

Chapter 284-55 WAC

MEDICARE SUPPLEMENT INSURANCE REGULATION

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

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284-55-130	Substitution of policies. [Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-130, filed 11/1/88.] Repealed by 89-20-017 (Order R 89-11), filed 9/27/89, effective 10/28/89. Statutory Authority: RCW 48.02.060, 48.44.050, 48.46.200 and 48.66.041.
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284-55-175 Form of annual adjustment notice—Policy changes effective January 1, 1991. [Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-175, filed 11/1/88.] Repealed by 89-11-096 (Order R 89-7), filed 5/24/89. Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050.

284-55-177 Form of annual adjustment notice—Policy changes effective January 1, 1991. [Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-177, filed 5/24/89.] Repealed by 90-17-038 (Order R 90-7), filed 8/10/90, effective 9/10/90. Statutory Authority: RCW 48.02.060 and 48.66.041.

WAC 284-55-010 Limited purpose of this chapter.

(1) Regulation of medicare supplemental insurance policies under chapter 284-55 WAC is limited to those guaranteed renewable policies which were delivered to residents of this state prior to January 1, 1989. Such guaranteed renewable policies shall also be subject to the requirements of chapter 284-66 WAC as provided at WAC 284-66-020 (2)(a). All medicare supplemental insurance policies delivered to residents of this state after December 31, 1988, are regulated by the provisions of chapter 284-66 WAC, adopted March 16, 1990. Policies that are not guaranteed renewable and which were delivered to residents of this state prior to January 1, 1990, are also subject to the provisions of chapter 284-66 WAC.

(2) The purpose of this regulation, chapter 284-55 WAC, is to effectuate the provisions of RCW 48.20.450, 48.20.460 and 48.20.470, and to supplement the requirements of chapter 48.66 RCW, the Medicare Supplemental Health Insurance Act, by establishing minimum standards for benefits and specific standards for medicare supplement insurance, by prescribing the "outline of coverage" to be used in the sale of medicare supplemental insurance, by establishing other disclosure requirements, by prohibiting the use of certain provisions in medicare supplement insurance policies, by defining and prohibiting certain practices as unfair acts and practices, and establishing loss ratio requirements; 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 insurance policies; to eliminate policy provisions which may duplicate medicare benefits; and to provide for refunds of premiums associated with benefits duplicating medicare program benefits.

[Statutory Authority: RCW 48.02.060 and 48.66.041. 90-17-038 (Order R 90-7), § 284-55-010, filed 8/10/90, effective 9/10/90. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-010, filed 11/1/88. Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-010, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), § 284-55-010, filed 12/9/81.]

WAC 284-55-020 Applicability and scope. (1) This chapter applies to guaranteed renewable medicare supplemental insurance policies delivered to residents of this state prior to January 1, 1989, including every such group and individual policy of disability insurance and to every such subscriber contract of an insurer, fraternal benefit society, health care service contractor, or health maintenance organization, which relates its benefits to medicare, or 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. Such policy or contract is referred to in this chapter as "medicare supplemental insurance" or "medicare supplement insurance policy."

(2) Except as required by federal law, this regulation shall not apply to:

(a) 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 combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations;

(b) A policy or contract of any professional, trade, or occupational association for its members or former members, or combination thereof, if such association:

(i) Is composed of individuals all of whom are or have been actively engaged in the same profession, trade or occupation;

(ii) Has been maintained in good faith for purposes other than obtaining insurance; and

(iii) Has been in existence for at least two years prior to the date of initial offering of such policy or plan to its members;

(c) Individual policies or contracts issued pursuant to a conversion privilege under a policy or contract of group or individual insurance when such group or individual policy or contract includes provisions which are inconsistent with the requirements of this regulation;

(d) Policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation, or

(e) Health maintenance organization contracts specified in RCW 48.66.160, to the extent they may be in conflict with this regulation.

[Statutory Authority: RCW 48.02.060 and 48.66.041. 90-17-038 (Order R 90-7), § 284-55-020, filed 8/10/90, effective 9/10/90. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-020, filed 11/1/88. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), § 284-55-020, filed 12/9/81.]

WAC 284-55-030 Definitions. For purposes of this regulation:

(1) "Applicant" means:

(a) In the case of an individual medicare supplement insurance policy or subscriber contract, the person who seeks to contract for insurance benefits, and

(b) In the case of a group medicare supplement insurance policy or subscriber contract, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group medicare supplement insurance policy, which policy has been delivered or issued for delivery in this state.

(3) "Insurer" includes insurance companies, fraternal benefit societies, health care service contractors and health maintenance organizations.

(4) "Direct response insurer" means an insurer who, as to a particular transaction, is transacting insurance directly with a potential insured without solicitation by, or the intervention of, a licensed insurance agent.

(5) "Guaranteed renewable" means a medicare supplemental insurance policy or certificate which is renewable solely at the option of the insured by the timely payment of premiums, except that the insurer may make changes in premium rates by classes.

