

WEST VIRGINIA
SECRETARY OF STATE
KEN HECHLER
ADMINISTRATIVE LAW DIVISION

Form #7

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1989 DEC 29 PM 1:44

OFFICE OF THE SECRETARY OF STATE
WEST VIRGINIA

NOTICE OF AN EMERGENCY RULE

AGENCY: Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY: _____

EMERGENCY AMENDMENT TO AN EXISTING RULE: YES X, NO _____

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 24

TITLE OF RULE BEING AMENDED: Requirements for Medicare Supplement
Insurance Benefits and Premiums to Conform to Medicare Program Revisions

IF NO, SERIES NUMBER OF RULE BEING FILED AS AN EMERGENCY: _____

TITLE OF RULE BEING FILED AS AN EMERGENCY: Transitional Requirements
for The Conversion of Medicare Supplement Insurance Benefits and Premiums
to Conform to Repeal of Medicare Catastrophic Coverage Act

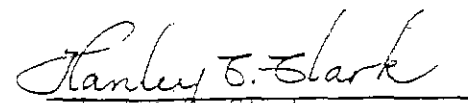
THE ABOVE RULE IS BEING FILED AS AN EMERGENCY RULE TO BECOME EFFECTIVE UPON FILING.

THE FACTS AND CIRCUMSTANCES CONSTITUTING THE EMERGENCY ARE AS FOLLOWS:

The Insurance Commissioner regulates insurance policies sold to supplement benefits provided under the federal medicare program. The benefit and premium levels of medicare supplement insurance policies are thus contingent upon and coordinated with benefits provided by the medicare program.

In 1988, Congress passed and President Reagan signed into law the Medicare Catastrophic Coverage Act (MCCA). This Act significantly altered the benefits provided by medicare, effective January 1, 1989. As a consequence, standards for medicare supplement insurance policies had to be altered to correspond with the new medicare benefit schedule. Transitional regulations were filed September 20, 1988, to meet this need on a temporary basis. Another set of regulations were filed August 14, 1989, and superceded the transitional regulation and was to be a permanent regulation. However, the U.S. Congress has now repealed (MCCA). This means the entire process must now begin over again.

Use Additional Sheets If Necessary.


Stanley G. Clark
Insurance Commissioner

Insurance Commissioner
Title 114
Series 24

THE FACTS AND CIRCUMSTANCES CONSTITUTING THE EMERGENCY (Cont.)

Therefore, this current transitional regulation is the first step in the process. This regulation is promulgated on an emergency basis pursuant to West Virginia Code §29A-3-15(g) due to necessary changes to conform to the federal Medicare program on January 1, 1990.



State of West Virginia
Department of Tax and Revenue

GASTON CAPERTON
GOVERNOR

Charleston 25305

CHARLES O. LORENSEN
SECRETARY

CONSENT TO PROPOSAL OF RULE

To Whom It May Concern:

Pursuant to West Virginia Code § 5F-2-2(a) (12), the undersigned hereby grants consent to the proposal of the following rule proposed by the Insurance Commissioner of the State of West Virginia: Title 33-28, Series 24, relating to transitional requirements for the conversion of Medicare Supplement Insurance benefits and premiums to conform to repeal of Medicare Catastrophic Coverage Act.

Signed this 29th day of December, 1989.

A handwritten signature in cursive script, reading "Charles O. Lorensen".

Charles O. Lorensen
Secretary of Tax and Revenue

EMERGENCY.

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 REPEAL OF MEDICARE CATASTROPHIC COVERAGE ACT

- Section 1. General
- Section 2. Definitions
- Section 3. Benefit Conversion Requirements
- Section 4. Form and Rate Filing Requirements
- Section 5. Offer of Reinstitution of Coverage
- Section 6. Requirements for New Policies and Certificates
- Section 7. Filing Requirements for Advertising
- Section 8. Buyer's Guide
- Section 9. Separability

