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(Plus all the volunteer
help we can get)

September 6, 2000

NOTICE OF EMERGENCY RULE DECISION BY THE SECRETARY OF STATE

AGENCY: Insurance Commission

RULE: Amendments, Series 24, Medicare Supplement Insurance

DATE FILED AS AN EMERGENCY RULE: August 1, 2000

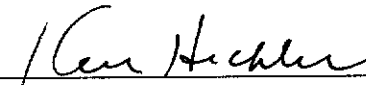
DECISION NO. 14-00

OFFICE OF THE
SECRETARY OF STATE

SEP 7 11 27 AM '00

FILED

Following review under W. Va. Code §29A-3-15a, it is the decision of the Secretary of State that the above emergency rule is **approved**. A copy of the complete decision with required findings is available from this office.



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EMERGENCY RULE DECISION
(ERD 14-00)

AGENCY: Insurance Commission
RULE: Amendments, Series 24, Medicare Supplement Insurance
FILED AS AN EMERGENCY RULE: August 1, 2000

- par. 1 The Insurance Commission (Commission) has filed the above amendments to an existing rule as an emergency rule.
- par. 2 W. Va. Code 29A-3-15a requires the Secretary of State to review all emergency rules filed after March 8, 1986. This review requires the Secretary of State to determine if the agency filing such emergency rule: 1) has complied with the procedures for adopting an emergency rule; 2) exceeded the scope of its statutory authority in promulgating the emergency rule; or 3) can show that an emergency exists justifying the promulgation of an emergency rule.
- par. 3 Following review, the Secretary of State shall issue a decision as to whether or not such an emergency rule should be disapproved [§29A-3-15a].
- par. 4 (A) Procedural Compliance: W. Va. Code §29A-3-15 permits an agency to adopt, amend or repeal, without hearing, any legislative rule by filing such rule, along with a statement of the circumstances constituting the emergency, with the Secretary of State and forthwith with the Legislative Rule-Making Review Committee (LRMRC).
- par. 5 If an agency has accomplished the above two required filings with the appropriate supporting documents by the time the emergency rule decision is issued or the expiration of the forty-two day review period, whichever is sooner, the Secretary of State shall rule in favor of procedural compliance.
- par. 6 The Commission filed this emergency rule with supporting documents with the Secretary of State August 1, 2000 and with the LRMRC August 1, 2000.
- par. 7 It is the determination of the Secretary of State that the Commission has complied

with the procedural requirements of W. Va. Code §29A-3-15 for adoption of an emergency rule.

par. 8 (B) Statutory Authority -- W. Va. Code §33-28-5b(b)(1) reads:

The commissioner shall issue reasonable rules to establish specific standards for policy provisions of medicare supplement policies.

par. 9 It is the determination of the Secretary of State that the Commission has not exceeded its statutory authority in promulgating this emergency rule.

par. 10 (C) Emergency -- W. Va. Code §29A-3-15(f) defines "emergency" as follows:

(f) For the purposes of this section, an emergency exists when the promulgation of a rule is necessary for the immediate preservation of the public peace, health, safety or welfare or is necessary to comply with a time limitation established by this code or by a federal statute or regulation or to prevent substantial harm to the public interest.

par. 11 There are essentially three classes of emergency broadly presented with the above provision: 1) immediate preservation; 2) time limitation; and 3) substantial harm. An agency need only document to the satisfaction of the Secretary of State that there exists a nexus between the proposal and the circumstances creating at least one of the above three emergency categories.

par. 12 The facts and circumstances as presented by the Commission are as follows:

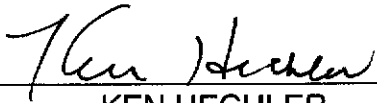
This rule will bring the State into compliance with the new federal minimum standards for Medicare Supplement Insurance. The State is in danger of losing its federal certification for meeting these standards if a review is conducted before these changes are made. (See Exhibit One)

The Balanced Budget Refinement Act (BBRA) of 1999 and the Ticket to Work & Work Incentives Improvement Act (TWWIIA) of 1999 made significant modifications to federal law governing Medicare supplement insurance. Specific requirements for Medicare supplement insurance policies are incorporated in the Social Security Act. Section 1882 of the Act designates the National Association of Insurance Commissioners (NAIC) as the body which establishes standards for the Medicare supplement insurance program. States are required to conform their laws to the minimum standards established by the NAIC immediately. Nationwide review for state compliance will not be initiated until one year after the NAIC formally adopts regulatory amendments. However, the US Department of Health & Human Services will conduct single-state reviews in the interim, if it receives consumer complaints. These standards are set forth in the proposed revisions to the "NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act."

