

**WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION**

Form #3

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OFFICE OF THE WEST VIRGINIA
SECRETARY OF STATE

**NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE**

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY: W. Va. Code §§ 33-2-10, 33-16-3d, and 33-28-5b

AMENDMENT TO AN EXISTING RULE: YES NO

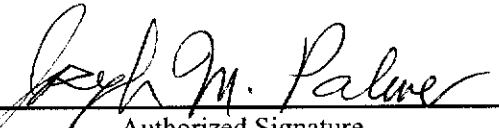
IF YES, SERIES NUMBER OF RULE BEING AMENDED: 24

TITLE OF RULE BEING AMENDED: Medicare Supplement Insurance

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: _____

TITLE OF RULE BEING PROPOSED: _____

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE FOR THEIR REVIEW.



Authorized Signature
Acting Secretary of Tax & Revenue



STATE OF WEST VIRGINIA
Offices of the Insurance Commissioner

Legal Division

CECIL H. UNDERWOOD
Governor

HANLEY C. CLARK
Insurance Commissioner

September 1, 2000

HAND DELIVERED

Ms. Judy Cooper, Director
Administrative Law Division
Office of Secretary of State
State Capitol
Charleston, West Virginia 25305

Dear Ms. Cooper:

Enclosed please find for filing one (1) copy of the following:

- 1) Notice of Agency Approval of a Proposed Rule and Consent of Acting Secretary of Tax and Revenue;
- 2) Fiscal Note for Proposed Rule;
- 3) Brief Summary of Rule;
- 4) Statement of Circumstances;
- 5) Legislative Rule-Making Review Committee Questionnaire;
- 6) Agency approved proposed rule entitled "Medicare Supplement Insurance" (Title 114, Series 24).

Please contact me if further information is required.

Sincerely,

A handwritten signature in cursive script that reads "Donna S. Quesenberry".

Donna S. Quesenberry
General Counsel

DSQ/jz
Enclosures

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Medicare Supplement Insurance
Title 114, Series 24

Type of Rule: Legislative Interpretive Procedural

Agency: Insurance Commissioner

Address: Post Office Box 50540
1124 Smith Street, Greenbrooke Building
Charleston, West Virginia 25305-0540

1. Effect of Proposed Rule

	ANNUAL FISCAL YEAR				
	Increase	Decrease	Current	Next	Thereafter
ESTIMATED TOTAL COST	None				
PERSONAL SERVICES	None				
CURRENT EXPENSE	None				
REPAIRS AND ALTERNATIONS	None				
EQUIPMENT	None				
OTHER	None				

2. Explanation of above estimates:

There will be no fiscal impact on state, local or federal government.

3. Objectives of these rules:

The objective of this rule is to adopt current minimum federal standards for Medicare supplement insurance policies as required by the Balanced Budget Refinement Act of 1999 and the Ticket to Work and Work Incentives Improvement Act of 1999. The rule includes all of the federally mandated provisions of the proposed revisions to the "NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act."

Rule Title: Medicare Supplement Insurance
Title 114, Series 24

4. Explanation of Overall Economic Impact of Proposed Rule.

A. Economic Impact on State Government.

None.

B. Economic Impact on Political Subdivisions; Specific Industries; Specific groups of Citizens.

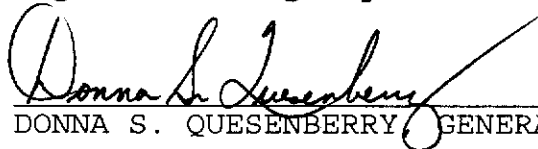
The effect on the insurance industry will be negligible, as federal law already mandates the standards set by this rule for Medicare supplement insurance. Medicare recipients will benefit economically by the rule's provision regarding benefit levels for Medicare supplement policies.

C. Economic Impact on Citizens/Public at Large.

None.

Date: 9/1/00

Signature of Agency Head or Authorized Representative



DONNA S. QUESENBERRY GENERAL COUNSEL

Insurance Commissioner
Legislative Rule
Title 114, Series 24

MEDICARE SUPPLEMENT INSURANCE

TITLE 114, SERIES 24

BRIEF SUMMARY OF RULE

This proposed rule adopts current minimum federal standards for Medicare supplement insurance policies as mandated by the Balanced Budget Refinement Act of 1999 and the Ticket to Work and Work Incentives Improvement Act of 1999. This rule amends and replaces the Insurance Commissioner's existing Series 24, and adopts proposed revisions to the "NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act." States are required to make the requisite changes to their regulatory programs to maintain approval as meeting minimum federal standards. The revisions increase consumers' rights to guaranteed issue of policies and allow persons covered under a group health plan to temporarily suspend a Medicare supplement policy, without canceling it.

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MEDICARE SUPPLEMENT INSURANCE

TITLE 114, SERIES 24

STATEMENT OF CIRCUMSTANCES

This proposed rule adopts current minimum federal standards for Medicare supplement insurance policies as mandated by the Balanced Budget Refinement Act of 1999 and the Ticket to Work and Work Incentives Improvement Act of 1999. This rule amends and replaces the Insurance Commissioner's existing Series 24, and adopts proposed revisions to the "NAIC Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act." States are required to make the requisite changes to their regulatory programs to maintain approval as meeting minimum federal standards. If the federal minimum standards are not implemented, Medicare supplement insurance policies may not be sold in this State.

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: SEPTEMBER 1, 2000

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: OFFICE OF THE INSURANCE COMMISSIONER
ATTN: Legal Division
1124 Smith Street
Post Office Box 50540
Charleston, West Virginia 25305-0540

LEGISLATIVE RULE TITLE: MEDICARE SUPPLEMENT INSURANCE
(TITLE 114, SERIES 24)

1. Authorizing statute(s) citation:

West Virginia Code §§ 33-2-10, 33-16-3d, and 33-28-5b

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:

August 1, 2000

b. What other notice, including advertising, did you give of the hearing?

None

c. Date of Public Hearing(s) or Public Comment Period ended:

Comment period ended August 31, 2000.

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached _____ No comments received _____

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

September 1, 2000

- f. Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all written correspondence regarding this rule: (Please type)

Donna S. Quesenberry, General Counsel
West Virginia Insurance Commission
Legal Division
P.O. Box 50540
Charleston, WV 25305-0540
Phone: (304) 558-0401
Fax: (304) 558-1362
E-mail: quosed@wvnm.wvnet.edu

- g. IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

Heidi L. Talmage, Associate Counsel
West Virginia Insurance Commission
Legal Division
P.O. Box 50540
Charleston, WV 25305-0540
Phone: (304) 558-0401
Fax: (304) 558-1362

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

- a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

Not applicable

- b. Date of hearing or comment period:

Not applicable

- c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

Not applicable

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d. Attach findings and determinations and reasons:

Not applicable

FILED

114CSR24

SEP 1 3 12 PM '00

**WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER**

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

**SERIES 24
MEDICARE SUPPLEMENT INSURANCE**

Section

- 114-24-1. General.
- 114-24-2. Definitions.
- 114-24-3. Policy Definitions and Terms.
- 114-24-4. Policy Provisions.
- 114-24-5. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to August 5, 1991.
- 114-24-6. Benefit Standards for Policies or Certificates Issued or Delivered on or After August 5, 1991.
- 114-24-7. Standard Medicare Supplement Benefit Plans.
- 114-24-8. Medicare Select Policies and Certificates.
- 114-24-9. Open Enrollment.
- 114-24-10. Guaranteed Issue for Eligible Persons.
- 114-24-11. Standards for Claims Payment.
- 114-24-12. Loss Ratio Standards and Refund or Credit of Premium.
- 114-24-13. Filing and Approval of Policies and Certificates and Premium Rates.
- 114-24-14. Permitted Compensation Arrangements.
- 114-24-15. Required Disclosure Provisions.

- 114-24-16. Requirements for Application Forms and Replacement Coverage.
- 114-24-17. Filing Requirements for Advertising.
- 114-24-18. Standards for Marketing.
- 114-24-19. Appropriateness of Recommended Purchase and Excessive Insurance.
- 114-24-20. Reporting of Multiple Policies.
- 114-24-21. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates.

- Appendix A. Medicare Supplement Refund Calculation Form.
- Appendix B. Outline of Medicare Supplement Coverage--Cover Page.
- Appendix C. Medicare Supplement Benefit Plans "A" through "J", Respectively (26 pages).
- Appendix D. Form for Reporting Medicare Supplement Policies.
- Appendix E. Outline of Medicare Supplement Coverage and Premium Information.
- Appendix F. Notice to Applicant Regarding Replacement of Medicare Supplement Insurance.
- Appendix G. Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare.

**TITLE 114
WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER**

**SERIES 24
MEDICARE SUPPLEMENT INSURANCE**

§ 114-24-1. General.

1.1. Scope. -- The purpose of this rule is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

1.2. Authority. -- W. Va. Code §§ 33-28-5b, 33-2-10, and 33-16-3d.

1.3. Filing Date. -- ~~April 24, 2000~~

1.4. Effective Date. -- ~~April 24, 2000~~

1.5. Applicability. -- This legislative rule amends West Virginia 114CSR24 "Medicare Supplement Insurance" filed ~~May 16, 1997~~ April 24, 2000 and effective on ~~May 16, 1997~~ April 24, 2000. Except as otherwise specifically provided, this rule shall apply to:

a. All Medicare supplement policies delivered or issued for delivery in this State or which are otherwise subject to the jurisdiction of this State on or after the effective date hereof, and

b. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this State.

c. This rule shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

§ 114-24-2. Definitions.

2.1. "Applicant" means:

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a. in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

b. in the case of a group Medicare supplement policy, the proposed certificateholder.

2.2. "Bankruptcy" means when a Medicare+Choice organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

2.3. "Certificate" means any certificate delivered or issued for delivery in this State under a group Medicare supplement policy.

2.4. "Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

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

2.6. "Creditable coverage" means:

a. With respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of Title 10 United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;

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8. A health plan offered under chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

9. A public health plan as defined in federal regulation; and

10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

b. "Creditable coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

c. "Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

3. Such other similar, limited benefits as are specified in federal

regulations.

d. "Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness; and
2. Hospital indemnity or other fixed indemnity insurance.

e. "Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and
3. Similar supplemental coverage provided to coverage under a group health plan.

2.7. "Commissioner" means the Insurance Commissioner of the State of West Virginia.

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

2.9. "Insolvency" means when an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

2.10. "Issuer" means insurance company, fraternal benefit society, health care service plan, health maintenance organization, or any other entity delivering or issuing for delivery in this State Medicare supplement policies or certificates.

2.11. "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

2.12. "Medicare+Choice plan" means a plan of coverage for health benefits under Medicare Part C as defined in ~~Section 1859, Title IV, Subtitle A, Chapter 1 of P.L. 105-33~~ 42 U.S.C. 1395w-28(b)(1), and includes:

a. 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;

b. Medical savings account plans coupled with a contribution into a Medicare+Choice medical savings account; and

c. Medicare+Choice private fee-for-service plans.

2.13. "Medicare Supplement Policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or corporations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. § 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

2.14. "Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

2.15. "Secretary" means the Secretary of the United States Department of Health and Human Services.

§ 114-24-3. Policy Definitions and Terms.

3.1. No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

3.2. "Accident," "Accidental Injury," or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

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

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

3.3. "Benefit Period" or "Medicare Benefit Period" shall not be defined more restrictively than as defined in the Medicare program.

3.4. "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined more restrictively than as defined in the Medicare program.

3.5. "Health Care Expenses" means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers. Such expenses shall not include:

- a. Home office and overhead costs;
- b. Advertising costs;
- c. Commissions and other acquisition costs;
- d. Taxes;
- e. Capital costs;
- f. Administrative costs; and
- g. Claims processing costs.

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

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

3.8. "Medicare Eligible Expenses" shall mean expenses of the kinds covered by

Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

3.9. "Physician" shall not be defined more restrictively than as defined in the Medicare program.

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

§ 114-24-4. Policy Provisions.

4.1. Except for permitted preexisting condition clauses as described in Paragraph Subdivision a of Subsection 5.2 and Paragraph Subdivision a of Subsection 6.2 of this rule, no policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

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

4.3. No Medicare supplement policy or certificate in force in the State shall contain benefits which duplicate benefits provided by Medicare.

§ 114-24-5. Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to August 5, 1991.

5.1. 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 minimum standards set forth in this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

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

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting

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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.

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

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premium modifications to correspond to such changes are permissible subject to prior approval of the commissioner. Any such proposed premium modifications shall be filed with the commissioner in compliance with procedures applicable to accident and sickness filings generally and with other applicable sections of this rule.

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

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

2. be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e. Except as authorized by the commissioner, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

1. If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in ~~Subparagraph C of this Paragraph~~ Paragraph 3 of this Subdivision, the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

A. an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

B. an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Subsection 6.3 of this

rule.

2. If membership in a group is terminated, the issuer shall:

A. offer the certificateholder such conversion opportunities as are described in ~~Subparagraph A of this Paragraph~~ Paragraph 1 of this Subdivision; or

B. at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

3. 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 group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

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

5.3. Minimum Benefit Standards.

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

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

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

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

e. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal

regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

f. Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [\$100];

g. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, 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.

§ 114-24-6. Benefit Standards for Policies or Certificates Issued or Delivered on or After August 5, 1991.

6.1. The standards set forth in this section are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State on or after August 5, 1991. 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.

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

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. 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.

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

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premium modifications to correspond to such changes are permissible subject to prior approval of the commissioner. Any such proposed premium modifications shall be filed with the commissioner in compliance with procedures applicable to accident and sickness filings generally and with other applicable sections of this rule.

d. 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.

e. Each Medicare supplement policy shall be guaranteed renewable.

1. The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

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

3. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under ~~Subparagraph E of this Paragraph~~ Paragraph 5 of this Subdivision, the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):

A. Provides for continuation of the benefits contained in the group policy, or

B. Provides for such benefits as otherwise meet the requirements of this subsection.

4. If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall

A. Offer the certificateholder the conversion opportunity described in ~~Subparagraph C of this Paragraph~~ Paragraph 3 of this Subdivision, or

B. At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

5. If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the 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. 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

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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 to payment of the maximum benefits.

g. 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 certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder 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 certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance.

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

2. Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for the period 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 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

23. Reinstitution of such coverages:

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

B. Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

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

6.3. Standards for Basic Core Benefits Common to All Benefit Plans. -- 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 thereof.

a. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

b. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

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

e. Coverage for the coinsurance amount (or in the case of hospital outpatient department services 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.

6.4. 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.

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

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

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

d. 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.

e. 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.

f. 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.

g. 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.

h. 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.

i. Preventive Medical Care Benefit: Coverage for the following preventive health services:

1. An annual clinical preventive medical history and physical examination that may include tests and services from ~~Subparagraph B of this Paragraph~~ Paragraph 2 of this Subdivision and patient education to address preventive health care measures.

2. Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

examination;
A. ~~Fecal occult blood test and/or digital~~ Digital rectal

~~B. Mammogram;~~

~~EB.~~ Dipstick urinalysis for hematuria, bacteriuria and proteinuria;

~~EC.~~ Pure tone (air only) hearing screening test, administered or
ordered by a physician;

~~ED.~~ Serum cholesterol screening (every five (5) years);

~~FE.~~ Thyroid function test;

~~GF.~~ Diabetes screening.

3. ~~Influenza vaccine administered at any appropriate time during the year~~
~~and Tetanus and Diphtheria booster (every ten (10) years).~~

4. Any other tests or preventive measures determined appropriate by the
attending physician.

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

j. 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.

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

A. "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.

B. "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 24-hour period of services provided by a care provider is one visit.

C. "Care provider" means a duly qualified or licensed home health aide/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.

D. "Home" shall mean any place used by the insured as a place of residence, provided that such 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.

2. Coverage Requirements and Limitations

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

B. 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.

C. Coverage is limited to:

1. 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;

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

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

4. Seven (7) visits in any one week;

5. Care furnished on a visiting basis in the insured's home;

6. Services provided by a care provider as defined in this section;

7. At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

8. 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.

3. Coverage is excluded for:

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

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

k. **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. Such 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.

§ 114-24-7. Standard Medicare Supplement Benefit Plans.

7.1. An issuer shall make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic core benefits, as defined in Subsection 6.3 of this rule.

7.2. 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~~ Subdivision k of Subsection 6.4 and in Section 8, [*Section 8 of this rule will not take effect until West Virginia is designated a Medicare Select State by the federal government], of this rule.

7.3. Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "J" listed in this subsection and conform to the definitions in Section 2 of this rule. Each benefit shall be structured in accordance with the format provided in Subsections 6.3 and 6.4 and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement and overall content of a benefit.

7.4. An issuer may use, in addition to the benefit plan designations required in Subsection 7.3, other designations to the extent permitted by law.

7.5. Make-up of benefit plans:

a. Standardized Medicare supplement benefit plan "A" shall be limited to the Basic Core Benefits Common to All Benefit Plans, as defined in Subsection 6.3 of this rule.

b. Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible as defined in ~~Paragraph~~ Subdivision a of Subsection 6.4.

c. Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in Subsection 6.3 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~~ Subdivisions a, b, c and h of Subsection 6.4 respectively.

d. Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit as defined in Subsection 6.3 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~~ Subdivisions a, b, h and j of Subsection 6.4 respectively.

e. Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit as defined in Subsection 6.3 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~~ Subdivisions a, b, h and i of Subsection 6.4 respectively.

f. Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit as defined in Subsection 6.3 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~~ Subdivisions a, b, c, e and h of Subsection 6.4 respectively.

g. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in

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Subsection 6.3 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 Subdivisions a, b, c, e, and h of Subsection 6.4. respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be \$1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

h. Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit as defined in Subsection 6.3 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 Subdivisions a, b, d, h and j of Subsection 6.4 respectively.

i. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit as defined in Subsection 6.3 of this rule, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Outpatient Prescription Drug Benefit, and Medically Necessary Emergency Care in a Foreign Country as defined in Paragraph Subdivisions a, b, f and h of Subsection 6.4 respectively.

j. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit as defined in Subsection 6.3 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 Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in Paragraph Subdivisions a, b, e, f, h and j of Subsection 6.4 respectively.

k. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit as defined in Subsection 6.3 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 and At-Home Recovery Benefit as defined in Paragraphs Subdivisions a, b, c, e, g, h, i and j of Subsection 6.4 respectively

l. Standardized Medicare supplement benefit high deductible plan "J" shall consist of only the following: 100% of covered expenses following the payment of the annual

high deductible plan "J" deductible. The covered expenses include the core benefit as defined in Subsection 6.3 of this regulation, plus the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, one hundred percent (100%) of the Medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care benefit and at-home recovery benefit as defined in ~~Paragraphs~~ Subdivisions a, b, c, e, g, h, i and j of Subsection 6.4. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be \$1500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of \$10.

§ 114-24-8. Medicare Select Policies and Certificates.

[*Section 8 of this rule will not take effect until West Virginia is designated a Medicare Select State by the federal government.]

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

8.2. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

8.3. For the purposes of this section:

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

b. "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.

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

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

e. "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.

f. "Restricted network provision" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

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

8.4. The commissioner 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 commissioner finds that the issuer has satisfied all of the requirements of this rule.

8.5. 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 commissioner.

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

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

1. 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.

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

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

B. To make appropriate referrals.

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

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

5. 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 such 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.

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

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

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

1. The formal organizational structure;

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

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

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

f. Copies of the written information proposed to be used by the issuer to comply with Subsection 8.10.

g. Any other information requested by the commissioner.

8.7. A Medicare Select issuer shall file:

a. Any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing such changes. Such changes shall be considered approved by the commissioner after thirty (30) days unless specifically disapproved.

b. An updated list of network providers with the commissioner at least quarterly.

8.8. A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

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

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

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

8.10. 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:

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

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

2. Other Medicare Select policies or certificates.

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

c. A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

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

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

f. A description of the policyholder's right to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

g. A description of the Medicare Select issuer's quality assurance program and

grievance procedure.

8.11. 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 8.10 of this Section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

8.12. A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

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

b. 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.

c. 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.

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

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

f. The issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

8.13. 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.

8.14. 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 such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six (6) months.

a. 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 or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this ~~paragraph~~ Subdivision, a significant benefit means coverage for the Medicare Part A deductible, coverage for outpatient prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

8.15. 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.

a. 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 such policies and certificates available without requiring evidence of insurability.

b. 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 or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this ~~paragraph~~ Subdivision, a significant benefit means coverage for the Medicare Part A deductible, coverage for outpatient prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

8.16. 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.

§ 114-24-9. Open Enrollment.

9.1. 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 such 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 an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard

to age.

9.2. If an applicant qualifies under Subsection 9.1 of this section and submits an application during the time period referenced in Subsection 9.1, 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.

9.3. If the applicant qualifies under Subsection 9.1 of this section and submits an application during the time period referenced in Subsection 9.1 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 an 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.

9.4. Except as provided in Subsections 9.2 and 9.3 of this section and Section 21, Subsection 9.1 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 certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage became effective.

§ 114-24-10. Guaranteed Issue for Eligible Persons.

10.1. Eligible persons are those individuals described in Subsection 10.2 of this section who, subject to Paragraph 2 of Subdivision b of Subsection 10.2, apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in Subsection 10.2 of this section, and who submit evidence of the date of termination or disenrollment with the application for a Medicare supplement policy.

a. With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in Subsection 10.3 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.

10.2. An eligible person is an individual described in any of the following ~~paragraphs~~ Subdivisions:

a. 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;

b. 1. The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 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+Choice plan:

~~1A.~~ The organization's plan or plan's certification [under this part] has been terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; The certification of the organization or plan under this series has been terminated, or the organization or plan has notified the individual of an impending termination of such certification;

B. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuance of such plan;

2C. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (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;

3D. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

A1. The organization offering the plan substantially violated a material provision of the organization's contract under this part series 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

B2. The organization or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

4E. The individual meets such other exceptional conditions as the Secretary may provide.

2. A. An individual described in Paragraph 1 of this Subdivision may elect to apply Subsection 10.1 by substituting, for the date of termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

B. In the case of an individual making the election in Subparagraph A of this Paragraph, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under Subsection 10.1 shall only become effective upon termination of coverage under the Medicare+Choice plan involved.

c. 1. The individual is enrolled with:

1A. An eligible organization under a contract under Section 1876 (Medicare risk or cost);

2B. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

3C. An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

4D. An organization under a Medicare Select policy; and

52. The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under ~~the first sentence of Section 1851(c)(4) of the federal Social Security Act as delineated in Paragraph~~ Subdivision b of Subsection 10.2 of this section.

d. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because;

1. Of the insolvency of the issuer or bankruptcy of the nonissuer organization or of other involuntary termination of coverage or enrollment under the policy;

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

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

e. 1. The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice 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 program 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

~~f. 2.~~ 2. The subsequent enrollment under ~~Paragraph e of this subsection~~ Paragraph 1 of this Subdivision 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

~~g f.~~ The individual, upon first becoming eligible for benefits under Part A of Medicare at age 65, enrolls in a Medicare+Choice plan under Part C of Medicare, or in a PACE program under Section 1894, and disenrolls from the plan or program by not later than twelve (12) months after the effective date of enrollment.

10.3. The Medicare supplement policy to which eligible persons are entitled under:

a. ~~Paragraphs Subdivisions~~ a, b, c, and d of Subsection 10.2 of this section is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, or F offered by any insurer.

b. ~~Paragraphs e and f~~ Subdivision e of Subsection 10.2 of this section is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Subdivision ~~(a)~~ a of this subsection.

c. ~~Paragraph Subdivision g f~~ of Subsection 10.2 of this section shall include any Medicare supplement policy offer by any issuer.

10.4. Notification provisions are as follows:

a. At the time of an event described in Subsection 10.2 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 10.1. Such notice shall be communicated contemporaneously with the notification of termination.

b. At the time of an event described in Subsection 10.2 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 10.1 of this section. Such notice shall be communicated within ten (10) working days of the issuer receiving notification of disenrollment.

§ 114-24-11. Standards for Claims Payment.

11.1. 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, Pub. L. No. 100-203) by:

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

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

c. Paying the participating physician or supplier directly;

d. 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;

e. Paying user fees for claim notices that are transmitted electronically or otherwise; and

f. 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.

11.2. Compliance with the requirements set forth in Subsection 10.1 above shall be certified on the Medicare supplement insurance experience reporting form.

§ 114-24-12. Loss Ratio Standards and Refund or Credit of Premium.

12.1. Loss Ratio Standards.

a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless:

1. 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 certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

A. At least 75 percent of the aggregate amount of premiums earned in the case of group policies, or

B. At least 65 percent of the aggregate amount of premiums earned in the case of individual policies;

2. 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 such period and in accordance with accepted actuarial principles and practices.

b. 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.

c. For purposes of applying Paragraph Subdivision a of Subsection 12.1 and Paragraph Subdivision b of Subsection 13.3 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.

d. For policies issued prior to April 28, 1996, expected claims in relation to premiums shall meet:

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

2. The appropriate loss ratio requirement from ~~Parts (a) and (b); Subparagraph A, Paragraph a~~ Subparagraphs A and B of Paragraph 1 of Subdivision a of Subsection 12.1 when combined with actual experience beginning April 28, 1996; and

3. The appropriate loss ratio requirement from ~~Parts (a) and (b); Subparagraph A, Paragraph a~~ Subparagraphs A and B of Paragraph 1 of Subdivision a of Subsection 12.1 over the entire future period for which the rates are computed to provide coverage.

12.2. Refund or Credit Calculation.

a. An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the applicable reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan. Appendix A, which is hereby incorporated into this rule by reference, is annexed hereto and entitled "Reporting Form for Calculation of Loss Ratios."

b. If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation 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.

c. For the purposes of this section, policies or certificates issued prior to April 28, 1996, 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 April 28, 1996. The first such report shall be due by May 31, 1998.

d. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such 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 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.

12.3. Annual filing of premium rates.

a. An issuer of Medicare supplement policies and certificates issued before or after the effective date of these "Permanent Regulations on Medicare Supplement Insurance" 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 commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. 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. Such 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.

b. 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 commissioner, in accordance with the applicable filing procedures of this State:

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

A. An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement insurance policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

B. If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner 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. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

12.4. Public Hearings.

a. The commissioner 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 this rule 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 such reporting period. Public notice of such hearing shall be furnished in a manner consistent with the provisions of W. Va. Code §§ 33-2-12 and 33-2-13. Nothing in this subsection shall be construed so as to limit the authority of the commissioner to conduct hearings regarding rates, to the extent that the laws of this State grant such authority.

§ 114-24-13. Filing and Approval of Policies and Certificates and Premium Rates.

13.1. 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 commissioner in accordance with filing requirements and procedures prescribed by the commissioner.

13.2. 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 commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

13.3. Except as provided in ~~Paragraph~~ Subdivision a of this Subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

a. An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

1. The inclusion of new or innovative benefits;
2. The addition of either direct response or agent marketing methods;
3. The addition of either guaranteed issue or underwritten coverage;

4. The offering of coverage to individuals eligible for Medicare by reason of disability.

b. 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. [*These provisions regarding Medicare Select policies will not take effect until West Virginia is designated a Medicare Select State by the federal government.]

13.4. Except as provided in ~~Subparagraph A~~, Paragraph 1 of Subdivision a of this Subsection, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this rule that has been approved by the commissioner.

a. 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 months.

1. An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this State.

2. An issuer that discontinues the availability of a policy form or certificate form pursuant to ~~Subparagraph A~~ of Paragraph 1 of Subdivision 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 commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

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

c. A change in the rating structure or methodology shall be considered a discontinuance under Subsection 13.4 unless the issuer complies with the following requirements:

1. The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

2. 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. The commissioner may approve a change to the differential which is in the public interest.

13.5. Refund or Credit Calculation.

a. Except as provided in Paragraph Subdivision b of this Subsection, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 12.

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

§ 114-24-14. Permitted Compensation Arrangements.

14.1. An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no greater than the commission or other compensation paid for selling or servicing the policy or certificate during each of the next four years or periods of the policy.

14.2. Beginning with the sixth year or period of the policy or certificate and for each year or period thereafter, the agent or producer shall receive no commission or compensation other than a maximum ten percent (10%) maintenance or service fee per policy year or period.

14.3. No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

14.4. 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.

§ 114-24-15. Required Disclosure Provisions.

15.1. General Rules.

a. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must 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.

b. 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 the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy 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, such premium charge shall be set forth in the policy.

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

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

e. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis to a person(s) eligible for Medicare shall provide to those applicants a ~~Guide to Health Insurance for People with Medicare~~ *Guide to Health Insurance for People with Medicare* in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. For purposes of this section, "form" means the

language, format, type size, promotional spacing, bold character, and line spacing. Delivery of the ~~Guide~~ Guide shall be made whether or not such 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~~ Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the ~~Guide~~ Guide shall be obtained by the issuer. Direct response issuers shall deliver the ~~Guide~~ Guide to the applicant upon request but not later than at the time the policy is delivered.