[Statutory Authority: RCW 48.02.060 and 48.66.041. 90-17-038 (Order R 90-7), § 284-55-030, filed 8/10/90, effective 9/10/90. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-030, filed 11/1/88. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), § 284-55-030, filed 12/9/81.]

WAC 284-55-035 Policy definitions and terms. No insurance policy or subscriber contract may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy unless such policy or contract contains definitions or terms which conform to the requirements of this section.

(1) "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 under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law.

(2) "Convalescent nursing home," "extended care facility," or "skilled nursing facility" shall be defined in relation to its status, facilities and available services.

(a) A definition of such home or facility shall not be more restrictive than one requiring that it:

(i) Be operated pursuant to law;

(ii) Be approved for payment of medicare benefits or be qualified to receive such approval, if so requested;

(iii) Be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

(iv) Provide continuous twenty-four hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

(v) Maintains a daily medical record of each patient.

(b) The definition of such home or facility may provide that such term shall not be inclusive of:

(i) Any home, facility or part thereof used primarily for rest;

(ii) A home or facility for the aged or for the treatment of chemical dependency; or

(iii) A home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

(3) "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 Health Care Organizations.

(a) The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

(i) Be an institution operated pursuant to law; and

(ii) Be primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a prearranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which charge is made; and

(iii) Provide twenty-four hour nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

(b) The definition of the term "hospital" may state that such term shall not be inclusive of:

(i) Convalescent homes, convalescent, rest, or nursing facilities; or

(ii) Facilities primarily affording custodial, educational, or rehabilitative care; or

(iii) Facilities for the aged, drug addicts, or alcoholics; or

(iv) Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

(4) "Mental or nervous disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

(5) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse," or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualified under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

(6) "Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(7) "Sickness" shall not be defined to be more restrictive than the following: "Sickness means sickness 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 work-

ers' compensation, occupational disease, employer's liability, or similar law.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-035, filed 5/24/89. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-035, filed 11/1/88. Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-035, filed 5/26/82.]

WAC 284-55-040 Prohibited policy provisions. (1)

No insurance policy or subscriber contract may be advertised, solicited or issued for delivery in this state as a medicare supplement policy unless such policy or contract meets the requirements of chapter 48.66 RCW, the Medicare Supplemental Health Insurance Act.

(2) No medicare supplement policy or certificate in force in this state shall contain benefits which duplicate benefits provided by medicare.

(3) No insurance policy or subscriber contract may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy if such policy or subscriber contract limits or excludes coverage by type of illness, accident, treatment, or medical condition, except as follows:

(a) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;

(b) Mental or emotional disorders and chemical dependency;

(c) Illness, treatment, or medical condition arising out of:

(i) War or act of war (whether declared or undeclared); participation in a felony, riot or insurrections; service in the armed forces or units auxiliary thereto;

(ii) Suicide (sane or insane), attempted suicide, or intentionally self-inflicted injury;

(iii) Aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

(d) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection, or other diseases of the involved part;

(e) Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment, or subluxation of, or in the vertebral column;

(f) Treatment provided in a governmental hospital; benefits provided under medicare or other governmental program (except medicaid), any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories, or other institutions; services performed by a member of the covered person's immediate family and services for which no charge is normally made in the absence of insurance;

(g) Dental care or treatment;

(h) Eye glasses, hearing aids, and examination for the prescription or fitting thereof;

(i) Rest cures, custodial care, transportation, and routine physical examinations;

(j) Territorial limitations:

Provided, That medicare supplement insurance policies may not contain, when issued, limitations or exclusions of the type enumerated in (a), (e), (i) or (j) of this subsection that are more restrictive than those of medicare. Medicare supplement policies may exclude coverage for any expense to the extent of any benefit available to the insured under medicare.

(4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" medicare supplement insurance policy shall not provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(5) Termination of a medicare supplement policy 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 payment of the maximum benefits. Any provision to the contrary is prohibited.

(6) No medicare supplement insurance policy shall restrict, exclude or limit benefits for a sickness through use of a probationary, or similar, provision.

(7) No insurer shall require any person covered under a medicare supplement insurance policy to purchase additional coverage in connection with the amendment thereof.

(8) The terms "medicare supplement," "Medigap," or words of similar import shall not be used to describe an insurance policy or contract unless such policy or contract is issued in compliance with chapter 48.66 RCW and this chapter.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-040, filed 11/1/88. Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-040, filed 5/26/82. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), § 284-55-040, filed 12/9/81.]

WAC 284-55-045 Minimum benefit standards.

Except as permitted by WAC 284-55-040(3), no insurance policy or subscriber contract may be advertised, solicited, or issued for delivery in this state as a medicare supplement policy which does not meet the following minimum benefit standards. Except in subsection (1) of this section which requires fixed benefits, these are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(1) Coverage for either all or none of the medicare Part A inpatient hospital deductible amount.

(2) Coverage for the daily copayment amount of medicare Part A eligible expenses for the first eight days per calendar year incurred for skilled nursing facility care.

(3) Coverage for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) under medicare Part A not replaced in accordance with federal regulations.