Failure to implement the minimum standards established by this rule may interfere with the ability to sell Medicare supplement insurance policies in WV.

par. 13 It is the determination of the Secretary of State that this proposal qualifies under the definition of an emergency as defined in §29A-3-15(f). . . "federal time limit" and "prevent substantial harm to the public interest."

par. 14 This decision shall be cited as Emergency Rule Decision 14-00 or ERD 14-00 and may be cited as precedent. This decision is available from the Secretary of State and has been filed with the Insurance Commission, the Attorney General and the Legislative Rule Making Review Committee.



KEN HECHLER
Secretary of State

Entered _____

FILED

SEP 7 11 17 AM '00

OFFICE OF THE SECRETARY OF STATE

NAIC

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

NOTICE

TO: All NAIC Members

FROM: Kathleen Sebelius, Chair, Health Insurance and Managed Care (B) Committee

DATE: September 1, 2000

SUBJECT: State Adoption of Amendments to the NAIC Medicare Supplement Insurance Model Regulation in Order to Retain Certification of State Medigap Regulatory Programs

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This notice is a follow-up to the memorandum sent to you on the above subject. At the request of the Health Care Financing Administration (HCFA), we have been asked to clarify the statement made in the August 22nd notice and memorandum. The statement is regarding the NAIC and HCFA's agreement "to allot states one year after the NAIC adopts relevant amendments to the Model Regulation to incorporate such changes into their regulatory programs..." The "changes" referenced in the notice and memorandum refer to amendments made to federal law by the Balanced Budget Refinement Act of 1999 (BBRA) and the Ticket to Work and Work Incentives Improvement Act of 1999 (TWIIA).

HCFA has requested that the NAIC emphasize to its members that, while HCFA has generally agreed not to conduct periodic reviews of state regulatory programs for one year after adoption of the technical BBRA and TWIIA amendments by the NAIC (unless it receives complaints about an issuer's noncompliance with federal standards in a state, and a state fails to take enforcement action), the effective dates of the standards are November 29, 1999 and December 17, 1999, respectively. Medigap issuers are presently bound by the federal standards. Therefore, HCFA is urging states to adopt the federal standards as soon as possible. Swift adoption will help avoid any potential issue that could arise if a Medigap issuer does not comply with the federal standards, and a state is unable to enforce the standards because they have not been adopted into state law or regulation. **In that case, HCFA may conduct a review of a state's regulatory program before the expiration of the one-year period and take appropriate action, which could jeopardize HCFA's approval of a state's regulatory program.**

NAIC

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MEMORANDUM

TO: All NAIC Members

FROM: Kathleen Sebelius, Chair, Health Insurance and Managed Care (B) Committee

DATE: July 21, 2000

SUBJECT: State Adoption and Enforcement of Amendments to Section 1882 of the Social Security Act Created by the Balanced Budget Refinement Act of 1999 and Ticket to Work and Work Incentives Improvement Act of 1999

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In November of 1999 Congress adopted two acts, the Balanced Budget Refinement Act (BBRA)¹ and Ticket To Work And Work Incentives Improvement Act² (TWWIIA), amending section 1882 of the Social Security Act³(SSA), which governs Medicare Supplement Insurance (Medigap). Both Acts became effective upon signature by the President on November 29, 1999 and December 17, 1999, respectively. Since such time Medigap issuers have been, and continue to be, responsible for adhering to the heightened standards created by the two Acts. The BBRA amends the guaranteed issue provisions and the TWWIIA amends the suspension of benefits and premiums under a Medigap policy provisions of the Social Security Act. Section 1882 (b)(1) of the Social Security Act⁴ provides requirements for certification of a state regulatory program by the Secretary of the U.S. Department of Health and Human Services. One such requirement is state adoption of standards equal to or more stringent than the NAIC Model Regulation, as it appears in the April 29, 1998 *Federal Register*. State regulatory programs are also required, under section 1882(b)(1)(B), to include requirements equal to or more stringent than subsections (o) through (t) of section 1882 (which incorporates, by reference, the heightened standards created by the BBRA and TWWIIA).