15.2. Notice Requirements.

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

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

2. Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

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

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

15.3. Outline of Coverage Requirements for Medicare Supplement Policies.

a. 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 acknowledgment of receipt of such outline from the applicant; and

b. 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 such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of

coverage provided upon application and the coverage originally applied for has not been issued."

c. The outline of coverage provided to applicants pursuant to this section consists of four 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 Medicare Supplement Benefit Plans "A" through "J" shall be shown on the cover page, and the plan(s) 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.

d. The following items shall be included in the outline of coverage in the order prescribed in Appendix E at the end of this rule. Appendix B, entitled "Outline of Medicare Supplement Coverage--Cover Page," which is incorporated into this rule by reference and annexed hereto, prescribes the information to be contained on the cover page. The required premium information and disclosure pages are in Appendix E of this rule. Examples of charts displaying the features of each Medicare supplement benefit plan offered by the issuer is contained in Appendix C, which is annexed hereto and incorporated herein by reference.

15.4. Notice Regarding Policies or Certificates Which Are Not Medicare Supplement Policies.

a. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. § 1395 et seq.); disability income policy; or other policy identified in Paragraph Subdivision c of Subsection 1.5 of this rule, issued for delivery in this State to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or certificate delivered to insureds. The notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

b. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in Paragraph Subdivision a of this Subsection shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates

Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

§ 114-24-16. Requirements for Application Forms and Replacement Coverage.

16.1. Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other accident and sickness insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

a. Statements:

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. The benefits and premiums under your Medicare supplement policy can be suspended if requested during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
5. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

b. Questions:

1. To the best of your knowledge:
 - A. Do you have another Medicare supplement policy or certificate in force?

1. If so, with which company?

2. If so, do you intend to replace your current Medicare supplement policy with this policy [certificate]?

B. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?

1. If so, with which company?

2. What kind of policy?

C. Are you covered for medical assistance through the State Medicaid program:

(SLMB)?

1. As a Specified Low Income Medicare Beneficiary

2. As a Qualified Medicare Beneficiary (QMB)?

3. For other Medicaid medical benefits?

16.2. Agents shall list any other health insurance policies they have sold to the applicant.

a. List policies sold which are still in force.

b. List policies sold in the past five (5) years which are no longer in force.

16.3. In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

16.4. Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One (1) copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant, at the time of the issuance of the policy, the notice regarding replacement of Medicare supplement coverage.

16.5. The notice required by Subsection 16.4 for an issuer shall be provided in substantially the form at the end of this rule (Appendix F) in no less than twelve (12) point type.

16.6. Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

§ 114-24-17. Filing Requirements for Advertising.

17.1. An issuer shall provide a copy of any Medicare supplement advertisement intended for use in this State whether through written, radio or television medium to the commissioner for review. Such advertisement shall comply with all laws of this State, including, when applicable, the provisions of W. Va. Code §§ 33-6-8(e), 33-6-35, and 33-11-4(2).

§ 114-24-18. Standards for Marketing.

18.1. An issuer, directly or through its producers, shall:

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

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

c. Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

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

e. Establish auditable procedures for verifying compliance with this Subsection.

18.2. In addition to the practices prohibited in this State's Unfair Trade Practices Act [W. Va. Code § 33-11-1 et seq.], the following acts and practices are prohibited:

a. Twisting. -- Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or

tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

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

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

18.3. The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this rule.

§ 114-24-19. Appropriateness of Recommended Purchase and Excessive Insurance.

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

19.2. Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

§ 114-24-20. Reporting of Multiple Policies.

20.1. On or before March 1 of each year, an issuer shall report the following information for every individual resident of this State for whom the issuer has in force more than one Medicare supplement policy or certificate:

- a. Policy and certificate number, and
- b. Date of issuance.

20.2. The items set forth above must be grouped by individual policyholder.

20.3. To comply with this section, an issuer shall use the form incorporated herein by reference and annexed hereto as Appendix D, entitled "Form for Reporting Duplicate Policies."

§ 114-24-21. Prohibition Against Preexisting Conditions, Waiting Periods, Elimination

Periods and Probationary Periods in Replacement Policies or Certificates.

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

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

Appendix A

**MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____**

TYPE ¹ _____	SMSBP ² _____
For the State of _____	Company Name _____
NAIC Group Code _____	NAIC Company Code _____
Address _____	Person Completing Exhibit _____
Title _____	Telephone Number _____

<u>Line</u>	(a) Earned Premium ³	(b) Incurred Claims ⁴
1. Current Year's Experience		
a. Total (all policy years)	_____	_____
b. Current year's issues ⁵	_____	_____
c. Net (for reporting purposes=1a-1b)	_____	_____
2. Past Years' Experience (all policy years)	_____	_____
3. Total Experience (Net Current Year + Past Year)	_____	_____
4. Refunds Last Year (Excluding Interest)		_____
5. Previous Since Inception (Excluding Interest)		_____
6. Refunds Since Inception (Excluding Interest)		_____
7. Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)		_____
8. Experienced Ratio Since Inception Total Actual Incurred Claims (line 3, col. b) = Ratio 2/ Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)		_____
9. Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.		_____
10. Tolerance Permitted (obtained from Credibility Table)		_____

Medicare Supplement Credibility Table

Life Years Exposed	
<u>Since Inception</u>	<u>Tolerance</u>
10,000+	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

¹ Individual Group, Individual Medicare Select, or Group Medicare Select Only.

² "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.

³ Includes Modal Loadings and Fees Charged

⁴ Excludes Active Life Reserves

⁵ This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE¹ _____
For the State of _____
NAIC Group Code _____
Address _____
Title _____

SMSBP² _____
Company Name _____
NAIC Company Code _____
Person Completing Exhibit _____
Telephone Number _____

11. Adjustment to Incurred Claims for Credibility
Ratio 3 = Ratio 2 + Tolerance _____

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required.
If Ratio 3 is less than the Benchmark Ratio, then proceed.

12. Adjusted Incurred Claims
[Total Earned Premiums (line 3, col. a) - Refunds since Inception (line 6)] X Ratio 3 (line 11) _____

13. Refund =
Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6) - Adjusted Incurred Claims (line 12)/
Benchmark Ratio (Ratio 1) _____

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

Signature

Name - Please Type

Title - Please Type

Date

**REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR INDIVIDUAL POLICIES FOR CALENDAR YEAR _____**

TYPE¹ _____
 For the State of _____
 NAIC Group Code _____
 Address _____
 Title _____

SMSBP² _____
 Company Name _____
 NAIC Company Code _____
 Person Completing Exhibit _____
 Telephone Number _____

(a) ³ Year	(b) ⁴ Earned Premium	(c) Factor	(d) (b)(c)	(e) Cumulative Loss Ratio	(f) (d)(e)	(g) Factor	(h) (b)(g)	(i) Cumulative Loss Ratio	(j) (h)(i)	(k) (j)	(l) Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000			0.40
2		4.175		0.493		0.000		0.000			0.55
3		4.175		0.493		1.194		0.659			0.65
4		4.175		0.493		2.245		0.669			0.67
5		4.175		0.493		3.170		0.678			0.69
6		4.175		0.493		3.998		0.686			0.71
7		4.175		0.493		4.754		0.695			0.73
8		4.175		0.493		5.445		0.702			0.75
9		4.175		0.493		6.075		0.708			0.76
10		4.175		0.493		6.650		0.713			0.76
11		4.175		0.493		7.176		0.717			0.76
12		4.175		0.493		7.655		0.720			0.77
13		4.175		0.493		8.093		0.723			0.77
14		4.175		0.493		8.493		0.725			0.77
15		4.175		0.493		8.684		0.725			0.77
Total:			(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: $(1+n)/(k+m)$: _____

- 1 Individual Group, Individual Medicare Select, or Group Medicare Select Only
- 2 "SMSBP" = Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
- 3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
- 4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- 5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

**REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES FOR CALENDAR YEAR**

TYPE¹ _____ SMSBP² _____
 For the State of _____ Company Name _____
 NAIC Group Code _____ NAIC Company Code _____
 Address _____ Person Completing Exhibit _____
 Title _____ Telephone Number _____

(a) ³ Year	(b) ⁴ Earned Premium	(c) Factor	(d) (b)×(c)	(e) Cumulative Loss Ratio	(f) (d)×(e)	(g) Factor	(h)×(g)	(i) Cumulative Loss Ratio	(j) (h)×(i)	(k) Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: $(1+n)/(k+m)$: _____

1 Individual Group, Individual Medicare Select, or Group Medicare Select Only.
 2 "SMSBP" - Standardized Medicare Supplement Benefit Plan - Use "P" for pre-standardized plans.
 3 Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.) (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)
 4 For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
 5 These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE -- COVER PAGE

Benefit Plan(s) ___ [Insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or, in the case of hospital outpatient department services under a prospective payment system, applicable copayments.

Blood: First three pints of blood each year.

A	B	C	D	E	F	F*	G	H	I	J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible	Part B Deductible		Part B Deductible	Part B Deductible				Part B Deductible	Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery	At-Home Recovery	At-Home Recovery
								Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Extended Drugs (\$3,000 Limit)
				Preventive Care							Preventive Care

*Plans F and J also have an option called a high deductible Plan F and high deductible Plan J. These high deductible plans pay the same or offer the same benefits as Plan F and J after one has paid a calendar year [\$(4500)(\$30) deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses are \$(4500)(\$30). Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but ~~does~~ do not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

APPENDIX C

PLAN A
 MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the Additional 365 days	All but \$764 [776] All but \$191 [194] a day All but \$382 [388] a day \$0 \$0	\$0 \$191 [194] a day \$382 [388] a day 100% of Medicare Eligible Expenses \$0	\$764 [776] (Part A Deductible) \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$95-50 [97] a day \$0	\$0 \$0 \$0	\$0 Up to \$95-50 [97] a day All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

PLAN A
MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts*	\$0	\$0	\$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0
Part B Excess Charges (Above Medicare Approved Amount(s))	\$0	\$0	All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
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**PLAN B
MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD**

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$764 [776] All but \$191 [194] a day All but \$382 [388] a day \$0	\$764 [776] (Part A Deductible) \$191 [194] a day \$382 [388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$95-50 [97] a day \$0		\$0 Up to \$95-50 [97] a day All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN B

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
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PLAN C

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$ 764 [776] All but \$ 191 [194] a day All but \$ 382 [388] a day \$0 \$0	\$ 764 [776] (Part A Deductible) \$ 191 [194] a day \$ 382 [388] a day 100% of Medicare Eligible Expenses \$0 All Costs	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$ 95.50 [97] a day \$0	\$0 Up to \$ 95.50 [97] a day \$0 All Costs	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

PLAN C

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% \$0	\$0 \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$100(Part B Deductible) 20%	\$0 \$0 \$0
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OTHER BENEFITS -- NOT COVERED BY MEDICARE

FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$0 20% and amounts over the \$50,000 lifetime maximum
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PLAN D

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$764 [776] All but \$194 [194] a day All but \$382 [388] a day \$0 \$0	\$764 [776] (Part A Deductible) \$194 [194] a day \$382 [388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$95.50 [97] a day \$0	\$0 Up to \$95.50 [97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN D

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
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PLAN D

MEDICARE (PARTS A & B) - (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>HOME HEALTH CARE - (Contd.) AT-HOME RECOVERY SERVICES -- NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan</p> <ul style="list-style-type: none"> - Benefit for each visit - Number of visits covered (must be received within 8 weeks of last Medicare Approved visit) - Calendar Year Maximum 	<p>\$0 \$0 \$0</p>	<p>Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600</p>	<p>Balance</p>

OTHER BENEFITS -- NOT COVERED BY MEDICARE

<p>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE. Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
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PLAN E

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$764 [776] All but \$194 [194] a day All but \$382 [388] a day \$0 \$0	\$764 [776] (Part A Deductible) \$194 [194] a day \$382 [388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$95-50 [97] a day \$0	\$0 Up to \$95-50 [97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLANE E

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
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PLAN E

OTHER BENEFITS -- NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<p>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA</p> <p>First \$250 each Calendar Year Remainder of Charges</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>
<p>*PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE</p> <p>Some Annual physical and preventive tests and services such as: digital rectal exam, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare</p> <p>First \$120 each Calendar Year Additional charges</p>	<p>\$0 \$0</p>	<p>\$120 \$0</p>	<p>\$0 All Costs</p>

* Medicare benefits are subject to change. Please consult the latest "Guide to Health Insurance for People with Medicare" Guide to Health Insurance for People with Medicare.

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [\$1500] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$ 1500 [1530] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$1500 [1530] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$764 [776] All but \$194 [194] a day All but \$382 [388] a day \$0 \$0	\$764 [776] (Part A Deductible) \$194 [194] a day \$382 [388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0*** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$95-50 [97] a day \$0	\$0 Up to \$95-50 [97] a day \$0	\$0 \$0 All Costs

PLAN F or HIGH DEDUCTIBLE PLAN F

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD -- (continued)

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1500] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1500] DEDUCTIBLE,** YOU PAY
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out- patient drugs and inpatient respite care	\$0	Balance

PLAN F OR HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.
 **This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year [\$1500-1530] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are [\$1500-1530]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1500-1530] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1500-1530] DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% \$100	\$0 \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$100 (Part B Deductible) 20%	\$0 \$0 \$0
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PLAN F OR HIGH DEDUCTIBLE PLAN F

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR -- (continued)

OTHER BENEFITS -- NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1500]530 DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1500]530 DEDUCTIBLE,** YOU PAY
<p>FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Chargcs</p>	<p>\$0 \$0</p>	<p>\$0 80% to a lifetime maximum benefit of \$50,000</p>	<p>\$250 20% and amounts over the \$50,000 lifetime maximum</p>

PLAN G

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest Guide to Health Insurance for People with Medicare.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$764 [776] All but \$194 [194] a day All but \$382 [388] a day \$0 \$0	\$764 [776] (Part A Deductible) \$194 [194] a day \$382 [388] a day 100% of Medicare Eligible Expenses \$0 All Costs	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$95-50 [97] a day \$0	\$0 Up to \$95-50 [97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN G

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 80%	\$100 (Part B Deductible) \$0 20%
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
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PLAN G

MEDICARE (PARTS A & B) -- (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (Contd.) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit - Number of visits covered (must be received within 8 weeks Of last Medicare Approved visit) - Calendar Year Maximum	\$0 \$0 \$0	Actual Charges to \$40 a visit Up to the number of Medicare Approved visits, not to exceed 7 each week \$1,600	Balance

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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PLAN H

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest Guide to Health Insurance for People with Medicare.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$764 [776] All but \$194 [194] a day All but \$382 [388] a day \$0 \$0	\$764 [776] (Part A Deductible) \$194 [194] a day \$382 [388] a day 100% of Medicare Eligible Expenses \$0 All Costs	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$95.50 [97] a day \$0	\$0 Up to \$95.50 [97] a day \$0 All Costs	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN H

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$100 (Part B Deductible) \$0 All Costs
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
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PLAN H

MEDICARE (PARTS A & B) -- (continued)

OTHER BENEFITS -- NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First \$250 each Calendar Year Next \$2,500 each Calendar Year Over \$2,500 each Calendar Year	\$0 \$0 \$0	\$0 50% - \$1,250 calendar year maximum benefit \$0	\$250 50% All Costs

PLAN I

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$764 [776] All but \$191 [194] a day All but \$382 [388] a day \$0 \$0	\$764 [776] (Part A Deductible) \$191 [194] a day \$382 [388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0 All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$95-50 [97] a day \$0	\$0 Up to \$95-50 [97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out-patient drugs and inpatient respite care	\$0	Balance

PLAN I

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the Calendar Year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic test, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$0 Generally 20% 100%	\$100 (Part B Deductible) \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$0 20%	\$0 \$100 (Part B Deductible) \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$100 (Part B Deductible) \$0
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PLAN I

MEDICARE (PARTS A & B) -- (continued)

SERVICES	MEDICARE PAY	PLAN PAYS	YOU PAY
HOME HEALTH CARE - (Contd.) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar Year Maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First \$250 each Calendar Year Next \$2,500 each Calendar Year Over \$2,500 each Calendar Year	\$0 \$0 \$0	\$0 50% - \$1,250 calendar year maximum benefit \$0	\$250 50% All Costs

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [\$1500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [\$1500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

NOTE: Amounts in brackets [] are revised January 1st each year. Please consult the latest *Guide to Health Insurance for People with Medicare*.

