DSH for Medicaid coverage of uninsured individuals as authorized by appropriation.

B. Hospitals which qualify as safety net hospitals under subparagraphs (6)(A)4.B. and C. shall receive payment up to one hundred percent (100%) of their proration. The percentage of proration payable to non-safety net hospitals shall be up to ninety-nine percent (99%), unless the hospital contributes through a plan that is approved by the director of the Department of Health and Senior Services to support the state's poison control center and the Primary Care Resource Initiative for Missouri (PRIMO) and Patient Safety Initiative, in which case they shall receive up to one hundred percent (100%).

3. For new hospitals that do not have a base-year cost report, uninsured payments shall be estimated as follows:

A. Hospitals receiving uninsured payments shall be divided into quartiles based on total beds;

B. Uninsured payments shall be individually summed by quartile and then divided by the total beds in the quartile to yield an average uninsured payment per bed; and

C. The numbers of beds for the new hospital without the base cost report shall be multiplied by the average uninsured payment per bed.

[(E)](F) Uninsured Add-On payments will coincide with the semi-monthly claim payment schedule established by the MO HealthNet fiscal agent. Each hospital's semi-monthly add-on payment shall be the hospital's total cost of the uninsured as determined in *[sub]section (18)[(D)]* divided by the number of semi-monthly pay dates available to the hospital in the state fiscal year.

(20) Hospital Mergers. Hospitals that merge their operations under one (1) Medicare and MO HealthNet provider number shall have their MO HealthNet reimbursement combined under the surviving hospital's (the hospital whose Medicare and MO HealthNet provider number remains active) MO HealthNet provider number.

(E) Merger of State Hospitals.

1. A state hospital is defined as a hospital which is either owned or operated by the DMH or owned or operated by the board of curators as provided for in Chapters 172 and 199, RSMo.

2. When a hospital owned or operated by the DMH merges with a hospital owned or operated by the board of curators, the per diem rate effective with the date of the merger shall be the

surviving state hospital's per diem rate prior to the merger and not calculated as defined in subsection (20)(B).

3. When a hospital owned or operated by the DMH merges with a hospital owned or operated by the board of curators, the Direct Medicaid Payments effective with the date of merger shall be calculated using the surviving state hospital's trended cost per day from the surviving hospital's base-year cost report, the surviving hospital's per diem rate, and the combined estimated MO HealthNet patient days for both hospitals.

4. When a hospital owned or operated by the DMH merges with a hospital owned or operated by the board of curators, the Uninsured Add-Ons effective with the date of the merger shall be the Uninsured Add-On for the surviving hospital as determined from the surviving hospital's base-year cost reports in accordance with subsection (18)(D).

AUTHORITY: sections 208.153, [and] 208.201, [RSMo 2000 and] 208.152, and 208.471, RSMo Supp. [2006] 2008. This rule was previously filed as 13 CSR 40-81.050. Original rule filed Feb. 13, 1969, effective Feb. 23, 1969. For intervening history, please consult the Code of State Regulations. Amended: Filed Aug. 3, 2009.

PUBLIC COST: This proposed amendment will not cost state agencies or political subdivisions more than five hundred dollars (\$500) in the aggregate.

PRIVATE COST: This proposed amendment will not cost private entities more than five hundred dollars (\$500) in the aggregate.

NOTICE TO SUBMIT COMMENTS: Anyone may file a statement in support of or in opposition to this proposed amendment with the Department of Social Services, MO HealthNet Division, 615 Howerton Court, Jefferson City, MO 65109. To be considered, comments must be delivered by regular mail, express or overnight mail, in person, or by courier within thirty (30) days after publication of this notice in the Missouri Register. If to be hand-delivered, comments must be brought to the MO HealthNet Division at 615 Howerton Court, Jefferson City, Missouri. No public hearing is scheduled.

**Title 20—DEPARTMENT OF INSURANCE,
FINANCIAL INSTITUTIONS AND PROFESSIONAL
REGISTRATION**

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

PROPOSED AMENDMENT

20 CSR 400-3.650 Medicare Supplement Insurance Minimum Standards Act. The director is amending sections (1)–(3) and (5)–(22), adding new sections (7), (9), (24), and (25), renumbering sections as needed, and amending Appendix C.

PURPOSE: Section 1882 of the Social Security Act states that, if a state does not implement standards at least as restrictive as the NAIC Model, the state loses its authority to certify Medicare Supplement policies. The National Association of Insurance Commissioners (NAIC) modified the model Medicare Supplement Insurance Minimum Standards Act. This proposed amendment conforms to the NAIC Model and is necessary to maintain Missouri's authority to certify Medicare Supplement policies.

(1) Applicability and Scope.

(A) Except as otherwise specifically provided in sections (5), [(10), (11), (14) and (21)] (12), (13), (16), and (23), this rule shall apply to—

1. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date of this rule; and

2. All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in this state.

(2) Definitions. For purposes of this rule—

(G) "Director" means the director of the Department of Insurance, **Financial Institutions and Professional Registration** of this state;

(H) "Employee welfare benefit plan" means a plan, fund, or program of employee benefits, including, but not limited to those defined in 29 U.S.C. [s/Section 1002 (Employee Retirement Income Security Act);

(M) "MedicareAdvantage plan" means a plan of coverage for health benefits under Medicare Part C as defined in section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes:

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

2. Medical savings account plans coupled with a contribution into a Medicare[-]Advantage medical savings account; and

3. MedicareAdvantage private fee-for-service plans;

(P) "Pre-standardized Medicare supplement benefit plan," "Pre-standardized benefit plan," or "Pre-standardized plan" means a group or individual policy of Medicare supplement [plan] insurance issued prior to July 30, 1992;

(R) ["Standardized Medicare Supplement Plan" means a Medicare supplement plan issued after July 30, 1992; and] "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 July 30, 1992, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured;

(S) "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; and

[(S)](T) "Secretary" means the Secretary of the United States Department of Health and Human Services.