¹ Public Law 106-170.

² Public Law 106-113.

³ 42 U.S.C.A. § 1395ss.

⁴ 42 U.S.C.A. § 1395ss(b)(1) (Supp. I 1999).

These two Acts do not direct the National Association of Insurance Commissioners (NAIC) to amend its Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (Model Regulation), which prior to adoption of amendments to the SSA set the federal standard for certification of state regulatory programs. Nor do the Acts provide a transition period for states' adoption of conforming amendments into their regulations in order to maintain certification. In light of the fact that Congress did not include a directive to the NAIC or a transitional period for states, HCFA has agreed to publish the amended Model Regulation (Attachment A), scheduled for adoption in the fall through an NAIC Executive/Plenary call, in the *Federal Register* as the federal standard for compliance. States will have one year (two years for states in which legislative action is required in order to adopt the amendments and the legislature is not scheduled to meet in 2000 in a legislative session in which such legislation could be considered) after the NAIC's adoption of the amended Model Regulation to change their regulations to comply with the Model. HCFA has agreed not to conduct any periodic reviews of state regulatory programs until after one year of the NAIC's adoption of the amended Model Regulation, unless it receives complaints about an issuer's non-compliance with federal standards in which case it may choose to review a state's regulatory program. HCFA will resume periodic reviews of state regulatory programs one year (two years in specified cases) after the NAIC has adopted an amended Model Regulation, at which time states will be responsible for having adopted provisions conforming to the amended Model Regulation in order to be deemed in compliance with certification requirements.

I. Relevant Provisions of the BBRA and TWWIA

Section 501(a) of the BBRA amends the Social Security Act to provide that a beneficiary may elect to begin his or her guaranteed issue period upon receipt of notification of impending termination of an Medicare+Choice (M+C) plan. Thus, under this provision a beneficiary does not have to wait until actual termination of the M+C plan to apply and receive a guaranteed issue Medigap policy. As a result of this amendment there are now two triggers for guaranteed issue; however, a beneficiary may only avail his or herself of one such trigger.

Section 536 of the BBRA expands the class of persons eligible for guaranteed issue to include individuals who are 65 years of age or older and enrolled in the Program for All-inclusive Care for the Elderly (PACE), if their enrollment with a PACE provider ceases under circumstances similar to those that provide guaranteed issue rights to beneficiaries enrolled in an M+C plan. Accordingly, a PACE program beneficiary is entitled to guaranteed issue of a Medigap policy if he or she loses coverage under a PACE plan because the plan has terminated, discontinued providing the plan in the area in which the beneficiary resides, or the plan has lost certification. A PACE beneficiary may elect to begin his or her guaranteed issue period upon receipt of a final notification of impending

termination. Additionally, a PACE program beneficiary is entitled to guaranteed issue of a Medigap policy under the following circumstances: 1) the individual is no longer able to elect the plan because of a change in the individual's place of residence; 2) the individual disenrolls from a Medigap policy to enroll in a PACE plan for the first time and disenrolls from the PACE plan within the first 12 months of subsequent enrollment; and 3) the beneficiary, upon first becoming eligible for Medicare, enrolls in a PACE plan. Further a PACE beneficiary who leaves a PACE plan because of material misrepresentation or substantial violation of a provision of the contract on the part of the organization is entitled to the guaranteed issue of a Medigap policy. This provision does not apply to beneficiaries enrolled in a PACE program prior to the effective date of the BBRA.

Section 205 of the TWWIA provides disabled beneficiaries who are entitled to Medicare benefits by reason of disability under section 226 of the Social Security Act, and covered under a group health plan, with the right to suspend benefits and premiums under a Medigap policy.

II. Amendments to the Model Regulation

Following is a summary of the amendments to the Model Regulation dated 6/12/00. (As referenced above, the amendments in their entirety are appended to this memorandum as Attachment A).