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$1500] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO [\$1500] DEDUCTIBLE,** YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after - While using 60 lifetime reserve days - Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	All but \$764 [776] All but \$194 [194] a day All but \$382 [388] a day \$0 \$0	\$764 [776] (Part A Deductible) \$194 [194] a day \$382 [388] a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0*** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$95-50 [97] a day \$0	\$0 Up to \$95-50 [97] a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART A) -- HOSPITAL SERVICES -- PER BENEFIT PERIOD, (continued)

SERVICES	MEDICARE PAYS	AFTER YOU PAY [\$+500]1530] DEDUCTIBLE, ** PLAN PAYS	IN ADDITION TO [\$+500]1530] DEDUCTIBLE, ** YOU PAY
<p>HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services</p>	<p>All but very limited coinsurance for outpatient drugs and inpatient respite care</p>	<p>\$0</p>	<p>Balance</p>

PLAN J or HIGH DEDUCTIBLE PLAN J

MEDICARE (PART B) -- MEDICAL SERVICES -- PER CALENDAR YEAR

*Once you have been billed \$100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This high deductible plan pays the same or offers the same benefits as Plan J after one has paid a calendar year [\$1,500] deductible. Benefits from high deductible Plan J will not begin until out-of-pocket expenses are [\$1,500]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate prescription drug deductible or the plan's separate foreign travel emergency deductible.

SERVICES	MEDICARE PAYS	AFTER YOU PAY \$[1,500] DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO \$[1,500] DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES -- IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment, First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts Part B Excess Charges (Above Medicare Approved Amounts)	\$0 Generally 80% \$0	\$100 (Part B Deductible) Generally 20% 100%	\$0 \$0 \$0
BLOOD First 3 pints Next \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0 \$0 80%	All Costs \$100 (Part B Deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES - BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES -- Medically necessary skilled care services and medical supplies -- Durable medical equipment	100% \$0 80%	\$0 \$100 (Part B Deductible) 20%	\$0 \$0 \$0
First \$100 of Medicare Approved Amounts* Remainder of Medicare Approved Amounts			

PLAN J or HIGH DEDUCTIBLE PLAN J

PARTS A & B (continued)

SERVICES	MEDICARE PAYS	AFTER YOU PAY [S1530] DEDUCTIBLE.** PLAN PAYS	IN ADDITION TO [S1530] DEDUCTIBLE.** YOU PAY
HOME HEALTH CARE - (Contd.) AT-HOME RECOVERY SERVICES - NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan - Benefit for each visit	\$0	Actual Charges to \$40 a visit	Balance
- Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
- Calendar Year Maximum	\$0	\$1,600	

OTHER BENEFITS - NOT COVERED BY MEDICARE

FOREIGN TRAVEL -- NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each Calendar Year Remainder of Charges	\$0 \$0	\$0 80% to a lifetime maximum benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS - NOT COVERED BY MEDICARE First \$250 each Calendar Year Next \$6,000 each Calendar Year Over \$6,000 each Calendar Year	\$0 \$0 \$0	\$0 50% - \$3,000 calendar year maximum benefit \$0	\$250 50% All Costs
PREVENTIVE MEDICAL CARE BENEFIT - NOT COVERED BY MEDICARE *** Annual physical and preventive tests and services such as: fecal occult blood test; digital rectal exam, mammogram; hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot; tetanus and diphtheria booster and education, administered or ordered by your doctor when not covered by Medicare First \$120 each Calendar Year Additional charges	\$0 \$0	\$120 \$0	\$0 All Costs

***Medicare benefits are subject to change. Please consult the latest Guide to Health Insurance for People with Medicare.

APPENDIX D

FORM FOR REPORTING MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

Signature

Name and Title (Please Type)

Date

APPENDIX E

[COMPANY NAME]
OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE
AND PREMIUM INFORMATION

PREMIUM INFORMATION [Boldface Type]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline, describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within thirty (30) days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct responses:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook"Medicare & You for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are incorporated into this regulation by reference and annexed hereto collectively as Appendix C, "Medicare Supplement Benefits Plans 'A' through 'J', Respectively." An issuer may use additional benefit plan designations on these charts pursuant to Subsection 7.4 of this regulation.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

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

APPENDIX F

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE

(Insurance company's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s):

- ___ Additional benefits.
- ___ No change in benefits, but lower premiums.
- ___ Fewer benefits and lower premiums.
- ___ Other. (please specify) _____
- _____
- _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) to the extent such time was spent (deleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent, Broker or
Other Representative*

[Typed Name and Address of
Issuer, Agent or Broker]

(Applicant's Signature)

(Date)

*Signature not required for direct response sales.

DISCLOSURE STATEMENTS

**Instructions for Use of the Disclosure Statements for
Health Insurance Policies Sold to Medicare Beneficiaries
that Duplicate Medicare**

1. Section 1882(d) of the federal Social Security Act [42U.S.C. 1395ss], prohibits the sale of a health insurance policy (the term policy or policies includes certificates) to Medicare beneficiaries that duplicate Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.
2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).
3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.
4. Property/casualty and life insurance policies are not considered health insurance.
5. Disability income policies are not considered to provide benefits that duplicate Medicare.
6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.
7. The federal law does not preempt state laws that are more stringent than the federal requirements.
8. The federal law does not preempt existing state form filing requirements.
9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix G remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for specified limited services]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that reimburse expenses incurred for specified disease(s) or other specified impairment(s). This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for policies that provide benefits for both expenses incurred and fixed indemnity basis]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Original disclosure statement for other health insurance policies not specifically identified in the previous statements]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited reimbursement for expenses if you meet the policy conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE**

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them.

These include:

- hospitalization
- physician services
- hospice
- other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before you Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

FULL TEXT OF P.L. 106-113 IS OVER 640 PAGES.

ATTACHED FOR REFERENCE ARE:

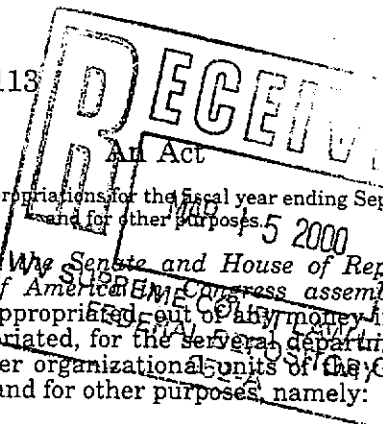
- 1) APPENDIX F - TABLE OF CONTENTS
- 2) APPENDIX F - TITLE V
- 3) RELEVANT PROVISIONS ARE SECTIONS 501 AND 536

AE 2.110: 106-113

PUBLIC LAW 106-113—NOV. 29, 1999

113 STAT. 1501

Public Law 106-113
106th Congress



An Act

Making consolidated appropriations for the fiscal year ending September 30, 2000,
and for other purposes.

Nov. 29, 1999
[H.R. 3194]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the several departments, agencies, corporations and other organizational units of the Government for the fiscal year 2000, and for other purposes, namely:

DIVISION A

DISTRICT OF COLUMBIA APPROPRIATIONS

TITLE I—FISCAL YEAR 2000 APPROPRIATIONS

FEDERAL FUNDS

District of
Columbia
Appropriations
Act, 1999.

FEDERAL PAYMENT FOR RESIDENT TUITION SUPPORT

For a Federal payment to the District of Columbia for a program to be administered by the Mayor for District of Columbia resident tuition support, subject to the enactment of authorizing legislation for such program by Congress, \$17,000,000, to remain available until expended: *Provided*, That such funds may be used on behalf of eligible District of Columbia residents to pay an amount based upon the difference between in-State and out-of-State tuition at public institutions of higher education, usable at both public and private institutions of higher education: *Provided further*, That the awarding of such funds may be prioritized on the basis of a resident's academic merit and such other factors as may be authorized: *Provided further*, That if the authorized program is a nationwide program, the Mayor may expend up to \$17,000,000: *Provided further*, That if the authorized program is for a limited number of States, the Mayor may expend up to \$11,000,000: *Provided further*, That the District of Columbia may expend funds other than the funds provided under this heading, including local tax revenues and contributions, to support such program.

FEDERAL PAYMENT FOR INCENTIVES FOR ADOPTION OF CHILDREN

For a Federal payment to the District of Columbia to create incentives to promote the adoption of children in the District of Columbia foster care system, \$5,000,000: *Provided*, That such funds shall remain available until September 30, 2001 and shall be used

APPENDIX F—H.R. 3426

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BBA; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the “Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999”.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO THE BALANCED BUDGET ACT OF 1997.—In this Act, the term “BBA” means the Balanced Budget Act of 1997 (Public Law 105-33).

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BBA; table of contents.

TITLE I—PROVISIONS RELATING TO PART A

Subtitle A—Adjustments to PPS Payments for Skilled Nursing Facilities

- Sec. 101. Temporary increase in payment for certain high cost patients.
- Sec. 102. Authorizing facilities to elect immediate transition to Federal rate.
- Sec. 103. Part A pass-through payment for certain ambulance services, prostheses, and chemotherapy drugs.
- Sec. 104. Provision for part B add-ons for facilities participating in the NHCMQ demonstration project.
- Sec. 105. Special consideration for facilities serving specialized patient populations.
- Sec. 106. MedPAC study on special payment for facilities located in Hawaii and Alaska.
- Sec. 107. Study and report regarding State licensure and certification standards and respiratory therapy competency examinations.

Subtitle B—PPS Hospitals

- Sec. 111. Modification in transition for indirect medical education (IME) percentage adjustment.
- Sec. 112. Decrease in reductions for disproportionate share hospitals; data collection requirements.

Subtitle C—PPS-Exempt Hospitals

- Sec. 121. Wage adjustment of percentile cap for PPS-exempt hospitals.
- Sec. 122. Enhanced payments for long-term care and psychiatric hospitals until development of prospective payment systems for those hospitals.
- Sec. 123. Per discharge prospective payment system for long-term care hospitals.
- Sec. 124. Per diem prospective payment system for psychiatric hospitals.
- Sec. 125. Refinement of prospective payment system for inpatient rehabilitation services.

Subtitle D—Hospice Care

- Sec. 131. Temporary increase in payment for hospice care.
- Sec. 132. Study and report to Congress regarding modification of the payment rates for hospice care.

113 STAT. 1501A-322 PUBLIC LAW 106-113—APPENDIX F

Subtitle E—Other Provisions

Sec. 141. MedPAC study on medicare payment for nonphysician health professional clinical training in hospitals.

Subtitle F—Transitional Provisions

- Sec. 151. Exception to CMI qualifier for one year.
- Sec. 152. Reclassification of certain counties and other areas for purposes of reimbursement under the medicare program.
- Sec. 153. Wage index correction.
- Sec. 154. Calculation and application of wage index floor for a certain area.
- Sec. 155. Special rule for certain skilled nursing facilities.

TITLE II—PROVISIONS RELATING TO PART B

Subtitle A—Hospital Outpatient Services

- Sec. 201. Outlier adjustment and transitional pass-through for certain medical devices, drugs, and biologicals.
- Sec. 202. Establishing a transitional corridor for application of OPD PPS.
- Sec. 203. Study and report to Congress regarding the special treatment of rural and cancer hospitals in prospective payment system for hospital outpatient department services.
- Sec. 204. Limitation on outpatient hospital copayment for a procedure to the hospital deductible amount.

Subtitle B—Physician Services

- Sec. 211. Modification of update adjustment factor provisions to reduce update oscillations and require estimate revisions.
- Sec. 212. Use of data collected by organizations and entities in determining practice expense relative values.
- Sec. 213. GAO study on resources required to provide safe and effective outpatient cancer therapy.

Subtitle C—Other Services

- Sec. 221. Revision of provisions relating to therapy services.
- Sec. 222. Update in renal dialysis composite rate.
- Sec. 223. Implementation of the inherent reasonableness (IR) authority.
- Sec. 224. Increase in reimbursement for pap smears.
- Sec. 225. Refinement of ambulance services demonstration project.
- Sec. 226. Phase-in of PPS for ambulatory surgical centers.
- Sec. 227. Extension of medicare benefits for immunosuppressive drugs.
- Sec. 228. Temporary increase in payment rates for durable medical equipment and oxygen.
- Sec. 229. Studies and reports.

TITLE III—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

- Sec. 301. Adjustment to reflect administrative costs not included in the interim payment system; GAO report on costs of compliance with OASIS data collection requirements.
- Sec. 302. Delay in application of 15 percent reduction in payment rates for home health services until one year after implementation of prospective payment system.
- Sec. 303. Increase in per beneficiary limits.
- Sec. 304. Clarification of surety bond requirements.
- Sec. 305. Refinement of home health agency consolidated billing.
- Sec. 306. Technical amendment clarifying applicable market basket increase for PPS.
- Sec. 307. Study and report to Congress regarding the exemption of rural agencies and populations from inclusion in the home health prospective payment system.

Subtitle B—Direct Graduate Medical Education

- Sec. 311. Use of national average payment methodology in computing direct graduate medical education (DGME) payments.
- Sec. 312. Initial residency period for child neurology residency training programs.

Subtitle C—Technical Corrections

- Sec. 321. BBA technical corrections.

