

WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

CHAPTER 33-28
SERIES 24

TRANSITIONAL REQUIREMENTS FOR THE CONVERSION
OF MEDICARE SUPPLEMENT INSURANCE BENEFITS AND
PREMIUMS TO CONFORM TO MEDICARE PROGRAM REVISIONS

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FILED

WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER 1989 MAY -1 AM 10:36

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

CHAPTER 33-28
SERIES 24

TRANSITIONAL REQUIREMENTS FOR THE CONVERSION
OF MEDICARE SUPPLEMENT INSURANCE BENEFITS AND
PREMIUMS TO CONFORM TO MEDICARE PROGRAM REVISIONS

Section 1. General

1.1 Scope - The purpose of this legislative rule is to assure the orderly implementation and conversion of Medicare supplement insurance benefits and premiums due to changes in the federal Medicare program; to provide for the reasonable standardization of the coverage, terms and benefits of Medicare supplement policies or contracts; to facilitate public understanding of such policies or contracts; to eliminate provisions contained in such policies or contracts which may be misleading or confusing in connection with the purchase of such policies or contracts; to eliminate policy or contract provisions which may duplicate Medicare benefits; to provide full disclosure of policy or contract benefits and benefit changes; and to provide for refunds of premiums associated with benefits duplicating Medicare program benefits.

1.2 Authority - West Virginia Code §33-28-5b, §33-2-10, §33-11-7, §33-16-3d, §33-24-4 and §33-25A-8.

1.3 Filing Date - May 1, 1989

1.4 Effective Date - May 1, 1989

Section 2. Applicability

2.1 This rule shall take precedence over other rules relating to Medicare supplement policies or contracts only to the extent necessary to assure that benefits are not duplicated, that applicants receive adequate notice and disclosure of changes in Medicare supplement policies and contracts, that appropriate premium adjustments are made in a timely manner, and that premiums are reasonable in relation to benefits.

2.2 Except as otherwise provided, this rule shall apply to:

(A) All Medicare supplement policies and contracts, including but not limited to policies or contracts issued by health maintenance organizations and hospital, medical and health service corporations, delivered, or issued for delivery, 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 as provided in subsection (A) above.

Section 3. Definitions - As used in this legislative rule:

3.1 "Applicant" - shall mean

(A) in the case of an individual Medicare supplement policy or contract, the person who seeks to contract for insurance benefits, and

(B) in the case of a group Medicare supplement policy or contract, the proposed certificateholder.

3.2 "Certificate" - shall mean any certificate issued under a group Medicare supplement policy.

3.3 Commissioner - shall mean the Insurance Commissioner of the State of West Virginia.

3.4 Medicare Supplement Policy - shall mean a group or individual policy of accident and sickness insurance or any other contract which is advertised, marketed or designed primarily to provide health care benefits as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

Section 4. Benefit Conversion Requirements

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

4.2 General Requirements

(A) No later than thirty (30) days prior to the annual effective date of Medicare benefit changes mandated by

the Medicare Catastrophic Coverage Act of 1988, every insurer, or other entity providing Medicare supplement insurance or benefits to a resident of this State shall notify its policyholders, contract holders and certificateholders of modifications it has made to Medicare supplement insurance policies or contracts. Such notice shall be in the format prescribed by Exhibit A of this rule. Only the material appearing in parentheses is to be composed by the insurer or other entity; all other material shall appear in exactly the form set forth by Exhibit A.

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

(2) The notice shall inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be made.

(3) 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. Such notice shall not contain or be accompanied by any solicitation.

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

(C) As soon as practicable, but no longer than forty-five (45) days after the effective date of the Medicare benefit changes, every insurer or other entity providing Medicare supplement insurance or contracts 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 originally anticipated for the applicable policies or contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(2) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit

duplications with Medicare. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

(D) Upon satisfying the filing and approval requirements of this State, every insurer or other entity providing Medicare supplement insurance in this State shall provide each covered person with any rider, endorsement or policy form necessary to eliminate any benefit duplications under the policy or contract with benefits provided by Medicare.

(E) No insurer or other entity shall require any person covered under a Medicare supplement policy or contract which was in force prior to January 1, 1989, to purchase additional coverage under such policy or contract, unless such additional coverage was provided for in the policy or contract.

(F) Every insurer or other entity providing Medicare supplement insurance or benefits to a resident of this State shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or contract 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 by the insurer or other entity for such Medicare supplement insurance policies or contracts. 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. Premium adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within sixty (60) days of the renewal date if a refund is provided to the premium payer.

Section 5. Requirements for New Policies and Certificates

5.1 Effective January 1, 1989, no Medicare supplement insurance policy, contract or certificate shall be issued or issued for delivery in this State which provides benefits which duplicate benefits provided by Medicare. No such policy, contract or certificate shall provide less benefits than those required under West Virginia Code §33-28-5b and §33-16-3d and 114 C.S.R.17 except where duplication of Medicare benefits would result.

5.2 General Requirements

(A) Within ninety (90) days of the effective date of this regulation, every insurer or other entity required to file its policies or contracts with this State shall file new Medicare supplement insurance policies or contracts which eliminate any duplication of Medicare supplement benefits with benefits provided by Medicare and which provides a clear description of the policy or contract benefit.

(B) The filing required under 5.2(A) shall provide for loss ratios which are in compliance with all minimum standards.

(C) Every applicant for a Medicare supplement insurance policy, contract or certificate shall be provided with an outline of coverage which simplifies and accurately describes benefits provided by Medicare and policy or contract benefits along with benefit limitations.