A. Amendments to the Model Regulation Pursuant to the BBRA and TWWIA

Section 8A(7), Benefit Standards for Policies or Certificates, of the Model Regulation (pg 5 of Att. A) is amended to insert language in subparagraph (c), which provides a Medicare beneficiary who is entitled to benefits under section 226 of the Social Security Act with the right to suspend benefits and premiums under a Medigap policy. A drafting note (pgs 5 & 6 of Att. A) has also been added to section 8A(7)(c) to make reference to anticipated guidance from HCFA on ambiguities within this provision. Additionally, restitution of coverage, which was previously subparagraph (c), has been changed to subparagraph (d).

Section 12A of the Model Regulation, Guaranteed Issue for Eligible Persons (pg 5, Att. A), has been amended to include the phrase "subject to Subsection B (2)(b)" which refers to the ability of a beneficiary to elect to begin his or her sixty-three day guaranteed issue period upon the date of notification of impending termination. Accordingly, a subparagraph (b) has been added to the section 12B(2) (pg 7, Att. A), which specifies that a beneficiary who falls within the eligible beneficiary category described in subparagraph (a) may elect to begin his or her guaranteed issue period upon receipt of notice of impending termination.

Section 12B(2)(a) (pg 10, Att. A), has been amended to include a PACE program beneficiary, who is 65 years of age or older, with the right to guaranteed issue of a Medigap policy as if he or she were covered under a M+C plan, if the individual loses coverage under circumstances similar to those providing M+C enrollees with a guaranteed issue right under this section. Additionally, section 12B(2)(a)(i) and (ii) (pg 10, Att. A) has been amended to include the phrase “or the plan has notified the individual of an impending termination or discontinuance of such plan,” and “or has notified the individual of an impending termination or discontinuance of such plan,” respectively. This phrase has been added to indicate that a beneficiary’s right to the guaranteed issue of Medigap plans A, B, C, or F, due to loss of benefits under an M+C plan, may now be triggered upon notification of impending termination.

Section 12B(5)(a) (pg 8, Att. A) is amended to include the PACE program under section 1984 of the Social Security Act as one of the organizations that a beneficiary may terminate a Medigap policy to join and be entitled to guaranteed issue if he or she subsequently terminates enrollment under the managed care organization to return to Medigap.

Section 12B(6) (pg 13, Att. A) is amended to provide that a beneficiary, who upon first becoming eligible for benefits at age 65 enrolls in a PACE program under section 1894 and disenrolls within 12 months, is eligible for guaranteed issue of a Medigap policy.

B. Technical Amendments to the Model Regulation

In addition to the changes to the Model Regulation necessitated by the BBRA and TWWIIA, various other technical amendments have been made to the Model.

The drafting note in section 4, Definitions (pg 4, Att. A), has been amended to add a citation for the interim rule issued by the Secretary of the U.S. Department of Health and Human Services addressing creditable coverage, as defined under HIPAA. Also, section 4K is amended to include the United States Code citation for the definition of a “Medicare+Choice plan” (the drafting note previously cited the public law number).

Section 8B(5), Standards for Basic (Core) Benefits Common to All Benefit Plans Coverage (pg 6, Att. A), has been amended to add the phrase “or in the case of hospital outpatient department services under a prospective payment system, the copayment amount” in relation to the new payment system for Medicare outpatient hospital services effective August 1, 2000. Under the Prospective Payment System (PPS) the methodology for calculating costs of hospital outpatient department services (including the Part B coinsurance) will

no longer be based upon the billed amount, but instead will utilize ambulatory payment classifications. Beginning August 1, 2000 a beneficiary's Part B coinsurance amount for hospital outpatient services will be calculated using either a set copayment amount for services, 20 % of the national median amount for a particular ambulatory payment category grouping, or a hospital-elected reduced copayment amount. A drafting note has been added to section 8B(5) (pg 6, Att. A) to explain the liability of beneficiaries/issuers for hospital outpatient services with relation to the applicable copayment terminology used under the PPS. Likewise, the outline of coverage cover page (pg 17, Att. A), has been amended to denote that all Medigap plans must cover Part B coinsurance, which under a PPS will be the applicable copayment.