(4)(a) Until January 1, 1990, coverage of twenty percent of the amount of medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket deductible of two hundred dollars of such expenses and to a maximum benefit of at least five thousand dollars per calendar year.

(b) Effective January 1, 1990, coverage for the copayment amount of medicare eligible expenses (excluding outpatient prescription drugs) under medicare Part B up to the maximum out-of-pocket amount for medicare Part B after the medicare deductible amount.

(5) Effective January 1, 1990, coverage under medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) under medicare Part B not replaced in accordance with federal regulations.

(6) Effective January 1, 1990, coverage for the copayment amount of medicare eligible expenses for covered home intravenous (IV) therapy drugs (as determined by the Secretary of Health and Human Services) subject to the medicare outpatient prescription drug deductible amount, if applicable.

(7) Effective January 1, 1990, coverage for the copayment amount of medicare eligible expenses for outpatient drugs used in immunosuppressive therapy subject to the medicare outpatient prescription drug deductible, if applicable.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-045, filed 11/1/88. Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-045, filed 5/26/82.]

WAC 284-55-050 Outline of coverage required. (1)

An agent or insurer initiating a sale of an individual or group medicare supplement insurance policy in this state shall complete and sign a disclosure form, and deliver the completed form to the applicant not later than the time of application for the policy.

(2) The disclosure form to be used shall be the "outline of coverage," which is set forth in WAC 284-55-060. The form of outline shall be filed with the commissioner prior to use in this state.

(3) Except for direct response insurers, an insurer shall obtain an acknowledgement of receipt of such outline from the applicant.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-050, filed 5/24/89. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-050, filed 11/1/88. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), § 284-55-050, filed 12/9/81.]

WAC 284-55-060 Form for "outline of coverage."

(COMPANY NAME)
OUTLINE OF MEDICARE
SUPPLEMENT COVERAGE

(1) Read your policy carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

(2) Medicare supplement coverage - Policies of this category are designed to supplement medicare by covering some hospital, medical, and surgical services which are partially covered by medicare. Coverage is provided for hospital inpatient charges and some physician charges, subject to any

deductibles and copayment provisions which may be in addition to those provided by medicare, and subject to other limitations which may be set forth in the policy. The policy does not provide benefits for custodial care such as help in walking, getting in and out of bed, eating, dressing, bathing and taking medicine (delete if such coverage is provided).

(3)(a) (for agents:)

Neither (Insert company's name) nor its agents are connected with medicare.

(b) (for direct responses:)

(Insert company's name) is not connected with medicare.

(4) (A brief summary of the major benefit gaps in medicare Parts A and B with a description of supplemental benefits, including dollar amounts, provided by the medicare supplement coverage in the following order:)

	THIS		
	POLICY	YOU	
SERVICE	PAYS	PAY	
I. Part A			
A. INPATIENT HOSPITAL SERVICES:			
			Semi-private room & board
			Miscellaneous hospital services & supplies, such as drugs, X-rays, lab tests & operating room
B. SKILLED NURSING CARE			
C. BLOOD			

	THIS		
	POLICY	YOU	
SERVICE	PAYS	PAY	
II. Part B			
A. MEDICAL EXPENSE:			
			Services of a physician/ outpatient services
			Medical supplies other than prescribed drugs
B. BLOOD			
C. MAMMOGRAPHY SCREENING			
D. OUT-OF-POCKET MAXIMUM			
E. PRESCRIPTION DRUGS			
III. Parts A & B			
			Home health services
IV. Miscellaneous			
			A. Home intravenous (IV) therapy drugs
			B. Immunosuppressive drugs
			C. Respite care benefits
IN ADDITION TO THIS OUTLINE OF COVERAGE, <u>(INSURANCE COMPANY NAME)</u> WILL SEND AN ANNUAL NOTICE TO YOU THIRTY DAYS PRIOR TO THE EFFECTIVE DATE OF MEDICARE CHANGED WHICH WILL DESCRIBE THESE CHANGES AND THE CHANGES IN YOUR MEDICARE SUPPLEMENT COVERAGE.			

(5) (The following chart shall accompany the outline of coverage and the form thereof shall be filed with the commissioner prior to use in this state:)

Part A
MEDICARE BENEFITS IN

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
PART A				
Inpatient Hospital Services	All but \$540 for first 60 days/benefit period	All but \$560 deductible for an unlimited number of days/calendar year	All but Part A deductible for an unlimited number of days/calendar year	All but Part A deductible for an unlimited number of days/calendar year
Semi-Private Room & Board	All but \$135 a day for 61st - 90th day/benefit period			
Miscellaneous Hospital Services & Supplies, such as Drugs, X-Rays, Lab Tests & Operating Room	All but \$270 a day for 91st - 150th days (if individual chooses to use 60 nonrenewable lifetime reserve days) per benefit period			

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<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Skilled Nursing Facility Care	100% of costs for for 1st 20 days (after 3-day prior hospital confinement) All but \$67.50 a day for 21st - 100th days Nothing beyond 100 days	80% of medicare reasonable costs for first 8 days per calendar year without prior hospitalization requirement 100% of costs thereafter up to 150 days/calendar year	80% for 1st 8 days/calendar year 100% for 9th-150th day/calendar year	80% for 1st 8 days/calendar year 100% for 9th-150th day/calendar year
Blood	Pays all costs except nonreplacement fees (blood deductible) for first 3 pints in <u>each benefit period</u>	Pays all costs except payment of deductible (equal to costs for first 3 pints) <u>each calendar year</u> .	All but blood deductible (equal to costs for first 3 pints)	All but blood deductible (equal to costs for first 3 pints)

Part A blood deductible reduced to the extent paid under Part B.