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Subtitle B—

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TITLE IV—RURAL PROVIDER PROVISIONS

Subtitle A—Rural Hospitals

- Sec. 401. Permitting reclassification of certain urban hospitals as rural hospitals.
- Sec. 402. Update of standards applied for geographic reclassification for certain hospitals.
- Sec. 403. Improvements in the critical access hospital (CAH) program.
- Sec. 404. 5-year extension of medicare dependent hospital (MDH) program.
- Sec. 405. Rebasings for certain sole community hospitals.
- Sec. 406. One year sole community hospital payment increase.
- Sec. 407. Increased flexibility in providing graduate physician training in rural and other areas.
- Sec. 408. Elimination of certain restrictions with respect to hospital swing bed program.
- Sec. 409. Grant program for rural hospital transition to prospective payment.
- Sec. 410. GAO study on geographic reclassification.

Subtitle B—Other Rural Provisions

- Sec. 411. MedPAC study of rural providers.
- Sec. 412. Expansion of access to paramedic intercept services in rural areas.
- Sec. 413. Promoting prompt implementation of informatics, telemedicine, and education demonstration project.

TITLE V—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PROGRAM) AND OTHER MEDICARE MANAGED CARE PROVISIONS

Subtitle A—Provisions To Accommodate and Protect Medicare Beneficiaries

- Sec. 501. Changes in Medicare+Choice enrollment rules.
- Sec. 502. Change in effective date of elections and changes of elections of Medicare+Choice plans.
- Sec. 503. 2-year extension of medicare cost contracts.

Subtitle B—Provisions To Facilitate Implementation of the Medicare+Choice Program

- Sec. 511. Phase-in of new risk adjustment methodology; studies and reports on risk adjustment.
- Sec. 512. Encouraging offering of Medicare+Choice plans in areas without plans.
- Sec. 513. Modification of 5-year re-entry rule for contract terminations.
- Sec. 514. Continued computation and publication of medicare original fee-for-service expenditures on a county-specific basis.
- Sec. 515. Flexibility to tailor benefits under Medicare+Choice plans.
- Sec. 516. Delay in deadline for submission of adjusted community rates.
- Sec. 517. Reduction in adjustment in national per capita Medicare+Choice growth percentage for 2002.
- Sec. 518. Deeming of Medicare+Choice organization to meet requirements.
- Sec. 519. Timing of Medicare+Choice health information fairs.
- Sec. 520. Quality assurance requirements for preferred provider organization plans.
- Sec. 521. Clarification of nonapplicability of certain provisions of discharge planning process to Medicare+Choice plans.
- Sec. 522. User fee for Medicare+Choice organizations based on number of enrolled beneficiaries.
- Sec. 523. Clarification regarding the ability of a religious fraternal benefit society to operate any Medicare+Choice plan.
- Sec. 524. Rules regarding physician referrals for Medicare+Choice program.

Subtitle C—Demonstration Projects and Special Medicare Populations

- Sec. 531. Extension of social health maintenance organization demonstration (SHMO) project authority.
- Sec. 532. Extension of medicare community nursing organization demonstration project.
- Sec. 533. Medicare+Choice competitive bidding demonstration project.
- Sec. 534. Extension of medicare municipal health services demonstration projects.
- Sec. 535. Medicare coordinated care demonstration project.
- Sec. 536. Medigap protections for PACE program enrollees.

Subtitle D—Medicare+Choice Nursing and Allied Health Professional Education Payments

- Sec. 541. Medicare+Choice nursing and allied health professional education payments.

Subtitle E—Studies and Reports

- Sec. 551. Report on accounting for VA and DOD expenditures for medicare beneficiaries.

- Sec. 552. Medicare Payment Advisory Commission studies and reports.
Sec. 553. GAO studies, audits, and reports.

TITLE VI—MEDICAID

- Sec. 601. Increase in DSH allotment for certain States and the District of Columbia.
Sec. 602. Removal of fiscal year limitation on certain transitional administrative costs assistance.
Sec. 603. Modification of the phase-out of payment for Federally-qualified health center services and rural health clinic services based on reasonable costs.
Sec. 604. Parity in reimbursement for certain utilization and quality control services; elimination of duplicative requirements for external quality review of medicaid managed care organizations.
Sec. 605. Inapplicability of enhanced match under the State children's health insurance program to medicaid DSH payments.
Sec. 606. Optional deferment of the effective date for outpatient drug agreements.
Sec. 607. Making medicaid DSH transition rule permanent.
Sec. 608. Medicaid technical corrections.

TITLE VII—STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

- Sec. 701. Stabilizing the State children's health insurance program allotment formula.
Sec. 702. Increased allotments for territories under the State children's health insurance program.
Sec. 703. Improved data collection and evaluations of the State children's health insurance program.
Sec. 704. References to SCHIP and State children's health insurance program.
Sec. 705. SCHIP technical corrections.

**TITLE I—PROVISIONS RELATING TO
PART A**

**Subtitle A—Adjustments to PPS Payments
for Skilled Nursing Facilities**

**SEC. 101. TEMPORARY INCREASE IN PAYMENT FOR CERTAIN HIGH
COST PATIENTS.**

(a) ADJUSTMENT FOR MEDICALLY COMPLEX PATIENTS UNTIL ESTABLISHMENT OF REFINED CASE-MIX ADJUSTMENT.—For purposes of computing payments for covered skilled nursing facility services under paragraph (1) of section 1888(e) of the Social Security Act (42 U.S.C. 1395yy(e)) for such services furnished on or after April 1, 2000, and before the date described in subsection (c), the Secretary of Health and Human Services shall increase by 20 percent the adjusted Federal per diem rate otherwise determined under paragraph (4) of such section (but for this section) for covered skilled nursing facility services for RUG-III groups described in subsection (b) furnished to an individual during the period in which such individual is classified in such a RUG-III category.

(b) GROUPS DESCRIBED.—The RUG-III groups for which the adjustment described in subsection (a) applies are SE3, SE2, SE1, SSC, SSB, SSA, CC2, CC1, CB2, CB1, CA2, CA1, RHC, RMC, and RMB as specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 30, 1999 (64 Fed. Reg. 41684).

(c) DATE DESCRIBED.—For purposes of subsection (a), the date described in this subsection is the later of—

- (1) October 1, 2000; or
- (2) the date on which the Secretary implements a refined case mix classification system under section 1888(e)(4)(G)(i)

(3) in subsection (c)(2), by striking “and the source and amount of non-Federal funds used in the project”;

(4) in subsection (d)(2)(A), by striking “at a rate of 50 percent of the costs that are reasonable and” and inserting “for the costs that are”;

(5) in subsection (d)(2)(B)(i), by striking “(but only in the case of patients located in medically underserved areas)” and inserting “or at sites providing health care to patients located in medically underserved areas”;

(6) in subsection (d)(2)(C)(i), by striking “to deliver medical informatics services under” and inserting “for activities related to”; and

(7) by amending paragraph (4) of subsection (d) to read as follows:

“(4) COST-SHARING.—The project may not impose cost-sharing on a medicare beneficiary for the receipt of services under the project. Project costs will cover all costs to medicare beneficiaries and providers related to participation in the project.”

TITLE V—PROVISIONS RELATING TO PART C (MEDICARE+CHOICE PRO- GRAM) AND OTHER MEDICARE MAN- AGED CARE PROVISIONS

Subtitle A—Provisions To Accommodate and Protect Medicare Beneficiaries

SEC. 501. CHANGES IN MEDICARE+CHOICE ENROLLMENT RULES.

(a) PERMITTING ENROLLMENT IN ALTERNATIVE MEDICARE+CHOICE PLANS AND MEDIGAP COVERAGE IN CASE OF INVOLUNTARY TERMINATION OF MEDICARE+CHOICE ENROLLMENT.—

(1) IN GENERAL.—Section 1851(e)(4) (42 U.S.C. 1395w-21(e)(4)) is amended by striking subparagraph (A) and inserting the following:

“(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

“(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;”

(2) CONFORMING MEDIGAP AMENDMENT.—Section 1882(s)(3) (42 U.S.C. 1395ss(s)(3)) is amended—

(A) in subparagraph (A) in the matter following clause (iii), by inserting “, subject to subparagraph (E),” after “in the case of an individual described in subparagraph (B) who”; and

(B) by adding at the end the following new subparagraph:

“(E)(i) An individual described in subparagraph (B)(ii) may elect to apply subparagraph (A) by substituting, for the date of

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RELATING TO MEDICARE+CHOICE PROGRAMS MANAGING

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termination of enrollment, the date on which the individual was notified by the Medicare+Choice organization of the impending termination or discontinuance of the Medicare+Choice plan it offers in the area in which the individual resides, but only if the individual disenrolls from the plan as a result of such notification.

"(ii) In the case of an individual making such an election, the issuer involved shall accept the application of the individual submitted before the date of termination of enrollment, but the coverage under subparagraph (A) shall only become effective upon termination of coverage under the Medicare+Choice plan involved."

(b) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—Section 1851(e)(2) (42 U.S.C. 1395w-21(e)(2)) is amended—

(1) in subparagraph (B)(i), by inserting "and subparagraph (D)" after "clause (ii)";

(2) in subparagraph (C)(i), by inserting "and subparagraph (D)" after "clause (ii)"; and

(3) by adding at the end the following new subparagraph:

"(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time after 2001 in the case of a Medicare+Choice eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

"(i) to enroll in a Medicare+Choice plan; or

"(ii) to change the Medicare+Choice plan in which the individual is enrolled."

(c) CONTINUING ENROLLMENT FOR CERTAIN ENROLLEES.—Section 1851(b)(1) (42 U.S.C. 1395w-21(b)(1)) is amended—

(1) in subparagraph (A), by inserting "and except as provided in subparagraph (C)" after "may otherwise provide"; and

(2) by adding at the end the following new subparagraph:

"(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a Medicare+Choice plan it offers so long as—

"(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

"(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election."

(d) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) apply to notices of impending terminations or discontinuances made on or after the date of the enactment of this Act.

(2) The amendments made by subsection (c) apply to elections made on or after the date of the enactment of this Act with respect to eliminations of Medicare+Choice payment areas from a service area that occur before, on, or after the date of the enactment of this Act.

SEC. 502. CHANGE IN EFFECTIVE DATE OF ELECTIONS AND CHANGES OF ELECTIONS OF MEDICARE+CHOICE PLANS.

(a) OPEN ENROLLMENT.—Section 1851(f)(2) (42 U.S.C. 1395w-21(f)(2)) is amended—

(1) by inserting “or change” before “is made”; and

(2) by inserting “, except that if such election or change is made after the 10th day of any calendar month, then the election or change shall not take effect until the first day of the second calendar month following the date on which the election or change is made” before the period.

(b) EFFECTIVE DATE.—The amendments made by this section apply to elections and changes of coverage made on or after January 1, 2000.

SEC. 503. 2-YEAR EXTENSION OF MEDICARE COST CONTRACTS.

Section 1876(h)(5)(B) (42 U.S.C. 1395mm(h)(5)(B)) is amended by striking “2002” and inserting “2004”.

Subtitle B—Provisions To Facilitate Implementation of the Medicare+Choice Program

SEC. 511. PHASE-IN OF NEW RISK ADJUSTMENT METHODOLOGY; STUDIES AND REPORTS ON RISK ADJUSTMENT.

(a) PHASE-IN.—Section 1853(a)(3)(C) (42 U.S.C. 1395w-23(a)(3)(C)) is amended—

(1) by redesignating the first sentence as clause (i) with the heading “IN GENERAL.—” and appropriate indentation; and

(2) by adding at the end the following new clause:

“(ii) PHASE-IN.—Such risk adjustment methodology shall be implemented in a phased-in manner so that the methodology insofar as it makes adjustments to capitation rates for health status applies to—

“(I) 10 percent of $\frac{1}{12}$ of the annual Medicare+Choice capitation rate in 2000 and 2001; and

“(II) not more than 20 percent of such capitation rate in 2002.”

(b) MEDPAC STUDY AND REPORT.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that evaluates the methodology used by the Secretary of Health and Human Services in developing the risk factors used in adjusting the Medicare+Choice capitation rate paid to Medicare+Choice organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w-23) and includes the issues described in paragraph (2).

(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

(A) The ability of the average risk adjustment factor applied to a Medicare+Choice plan to explain variations in plans’ average per capita medicare costs, as reported by Medicare+Choice plans in the plans’ adjusted community rate filings.

(B) The year-to-year stability of the risk factors applied to each Medicare+Choice plan and the potential for

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plans.

(C) For Medicare beneficiaries newly enrolled in
Medicare+Choice plans in a given year, the correspondence
between the average risk factor calculated from Medicare
fee-for-service data for those individuals from the period
prior to their enrollment in a Medicare+Choice plan and
the average risk factor calculated for such individuals
during their initial year of enrollment in a Medicare+Choice
plan.

(D) For Medicare beneficiaries disenrolling from or
switching among Medicare+Choice plans in a given year,
the correspondence between the average risk factor calcu-
lated from data pertaining to the period prior to their
disenrollment from a Medicare+Choice plan and the aver-
age risk factor calculated from data pertaining to the period
after disenrollment.

(E) An evaluation of the exclusion of "discretionary"
hospitalizations from consideration in the risk adjustment
methodology.

(F) Suggestions for changes or improvements in the
risk adjustment methodology.

(3) REPORT.—Not later than December 1, 2000, the
Commission shall submit a report to Congress on the study
conducted under paragraph (1), together with any recommenda-
tions for legislation that the Commission determines to be
appropriate as a result of such study.

(c) STUDY AND REPORT REGARDING REPORTING OF ENCOUNTER
DATA.—

(1) STUDY.—The Secretary of Health and Human Services
shall conduct a study on how to reduce the costs and burdens
on Medicare+Choice organizations of their complying with
reporting requirements for encounter data imposed by the Sec-
retary in establishing and implementing a risk adjustment
methodology used in making payments to such organizations
under section 1853 of the Social Security Act (42 U.S.C. 1395w-
23). The Secretary shall consult with representatives of
Medicare+Choice organizations in conducting the study. The
study shall address the following issues:

(A) Limiting the number and types of sites of services
(that are in addition to inpatient sites) for which encounter
data must be reported.

(B) Establishing alternative risk adjustment methods
that would require submission of less data.

(C) The potential for Medicare+Choice organizations
to misreport, overreport, or underreport prevalence of
diagnoses in outpatient sites of care, the potential for
increases in payments to Medicare+Choice organizations
from changes in Medicare+Choice plan coding practices
(commonly known as "coding creep") and proposed methods
for detecting and adjusting for such variations in diagnosis
coding as part of the risk adjustment methodology using
encounter data from multiple sites of care.

(D) The impact of such requirements on the willingness
of insurers to offer Medicare+Choice MSA plans and options
for modifying encounter data reporting requirements to
accommodate such plans.