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

(D) "Health care expenses" means, for purposes of section [(12)] (14), expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

(5) Minimum Benefit Standards for **Pre-Standardized Medicare Supplement Benefit Plan** Policies or Certificates Issued for Delivery Prior to July 30, 1992. No policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(B) Minimum Benefit Standards.

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

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

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

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

5. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B.

6. Coverage for the coinsurance amount, **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.

7. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

(6) Benefit Standards for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued [or Delivered] for Delivery on or After July 30, 1992, and with an Effective Date for Coverage Prior to June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after July 30, 1992, **and with an effective date for coverage prior to June 1, 2010.** No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

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

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

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

3. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible *[amount and copayment percentage factors]*, **copayment, or coinsurance amounts.** Premiums may be modified to correspond with such changes.

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

A. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

B. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (6)(A)5.E., the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

(I) Provides for continuation of the benefits contained in the group policy; or

(II) Provides for benefits that otherwise meet the requirements of this subsection.

D. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall—

(I) Offer the certificate holder the conversion opportunity described in subparagraph (6)(A)5.C.; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

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

F. If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

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

7.

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

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

C. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal rule) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the

period, effective as of the date of termination of enrollment in the group health plan.

D. Reinstitution of coverages as described in subparagraphs (6)(A)7.B. and (6)(A)7.C.:

(I) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(II) Shall provide for resumption of coverage which is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstatement of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

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

8. If an issuer makes a written offer to the Medicare supplement policyholders or certificate holders of one (1) or more of its plans, to exchange during a specified period from his or her 1990 Standardized plan (as described in section (8) of this regulation) to a 2010 Standardized plan (as described in section (9) of this regulation), the offer and subsequent exchange shall comply with the following requirements:

A. An issuer need not provide justification to the director if the insured replaces a 1990 Standardized policy or certificate with an issue age rated 2010 Standardized policy or certificate at the insured's original issue age and duration. If an insured's policy or certificate to be replaced is priced on an issue age rate schedule at the time of such offer, the rate charged to the insured for the new exchanged policy shall recognize the policy reserve buildup, due to the pre-funding inherent in the use of an issue age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the director;

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

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

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

(B) Standards for Basic (Core) Benefits Common to Benefit Plans A-J. Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

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

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

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

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

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by section (7) of this rule.

1. Medicare Part A Deductible. Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

3. Medicare Part B Deductible. Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4. Eighty Percent (80%) of the Medicare Part B Excess Charges. Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

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

6. Basic Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars (\$1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

7. Extended Outpatient Prescription Drug Benefit. Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar (\$250) calendar year deductible to a maximum of three thousand dollars (\$3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

8. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

9. Preventive Medical Care Benefit. 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 B. and patient education to address preventive health care measures;

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

[C. Influenza vaccine administered at any appropriate time during the year and tetanus and diphtheria booster as medically appropriate; and]

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

10. At-Home Recovery Benefit. Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

A. For purposes of this benefit, the following definitions shall apply:

(I) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings;

(II) "Care provider" means a duly qualified or licensed home health aide or homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry;

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

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

B. Coverage Requirements and Limitations.

(I) At-home recovery services provided must be primarily services which assist in activities of daily living.

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

(III) Coverage is limited to—

(a) 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;

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

(c) One thousand six hundred dollars (\$1,600) per calendar year;

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

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

(f) Services provided by a care provider as defined in this section;

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

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

C. Coverage is excluded for—

(I) Home care visits paid for by Medicare or other government programs; and

(II) Care provided by family members, unpaid volunteers, or providers who are not care providers.

[11. New or Innovative Benefits. An issuer may, with the prior approval of the director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which 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.]

(7) Benefit Standards for 2010 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery with an Effective Date of Coverage on or After June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 Standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of section (6) of this regulation.

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

1. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

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

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

4. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

5. Each Medicare supplement policy shall be guaranteed renewable.

A. The issuer shall not cancel or non-renew the policy solely on the ground of health status of the individual.

B. The issuer shall not cancel or non-renew the policy for any reason other than nonpayment of premium or material misrepresentation.

C. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph (7)(A)5.E. of this regulation, the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder)—

(I) Provides for continuation of the benefits contained in

the group policy; or

(II) Provides for benefits that otherwise meet the requirements of this section.

D. If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall—

(I) Offer the certificate holder the conversion opportunity described in subparagraph (7)(A)5.C. of this regulation; or

(II) At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

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

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

7.