Part B
MEDICARE BENEFITS IN

<u>Service</u>	<u>1988</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
Parts A & B:				
Home Health Services	Intermittent skilled nursing home care and other services in the home (daily skilled nursing care for up to 21 days or longer in some cases) — 100% of covered services and 80% of durable medical equipment under both Parts A & B (same 1988 and 1989)		Intermittent skilled nursing care for up to 7 days a week for up to 38 days allowing for continuation of services under unusual circumstances — other services, — 100% of covered services and 80% of durable medical equipment under both Parts A & B (same 1990 & 1991)	
PART B				
Medical Expense: Services of a Physician/ Outpatient Services — Medical Supplies Other than Prescribed Drugs	80% of reasonable charges after an annual \$75 deductible	80% after \$75 deductible	80% of reasonable charges after \$75 deductible until out-of-pocket maximum is reached. 100% of reasonable charges are covered for the remainder of the calendar year. (same 1990 and 1991)	
Blood	80% of costs except non-replacement fees (blood deductible) for 1st 3 pints in <u>each benefit period</u> after \$75 deductible	Pays 80% of all costs except payment of deductible (equal to costs for first 3 pints) <u>each calendar year</u> (same 1989, 1990, 1991)		

Service	1988	1989	1990	1991
Mammography Screening			80% of approved charge for elderly and disabled medicare beneficiaries — exams available every other year for women age 65 and older (same 1990 and 1991)	
Out-of-Pocket Maximum			\$1,370 consisting of Part B \$75 deductible, Part B blood deductible and 20% co-insurance (same 1990 & 1991, except \$1,370 will be adjusted annually by Sec. Health & Human Services)	
Outpatient Prescription Drugs			There is a \$550 total deductible for home IV drug and immunosuppressive drug therapies as noted below	Covered after \$600 deductible subject to 50% co-insurance
Home IV Drug Therapy			80% of IV therapy drugs subject to \$550 deductible (deductible waived if home therapy is a continuation of therapy initiated in a hospital)	80% of IV therapy drugs subject to standard drug deductible (deductible waived if home therapy is a continuation of therapy initiated in a hospital)
Immunosuppressive Drug Therapy	80% of costs during 1st year following a covered organ transplant (no special drug deductible — only the regular Part B deductible) (same benefit 1988 and 1989)		Same as 1988 & 1989 for 1st year following covered transplant; then 50% of costs during 2nd and following years (subject to \$550 deductible in 1990, \$600 in 1991)	
Respite Care Benefit			In-home care for chronically dependent individual covered for up to 80 hours after either the out-of-pocket limit or the outpatient drug deductible has been met (same in 1990 and 1991)	

(6) (Statement that the policy DOES OR DOES NOT cover the following:)

- (a) Private duty nursing,
- (b) Skilled nursing home care costs (beyond what is covered by medicare),
- (c) Custodial nursing home care costs,
- (d) Intermediate nursing home care costs,
- (e) Home health care above number of visits covered by medicare,
- (f) Physician charges (above medicare's reasonable charge),

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(g) Drugs and insulin (other than prescription drugs furnished during a hospital or skilled nursing facility stay),

- (h) Care received outside of U.S.A. (and its territories),
- (i) Dental care or dentures, checkups, routine immunizations, cosmetic surgery, routine foot care, examinations for, or the cost of, eyeglasses or hearing aids.

(7) (An explanation of such terms as "usual and customary," "reasonable and customary," or words of similar import, if used in the policy.)

(8) A description of any policy provisions which exclude, eliminate, resist, reduce, limit, delay, or in any other manner operate to qualify payments of the benefits described

in subsection (4) of this section, including conspicuous statements:

(a) That the chart summarizing medicare benefits only briefly describes such benefits.

(b) That the Health Care Financing Administration or its medicare publications should be consulted for further details and limitations.

(9) A description of policy provisions respecting renewability or continuation of coverage, including any reservation of rights to change premium.

(10) The amount of premium for this policy.

.....
(Insurer's Name)
By Date
.....
(Agent's or Officer's Signature)

(Drafting note. Where inappropriate terms are used, such as "insurance," "policy," or "insurance company," a fraternal benefit society, health care service contractor or health maintenance organization shall substitute appropriate terminology.)

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-060, filed 5/24/89. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-060, filed 11/1/88. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), § 284-55-060, filed 12/9/81.]

WAC 284-55-065 Buyer's guide. (1) Insurers issuing accident and sickness policies, certificates, or subscriber contracts that provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to persons eligible for medicare by reason of age must provide to all applicants a medicare supplement "buyer's guide."