EMERGENCY

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WEST VIRGINIA LEGISLATIVE RULE
INSURANCE COMMISSIONER

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CHAPTER 33-28
SERIES 24

OFFICE OF WEST VIRGINIA
SECRETARY OF STATE

TRANSITIONAL REQUIREMENTS FOR THE
CONVERSION OF MEDICARE SUPPLEMENT
INSURANCE BENEFITS AND PREMIUMS TO CONFORM
TO REPEAL OF MEDICARE CATASTROPHIC COVERAGE ACT

Section 1. General

1.1 Purpose. The purpose of this regulation 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 for adjustment of required minimum benefits for Medicare supplement policies; to provide notice to former policyholders of offer to reinstitute coverage; to provide full disclosure of policy or contract benefits and benefit changes; and to provide for appropriate premium adjustments.

1.2 Authority - West Virginia Code §33-28-5b, §33-2-10, §33-11-7, §33-16-3d, §33-24-4, §33-25A-8 and §33-25A-20.

1.3 Filing Date -

1.4 Effective Date -

1.5 Scope and Applicability - This regulation shall supercede the previous Series 24 of the Rules and Regulations of the West Virginia Insurance Commissioner and such other regulations of the Commissioner to the extent that they are inconsistent with the provisions hereof. Except as otherwise specifically provided, this regulation shall apply to:

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(A) All Medicare supplement policies and subscriber contracts 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 or subscriber contracts, which certificates have been delivered or issued for delivery in this State.

Section 2. Definitions

2.1 "Applicant" means:

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

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

2.2 "Certificate" means any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this State.

2.3 "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 health maintenance organizations 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 by reason of age.

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

Section 3. Benefit Conversion Requirements

3.1 Effective January 1, 1990, no Medicare supplement insurance policy, contract or certificate in force in this State shall contain benefits which duplicate benefits provided by Medicare.

3.2 Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 transition provisions shall be restored.

Insurance Commissioner
Leg. Rule 33-28
Series 24, Sec. 3
EMERGENCY

3.3 For Medicare supplement policies subject to the minimum standards adopted by the states pursuant to Medicare Catastrophic Coverage Act of 1988, the minimum benefits shall be:

(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 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 [\$75].

(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.

3.4 General Requirements

(A) No later than January 31, 1990, every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits to a resident of this State

Insurance Commissioner
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Series 24, Sec. 3
EMERGENCY

shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts. Such notice shall be in a format prescribed by the Commissioner or in the format set out in Appendix A--if no other format is prescribed by the Commissioner.

(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 effective.

(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.

(4) 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 regulation except to the extent necessary to accomplish the purposes articulated in Section 1 of this regulation.

Section 4. Form and Rate Filing Requirements

4.1 As soon as practicable, but no longer than forty-five (45) days after the effective date of the Medicare benefit changes, every insurer, health care service plan or other entity providing Medicare supplement insurance or contracts in this State shall file with the Department, in accordance with the applicable filing procedures of this State:

(A) 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.

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

Insurance Commissioner
Leg. Rule 33-28
Series 24, Sec. 4
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Medicare and to provide the benefits required by Section 3. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

4.2 Upon satisfying the filing and approval requirements of this State, every insurer, health care service plan or other entity providing Medicare supplement insurance in this State shall provide each covered person with any rider, endorsement or policy form necessary to make the adjustments outlined in Section 3 above.

4.3 Any premium adjustments shall provide an expected loss ratio under such policy or contract as will conform with minimum loss ratio standards for Medicare supplement policies and shall result in an expected loss ratio at least as great as that originally anticipated by the insurer, health care service plan or other entity for such Medicare supplement insurance policies or contracts. Premium adjustments may be calculated for the period commencing with Medicare benefit changes.

Section 5. Offer of Reinstitution of Coverage

5.1 Except as provided in Subsection 5.2, in the case of an individual who had in effect, as of December 31, 1988, a Medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before the date of the enactment of the repeal of the Medicare Catastrophic Coverage Act of 1988, the insurer shall:

(A) Provide written notice no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described below, and

(B) Offer the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstatement of coverage (with coverage effective as of January 1, 1990), under the terms which:

(1) Does not provide for any waiting period with respect to treatment of pre-existing conditions;

(2) Provides for coverage which is substantially equivalent to coverage in effect before the date of such termination; and

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(3) Provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

5.2 An insurer is not required to make the offer under Paragraph (B) above in the case of an individual who is a policyholder or certificate holder in another Medicare supplemental policy as of January 1, 1990, if the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.