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

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

C. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) of the Social Security Act and is covered under a group health plan (as defined in section 1862 (b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstated (effective as of the date of loss of coverage) if the policyholder provides notice of loss of coverage within ninety (90) days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

D. Reinstatement of coverages as described in subparagraphs (7)(A)7.B. and (7)(A)7.C.—

(I) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(II) Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

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

(B) Standards for Basic (Core) Benefits Common to Medicare Supplement Insurance Benefit Plans A, B, C, D, F, F with High Deductible, G, M, and N. Every issuer of Medicare supplement insurance benefit plans shall make available a policy or certificate including only the following basic “core” package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it.

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

2. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used.

3. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance.

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

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

6. Hospice care. Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(C) Standards for Additional Benefits. The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with High Deductible, G, M, and N as provided by section (9) of this regulation.

1. Medicare Part A Deductible. Coverage for one hundred percent (100%) of the Medicare Part A inpatient hospital deductible amount per benefit period.

2. Medicare Part A Deductible. Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period;

3. Skilled Nursing Facility Care. Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A.

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

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

6. Medically Necessary Emergency Care in a Foreign Country. Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible

expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250), and a lifetime maximum benefit of fifty thousand dollars (\$50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

[(7)](8) Standard Medicare Supplement Benefit Plans for 1990 Standardized Medicare Supplement Benefit Plan Policies or Certificates Issued for Delivery on or After July 30, 1992, and with an Effective Date for Coverage Prior to June 1, 2010.

(A) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic core benefits, as defined in subsection (6)(B) [and (6)(C)] of this rule.

(B) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in paragraph (6)(C)11. and in section [(8)](10) of this rule.

(C) 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 (3) of this rule. Each benefit shall be structured in accordance with the format provided in subsections (6)(B), (6)(C), and (6)(D) and list the benefits in the order shown in this section. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(D) An issuer may use, in addition to the benefit plan designations required in subsection [(7)](8)(C), other designations to the extent permitted by law.

(E) Make-Up of Benefit Plans.

1. Standardized Medicare supplement benefit plan "A" shall be limited to the basic (core) benefits common to all benefit plans, as defined in subsection (6)(B) of this rule.

2. Standardized Medicare supplement benefit plan "B" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible as defined in paragraph (6)(C)1.

3. Standardized Medicare supplement benefit plan "C" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., and 8., respectively.

4. Standardized Medicare supplement benefit plan "D" shall include only the following: The core benefit (as defined in subsection (6)(B) of this rule), plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 8., and 10., respectively.

5. Standardized Medicare supplement benefit plan "E" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country, and preventive medical care as defined in paragraphs (6)(C)1., 2., 8., and 9., respectively.

6. Standardized Medicare supplement benefit plan "F" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., 5., and 8., respectively.

7. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: /o/One hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 3., 5., and 8., respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be one thousand five hundred dollars (\$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 (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10).

8. Standardized Medicare supplement benefit plan "G" shall include only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, eighty percent (80%) of the Medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 4., 8., and 10., respectively.

9. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in paragraphs (6)(C)1., 2., 6., and 8., respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

10. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 5., 6., 8., and 10., respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

11. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9., and 10., respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

12. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: one hundred percent (100%) of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in subsection (6)(B) of this rule, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit, and at-home recovery benefit as defined in paragraphs (6)(C)1., 2., 3., 5., 7., 8., 9., and 10., respectively. The

annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be fifteen hundred dollars (\$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 (12)-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars (\$10). The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(F) Make-up of two (2) Medicare supplement plans mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA).

1. Standardized Medicare supplement benefit plan "K" shall consist of only those benefits described in paragraph (6)(D)1.

2. Standardized Medicare supplement plan "L" shall consist only of those benefits described in paragraph (6)(D)2.

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

(9) **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 are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of section (6) of this regulation.

(A)

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

2. If an issuer makes available any of the additional benefits described in subsection (7)(C), or offers standardized benefit Plans K or L (as described in paragraphs (9)(E)8. and 9. of this regulation), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to the basic (core) benefits as described in paragraph (9)(A)1. above, a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph (9)(E)3. of this regulation) or standardized benefit Plan F (as described in paragraph (9)(E)5. of this regulation).

(B) No groups, packages, or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in this state, except as may be permitted in subsection (9)(F) and in section (10) of this regulation.

(C) Benefit plans shall be uniform in structure, language, designation, and format to the standard benefit plans listed in this subsection and conform to the definitions in section (2) of this regulation. Each benefit shall be structured in accordance with the format provided in subsections (7)(B) and (7)(C) of this reg-

ulation; or, in the case of Plans K or L, in paragraphs (9)(E)8. or 9. of this regulation and list the benefits in the order shown. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of a benefit.

(D) In addition to the benefit plan designations required in subsection (C) of this section, an issuer may use other designations to the extent permitted by law.

(E) **Make-up of 2010 Standardized Benefit Plans.**

1. Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subsection (7)(B) of this regulation.

2. Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible as defined in paragraph (7)(C)1. of this regulation.

3. Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., 4., and 6. of this regulation, respectively.

4. Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit (as defined in subsection (7)(B) of this regulation), plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., and 6. of this regulation, respectively.

5. Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, the skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 2., 4., 5., and 6., respectively.

6. Standardized Medicare supplement Plan F With High Deductible shall include only the following: One hundred percent (100%) of covered expenses following the payment of the annual deductible set forth in subparagraph (9)(E)6.B.

A. The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., 4., 5., and 6., of this regulation, respectively.

B. The annual deductible in Plan F With High Deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by regular Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be one thousand five hundred dollars (\$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 dollars (\$10).

7. Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, one hundred percent (100%) of the Medicare Part B

excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., 5., and 6., respectively.

8. Standardized Medicare supplement Plan K is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

A. Part A Hospital Coinsurance sixty-first through ninety-first through the ninety-first day in any Medicare benefit period; Coverage of one hundred percent (100%) of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninety-first day in any Medicare benefit period;

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

C. Part A Hospitalization After One Hundred Fifty (150) Days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five (365) days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

D. Medicare Part A Deductible: Coverage for fifty percent (50%) of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

E. Skilled Nursing Facility Care: Coverage for fifty percent (50%) of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

F. Hospice Care: Coverage for fifty percent (50%) of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

G. Blood: Coverage for fifty percent (50%), under Medicare Part A or B, of the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph (9)(E)8.J.;

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

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

J. Cost Sharing After Out-of-Pocket Limits: Coverage of one hundred percent (100%) of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of four thousand dollars (\$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.

9. Standardized Medicare supplement Plan L is mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

A. The benefits described in subparagraphs (9)(E)8.A.,

B., C., and I.;

B. The benefit described in subparagraphs (9)(E)8.D., E., F., G., and H., but substituting seventy-five percent (75%) for fifty percent (50%); and

C. The benefit described in subparagraph (9)(E)8.J, but substituting two thousand dollars (\$2,000) for four thousand dollars (\$4,000).

10. Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus fifty percent (50%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)2., 3., and 6. of this regulation, respectively.

11. Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subsection (7)(B) of this regulation, plus one hundred percent (100%) of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs (7)(C)1., 3., and 6., of this regulation, respectively, with copayments in the following amounts:

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

B. The lesser of fifty dollars (\$50) 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.

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

/(8)/(10) Medicare Select Policies and Certificates.

(A)

1. This section shall apply to Medicare Select policies and certificates, as defined in this section.

/(A)/2. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(B) For the purposes of this section—

1. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers;

2. "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 issuer or its network providers;

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

4. "Medicare Select policy" or "Medicare Select certificate" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions;

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

6. "Restricted network provision" means any provision which

conditions the payment of benefits, in whole or in part, on the use of network providers; and

7. "Service area" means the geographic area approved by the director within which an issuer is authorized to offer a Medicare Select policy.

(C) The director may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the director finds that the issuer has satisfied all of the requirements of this rule.

(D) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the director.

(E) A Medicare Select issuer shall file a proposed plan of operation with the director in a format prescribed by the director. The plan of operation shall contain at least the following information:

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

A. Services can 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 reflect the usual travel times within the community;

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

(I) To deliver adequately all services that are subject to a restricted network provision; or

(II) To make appropriate referrals;

C. There are written agreements with network providers describing specific responsibilities;

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

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

2. A statement or map providing a clear description of the service area;

3. A description of the grievance procedure to be utilized;

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

A. The formal organizational structure;

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

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

5. A list and description, by specialty, of the network providers;

6. Copies of the written information proposed to be used by the issuer to comply with subsection (I) of this section; and

7. Any other information requested by the director.

(F)

1. A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the director prior to implementing the changes. Changes shall be considered approved by the director after thirty (30) days unless specifically disapproved.

2. An updated list of network providers shall be filed with the director at least quarterly.

(G) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if—

1. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

2. It is not reasonable to obtain services through a network provider.

(H) 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.

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

1. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with—

A. Other Medicare supplement policies or certificates offered by the issuer; and

B. Other Medicare Select policies or certificates;

2. A description (including address, phone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;

3. 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 do not count toward the out-of-pocket annual limit contained in plans "K" and "L";

4. A description of coverage for emergency and urgently needed care and other out-of-service area coverage;

5. A description of limitations on referrals to restricted network providers and to other providers;

6. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

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

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

(K) A Medicare Select issuer 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.

1. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

2. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3. Grievances 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.

4. If a grievance is found to be valid, corrective action shall be taken promptly.

5. All concerned parties shall be notified about the results of a grievance.

6. The issuer shall report no later than each March thirty-first to the director regarding its grievance procedure. The report shall be in a format prescribed by the director and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

(L) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(M)

1. At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer 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.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Part B excess charges.

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

1. Each Medicare Select issuer 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 issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies and certificates available without requiring evidence of insurability.

2. For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one (1) or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Part B excess charges.

(O) A Medicare Select issuer 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.

//(9)/(11) Open Enrollment.

(A) *[No]* An issuer shall **not** deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six (6)-month period beginning with the first day of the first month in which the applicant is both sixty-five (65) years of age or older and is enrolled for benefits under Medicare Part B.

1. 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.

(B) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of that policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant under age sixty-five (65), if:

1. The application for the policy or certificate is submitted prior to or during the six (6)-month period beginning with the first day of the first month during which the applicant becomes enrolled for benefits under Medicare Part B, without regard to age, after June 30, 1998; or

2. The applicant was enrolled for benefits under Medicare Part B without regard to age on or prior to June 30, 1998, and the application for a policy or certificate is submitted during the six (6)-month period beginning with June 30, 1998.

(C)

1. If an applicant qualifies under either subsection //(9)/(11)(A) or (B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage of at least six (6) months, the issuer shall not exclude benefits based on a preexisting condition.