Section 6. Filing Requirements for Advertising

Every insurer or other entity providing Medicare supplement insurance or benefits in this State shall provide a copy of any advertisement intended for use in this State whether through written, radio or television medium to the Commissioner for review. Such advertisement shall comply with all laws of this State, including, when applicable, the provisions of West Virginia Code §33-6-8(e) and §33-6-35.

Section 7. Buyer's Guide

No insurer or other entity shall make use of or otherwise disseminate any Buyer's Guide or informational brochure which does not accurately outline current Medicare benefits.

Section 8. Severability

If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

(COMPANY NAME)

NOTICE ON CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT INSURANCE - 1989

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

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

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	Medicare How Pays Per Benefit Period	Effective January 1, 1989 Medicare Will Pay Per Calendar Year	Your 1988 Coverage Per Benefit Period	Effective January 1, 1989 Your Coverage Will Pay Per Calendar year
MEDICARE PART A SERVICES AND SUPPLIES	First 60 days - All but \$540 61st to 90th day - All but \$135 a day 91st to 150th day - All but \$270 a day Beyond 150th day - Nothing	Unlimited number of hospital days after \$564 deductible.		

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	<u>Medicare How Pays Per Benefit Period</u>	<u>Effective January 1, 1989 Medicare Will Pay Per Calendar Year</u>	<u>Your 1988 Coverage Per Benefit Period</u>	<u>Effective January 1, 1989 Your Coverage Will Pay Per Calendar year</u>
SKILLED NURSING FACILITY CARE	Requires a 3 day prior stay and enter facility generally within 14 days after hospital discharge.	There is no prior confinement requirement for this benefit.		
	First 20 days - 100% of costs	First 8 days - All but \$() a day		
	21st through 100th day - All but \$67.50 a day	9th through 150th day - 100% of costs		
	Beyond 100 days - Nothing	Beyond 150 days - Nothing		

MEDICARE BENEFITS YOUR MEDICARE SUPPLEMENT COVERAGE

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	Medicare How Pays Per Calendar Year	In 1989 Medicare Part B Pays the Same as in 1988	Your Policy Now Pays	Effective January 1, 1989 Your Policy Will Pay
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$(75) deductible)	NOTE: Medicare Benefits changes on January 1990 as follows: 80% of allowable charges (after \$(75) deductible) until an annual Medicare Catastrophic limit is met. 100% of allowable charges for the remainder of the calendar year. The limit in 1990 is \$1,370* and will be adjusted on an annual basis.		
PRESCRIPTION DRUGS	Inpatient prescription drugs only	In 1989 Medicare covers inpatient prescription drugs only		
		Effective January 1, 1990 <u>Per Calendar Year</u> 80% of allowable charges for home intravenous (IV) therapy drugs and 50% of allowable charges for immunosuppressive drugs after (\$550 in 1990) calendar year deductible is met.		

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<u>Medicare How Pays Per Calendar Year</u>	<u>In 1989 Medicare Part B Pays the Same as in 1988</u>	<u>Your Policy Now Pays</u>	<u>Effective January 1, 1989 Your Policy Will Pay</u>
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Effective January 1, 1991
 Per Calendar Year

Inpatient prescription
 drugs. 50% of allowable
 charges for all other
 outpatient prescription
 after a \$600 deductible
 (the deductible will
 change) calendar year
 deductible is met.
 Coverage will increase to
 60% of allowable charges
 in 1992 and to 80% of
 allowable charges from
 1993 on.

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

(ANY ADDITIONAL BENEFITS)

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

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

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

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



KEN HECHLER
Secretary of State

MARY P. RATLIFF
Deputy Secretary of State

BARBARA STARCHER
Deputy Secretary of State

RICHARD S. STEPHENSON
Deputy Secretary of State

Telephone: (304) 345-4000
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WILLIAM H. HARRINGTON
Chief of Staff

RICH O. HARTMAN
Director, Administrative Law

DONALD R. WILKES
Director, Corporations

VIRGINIA SKEEN
Special Assistant

(Plus all the volunteer
help we can get)

STATE OF WEST VIRGINIA

SECRETARY OF STATE

Charleston 25305

RECEIVED
JUN 9 1989

W.V. INSURANCE COMMISSIONER

TO: Hanley C. Clark, Insurance Commissioner

FROM: RICH O. HARTMAN, DIR. ADMIN. LAW DIV.

DATE: June 8, 1989

THE ATTACHED RULE(S) RECENTLY FILED BY YOUR AGENCY HAVE BEEN ENTERED INTO THE COMPUTER. PLEASE REVIEW AND PROOF AND RETURN WITH ANY CORRECTIONS. IF THERE ARE NO CORRECTIONS PLEASE SIGN THIS MEMO AND RETURN TO THIS OFFICE. YOU WILL BE SENT A FINAL VERSION OF YOUR RULE(S) FOR YOUR RECORDS.

PLEASE RETURN EITHER THE CORRECTED RULE OR THIS FORM WITHIN TEN (10) WORKING DAYS OF THE DATE YOU RECEIVED THIS REQUEST. CALL IF YOU HAVE ANY QUESTIONS.

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THE ATTACHED RULE(S) HAVE BEEN REVIEWED AND ARE CORRECT.

SIGNED: B. Keith Harrison

TITLE OF PERSON SIGNING: General Counsel

DATE: June 19, 1989

THE ATTACHED RULE(S) HAVE BEEN REVIEWED AND NEEDS CORRECTED. THESE CORRECTIONS HAVE BEEN MARKED.

SIGNED: _____

TITLE OF PERSON SIGNING: _____

DATE: _____