(E) Differences in the ability of Medicare+Choice organizations to report encounter data, and the potential for adverse competitive impacts on group and staff model health maintenance organizations or other integrated providers of care based on data reporting capabilities.

(2) REPORT.—Not later than January 1, 2001, the Secretary shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.

SEC. 512. ENCOURAGING OFFERING OF MEDICARE+CHOICE PLANS IN AREAS WITHOUT PLANS.

Section 1853 (42 U.S.C. 1395w-23) is amended—

(1) in subsection (a)(1), by striking “subsections (e) and (f)” and inserting “subsections (e), (g), and (i)”;

(2) in subsection (c)(5), by inserting “(other than those attributable to subsection (i))” after “payments under this part”; and

(3) by adding at the end the following new subsection: “(i) NEW ENTRY BONUS.—

“(1) IN GENERAL.—Subject to paragraphs (2) and (3), in the case of Medicare+Choice payment area in which a Medicare+Choice plan has not been offered since 1997 (or in which all organizations that offered a plan since such date have filed notice with the Secretary, as of October 13, 1999, that they will not be offering such a plan as of January 1, 2000), the amount of the monthly payment otherwise made under this section shall be increased—

“(A) only for the first 12 months in which any Medicare+Choice plan is offered in the area, by 5 percent of the total monthly payment otherwise computed for such payment area; and

“(B) only for the subsequent 12 months, by 3 percent of the total monthly payment otherwise computed for such payment area.

“(2) PERIOD OF APPLICATION.—Paragraph (1) shall only apply to payment for Medicare+Choice plans which are first offered in a Medicare+Choice payment area during the 2-year period beginning on January 1, 2000.

“(3) LIMITATION TO ORGANIZATION OFFERING FIRST PLAN IN AN AREA.—Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

“(4) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as affecting the calculation of the annual Medicare+Choice capitation rate under subsection (c) for any payment area or as applying to payment for any period not described in such paragraph and paragraph (2).

“(5) OFFERED DEFINED.—In this subsection, the term ‘offered’ means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment

takes effect o plan.”.

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takes effect or when the individual obtains benefits under the plan."

SEC. 513. MODIFICATION OF 5-YEAR RE-ENTRY RULE FOR CONTRACT TERMINATIONS.

(a) REDUCTION OF GENERAL EXCLUSION PERIOD TO 2 YEARS.—Section 1857(c)(4) (42 U.S.C. 1395w-27(c)(4)) is amended by striking "5-year period" and inserting "2-year period".

(b) SPECIFIC EXCEPTION WHERE CHANGE IN PAYMENT POLICY.—

(1) IN GENERAL.—Section 1857(c)(4) (42 U.S.C. 1395w-27(c)(4)) is amended—

(A) by striking "except in circumstances" and inserting "except as provided in subparagraph (B) and except in such other circumstances";

(B) by redesignating the sentence following "(4)" as a subparagraph (A) with an appropriate indentation and the heading "IN GENERAL.—"; and

(C) by adding at the end the following new subparagraph:

"(B) EARLIER RE-ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY.—Subparagraph (A) shall not apply with respect to the offering by a Medicare+Choice organization of a Medicare+Choice plan in a Medicare+Choice payment area if during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment amounts under section 1853 for that Medicare+Choice payment area."

(2) CONSTRUCTION RELATING TO ADDITIONAL EXCEPTIONS.—Nothing in the amendment made by paragraph (1)(C) shall be construed to affect the authority of the Secretary of Health and Human Services to provide for exceptions in addition to the exception provided in such amendment, including exceptions provided under Operational Policy Letter #103 (OPL99.103).

(c) EFFECTIVE DATE.—The amendments made by this section apply to contract terminations occurring before, on, or after the date of the enactment of this Act.

SEC. 514. CONTINUED COMPUTATION AND PUBLICATION OF MEDICARE ORIGINAL FEE-FOR-SERVICE EXPENDITURES ON A COUNTY-SPECIFIC BASIS.

(a) IN GENERAL.—Section 1853(b) (42 U.S.C. 1395w-23(b)) is amended by adding at the end the following new paragraph:

"(4) CONTINUED COMPUTATION AND PUBLICATION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-SERVICE EXPENDITURE INFORMATION.—The Secretary, through the Chief Actuary of the Health Care Financing Administration, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee-for-service program under parts A and B (exclusive of individuals eligible for coverage under section 226A) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

“(A) Total expenditures per capita per month, computed separately for part A and for part B.

“(B) The expenditures described in subparagraph (A) reduced by the best estimate of the expenditures (such as graduate medical education and disproportionate share hospital payments) not related to the payment of claims.

“(C) The average risk factor for the covered population based on diagnoses reported for medicare inpatient services, using the same methodology as is expected to be applied in making payments under subsection (a).

“(D) Such average risk factor based on diagnoses for inpatient and other sites of service, using the same methodology as is expected to be applied in making payments under subsection (a).”

(b) SPECIAL RULE FOR 2001.—In providing for the publication of information under section 1853(b)(4) of the Social Security Act (42 U.S.C. 1395w-23(b)(4)), as added by subsection (a), in 2001, the Secretary of Health and Human Services shall also include the information described in such section for 1998, as well as for 1999.

SEC. 515. FLEXIBILITY TO TAILOR BENEFITS UNDER MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1854 (42 U.S.C. 1395w-24) is amended—

(1) in subsection (a)(1), by inserting “(or segment of such an area if permitted under subsection (h))” after “service area” in the matter preceding subparagraph (A); and

(2) by adding at the end the following:

“(h) PERMITTING USE OF SEGMENTS OF SERVICE AREAS.—The Secretary shall permit a Medicare+Choice organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of one or more Medicare+Choice payment areas.”

(b) EFFECTIVE DATE.—The amendments made by this section apply to contract years beginning on or after January 1, 2001.

SEC. 516. DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES.

(a) DELAY IN DEADLINE FOR SUBMISSION OF ADJUSTED COMMUNITY RATES.—Section 1854(a)(1) (42 U.S.C. 1395w-24(a)(1)) is amended by striking “May 1” and inserting “July 1” in the matter preceding subparagraph (A).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to information submitted by Medicare+Choice organizations for years beginning with 1999.

SEC. 517. REDUCTION IN ADJUSTMENT IN NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE FOR 2002.

Section 1853(c)(6)(B)(v) (42 U.S.C. 1395w-23(c)(6)(B)(v)) is amended by striking “0.5 percentage points” and inserting “0.3 percentage points”.

SEC. 518. DEEMING OF MEDICARE+CHOICE ORGANIZATION TO MEET REQUIREMENTS.

Section 1852(e)(4) (42 U.S.C. 1395w-22(e)(4)) is amended to read as follows:

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“(4) TREATMENT OF ACCREDITATION.—

“(A) IN GENERAL.—The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

“(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

“(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

“(ii) Subsection (b) (relating to antidiscrimination).

“(iii) Subsection (d) (relating to access to services).

“(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

“(v) Subsection (i) (relating to information on advance directives).

“(vi) Subsection (j) (relating to provider participation rules).

“(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(b)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

“(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.”

SEC. 519. TIMING OF MEDICARE+CHOICE HEALTH INFORMATION FAIRS.

(a) IN GENERAL.—Section 1851(e)(3)(C) (42 U.S.C. 1395w-21(e)(3)(C)) is amended by striking “In the month of November” and inserting “During the fall season”.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) first applies to campaigns conducted beginning in 2000.

SEC. 520. QUALITY ASSURANCE REQUIREMENTS FOR PREFERRED PROVIDER ORGANIZATION PLANS.

(a) IN GENERAL.—Section 1852(e)(2) (42 U.S.C. 1395w-22(e)(2)) is amended—

(1) in subparagraph (A), by striking “or a non-network MSA plan” and inserting “; a non-network MSA plan, or a preferred provider organization plan”;

(2) in subparagraph (B)—

(A) in the heading, by striking “AND NON-NETWORK MSA PLANS” and inserting “, NON-NETWORK MSA PLANS, AND PREFERRED PROVIDER ORGANIZATION PLANS”; and

(B) by striking "or a non-network MSA plan" and inserting ", a non-network MSA plan, or a preferred provider organization plan";

(3) by adding at the end the following:

"(D) DEFINITION OF PREFERRED PROVIDER ORGANIZATION PLAN.—In this paragraph, the term 'preferred provider organization plan' means a Medicare+Choice plan that—

"(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

"(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

"(iii) is offered by an organization that is not licensed or organized under State law as a health maintenance organization."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to contract years beginning on or after January 1, 2000.

(c) QUALITY IMPROVEMENT STANDARDS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the appropriate quality improvement standards that should apply to—

(A) each type of Medicare+Choice plan described in section 1851(a)(2) of the Social Security Act (42 U.S.C. 1395w-21(a)(2)), including each type of Medicare+Choice plan that is a coordinated care plan (as described in subparagraph (A) of such section); and

(B) the original medicare fee-for-service program under parts A and B title XVIII of such Act (42 U.S.C. 1395 et seq.).

(2) CONSIDERATIONS.—Such study shall specifically examine the effects, costs, and feasibility of requiring entities, physicians, and other health care providers that provide items and services under the original medicare fee-for-service program to comply with quality standards and related reporting requirements that are comparable to the quality standards and related reporting requirements that are applicable to Medicare+Choice organizations.

(3) REPORT.—Not later than 2 years after the date of the enactment of this Act, such Commission shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that it determines to be appropriate as a result of such study.

SEC. 521. CLARIFICATION OF NONAPPLICABILITY OF CERTAIN PROVISIONS OF DISCHARGE PLANNING PROCESS TO MEDICARE+CHOICE PLANS.

Section 1861(ee) (42 U.S.C. 1395x(ee)(2)(H)) is amended by adding at the end the following:

"(3) With respect to a discharge plan for an individual who is enrolled with a Medicare+Choice organization under a Medicare+Choice plan and is furnished inpatient hospital services by a hospital under a contract with the organization—

"(A) the discharge planning evaluation under paragraph (2)(D) is not required to include information on the availability of home health services through individuals and entities which do not have a contract with the organization; and

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"(B) notwithstanding subparagraph (H)(i), the plan may specify or limit the provider (or providers) of post-hospital home health services or other post-hospital services under the plan."

SEC. 522. USER FEE FOR MEDICARE+CHOICE ORGANIZATIONS BASED ON NUMBER OF ENROLLED BENEFICIARIES.

(a) IN GENERAL.—Section 1857(e)(2) (42 U.S.C. 1395w-27(e)(2)) is amended—

(1) in subparagraph (B), by striking "Any amounts collected are authorized to be appropriated only for" and inserting "Any amounts collected shall be available without further appropriation to the Secretary for";

(2) by amending subparagraph (C) to read as follows:

"(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 an amount equal to \$100,000,000, reduced by the amount of fees authorized to be collected under this paragraph for the fiscal year.";

(3) in subparagraph (D)(ii)—

(A) in subclause (II), by striking "and";

(B) in subclause (III), by striking "and each subsequent fiscal year." and inserting "; and"; and

(C) by adding at the end the following:

"(IV) the Medicare+Choice portion (as defined in subparagraph (E)) of \$100,000,000 in fiscal year 2001 and each succeeding fiscal year."; and

(4) by adding at the end the following:

"(E) MEDICARE+CHOICE PORTION DEFINED.—In this paragraph, the term 'Medicare+Choice portion' means, for a fiscal year, the ratio, as estimated by the Secretary, of—

"(i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to

"(ii) the average number of individuals entitled to benefits under part A, and enrolled under part B, during the fiscal year."

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to fees charged on or after January 1, 2001. The Secretary of Health and Human Services may not increase the fees charged under section 1857(e)(2) of the Social Security Act (42 U.S.C. 1395w-27(e)(2)) for the 3-month period beginning with October 2000 above the level in effect during the previous 9-month period.

SEC. 523. CLARIFICATION REGARDING THE ABILITY OF A RELIGIOUS FRATERNAL BENEFIT SOCIETY TO OPERATE ANY MEDICARE+CHOICE PLAN.

Section 1859(e)(2) (42 U.S.C. 1395w-29(e)(2)) is amended in the matter preceding subparagraph (A) by striking "section 1851(a)(2)(A)" and inserting "section 1851(a)(2)".

SEC. 524. RULES REGARDING PHYSICIAN REFERRALS FOR MEDICARE+CHOICE PROGRAM.

(a) IN GENERAL.—Section 1877(b)(3) (42 U.S.C. 1395nn(b)(3)) is amended—

(1) in subparagraph (C), by striking "or" at the end;

(3) by adding at the end the following:

(2) in subparagraph (D), by striking the period at the end and inserting “, or”; and

“(E) that is a Medicare+Choice organization under part C that is offering a coordinated care plan described in section 1851(a)(2)(A) to an individual enrolled with the organization.”.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after the date of the enactment of this Act.

Subtitle C—Demonstration Projects and Special Medicare Populations

SEC. 531. EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION DEMONSTRATION (SHMO) PROJECT AUTHORITY.

(a) EXTENSION.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203) is amended—

(1) in paragraph (1), by striking “December 31, 2000” and inserting “the date that is 18 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997”;

(2) in paragraph (4), by striking “March 31, 2001” and inserting “the date that is 21 months after the date on which Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997”; and

(3) by adding at the end of paragraph (4) the following: “Not later than 6 months after the date the Secretary submits such final report, the Medicare Payment Advisory Commission shall submit to Congress a report containing recommendations regarding such project.”.

(b) SUBSTITUTION OF AGGREGATE CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66) is amended to read as follows:

“(c) AGGREGATE LIMIT ON NUMBER OF MEMBERS.—The Secretary of Health and Human Services may not impose a limit on the number of individuals that may participate in a project conducted under section 2355 of the Deficit Reduction Act of 1984, other than an aggregate limit of not less than 324,000 for all sites.”.

SEC. 532. EXTENSION OF MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECT.

(a) EXTENSION.—Notwithstanding any other provision of law, any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-123; 42 U.S.C. 1395mm note) and conducted for the additional period of 2 years as provided for under section 4019 of BBA, shall be conducted for an additional period of 2 years. The Secretary of Health and Human Services shall provide for such reduction in payments under such project in the extension period provided under the previous sentence as the Secretary determines is necessary to ensure that total Federal expenditures during the extension period under the project do not exceed the total Federal expenditures that would have been made under title XVIII of the Social Security Act if such project had not been so extended.

(b) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report describing the results of a study conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 and describing the data and analysis of the results of the study. The report shall be available through the Medicare+Choice Demonstration Project.

SEC. 533. MEDICARE+CHOICE DEMONSTRATION PROJECT.