(2) The "buyer's guide" required to be provided is the pamphlet *Guide to Health Insurance for People with Medicare*, developed jointly by the National Association of Insurance Commissioners and Health Care Financing Administration of the United States Department of Health and Human Services, or any reproduction or official revision of that pamphlet. Specimen copies may be obtained from the Superintendent of Documents, United States Government Printing Office, Washington, D.C.

(3) Delivery of the "buyer's guide" must be made whether or not such policies, certificates, or subscriber contracts are advertised, solicited, or issued as medicare supplement insurance policies. Except in the case of direct response insurers, delivery of the "buyer's guide" must be made to the applicant at the time of application and acknowledgement of receipt of the "buyer's guide" must be obtained by the insurer. Direct response insurers must deliver the "buyer's guide" to the applicant upon request but not later than at the time the policy is delivered.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-065, filed 11/1/88. Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-065, filed 5/26/82.]

WAC 284-55-067 Notice regarding policies or subscriber contracts which are not medicare supplement pol-

icies. Any accident and sickness insurance policy or subscriber contract, other than a medicare supplement policy, disability income policy, basic, comprehensive, or major medical expense policy, single premium nonrenewable policy or other policy identified in WAC 284-55-020 (2)(c) and (d), issued for delivery in this state to persons eligible for medicare by reason of age, shall notify insureds under the policy or subscriber contract that the policy or subscriber contract is not a medicare supplement insurance policy. Such notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy or subscriber contract, or if no outline of coverage is delivered, to the first page of the policy, certificate or subscriber contract delivered to insureds. Such notice shall be in no less than twelve point type and shall contain the following language: "THIS (POLICY, CERTIFICATE OR SUBSCRIBER CONTRACT) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). If you are eligible for medicare, review the Medicare Supplement Buyers Guide available from the company."

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-067, filed 11/1/88. Statutory Authority: RCW 48.66.100, 48.20.470 and 1982 c 200 § 1. 82-12-032 (Order R 82-3), § 284-55-067, filed 5/26/82.]

WAC 284-55-070 Requirements for application forms, replacement. (1) Application forms shall include a question designed to elicit information as to whether a medicare supplement insurance policy or certificate is intended to replace any other health care service contract, health maintenance organization contract, disability insurance policy or certificate presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

(2) Upon determining that a sale will involve replacement, the insurer, other than a direct response insurer, or its agent, shall furnish the applicant, prior to issuance or delivery of the medicare supplement insurance policy or certificate, a notice regarding replacement of accident and sickness coverage. One copy of such notice shall be provided to the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage. The form shall be filed with the commissioner prior to use in this state.

(3) The notice required by subsection (2) of this section for an insurer, other than a direct response insurer, shall be provided in substantially the form set forth in WAC 284-55-080.

(4) The notice required by subsection (2) of this section for a direct response insurer shall be in substantially the form set forth in WAC 284-55-090.

(5) The application form shall also contain questions as to whether, as of the date of the application, the applicant:

(a) Has any other health care service contract, health maintenance organization contract, disability insurance policy or certificate in force, and

(b) Is eligible for state medical assistance coupons (medicaid).

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-070, filed 5/24/89. Statutory Authority: RCW

48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-070, filed 11/1/88. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), § 284-55-070, filed 12/9/81.]

WAC 284-55-080 Form for "replacement notice."

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by (company name) insurance company. Federal and state law provides thirty days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (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.

Drafting note. This subsection may be modified if preexisting conditions are covered under the new policy.

- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, 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/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, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

.....
(Date)
.....
(Applicant's Signature)

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-080, filed 11/1/88. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), § 284-55-080, filed 12/9/81.]

WAC 284-55-090 Form for "replacement notice" by direct response insurer.

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with the policy delivered herewith issued by (company name) insurance company. Federal and state law provides thirty days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (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) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (company name and address) within thirty days if any information is not correct and complete, or if any past medical history has been left out of the application.

.....
(Company Name)

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-090, filed 11/1/88. Statutory Authority: RCW 48.02.060, 48.44.050 and 48.46.200. 82-01-016 (Order R 81-6), § 284-55-090, filed 12/9/81.]

WAC 284-55-095 Prohibited compensation for replacement with the same insurer. No insurer shall provide compensation to its agents or other producers which is greater than the renewal medicare compensation which would have been paid on an existing medicare supplement insurance policy if an existing medicare supplement insurance policy is replaced by another such policy where the new benefits are substantially similar to the benefits under the old medicare supplement insurance policy and such old policy was issued by the same insurer or insurer group.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-095, filed 11/1/88.]

WAC 284-55-115 Standards for loss ratios. (1) Medicare supplement insurance policies shall return to policyholders in the form of aggregated benefits under such policy, for the entire period for which rates are computed to provide coverage, loss ratios not less than those set forth in this section. Such aggregated benefits shall be on the basis of incurred

claims experience and earned premiums for such period in accordance with accepted actuarial principles. The loss ratio standards of this section are more stringent and more appropriate than those imposed by RCW 48.66.100, and are necessary for the protection of the public interest. Where coverage is provided by a health maintenance organization on a service rather than reimbursement basis, such aggregated benefits shall be on the basis of incurred health care expenses and earned premiums for such period.