Section 6. Requirements for New Policies and Certificates

6.1 Effective January 1, 1990, no Medicare supplement insurance policy, contract or certificate shall be delivered 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 by this regulation except where duplication of Medicare benefits would result and except as required by these transition provisions.

6.2 General Requirements.

(A) Within ninety (90) days of the effective date of this regulation, every insurer, health care service plan 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, which adjust minimum required benefits to changes in Medicare benefits and minimum required benefits to changes in Medicare benefits and which provide a clear description of the policy or contract benefit.

(B) The filing required under section 4.1(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.

Insurance Commissioner
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Series 24, Sec. 7
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Section 7. Filing Requirements of Advertising

7.1 Every insurer, health care service plan or other entity providing Medicare supplement insurance or benefits in this State 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 West Virginia Code §33-6-8(e), §33-6-35, and §33-11-4(2).

Section 8. Buyer's Guide

No insurer, health care service plan 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 and which has not been adopted by the Commissioner.

Section 9. Separability

9.1 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.

Insurance Commissioner
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 Series 24
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[COMPANY NAME]

APPENDIX A

NOTICE OF CHANGES IN MEDICARE AND YOUR MEDICARE SUPPLEMENT COVERAGE - 1990

THE FOLLOWING OUTLINE BRIEFLY DESCRIBES THE MODIFICATIONS IN MEDICARE AND IN YOUR MEDICARE SUPPLEMENT COVERAGE. PLEASE READ THIS 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	
	In 1989 Medicare Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990, Your Coverage Will Pay
MEDICARE PART A SERVICES AND SUPPLIES				
Inpatient Hospital Services	Unlimited number of hospital days after \$560 deductible	All but \$592 for first 60 days/benefit period		
Semi-Private Room & Board		All but \$148 a day for 61st-90th days/benefit period		
Misc. Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room		All but \$296 a day for 91st-150th days (if individual chooses to use 60 nonrenewable lifetime reserve days)		
BLOOD	Pays all costs except payment of deductible (equal to costs for first 3 pints) each calendar year. Part A blood deductible reduced to the extent paid under Part B	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in each benefit period		

Insurance Commissioner
 Leg. Rule 33-28
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 EMERGENCY

SERVICES	MEDICARE BENEFITS		YOUR MEDICARE SUPPLEMENT COVERAGE	
	In 1989 Medicare Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990, Your Coverage Will Pay
SKILLED NURSING FACILITY CARE	There is no prior confinement requirement for this benefit	100% of costs for 1st 20 days (after a 3 day prior hospital confinement)/ benefit period		
	First 8 days - All but \$25.50 a day	All but \$74.00 a day for 21st-100th days/benefit period		
	9th through 150th day - 100% of costs	Beyond 100 days - Nothing/benefit period		
	Beyond 150 days - Nothing			
MEDICARE PART B SERVICES AND SUPPLIES	80% of allowable charges (after \$75 deductible)	80% of allowable charges (after \$75 deductible/ calendar year)		
PRESCRIPTION DRUGS	Inpatient prescription drugs. 80% of allowable charges for immuno- suppressive drugs during the first year following a covered trans- plant (after \$75 deductible/ calendar year)	Inpatient prescription drugs. 80% of allowable charges for immunosup- pressive drugs during the first year following a covered transplant (after \$75 deductible/calendar year)		

Insurance Commissioner
 Leg. Rule 33-28
 Series 24
 EMERGENCY

SERVICES

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT COVERAGE

	In 1989 Medicare Pays Per Calendar Year	Effective January 1, 1990, Medicare Will Pay	In 1989 Your Coverage Pays	Effective January 1, 1990, Your Coverage Will Pay
BLOOD	80% of all costs except non-replacement fees (blood deductible) for first 3 pints in each benefit period (after \$75 deductible/calendar year)	80% of costs except nonreplacement fees (blood deductible) for first 3 pints (after \$75 deductible/calendar year)		

[Any other policy benefits not mentioned in this chart should be added to the chart in the order prescribed by the outline of coverage. If there are corresponding Medicare benefits, they should be shown.]