2. If the applicant qualifies under either subsection //(9)/(11)(A) or (B), submits an application during the applicable time period referenced in those subsections, and, as of the date of application, has had a continuous period of creditable coverage that is less than six (6) months, the issuer 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.

(D) Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants to whom an issuer is required to issue a policy or certificate of Medicare supplement insurance under this section.

(E) No issuer required by subsection (B) of this section to issue policies or certificates of Medicare supplement insurance shall discriminate as to rates, between the rates charged to persons enrolled under subsection (B) of this section and the average rates charged for participation in that policy form number or certificate form number by persons enrolled in Medicare Part B by reason of age, or discriminate between persons entitled to enroll in the policy form number or certificate form number under subsection (B) of this section and other enrollees in the policy form number or certificate form number in other terms or conditions of the plan, policy form number, or certificate form number.

1. An issuer must demonstrate compliance with this section for each plan, type, and form level permitted under subsection //(13)/(15)(D) by either—

A. Charging a premium rate for disabled persons that does not exceed the lowest available aged premium rate for that plan, type, and form level; or

B. Charging a premium rate for disabled persons that does not exceed the “weighted average aged premium rate” for that plan, type, and form level, and providing, at the time of each rate filing, its calculation of the “weighted average aged premium rate” for each plan, type, and form level.

2. The “weighted average aged premium rate” is determined by—

A. First multiplying the premium rate (calculated prior to modal, area, and other factors) for each age band, age sixty-five (65) and over, by the number of Missouri insureds in-force in that age band to arrive at the total Missouri premium for each age band age sixty-five (65) and over; and

B. Then calculating the sum of the Missouri premium for all age bands age sixty-five (65) and over to arrive at the total Missouri premium for all age bands age sixty-five (65) and over; and

C. Then calculating the sum of the Missouri insureds in-force for all age bands age sixty-five (65) and over to arrive at the total number of Missouri insureds in-force for all age bands age sixty-five (65) and over; and

D. Then dividing the total Missouri premium for all age bands age sixty-five (65) and over by the total number of Missouri insureds in-force for all age bands, age sixty-five (65) and over to determine the weighted average aged premium rate.

3. Modal, area, and other factors may be added to the disabled premium.

(F) Each Medicare supplement carrier shall actively market Medicare supplement insurance during the open enrollment periods

described in subsection (B) of this section.

(G) No Medicare supplement carrier shall directly or indirectly engage in the following activities respecting persons enrolled in Medicare Part B by reason of disability during the open enrollment periods described in subsection (B) of this section:

1. Encouraging or directing such persons to refrain from filing an application for Medicare supplement insurance because of the health status, claims experience, receipt of health care, or medical condition of the person; and

2. Encouraging or directing such persons to seek coverage from another carrier because of the health status, claims experience, receipt of health care, or medical condition of the person.

(H) No Medicare supplement carrier shall, directly or indirectly, enter into any contract, agreement, or arrangement with an insurance producer that provides for or results in the compensation paid to an insurance producer for the sale of a Medicare supplement policy or certificate to be varied because of the age, health status, claims experience, receipt of health care, or medical condition of an applicant eligible by reason of subsection (B) of this section for Medicare supplement insurance.

(I) A Medicare supplement carrier shall provide reasonable compensation, as provided under the plan of operation of the program, to an insurance producer, if any, for the sale, during the open enrollment periods described in subsection (B) of this section, of a Medicare supplement insurance policy or certificate.

(J) No Medicare supplement insurance carrier shall terminate, fail to renew, or limit its contract or agreement of representation with an insurance producer for any reason related to the age, health status, claims experience, receipt of health care, or medical condition of an applicant, eligible by reason of subsection (B) of this section for Medicare supplement insurance, placed by the insurance producer with the Medicare supplement insurance carrier.

(K) Denial by a Medicare supplement insurance carrier of an application for coverage made during either of the open enrollment periods described in subsection (B) of this section shall be in writing and state the specific reason or reasons for the denial.

(L) Except as provided in subsection (C) of this section and section ~~/(21)/(23)~~, subsections (A) and (B) 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 otherwise diagnosed during the six (6) months before the coverage became effective.

~~/(10)/(12)~~ Guaranteed Issue for Eligible Persons.

(A) Guaranteed Issue.

1. Eligible persons are those individuals described in subsection (B) of this section who seek to enroll under the policy during the period specified in subsection (C) 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.

2. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (E) of this section that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(B) Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual, **or the individual leaves the plan;**

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

A. The ~~[organization's or plan's]~~ certification of the organization or plan has been terminated ~~[or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides];~~

B. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

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

~~[C./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 such covered care in accordance with applicable quality standards; or

(II) The organization, insurance producer, or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

~~[D./E.~~ The individual meets such other exceptional conditions as the secretary may provide;

3.

A. The individual is enrolled with—

(I) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare risk or cost);

(II) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(III) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(IV) An organization under a Medicare Select Policy; and

B. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph ~~/(10)/(12)(B)2.~~;

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because—

A.

(I) Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or

(II) Of other involuntary termination of coverage or enrollment under the policy;

B. The issuer of the policy substantially violated a material provision of the policy; or

C. The issuer, insurance producer, or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

5.

A. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the

first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 (Medicare *[risk or]* cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, *[an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan),]* or a Medicare Select policy; and

B. The subsequent enrollment under subparagraph *[(10)](12)(B)5.A.* is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

6. The individual, upon first becoming eligible for benefits under Part A of Medicare at age sixty-five (65), enrolls in a Medicare Advantage plan under Part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment; *[and]*

7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph (E)4. of this section; and

8. Any individual who terminates Medicare supplement coverage within thirty (30) days of the annual policy anniversary.

(C) Guarantee Issue Time Periods.

1. In the case of an individual described in paragraph (B)1. of this section, the guaranteed issue period begins on the later of: (i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

2. In the case of an individual described in paragraph (B)2., (B)3., (B)5., or (B)6. of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage *[was]* is terminated;

3. In the case of an individual described in subparagraph (B)4.A. of this section, the guarantee issue period begins on the earlier of: (i) the date that individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage *[was]* is terminated;

4. In the case of an individual described in paragraph (B)2., subparagraph (B)4.B.*[,]* or (B)4.C., or paragraph (B)5. or (B)6.*[,]* of this section who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

5. In the case of an individual described in paragraph (B)7. of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty (60)-day period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

6. In the case of an individual described in subsection (B) of this section but not described in the preceding provisions of this subsection, the guaranteed issue period begins on the effective date of disenrollment or the effective date of the loss of coverage under the

group health plan and ends on the date that is sixty-three (63) days after the effective date.

(D) Extended Medigap Access for Interrupted Trial Periods.

1. In the case of an individual described in paragraph (B)5. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with an organization or provider described in subparagraph (B)5.A. 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 paragraph *[(10)](12)(B)6.5.*; and

2. In the case of an individual described in paragraph (B)6. of this section (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in paragraph (B)6. of this section is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in paragraph *[(10)](12)(B)6.*; and

3. For purposes of paragraphs (B)5. and (B)6. of this section, no enrollment of an individual with an organization or provider described in subparagraph (B)5.A. of this section, or with a plan or in a program described in paragraph (B)6. of this section, may 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 such an organization, provider, plan, or program.

(E) Products to Which Eligible Persons Are Entitled. The Medicare supplement policy to which eligible persons are entitled under—

1. Paragraphs *[(10)](12)(B)1.*, 2., 3., and 4. is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, *[or]* F (including F with a high deductible), K, or L offered by any issuer;

2.

A. Subject to subparagraph B., paragraph *[(10)](12)(B)5.* is the same Medicare supplement policy in which the individual was most recently enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph 1. of this subsection;

B. 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:

(I) The policy available from the same issuer but modified to remove the outpatient prescription drug coverage; or

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

[2.]3. Paragraph *[(10)](12)(B)6.* shall include any Medicare supplement policy offered by any issuer;

[3.]4. Paragraph *[(10)](12)(B)7.* is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage; and

[4.]5. Paragraph *[(10)](B)8.* shall include any Medicare supplement policy offered by any issuer but only a policy of the same plan as the coverage in which the individual was most recently enrolled.*[(12)(B)8.* shall include any Medicare supplement policy offered by any issuer, but only a policy of the same plan as the coverage in which the individual was most recently enrolled, if available, or, if not so available due to changes in the Medicare supplement plan designs, a policy with a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L.

(F) Notification Provisions.

1. At the time of an event described in subsection (B) of this

section because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A). Such notice shall be communicated contemporaneously with the notification of termination.

2. At the time of an event described in subsection (B) of this section because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under subsection (A) of this section. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

[(11)](13) Standards for Claims Payment.

(A) An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, P.L. No. 100-203) by—

1. 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 otherwise required and making a payment determination on the basis of the information contained in that notice;
2. Notifying the participating physician or supplier and the beneficiary of the payment determination;
3. Paying the participating physician or supplier directly;
4. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;
5. Paying user fees for claim notices that are transmitted electronically or otherwise; and
6. Providing to the secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

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

[(12)](14) Loss Ratio Standards and Refund or Credit of Premium.

(A) Loss Ratio Standards.

1.

A. A Medicare Supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form the higher of the originally filed anticipated loss ratio or—

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

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

B. *[The ratios specified in this subsection shall be c/*Calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a 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.

2. All filings 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 *[(future loss ratio)]*.

3. For purposes of applying paragraph (A)1. of this section and paragraph *[(D)](C)*3. of section *[(13)](15)* only, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4. For policies issued prior to July 30, 1992, expected claims in relation to premiums shall meet—

A. The originally filed anticipated loss ratio when combined with the actual experience since inception (the lifetime loss ratio);

B. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section when combined with actual experience beginning with January 1, 2006 to date; and

C. The appropriate loss ratio requirement from parts (A)1.A.(I) and (II) of this section over the entire future period for which the rates are computed to provide coverage.

(B) Refund or Credit Calculation.

1. An issuer shall collect and file with the director by May 31 of each year the data contained in the applicable reporting form contained in Appendix A, **included herein**, for each type in a standard Medicare supplement benefit plan.

2. 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 is 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.

3. For the purposes of this section, policies or certificates issued prior to July 30, 1992, the issuer 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 January 1, 2006. The first report shall be due by May 31, 2008.

4. 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 a *de minimis* level. 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 in no event shall it 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.