(2) All filings of rates and rating schedules shall demonstrate that actual and expected losses in relation to premiums comply with the requirements of this chapter.

(3) Every insurer providing medicare supplement policies in this state shall annually file its rates, rating schedules, and supporting documentation including ratios of incurred losses to earned premiums by number of years of policy duration demonstrating that it is in compliance with the applicable loss ratio standards and that the period for which the policy is rated is reasonable in accordance with accepted actuarial principles and experience. Supporting documentation shall include the amounts of unearned premium reserve, policy reserves, and claim reserves and liabilities, both nationally and for this state. The form for filing this information is provided at WAC 284-55-205 through 284-55-210.

(4) Incurred losses shall include claims paid and the change in claim reserves and liabilities. Incurred losses shall not include policy reserves, home office or field overhead, acquisition and selling costs, taxes or other expenses, contributions to surplus, profit, or claims processing costs.

(5) The following criteria will be used to determine whether policy forms are in compliance with the loss ratio standards of this section:

(a) For the most recent year, the ratio of the incurred losses to earned premiums is greater than or equal to the applicable percentages contained in this section; and

(b) The expected losses in relation to premiums over the entire period for which the policy is rated complies with the requirements of this section, relying on the judgment of the pricing actuary and acceptable to the commissioner; and

(c) An expected loss ratio for the third policy year, greater than or equal to the applicable percentage, shall be demonstrated for policies or certificates in force less than three years. The applicable percentage shall be as defined in subsection (6), (7), or (8) of this section.

(d) Similar policy forms shall be grouped together according to the rules set forth in WAC 284-60-040.

(e) The commissioner may consider additional criteria including, but not limited to:

(i) Equitable treatment of policyholders; and

(ii) The amount of policy reserves as defined for the insurer's statutory annual statement.

(6) Medicare supplement insurance policies issued by disability insurers and fraternal benefit societies shall be expected to return to a policyholder in the form of aggregated loss ratios under the policy, at least sixty-five percent of the earned premiums in the case of individual policies, and seventy-five percent in the case of group policies.

(7) The minimum anticipated loss ratio requirement for health care service contractors shall be seventy percent for individual forms and eighty percent for group contract forms.

(8)(a) The minimum anticipated loss ratios for a health maintenance organization are deemed to be met if its health care expense costs are seventy percent or more of the earned premium charged individual subscribers, or eighty percent or more of the earned premium charged subscribers covered under a group contract.

(b) For purposes of this chapter, "health care expense costs" means expenses of a health maintenance organization associated with the delivery of health care services which are analogous to incurred losses of insurers. Such expenses shall not include home office and overhead costs, advertising costs, commissions and other acquisition costs, taxes, capital costs, administrative costs and "claims" processing costs.

(9) For purposes of this chapter, "premium" means all sums charged, received, or deposited as consideration for a medicare supplement insurance policy or the continuance thereof. An assessment or a membership, contract, survey, inspection, service, or other similar fee or charge made by the insurer in consideration for such contract is deemed part of the premium.

(10) For purposes of this chapter, "earned premium" shall mean the "premium" applicable to an accounting period whether received before, during, or after such period.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-115, filed 5/24/89. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-115, filed 11/1/88.]

WAC 284-55-120 Attained age rating prohibited.

Effective January 1, 1989, with respect to medicare supplement insurance policies initially sold to residents of this state on or after that date, it is an unfair practice and an unfair method of competition for any insurer, and a prohibited practice for any health care service contractor or health maintenance organization, to use the increasing age of an insured, subscriber, or participant as the basis for increasing premiums or prepayment charges.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-120, filed 11/1/88.]

WAC 284-55-125 Riders and endorsements.

(1) In order to assure the orderly implementation and conversion of medicare supplement insurance benefits due to changes in the federal medicare program and to eliminate provisions which may duplicate medicare:

(a) No later than January 1, 1990, all insurers must substitute new policies for all medicare supplement insurance policies or contracts sold to residents of this state prior to January 1, 1990, where policies were amended by riders or endorsements to comply with changes to medicare.

(b) Effective January 1, 1990, subject to RCW 48.66.050 (2), and except for riders or endorsements issued in accordance with subsection (2) of this section, no rider, endorsement, waiver, or any other means of contractual modification may be used by an insurer to exclude, limit, or reduce the coverage or benefits of a medicare supplement insurance policy issued to a resident of this state.

(2)(a) Effective January 1, 1990, only riders or endorsements which increase benefits or coverage may be used in this state.

(b) A medicare supplement insurance policy amendment which increases the premium must be requested or accepted by the insured in writing.

(c) Where separate additional premium is charged for a medicare supplement insurance policy rider, endorsement or other amendment thereto, such premium charge shall be set forth in the policy.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-125, filed 11/1/88.]