[Describe any coverage provisions changing due to Medicare modifications.]

[Include information about when premium adjustments that may be necessary due to changes in Medicare benefits will be effective.]

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 OR 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

ROBERT E. WILKINSON
Deputy Secretary of State

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Special Assistant

(Plus all the volunteer
help we can get)

STATE OF WEST VIRGINIA

SECRETARY OF STATE

Charleston 25305

FILED IN THE OFFICE OF
THE SECRETARY OF STATE

THIS DATE Feb. 9, 1990
ADMINISTRATIVE LAW DIVISION

February 9, 1990

NOTICE OF EMERGENCY RULE DECISION BY THE SECRETARY OF STATE

AGENCY: West Virginia Insurance Commissioner

RULE: Amendments, Series 24; Requirements for Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions / Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of Medicare Catastrophic Coverage Act

DATE FILED AS AN EMERGENCY RULE: December 29, 1989

DECISION NO. 1-90

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

KEN HECHLER
Secretary of State

KEN HECHLER
Secretary of State

MARY P. RATLIFF
Deputy Secretary of State

ROBERT E. WILKINSON
Deputy Secretary of State

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STATE OF WEST VIRGINIA
SECRETARY OF STATE

Charleston 25305

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(Plus all the volunteer
help we can get)

DECISION EMERGENCY RULE DECISION
(ERD 1-90)

AGENCY: Insurance Commissioner
RULE: Amendments, Series 24, Requirements for Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions/Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of Medicare Catastrophic Coverage Act

FILED AS AN EMERGENCY RULE: December 29, 1990

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

par. 6 The Insurance Commissioner filed this emergency rule with supporting documents with the Secretary of State on December 29, 1989 and with the LRMRC on December 29, 1989.

par. 7 It is the determination of the Secretary of State that the Insurance Commissioner has complied with the procedural requirements of WV Code §29A-3-15 for adoption of an emergency rule.

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

§33-28-5b. Medicare supplement insurance.

(b) Standards for policy provisions. -- (1) The commissioner shall issue reasonable regulations to establish specific standards for policy provisions of medicare supplement policies.

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

par. 10 (C) Emergency: WV Code 29A-3-15(g) defines "emergency" as follows:

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

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

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

The Insurance Commissioner regulates insurance policies sold to supplement benefits provided under the federal medicare program. The benefit and premium levels of medicare supplement insurance policies are thus contingent upon and coordinated with benefits provided by the medicare program.

In 1988, Congress passed and President Reagan signed into law the Medicare Catastrophic Coverage Act (MCCA). This Act significantly altered the benefits provided by medicare, effective January 1, 1989. As a consequence, standards for medicare supplement insurance policies had to be altered to correspond with the new medicare benefit schedule. Transitional regulations were filed September 20, 1988, to meet

this need on a temporary basis. Another set of regulations were filed August 14, 1989, and superceded the transitional regulation and was to be a permanent regulation. However, the U.S. Congress has now repealed (MCCA). This means the entire process must now begin over again.

Therefore, this current transitional regulation is the first step in the process. This regulation is promulgated on an emergency basis pursuant to West Virginia Code §29A-3-15(g) due to necessary changes to conform to federal Medicare program on January 1, 1990.

par. 13 It is the determination of the Secretary of State that this proposal qualifies under the definition of emergency.

par. 14 This decision shall be cited as Emergency Rule Decision 1-90 or ERD 1-90 and may be cited as precedent. This decision is available from the Secretary of State's office and has been filed with the Insurance Commissioner, the Attorney General and the Legislative Rule Making Review Commission.



KEN HECHLER
SECRETARY OF STATE

FILED IN THE OFFICE OF
THE SECRETARY OF STATE
THIS DATE Feb. 9, 1990
ADMINISTRATIVE LAW DIVISION

Entered _____