(C) Annual Filing of Premium Rates. An issuer of Medicare supplement policies and certificates issued before or after the effective date of April 3, 1993, in this state shall file annually its rates, rating schedule, and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the director in accordance with the filing requirements and procedures prescribed by the director. The supporting documentation 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. An

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

[1.] As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the director, in accordance with the applicable filing procedures of this state—

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. An issuer shall make 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 which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for the Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date; and

C. If an issuer fails to make premium adjustments acceptable to the director, the director may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio 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.

(D) Public Hearings. The director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of April 8, 1993, 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 is made without consideration of any refund or credit for the reporting period. Public notice of the hearing shall be furnished in a manner deemed appropriate by the director.

[(13)](15) Filing and Approval of Policies and Certificates and Premium Rates.

(A) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the director in accordance with filing requirements prescribed by the director.

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

(C) An issuer 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 director in accordance with the filing requirements and procedures prescribed by the director.

(D)

1. Except as provided in paragraph 2. of this subsection, an issuer 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.

2. An issuer may offer, with the approval of the director, 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:

A. The inclusion of new or innovative benefits;

B. The addition of either direct response or insurance producer marketing methods;

C. The addition of either guaranteed issue or underwritten coverage; and

D. The offering of coverage to individuals eligible for Medicare by reason of disability.

3. For the purposes of this section, a “type” means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

(E)

1. Except as provided in subparagraph 1.A. of this subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after April 8, 1993, that has been approved by the director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

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

B. An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph 1.A. of this subsection 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 issuer provides notice to the director of the discontinuance. The period of discontinuance may be reduced if the director determines that a shorter period is appropriate.

2. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

[3. Effect of change in rating structure or methodology.

A. A change in the rating structure or methodology includes, but is not limited to:

(I) A change between community rating, issue-age rating, and attained-age rating;

(II) A change in class structure (e.g., one class v. smoker/non-smoker class, unisex v. male/female classes); and

(III) A change between rating for each age v. age-banded rates.]

[B.3.] A change in the rating structure or methodology shall be considered a discontinuance under paragraph 1. of this subsection unless the issuer complies with the following requirements:

[(I)]A. The issuer provides an actuarial memorandum, in a form and manner prescribed by the director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates; and

[(II)]B. The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. Such actuarially equivalent policies or certificates shall be combined for filing purposes under paragraph *[(13)](15)(H)11*. The director may approve a change to the differential which is in the public interest.

[C. Notwithstanding subparagraph B. of this paragraph, where an issuer changes a rating structure or methodology and rates calculated under the new methodology are not actuarially equivalent to the old rates, the change in rating structure or methodology will be considered a discontinuance under subparagraph (13)(E)1.A. The actuarial equivalency of rates must be determined by a comparison of weighted average premium rate under the old and the new methodology, except in the case of a change between

attained-age and issue-age rating where the actuarial equivalency of the rates will be determined from a comparison of actuarial present value of lifetime premiums by age or age-band.]

(F)

1. Except as provided in paragraph (F)2. of this section, 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 *[(12)](14)* of this rule.

2. 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.

(G)

1. An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after January 1, 2000, based upon attained-age rating as a structure or methodology. Notwithstanding, an issuer may continue in-force policies and certificates issued prior to January 1, 2000.

2. Where an issuer files for approval of a rate structure for policy forms or certificate forms which reflects a change in methodology from attained age to issue age, the issuer must demonstrate the actuarial equivalency of the rates proposed with the previously approved attained-age rates as required by paragraph *[(13)](15)(E)3*. If the policy forms or certificate forms were at any time approved by the director under an issue-age methodology, the issuer must use the most recently approved issue-age rate schedule as its proposed rate schedule for the policy forms or certificate forms and need make no further showing of actuarial equivalency under *[(13)](15)(E)3*.

(H) Filing requirements and procedures for change of Medicare supplement insurance premium rate and for annual filing of premium rates.

1. When an issuer files for approval of annual premium rates for a plan under subsection *[(12)](14)(C)* or a change of premium rates for a plan under subsection *[(13)](15)(C)*, the following documentation must be provided to the director as part of the rate filing in addition to any other documentation required by law or regulation:

A. A completed Medicare Supplement Rate Filing Document (Missouri Form 375-0065, revised 10/98), which can be accessed at the department's website at www.insurance.mo.gov;

B. An actuarial memorandum supporting the rating schedule;

C. A report of durational experience (for standardized Medicare supplement plans only);

D. A projection correctly derived from reasonable assumptions;

E. A clear statement of all of the assumptions used to prepare the rate filing, including the source of trend;

F. All formulas used to prepare the projection except for formulas which can be ascertained from a cursory inspection of the projection itself; and

G. The issuer's current rate schedule and the proposed rate schedule for this state, including rates for disabled persons, if any, and all rating factors, including, but not limited to: area; smoker/non-smoker; standard/substandard.

2. The report of durational experience must contain for each calendar year of issue the following data by duration: incurred claims and earned premium; resultant loss ratio, and life-years. The durational split may be either by policy or certificate duration, calendar duration, or calendar year of experience within each calendar year of issue.