WAC 284-55-150 Filing requirements and premium adjustments. (1) For medicare supplement insurance policies initially sold to residents of this state on or after January 1, 1989:

(a) Within ninety days of the effective date of this rule, every insurer required to file its medicare supplement insurance policy forms with the commissioner shall file with the commissioner new medicare supplement insurance policy forms which eliminate any duplication of medicare supplement benefits with benefits provided by medicare and which provide a clear description of the policy or contract benefit; and

(b) The filing required under this subsection shall provide for loss ratios which are at least as favorable to the insured as the minimum loss ratio standards established by WAC 284-55-115.

(2) Annually, beginning with changes to be effective January 1, 1990, as soon as practicable, but not less than sixty days prior to the annual effective date of the changes required by the Medicare Catastrophic Coverage Act of 1988, every insurer providing medicare supplement insurance policies in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state:

(a) Policy forms necessary to accomplish the medicare supplement insurance modifications necessary to eliminate benefit duplications with medicare, such forms providing a clear description of the medicare supplement benefits provided by the policy or contract; and

(b) Appropriate premium adjustments necessary to produce complying loss ratios originally anticipated for the applicable policies or contracts and such supporting documents necessary in the opinion of the commissioner to justify the adjustments.

(3) Every insurer 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 the minimum loss ratio standards of WAC 284-55-115.

(4) No premium adjustment which would modify the loss ratio experience under the policy, other than the adjustments described in this section, may be made with respect to a policy at any time other than upon its renewal or anniversary date.

(5) 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 days of the renewal or anniversary date if a refund is provided to the premium payer.

(6) For purposes of rate making and requests for rate increases, all individual medicare supplement policy forms of

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an insurer are considered "similar policy forms" including forms no longer being marketed.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-150, filed 5/24/89. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-150, filed 11/1/88.]

WAC 284-55-155 Filing requirements for out-of-state group policies. Every insurer providing group medicare supplement insurance benefits to a resident of this state shall, within thirty days of its use in this state, file with the commissioner a copy of the master policy and any certificate used in this state.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-155, filed 11/1/88.]

WAC 284-55-160 Annual adjustment notice to conform existing medicare supplement policies to medicare changes. No later than thirty days prior to the annual effective date of changes required by the Medicare Catastrophic Coverage Act of 1988, every insurer providing medicare supplement insurance policies to a resident of this state shall notify its insureds of modifications it has made to medicare supplement insurance policies in an annual adjustment notice. For the years 1989 and 1990, and in 1990 only if outpatient prescription drugs are covered by the policy or contract, such notice shall be substantially in the format prescribed by the commissioner at WAC 284-55-165 through 284-55-177. The annual adjustment notice is intended to be informational only and for the sole purpose of informing policy and certificate holders about changes in medicare benefits, indexed deductible and copayment provisions, premium adjustments, and the like. The forms of annual adjustment notices provided to residents of this state shall be filed with the commissioner prior to use.

(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.

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

(3) Such annual adjustment notice of benefit modifications and any premium adjustment shall be furnished 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.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-160, filed 5/24/89. Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-160, filed 11/1/88.]

WAC 284-55-165 Form of annual adjustment notice—Policy changes effective January 1, 1989.

(COMPANY NAME)

NOTICE OF 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 change 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.)

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT COVERAGE

Medicare Now Pays Per Benefit Period	Effective January 1, 1989 medicare Will Pay Per Calendar Year	Your 1988 Coverage Per Benefit Period	Effective Jan. 1, 1989 Your Coverage Will Pay Per Calendar Year
---	--	--	--

MEDICARE PART A: SERVICES AND SUPPLIES

First 60 days - all but \$540	Unlimited number of hospital days after \$564 deductible
61st to 90th day - all but \$135/day	
91st to 150th day - all but \$270/day (if individual chooses to use 60 nonrenewable lifetime days)	
Beyond 150th day — nothing	

SKILLED NURSING FACILITY CARE

Requires a 3-day prior stay and enter the facility generally within 30 days after hospital discharge	There is no prior confinement requirement for this benefit
First 20 days - 100% of costs	First 8 days - All but \$(22.00) a day
21st through 100th day - all but \$67.50 a day	9th through 150th 100% of costs
Beyond 100 days - Nothing	Beyond 150 days - Nothing

MEDICARE PART B: SERVICES AND SUPPLIES

80% of allowable charges (after \$75.00 deductible)	In 1989 medicare Part B pays the same as in 1989
---	--

NOTE: Medicare benefits changes on January 1, 1990 as follows:

80% of allowable charges (after \$75.00 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 \$1370* and will be adjusted on an annual basis.

* 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.

PRESCRIPTION DRUGS

Inpatient prescription drugs only	In 1989 medicare covers inpatient prescription drugs only
-----------------------------------	---

NOTE: Effective January 1, 1990, per calendar year — 80% of allowable charges for home intravenous (IV) therapy drugs and 50% of allowable charges for immunosuppressive drugs after calendar year deductible is met (\$550 in 1990).