Section 4011 of BBA

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MAINTENANCE ORGANIZATION PROJECT AUTHORITY.

the Omnibus Budget Reconciliation Act of 1997 is amended—
 “December 31, 2000” and “after the date that the report described in section 4019 of BBA, 1997”;

“March 31, 2001” and “after the date on which the report described in section 4019 of BBA, 1997”; and paragraph (4) the following: “The Secretary shall submit to the Advisory Commission on Intergovernmental Relations recommendations

—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103-66)

OF MEMBERS.—The Secretary may not impose a limit on the number of participants in a project under the Budget Reduction Act of 1984, except as provided in section 324,000 for all

QUALITY NURSING ORGANIZATION.

under any other provision of law, under section 4079 of the Omnibus Budget Reconciliation Act of 1997 (Public Law 100-123); or for the additional period under section 4019 of BBA, shall be extended for 2 years. The Secretary of Health and Human Services shall determine the period provided under section 4019 of BBA, 1997, if such extension is necessary as during the extension of the total Federal expenditure under title XVIII of the Social Security Act is extended.

(b) REPORT.—Not later than July 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report describing the results of any demonstration project conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987, and describing the data collected by the Secretary relevant to the analysis of the results of such project, including the most recently available data through the end of 2000.

SEC. 533. MEDICARE-CHOICE COMPETITIVE BIDDING DEMONSTRATION PROJECT.

Section 4011 of BBA (42 U.S.C. 1395w-23 note) is amended—

(1) in subsection (a)—

(A) by striking “The Secretary” and inserting the following (and conforming the indentation for the remainder of the subsection accordingly):

“(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary”; and

(B) by adding at the end the following:

“(2) DELAY IN IMPLEMENTATION.—The Secretary shall not implement the project until January 1, 2002, or, if later, 6 months after the date the Competitive Pricing Advisory Committee has submitted to Congress a report on each of the following topics:

“(A) INCORPORATION OF ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original medicare fee-for-service program into the project in the areas in which the project is operational.

“(B) QUALITY ACTIVITIES.—The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original medicare fee-for-service program generally.

“(C) RURAL PROJECT.—The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project under subsection (g), and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

“(D) BENEFIT STRUCTURE.—The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential

implications of expanding the project (in conjunction with the potential inclusion of the original medicare fee-for-service program) to require medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

“(3) CONFORMING DEADLINES.—Any dates specified in the succeeding provisions of this section shall be delayed (as specified by the Secretary) in a manner consistent with the delay effected under paragraph (2).”; and

(2) in subsection (c)(1)(A)—

(A) by striking “and” at the end of clause (i); and
(B) by adding at the end the following new clause:

“(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan the per capita bid for which is less than the standard per capita government contribution (as established by the competitive pricing methodology established for such area) may, at the plan’s election, be offered a rebate of some or all of the medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and”.

SEC. 534. EXTENSION OF MEDICARE MUNICIPAL HEALTH SERVICES DEMONSTRATION PROJECTS.

Section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 6135 of the Omnibus Budget Reconciliation Act of 1989, section 13557 of the Omnibus Budget Reconciliation Act of 1993, and section 4017 of BBA, is amended by striking “December 31, 2000” and inserting “December 31, 2002”.

SEC. 535. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.

Section 4016(e)(1)(A)(ii) of BBA (42 U.S.C. 1395b-1 note) is amended to read as follows:

“(ii) CANCER HOSPITAL.—In the case of the project described in subsection (b)(2)(C), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary to cover costs of the project, including costs for information infrastructure and recurring costs of case management services, flexible benefits, and program management.”.

SEC. 536. MEDIGAP PROTECTIONS FOR PACE PROGRAM ENROLLEES.

(a) IN GENERAL.—Section 1882(s)(3)(B) (42 U.S.C. 1395ss(s)(3)(B)) is amended—

(1) in clause (ii), by inserting “or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894, and there are circumstances that would permit the discontinuance of the individual’s enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual’s

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omibus Budget Reconciliation Act of 1996 (Public Law 104-135) of the Omnibus Budget Reconciliation Act of 1995 (Public Law 104-135), is amended by inserting "December

DEMONSTRATION PROJECT.

S.C. 1395b-1 note) is the case of the project (b)(1), the Secretary shall the Federal Hospital Federal Supplementary Act XVIII of the Social Security Act (Public Law 104-395t), in such proportions to be appropriate, to cover costs of the information infrastructure management services, management."

PROGRAM ENROLLEES.

(3)(B) (42 U.S.C. 1395b-1) the individual is 65 with a PACE provider in circumstances that would be similar to the circumstances of the individual's

election under the first sentence of such section if such individual were enrolled in a Medicare+Choice plan" before the period;

(2) in clause (v)(II), by inserting "any PACE provider under section 1894," after "demonstration project authority,"; and

(3) in clause (vi)—
 (A) by inserting "or in a PACE program under section 1894" after "part C"; and

(B) by striking "such plan" and inserting "such plan or such program".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to terminations or discontinuances made on or after the date of the enactment of this Act.

Subtitle D—Medicare+Choice Nursing and Allied Health Professional Education Payments

SEC. 541. MEDICARE+CHOICE NURSING AND ALLIED HEALTH PROFESSIONAL EDUCATION PAYMENTS.

(a) ADDITIONAL PAYMENTS FOR NURSING AND ALLIED HEALTH EDUCATION.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(1) PAYMENT FOR NURSING AND ALLIED HEALTH EDUCATION FOR MANAGED CARE ENROLLEES.—

"(1) IN GENERAL.—For portions of cost reporting periods occurring in a year (beginning with 2000), the Secretary shall provide for an additional payment amount for any hospital that receives payments for the costs of approved educational activities for nurse and allied health professional training under section 1861(v)(1).

"(2) PAYMENT AMOUNT.—The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

"(A) DETERMINATION OF MANAGED CARE ENROLLEE PAYMENT RATIO FOR GRADUATE MEDICAL EDUCATION PAYMENTS.—The Secretary shall estimate the ratio of payments for all hospitals for portions of cost reporting periods occurring in the year under subsection (h)(3)(D) to total direct graduate medical education payments estimated for such portions of periods under subsection (h)(3).

"(B) APPLICATION TO FEE-FOR-SERVICE NURSING AND ALLIED HEALTH EDUCATION PAYMENTS.—Such ratio shall be applied to the Secretary's estimate of total payments for nursing and allied health education determined under section 1861(v) for portions of cost reporting periods occurring in the year to determine a total amount of additional payments for nursing and allied health education to be distributed to hospitals under this subsection for portions of cost reporting periods occurring in the year; except that in no case shall such total amount exceed \$60,000,000 in any year.

"(C) APPLICATION TO HOSPITAL.—The amount of payment under this subsection to a hospital for portions of

cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the Secretary's estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year to the total of such amounts for all hospitals for such cost reporting periods."

(b) ADJUSTMENTS IN PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION.—Section 1886(h)(3)(D) (42 U.S.C. 1395ww(h)(3)(D)) is amended—

(1) in clause (i), by inserting ", subject to clause (iii)," after "shall equal";

(2) by redesignating clause (iii) as clause (iv); and

(3) by inserting after clause (ii) the following new clause:

"(iii) PROPORTIONAL REDUCTION FOR NURSING AND ALLIED HEALTH EDUCATION.—The Secretary shall estimate a proportional adjustment in payments to all hospitals determined under clauses (i) and (ii) for portions of cost reporting periods beginning in a year (beginning with 2000) such that the proportional adjustment reduces payments in an amount for such year equal to the total additional payment amounts for nursing and allied health education determined under subsection (1) for portions of cost reporting periods occurring in that year."

Subtitle E—Studies and Reports

SEC. 551. REPORT ON ACCOUNTING FOR VA AND DOD EXPENDITURES FOR MEDICARE BENEFICIARIES.

Not later April 1, 2001, the Secretary of Health and Human Services, jointly with the Secretaries of Defense and of Veterans Affairs, shall submit to Congress a report on the estimated use of health care services furnished by the Departments of Defense and of Veterans Affairs to medicare beneficiaries, including both beneficiaries under the original medicare fee-for-service program and under the Medicare+Choice program. The report shall include an analysis of how best to properly account for expenditures for such services in the computation of Medicare+Choice capitation rates.

SEC. 552. MEDICARE PAYMENT ADVISORY COMMISSION STUDIES AND REPORTS.

(a) DEVELOPMENT OF SPECIAL PAYMENT RULES UNDER THE MEDICARE+CHOICE PROGRAM FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the development of a payment methodology under the Medicare+Choice program for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly that—

(A) accounts for the prevalence, mix, and severity of chronic conditions among such frail elderly Medicare+Choice beneficiaries;

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(B) includes medical diagnostic factors from all provider settings (including hospital and nursing facility settings); and

(C) includes functional indicators of health status and such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.

(b) REPORT ON MEDICARE MSA (MEDICAL SAVINGS ACCOUNT) PLANS.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Assessment Commission shall submit to Congress a report on specific legislative changes that should be made to make MSA plans (as defined in section 1859(b)(3) of the Social Security Act, 42 U.S.C. 1395w-29(b)(3)) a viable option under the Medicare+Choice program.

SEC. 553. GAO STUDIES, AUDITS, AND REPORTS.

(a) STUDY OF MEDIGAP POLICIES.—

(1) IN GENERAL.—The Comptroller General of the United States (in this section referred to as the "Comptroller General") shall conduct a study of the issues described in paragraph (2) regarding medicare supplemental policies described in section 1882(g)(1) of the Social Security Act (42 U.S.C. 1395ss(g)(1)).

(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

(A) The level of coverage provided by each type of medicare supplemental policy.

(B) The current enrollment levels in each type of medicare supplemental policy.

(C) The availability of each type of medicare supplemental policy to medicare beneficiaries over age 65½.

(D) The number and type of medicare supplemental policies offered in each State.

(E) The average out-of-pocket costs (including premiums) per beneficiary under each type of medicare supplemental policy.

(2) REPORT.—Not later than July 31, 2001, the Comptroller General shall submit a report to Congress on the results of the study conducted under this subsection, together with any recommendations for legislation that the Comptroller General determines to be appropriate as a result of such study.

(b) GAO AUDIT AND REPORTS ON THE PROVISION OF MEDICARE+CHOICE HEALTH INFORMATION TO BENEFICIARIES.—

(1) IN GENERAL.—Beginning in 2000, the Comptroller General shall conduct an annual audit of the expenditures by the Secretary of Health and Human Services during the preceding year in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w-21 et seq.) to eligible medicare beneficiaries.

(3) REPORTS.—Not later than March 31 of 2001, 2004, 2007, and 2010, the Comptroller General shall submit a report

ENDIX F

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to Congress on the results of the audit of the expenditures of the preceding 3 years conducted pursuant to subsection (a), together with an evaluation of the effectiveness of the means used by the Secretary of Health and Human Services in providing information regarding the Medicare+Choice program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w-21 et seq.) to eligible medicare beneficiaries.

TITLE VI—MEDICAID

SEC. 601. INCREASE IN DSH ALLOTMENT FOR CERTAIN STATES AND THE DISTRICT OF COLUMBIA.

(a) IN GENERAL.—The table in section 1923(f)(2) (42 U.S.C. 1396r-4(f)(2)) is amended under each of the columns for FY 00, FY 01, and FY 02—

(1) in the entry for the District of Columbia, by striking “23” and inserting “32”;

(2) in the entry for Minnesota, by striking “16” and inserting “33”;

(3) in the entry for New Mexico, by striking “5” and inserting “9”; and

(4) in the entry for Wyoming, by striking “0” and inserting “0.1”.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on October 1, 1999, and applies to expenditures made on or after such date.

SEC. 602. REMOVAL OF FISCAL YEAR LIMITATION ON CERTAIN TRANSITIONAL ADMINISTRATIVE COSTS ASSISTANCE.

(a) IN GENERAL.—Section 1931(h) (42 U.S.C. 1396u-1(h)) is amended—

(1) in paragraph (3), by striking “and ending with fiscal year 2000”; and

(2) by striking paragraph (4).

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect as if included in the enactment of section 114 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193; 110 Stat. 2177).

SEC. 603. MODIFICATION OF THE PHASE-OUT OF PAYMENT FOR FEDERALLY-QUALIFIED HEALTH CENTER SERVICES AND RURAL HEALTH CLINIC SERVICES BASED ON REASONABLE COSTS.

(a) MODIFICATION OF PHASE-OUT.—

(1) IN GENERAL.—Section 1902(a)(13)(C)(i) (42 U.S.C. 1396a(a)(13)(C)(i)) is amended by striking “90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003” and inserting “fiscal year 2001, or fiscal year 2002, 90 percent for services furnished during fiscal year 2003, or 85 percent for services furnished during fiscal year 2004”.

(2) CONFORMING AMENDMENT TO END OF TRANSITIONAL PAYMENT RULES.—Section 4712(c) of BBA (111 Stat. 509) is amended by striking “2003” and inserting “2004”.

(3) EFFECTIVE section shall take section 4712 of BB (b) GAO STUDY

the date of the enact of the United States s ates the effect on Fede: clinics and on the pop of the phase-out and payment for Federally health clinic services the Social Security Ac by section 4712 of BB. section. Such report method, and impact of for payment under tit basis other than payme to the cost of furnish ommandations for legi system is needed, that appropriate as a result c

SEC. 604. PARITY IN REIM QUALITY DUPLICATT REVIEW OF

(a) PARITY IN REIM QUALITY CONTROL SERV.

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FULL TEXT OF P.L. 106-170 APPROXIMATELY 90 PAGES.

ATTACHED FOR REFERENCE ARE:

- 1) TABLE OF CONTENTS
- 2) FINDINGS AND PURPOSES
- 3) THE ONLY RELEVANT PROVISION (SECTION 205)

AE 2.110:106-170

PUBLIC LAW 106-170—DEC. 17, 1999

TICKET TO WORK AND WORK INCENTIVES
IMPROVEMENT ACT OF 1999

Public Law 106-170
106th Congress

An Act

To amend the Social Security Act to expand the availability of health care coverage for working individuals with disabilities, to establish a Ticket to Work and Self-Sufficiency Program in the Social Security Administration to provide such individuals with meaningful opportunities to work, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Ticket to Work and Work Incentives Improvement Act of 1999".

(b) TABLE OF CONTENTS.—The table of contents is as follows:

- Sec. 1. Short title; table of contents.
- Sec. 2. Findings and purposes.

TITLE I—TICKET TO WORK AND SELF-SUFFICIENCY AND RELATED PROVISIONS

Subtitle A—Ticket to Work and Self-Sufficiency

Sec. 101. Establishment of the Ticket to Work and Self-Sufficiency Program.