3. The projection must—

A. State the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for each of the preceding calendar years beginning with the year in which the policy or certificate was first issued and must include the total for each category (incurred claims and earned premium, resultant loss ratio, and corresponding life-years) for all preceding calendar years;

B. State the projected incurred claims and projected earned premium, resultant loss ratios, and corresponding life-years for at least each of the ten (10) calendar years subsequent to the rate filing and must include the total for each category (projected incurred claims and projected earned premium, resultant loss ratio, and corresponding life-years) for all projected calendar years;

C. Include a calculation of the sums of the combined total figures reported under subparagraph A. of this paragraph and those reported under subparagraph B. of this paragraph; and

D. Include, for pre-standardized Medicare supplement plans, the respective totals of the incurred claims and earned premium, resultant loss ratio, and corresponding life-years for the period beginning April 28, 1996, or alternatively, January 1, 1996, through the end of the projection period described in subparagraph B. of this paragraph.

4. Where assumptions include interest, the totals for incurred claims accumulated/deducted with interest, earned premium accumulated/deducted with interest, and the resultant loss ratio must also be shown in all parts of the projection described in paragraph (H)3. of this section.

5. Both the report of durational experience and the projection must report Missouri and national data with respect to incurred claims, earned premium, loss ratio, and life-years. The projection must also report this information both with and without the rate change requested.

6. The issuer must specify whether the figures reported as incurred claims were determined by adding claims paid to unpaid claims reserves or by the actual runoff of claims. The method of determining the incurred claims must be consistent throughout the filing and supporting documentation.

7. Changes in active life reserves or claims expenses may not be included in incurred claims in the rate filing or any supplemental documentation.

8. For purposes of this section, "incurred claims" means the dollar amount of incurred claims.

9. Earned premium reported in the rate filing or any supporting documentation must include modal loadings and policy fees. An adjustment for premium refunds, if any, must also be made to earned premium and the details of the adjustment must be provided to the director with the filing. Changes in active life reserves may not be included in earned premium.

10. Life-years reported in a rate filing or supplemental documentation must be calculated in the same manner as for refund calculations.

11. Rate filings for each plan, type, and form level permitted under subsection *[(13)](15)(D)* for standardized Medicare supplement plans marketed after June 30, 1998, must demonstrate compliance with the requirements of subsection *[(9)](11)(E)*. The "weighted average aged premium," must be recalculated for each filing using current data, unless the issuer demonstrates compliance under subparagraph *[(9)](11)(E)1.A*. The figure used in the calculation for the total number of insureds in-force for all age bands, age sixty-five (65) and over, must be the same as the figure reported on Missouri Form 375-0065 for the "Number of Missouri Aged Insureds."

12. For standardized Medicare supplement plans, the Medicare Supplement Rate Filing Document, the report of durational experience, and the projection must be provided separately for each plan, type, and form level permitted under subsection *[(13)](15)(D)*.

13. For pre-standardized Medicare supplement rate plans, the information contained in the Medicare Supplement Rate Filing Document and projection may be pooled within a type.

14. The rates, rating schedule, and supporting documentation required to be filed under subsection (H) of this section as part of a rate filing and all supplementary documentation in connection with the rate filing must be accompanied by the certification of a qualified actuary that to the best of the actuary's knowledge and judgment, the following items are true with respect to the documentation submitted:

A. The assumptions present the actuary's best judgment as to the expected value for each assumption and are consistent with the issuer's business plan at the time of the filing;

B. The anticipated lifetime, future, and third-year loss ratios for the policy form or certificate form for which the rates are filed comply with the loss ratio requirements of subsection *[(12)](14)(A)* for policy forms or certificate forms of its type delivered or issued for delivery in this state;

C. With respect to rate filings concerning pre-standardized plans, the loss ratio for year 1996 (from April 28 or from January 1) through the end of the projection period complies with the loss ratio requirements of subsection *[(12)](14)(A)* for policies or certificates issued prior to July 30, 1992, and delivered or issued for delivery in this state;

D. Where the rate filing concerns a policy or certificate as to which rating methodologies have changed or are presented for approval based on a change in methodology, the percentage differential between the discontinued and subsequent (or new) rates has not changed;

E. All components of the filing, including rates, rating schedules, and supporting documentation, were prepared based on the current standards of practice promulgated by the Actuarial Standards Board;

F. The rate filing, including rates, rating schedule, and supporting documentation, is in compliance with the applicable laws and regulations of this state; and

G. The rates requested are reasonable in relationship to the benefits provided by the policy or certificate.

[(14)](16) Permitted Compensation Arrangements.

(A) An issuer or other entity may provide commission or other compensation to an insurance producer or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

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

(C) No issuer or other entity shall provide compensation to its insurance producers and no producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

(D) For purposes of this section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards, and finder's fees.

[(15)](17) Required Disclosure Provisions.

(A) General Rules.

1. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of the provision shall be consistent with the type of contract issued. The provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall

require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the premium charge shall be set forth in the policy.

3. 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.

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

5. 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.

6.

A. Issuers 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 form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services (CMS) and in a type size no smaller than twelve (12)-point type. Delivery of the Guide shall be made whether or not the policies or certificates are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this rule. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

B. For the purposes of this section, "form" means the language, format, type size, type proportional spacing, bold character, and line spacing.

(B) Notice Requirements.

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

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

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

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

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

(C) MMA Notice Requirements. Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

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

1. Issuers shall provide an outline of coverage to all applicants at the time 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.

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

3. The outline of coverage provided to applicants pursuant to this section consists of four (4) parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than twelve (12)-point type. All plans [A-L] shall be shown on the cover page, and the plans that are offered by the issuer 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.

4. The following items shall be included in the outline of coverage in the order prescribed below.