MEDICARE BENEFITS

YOUR MEDICARE SUPPLEMENT COVERAGE

Medicare Now Pays Per Benefit Period	Effective January 1, 1989 medicare Will Pay Per Calendar Year	Your 1988 Coverage Per Benefit Period	Effective Jan. 1, 1989 Your Coverage Will Pay Per Calendar Year
---	--	--	--

Effective January 1, 1991, per calendar year — Inpatient prescription drugs: 50% of allowable charges for all other outpatient prescription drugs after a \$600 calendar year deductible is met. (The deductible will change.) Coverage will increase to 60% of allowable charges in 1992 and to 80% of allowable charges from 1993 on.

(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 information will be sent.)

This chart summarizing the changes in your medicare benefits and in your medicare supplement insurance 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 name — or name of agent) (address) (phone number).

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-165, filed 11/1/88.]

WAC 284-55-180 Requirements for advertising. (1)

At least thirty days prior to use in this state, every insurer who provides medicare supplement insurance coverage to a resident of this state shall provide the commissioner with a copy of any advertisement, as defined at WAC 284-50-030, intended for use in this state, whether through written, radio, or television medium. In the case of radio or television advertising, an audio cassette or VHS video cassette shall be supplied on request of the commissioner.

(2) Advertisements shall comply with the Washington disability advertising regulation, RCW 48.30.040 through 48.30.090, and all other applicable state laws.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-180, filed 11/1/88.]

WAC 284-55-185 Compliance with Omnibus Budget Reconciliation Act of 1987. Every insurer to whom it applies shall certify to the commissioner on the medicare supplement experience exhibit of its annual statement that it has complied with Section 4081 of the Omnibus Budget Reconciliation Act of 1987, P.L. 100-203, (1987).

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-185, filed 11/1/88.]

WAC 284-55-190 Chapter not exclusive. Nothing contained in this chapter shall be construed to limit the authority of the commissioner to regulate a medicare supplement insurance policy under other sections of Title 48 RCW.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.30.010(2). 88-22-061 (Order R 88-9), § 284-55-190, filed 11/1/88.]

WAC 284-55-205 Medicare supplement loss ratio experience form required. The form provided at WAC 284-

WAC 284-55-210 Form of medicare supplement loss ratio experience. The following form of medicare supplement loss ratio experience shall be used by all insurers:

MEDICARE SUPPLEMENT LOSS RATIO EXPERIENCE
(SUMMARIZED BY POLICY YEAR)

Experience reported for January 1 to December 31 of 19 _____
To be filed on or before June 30

of the _____

55-210 shall be filed with the commissioner annually not later than June 30th of each calendar year beginning June 30, 1990. The form is to be filed in addition to the NAIC experience exhibit and not in lieu thereof.

The following instructions must be followed when completing the form:

(1) The data shall be furnished in the same format and order as that shown at WAC 284-55-210;

(2) The name of the insurer must be clearly shown at the top of each page;

(3) Separate data must be shown for each policy form number and for each policy duration of each form;

(4) The current approved rate schedule for each policy form number shall be attached to the experience form and shall show the policy form number for purposes of identification;

(5) Incurred losses shall include claims paid and the change in claim reserves and liabilities. A list of items that are not to be included in incurred losses is provided at WAC 284-55-115(4);

(6) The loss ratio shall be the ratio of incurred losses to earned premium;

(7) The experience form shall be certified by an officer of the insurer;

(8) Complete data is required for each policy form on both a national basis and for policies sold in the state of Washington;

(9) Policy reserves shall include:

(a) Active life reserves;

(b) Contingency and additional reserves;

(c) Increased reserves which may be required by the commissioner.

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-205, filed 5/24/89.]

Medicare Supplement Insurance Regulation

MEDICARE SUPPLEMENT LOSS RATIO EXPERIENCE
(SUMMARIZED BY POLICY YEAR)

Address (City, State, and Zip Code)		NAIC Company Code				CIC Code		
National Experience		Washington Experience				Unearned Premium Reserve		
<u>Form No.</u>	<u>No. of Contracts in Force</u>	<u>Policy Duration</u>	<u>Incurred Losses</u>	<u>Earned Premiums</u>	<u>Loss Ratio</u>	<u>Policy Reserves</u>	<u>Claim Reserves</u>	

Washington Experience		Unearned Premium Reserve				Policy Reserves		
<u>Form No.</u>	<u>No. of Contracts in Force</u>	<u>Policy Duration</u>	<u>Incurred Losses</u>	<u>Earned Premiums</u>	<u>Loss Ratio</u>	<u>Policy Reserves</u>	<u>Claim Reserves</u>	

I hereby certify that I have supervised the preparation of this experience exhibit, that it is complete and accurate to the best of my knowledge, and it is in compliance with RCW 48-66-150, and WAC 284-55-115, and WAC 284-55-150.

_____ Signature of Officer	_____ Date
_____ Name and Title of Officer	_____ Prepared by
	_____ Phone Number

[Statutory Authority: RCW 48.02.060 (3)(a) and 48.66.050. 89-11-096 (Order R 89-7), § 284-55-210, filed 5/24/89.]