Section 8C(9), Additional Benefits, has been amended to delete "Fecal Occult Blood Test," "Mammogram," and "Influenza Vaccine" from the list of preventive screening tests or preventive services because, pursuant to the BBA-97, all three are covered under Medicare Part B and should therefore not be included in benefits covered under a Medigap plan.

The drafting note in section 9 (pg 8, Att. A) is amended to italicize the name of the *Guide to Health insurance for People with Medicare*. Also, the drafting note in section 10, Medicare Select Policies and Certificates (pg 8 Att. A), is amended to delete all references to the Secretary of Health and Human Services' authorization of the sale of Medicare SELECT policies within a state. Medicare Select policies may now be sold in all states so the need for specific authorization by the Secretary is defunct.

The drafting note in section 12(2)(b) (pg 11, Att. A) has been deleted because the guaranteed issue provision for eligible beneficiaries in section 12(2)(a), created by the Balanced Budget Act of 1997, was originally interpreted as not going into effect until 2002, when in fact it became effective immediately.

The outline of coverage for Medicare (Part B) Medical Services under Plan C (pg 18, Att. A) has been amended to correctly cite the issuer copayment amount as \$250. Finally, the outlines of coverages' reference to annual deductible for high deductible plans F and J (pg 18, 20, 21, 22, 24, 25, and 26, Att. A) have been amended to insert brackets around the dollar amount cited as the annual deductible in order to allow for automated changes as this dollar amount may change pursuant to any increase made by the Secretary. Also, the annual deductible amount for the year 2000 (\$1530) had been inserted into the outlines.

III. NAIC Recommendation to States with Regard to Adoption of the Provisions of the BBRA and TWWIIA, As Incorporated in the Social Security Act

The NAIC Health Insurance and Managed Care (B) Committee is recommending that states adopt the amended Model Regulation into their

regulations as soon as possible, and at the latest one year after adoption by the NAIC. If a state requires legislative action to adopt the changes and the legislature is not scheduled to meet in 2000, that state has two years to amend its regulation. States, however, do not have to wait until the Model Regulation is adopted in September to begin amending their regulations, and in fact, the NAIC is encouraging states to begin the amendment process now. Until such time as a state's regulation is amended there exists the possibility that the Secretary may call the regulatory program into question. The Secretary has the right to revoke a state's certification after giving the state an opportunity to amend its regulation.

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NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

NOTICE

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TO: All NAIC Members

FROM: Kathleen Sebelius, Chair, Health Insurance and Managed Care (B) Committee

DATE: July 21, 2000

SUBJECT: State Adoption of Amendments to the NAIC Medicare Supplement Insurance Model Regulation in Order to Retain Certification of State Medigap Regulatory Programs

As a result of amendments made to section 1882 of the Social Security Act (SSA), which governs Medicare supplement insurance (Medigap), there is an immediate need for states to amend their Medigap regulations in order to maintain certification of their regulatory programs. As you are aware, the regulatory scheme for Medigap insurance is a complex one, with states retaining authority over this insurance product provided that their regulatory programs, at a minimum, meet the minimum standards set forth in federal law. Prior to amendment of the SSA, the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (Model Regulation) set the standard for state certification. The current federal standard, however, consists of the Model Regulation **and** several new provisions added to the SSA. **Therefore, current state Medigap regulatory programs, which include only the provisions contained in the Model Regulation, are not in compliance with federal standards and are in danger of having certification of their regulatory programs revoked by the Secretary of the Department of Health and Human Services (Secretary).**

The NAIC has drafted amendments to the Model Regulation that incorporate the necessary federal standards. The NAIC's Executive and Plenary committees will adopt these amendments via conference call in the fall. **Adoption of these amendments by the state will bring a state's Medigap regulatory program into compliance with current federal standards.** Although the NAIC and U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA) have agreed to allot states one year after the NAIC adopts relevant amendments to the Model Regulation to incorporate such changes into their regulatory programs, it is imperative that states adopt these

amendments as soon as possible. If issuers in a state are found not to be in compliance with the heightened standards and the state's regulatory program does not include such provisions the Secretary could revoke the state's certification. **Therefore, the NAIC is strongly urging states to adopt these amendments into their regulations by emergency rule or regulation.**

The attached memorandum will assist you with amendments that your state should make to the Model Regulation in order to retain certification of the state regulatory program.

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