Subtitle B—Elimination of Work Disincentives

- Sec. 111. Work activity standard as a basis for review of an individual's disabled status.
- Sec. 112. Expedited reinstatement of disability benefits.

Subtitle C—Work Incentives Planning, Assistance, and Outreach

- Sec. 121. Work incentives outreach program.
- Sec. 122. State grants for work incentives assistance to disabled beneficiaries.

TITLE II—EXPANDED AVAILABILITY OF HEALTH CARE SERVICES

- Sec. 201. Expanding State options under the medicaid program for workers with disabilities.
- Sec. 202. Extending medicare coverage for OASDI disability benefit recipients.
- Sec. 203. Grants to develop and establish State infrastructures to support working individuals with disabilities.
- Sec. 204. Demonstration of coverage under the medicaid program of workers with potentially severe disabilities.
- Sec. 205. Election by disabled beneficiaries to suspend medigap insurance when covered under a group health plan.

TITLE III—DEMONSTRATION PROJECTS AND STUDIES

- Sec. 301. Extension of disability insurance program demonstration project authority.
- Sec. 302. Demonstration projects providing for reductions in disability insurance benefits based on earnings.
- Sec. 303. Studies and reports.

TITLE IV—MISCELLANEOUS AND TECHNICAL AMENDMENTS

- Sec. 401. Technical amendments relating to drug addicts and alcoholics.
- Sec. 402. Treatment of prisoners.

- Sec. 403. Revocation by members of coverage.
- Sec. 404. Additional technical amendr onstration projects under ti
- Sec. 405. Authorization for State to pe
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for other purposes.

House of Representatives of
assembled,

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SEC. 2. FINDINGS AND PURPOSES.

- (a) FINDINGS.—The Congress makes the following findings:
 - (1) It is the policy of the United States to provide assistance to individuals with disabilities to lead productive work lives.
 - (2) Health care is important to all Americans.
 - (3) Health care is particularly important to individuals with disabilities and special health care needs who often cannot afford the insurance available to them through the private market, are uninsurable by the plans available in the private sector, and are at great risk of incurring very high and economically devastating health care costs.
 - (4) Americans with significant disabilities often are unable to obtain health care insurance that provides coverage of the services and supports that enable them to live independently and enter or rejoin the workforce. Personal assistance services (such as attendant services, personal assistance with transportation to and from work, reader services, job coaches, and related assistance) remove many of the barriers between significant disability and work. Coverage for such services, as well as for prescription drugs, durable medical equipment, and basic health care are powerful and proven tools for individuals with significant disabilities to obtain and retain employment.
 - (5) For individuals with disabilities, the fear of losing health care and related services is one of the greatest barriers keeping the individuals from maximizing their employment, earning potential, and independence.
 - (6) Social Security Disability Insurance and Supplemental Security Income beneficiaries risk losing medicare or medicaid coverage that is linked to their cash benefits, a risk that is an equal, or greater, work disincentive than the loss of cash benefits associated with working.
 - (7) Individuals with disabilities have greater opportunities for employment than ever before, aided by important public policy initiatives such as the Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), advancements in public understanding of disability, and innovations in assistive technology, medical treatment, and rehabilitation.
 - (8) Despite such historic opportunities and the desire of millions of disability recipients to work and support themselves, fewer than one-half of one percent of Social Security Disability

Insurance and Supplemental Security Income beneficiaries leave the disability rolls and

(9) In addition to the findings and purposes of the Act, beneficiaries cite financial hardship, lack of adequate income and lack of adequate health care services as barriers to employment.

(10) Eliminating such barriers will remove disincentives to work and by providing a real choice in obtaining the services they need to find, enter, and maintain their short and long-term financial well-being.

(11) In addition to the findings and purposes of the Act, the promise for individuals with disabilities to enter the workforce through employment programs to help individuals with disabilities work may result in significant increases in the number of individuals covered by the Social Security Disability Insurance program.

(12) If only an additional \$3,500,000,000 over the current Social Security Disability Insurance program, the total \$3,500,000,000 over the current Social Security Disability Insurance program, exceeding the cost of providing health care to assist them in entering the workforce to the best of their ability.

- (b) PURPOSES.—The purpose of this Act is—
 - (1) To provide health care and placement services to individuals with disabilities who will enable those individuals to enter or rejoin the workforce and cash benefit programs.
 - (2) To encourage State and local governments to provide health care and placement services to individuals with disabilities is necessary to enable such individuals to enter or rejoin the workforce.
 - (3) To provide individuals with disabilities maintaining medicare coverage.
 - (4) To establish a return to work program to allow individuals with disabilities to obtain and retain employment on cash benefit programs.

TITLE I—TICKET TO RIDE
SUFFICIENCY AND
ASSISTANCE

Subtitle A—Ticket to Ride
Sufficiency and Assistance

SEC. 101. ESTABLISHMENT OF THE TICKET TO RIDE SUFFICIENCY PROGRAM.

- (a) IN GENERAL.—Part A of this Act (42 U.S.C. 1301 et seq.) is amended by adding the following new section:

42 USC 1320b-19 note.

s.
 ENT COMPANY RULES
 rules.
 SSIBLE TENANT SERVICE
 tors.
 PROFITS RULES
 TAX RULES
 eld real estate investment

Insurance and Supplemental Security Income beneficiaries leave the disability rolls and return to work.

(9) In addition to the fear of loss of health care coverage, beneficiaries cite financial disincentives to work and earn income and lack of adequate employment training and placement services as barriers to employment.

(10) Eliminating such barriers to work by creating financial incentives to work and by providing individuals with disabilities real choice in obtaining the services and technology they need to find, enter, and maintain employment can greatly improve their short and long-term financial independence and personal well-being.

(11) In addition to the enormous advantages such changes promise for individuals with disabilities, redesigning government programs to help individuals with disabilities return to work may result in significant savings and extend the life of the Social Security Disability Insurance Trust Fund.

(12) If only an additional one-half of one percent of the current Social Security Disability Insurance and Supplemental Security Income recipients were to cease receiving benefits as a result of employment, the savings to the Social Security Trust Funds and to the Treasury in cash assistance would total \$3,500,000,000 over the worklife of such individuals, far exceeding the cost of providing incentives and services needed to assist them in entering work and achieving financial independence to the best of their abilities.

(b) PURPOSES.—The purposes of this Act are as follows:

(1) To provide health care and employment preparation and placement services to individuals with disabilities that will enable those individuals to reduce their dependency on cash benefit programs.

(2) To encourage States to adopt the option of allowing individuals with disabilities to purchase medicaid coverage that is necessary to enable such individuals to maintain employment.

(3) To provide individuals with disabilities the option of maintaining medicare coverage while working.

(4) To establish a return to work ticket program that will allow individuals with disabilities to seek the services necessary to obtain and retain employment and reduce their dependency on cash benefit programs.

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TITLE I—TICKET TO WORK AND SELF-SUFFICIENCY AND RELATED PROVISIONS

Subtitle A—Ticket to Work and Self-Sufficiency

SEC. 101. ESTABLISHMENT OF THE TICKET TO WORK AND SELF-SUFFICIENCY PROGRAM.

(a) IN GENERAL.—Part A of title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new section:

m “worker with a potentially
h respect to a demonstration

at less than 65, years of age;
ical or mental impairment that,
nder the demonstration project,
at for the receipt of items and
n 1905(a) of the Social Security
to become blind or disabled (as
4(a) of the Social Security Act

ned in paragraph (2)).

ED.—An individual is considered
al—

the applicable minimum wage
6 of the Fair Labor Standards
working at least 40 hours per

ork effort that meets substantial
riteria for hours of work, wages,
fined under the demonstration
e Secretary.

ON PROJECTS.—

to paragraph (3), the Secretary
der subsection (a) that meet the
and such additional terms and
ay require. The Secretary may
on 1902(a)(1) of the Social Secu-
1) to allow for sub-State dem-

S OF DEMONSTRATION PROJECTS.—
e a demonstration project under
provides assurances satisfactory
owing conditions are or will be

STATE EFFORT.—Federal funds
t to this section must be used
upplant, the level of State funds
th potentially severe disabilities
for such individuals at the time
is approved under this section.

VALUATION.—The State provides for
a of the project.

AL FUNDING.—

Out of any funds in the Treasury
riated, there is appropriated to

00 for each of fiscal years 2001

d
000 for each of fiscal years 2005

THORITY.—Clause (i) constitutes
advance of appropriations Acts
obligation of the Federal Govern-
ne payment of the amounts appro-
(i).

(B) LIMITATION ON PAYMENTS.—In no case may—

(i) the aggregate amount of payments made by
the Secretary to States under this section exceed
\$250,000,000;

(ii) the aggregate amount of payments made by
the Secretary to States for administrative expenses
relating to annual reports required under subsection
(d) exceed \$2,000,000 of such \$250,000,000; or

(iii) payments be provided by the Secretary for
a fiscal year after fiscal year 2009.

(C) FUNDS ALLOCATED TO STATES.—The Secretary shall
allocate funds to States based on their applications and
the availability of funds. Funds allocated to a State under
a grant made under this section for a fiscal year shall
remain available until expended.

(D) FUNDS NOT ALLOCATED TO STATES.—Funds not allo-
cated to States in the fiscal year for which they are appro-
priated shall remain available in succeeding fiscal years
for allocation by the Secretary using the allocation formula
established under this section.

(E) PAYMENTS TO STATES.—The Secretary shall pay
to each State with a demonstration project approved under
this section, from its allocation under subparagraph (C),
an amount for each quarter equal to the Federal medical
assistance percentage (as defined in section 1905(b) of the
Social Security Act (42 U.S.C. 1395d(b)) of expenditures
in the quarter for medical assistance provided to workers
with a potentially severe disability.

(d) ANNUAL REPORT.—A State with a demonstration project
approved under this section shall submit an annual report to the
Secretary on the use of funds provided under the grant. Each
report shall include enrollment and financial statistics on—

(1) the total population of workers with potentially severe
disabilities served by the demonstration project; and

(2) each population of such workers with a specific physical
or mental impairment described in subsection (b)(1)(B) served
by such project.

(e) RECOMMENDATION.—Not later than October 1, 2004, the
Secretary shall submit a recommendation to the Committee on
Commerce of the House of Representatives and the Committee
on Finance of the Senate regarding whether the demonstration
project established under this section should be continued after
fiscal year 2006.

(f) STATE DEFINED.—In this section, the term “State” has the
meaning given such term for purposes of title XIX of the Social
Security Act (42 U.S.C. 1396 et seq.).

**SEC. 205. ELECTION BY DISABLED BENEFICIARIES TO SUSPEND
MEDIGAP INSURANCE WHEN COVERED UNDER A GROUP
HEALTH PLAN.**

(a) IN GENERAL.—Section 1882(q) of the Social Security Act
(42 U.S.C. 1395ss(q)) is amended—

(1) in paragraph (5)(C), by inserting “or paragraph (6)”
after “this paragraph”; and

(2) by adding at the end the following new paragraph:
“(6) Each medicare supplemental policy shall provide that
benefits and premiums under the policy shall be suspended

Deadline.

at the request of the policyholder if the policyholder is entitled to benefits under section 226(b) and is covered under a group health plan (as defined in section 1862(b)(1)(A)(v)). If such suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, such policy shall be automatically reinstated (effective as of the date of such loss of coverage) under terms described in subsection (n)(6)(A)(ii) as of the loss of such coverage if the policyholder provides notice of loss of such coverage within 90 days after the date of such loss."

42 USC 1395ss
note.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply with respect to requests made after the date of the enactment of this Act.

TITLE III—DEMONSTRATION PROJECTS AND STUDIES

SEC. 301. EXTENSION OF DISABILITY INSURANCE PROGRAM DEMONSTRATION PROJECT AUTHORITY.

(a) EXTENSION OF AUTHORITY.—Title II of the Social Security Act (42 U.S.C. 401 et seq.) is amended by adding at the end the following new section:

"DEMONSTRATION PROJECT AUTHORITY

"SEC. 234. (a) AUTHORITY.—

"(1) IN GENERAL.—The Commissioner of Social Security (in this section referred to as the 'Commissioner') shall develop and carry out experiments and demonstration projects designed to determine the relative advantages and disadvantages of—

"(A) various alternative methods of treating the work activity of individuals entitled to disability insurance benefits under section 223 or to monthly insurance benefits under section 202 based on such individual's disability (as defined in section 223(d)), including such methods as a reduction in benefits based on earnings, designed to encourage the return to work of such individuals;

"(B) altering other limitations and conditions applicable to such individuals (including lengthening the trial work period (as defined in section 222(c)), altering the 24-month waiting period for hospital insurance benefits under section 226, altering the manner in which the program under this title is administered, earlier referral of such individuals for rehabilitation, and greater use of employers and others to develop, perform, and otherwise stimulate new forms of rehabilitation); and

"(C) implementing sliding scale benefit offsets using variations in—

"(i) the amount of the offset as a proportion of earned income;

"(ii) the duration of the offset period; and

"(iii) the method of determining the amount of income earned by such individuals,

to the end that savings will accrue to the Trust Funds, or to otherwise promote the objectives or facilitate the administration of this title.

42 USC 434.

"(2) AUTHORITY FOR EXPANSION.—The Commissioner may expand the scope of a demonstration project to include activities under the program establishment purposes that reasonably may be necessary for the purposes of such demonstration project to the extent of any such project.

"(b) REQUIREMENTS.—The demonstration projects developed under subsection (a) and shall be carried out on a wide scale and shall be subject to a wide evaluation of the alternative methods of giving assurance that the results of the demonstration projects will obtain generally under the program under this title and shall be subject to the adoption of any program nationally.

"(c) AUTHORITY TO WAIVE REQUIREMENTS.—In the case of a demonstration project conducted under subsection (a), the Commissioner may waive compliance with the benefit requirements of section 114 established under this title, at the request of the Commissioner) with the requirements of title XVIII, insofar as they apply to the evaluation of the alternative method of experiment or project shall be a condition of approval. At least 90 days prior thereto a written notice of notification and information of complete description thereof, has been submitted to the Committee on Ways and Means and to the Committee on Finance and to the Committee on Education and the Labor Force. Reports on the progress of such projects shall be submitted by the Commissioner. When appropriate, such recommendations for changes in the program shall be carried out the objectives stated in the report.

"(d) REPORTS.—

"(1) INTERIM REPORTS.—The Commissioner shall submit reports to the Committee on Finance and to the Committee on Education and the Labor Force on the progress of the experiment carried out under this subsection and shall submit the data and materials that the Committee may require.

"(2) TERMINATION AND FUTURE.—If the Commissioner determines that the preceding provisions of this section are not warranted after the date of the enactment of this Act, the Commissioner shall submit to the Committee on Finance and to the Committee on Education and the Labor Force a final report on the demonstration project."