



# RULE-MAKING ORDER

**CR-103P (May 2009)**  
(Implements RCW 34.05.360)

**Agency:** Insurance Commissioner

**Permanent Rule Only**

**Effective date of rule:**

**Permanent Rules**

- 31 days after filing.
- Other (specify) January 19, 2010 (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**

- Yes
  - No
- If Yes, explain:

**Purpose:** Public Law 110-275, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), directed states to adopt the NAIC Model Law for Medicare supplement policies. These new rules comply with the provisions of MIPPA and set forth standards for Medicare supplement policies issued after June 1, 2010.

Insurance Commissioner Matter No. R 2009-08

**Citation of existing rules affected by this order:**

- Repealed: WAC 284-66-092 and WAC 284-66-247
- Amended: WAC 284-66-030, 284-66-063, 284-66-064, 284-66-066, 284-66-067, 284-66-080, 284-66-232, 284-66-243, 284-66-323
- Suspended:

**Statutory authority for adoption:** RCW 48.66.030(3)(a), 48.66.041, 48.66.165

**Other authority :**

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR 09-19-100 on September 21, 2009.  
Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: \_\_\_\_\_ phone ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ fax ( ) \_\_\_\_\_  
 e-mail \_\_\_\_\_

**Date adopted:**

November 24, 2009

**NAME (TYPE OR PRINT)**

Mike Kreidler

**SIGNATURE**

**TITLE**

Insurance Commissioner

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

DATE: November 24, 2009

TIME: 1:38 PM

**WSR 09-24-052**

**Note: If any category is left blank, it will be calculated as zero.  
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.  
A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

<b>Federal statute:</b>	New	_____	Amended	<u>9</u>	Repealed	<u>2</u>
<b>Federal rules or standards:</b>	New	_____	Amended	_____	Repealed	_____
<b>Recently enacted state statutes:</b>	New	_____	Amended	_____	Repealed	_____

**The number of sections adopted at the request of a nongovernmental entity:**

New	_____	Amended	_____	Repealed	_____
-----	-------	---------	-------	----------	-------

**The number of sections adopted in the agency's own initiative:**

New	_____	Amended	_____	Repealed	_____
-----	-------	---------	-------	----------	-------

**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New	_____	Amended	_____	Repealed	_____
-----	-------	---------	-------	----------	-------

**The number of sections adopted using:**

<b>Negotiated rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Pilot rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Other alternative rule making:</b>	New	_____	Amended	<u>9</u>	Repealed	<u>2</u>

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

**WAC 284-66-030 Definitions.** For purposes of this chapter:

(1) "Applicant" means:

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

(b) In the case of a group medicare supplement insurance policy, the proposed certificateholder.

(2) "Certificate" means any certificate delivered or issued for delivery in this state under a group medicare supplement insurance policy regardless of the situs of the group master policy.

(3) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(4) "Issuer" includes insurance companies, fraternal benefit societies, health care service contractors, health maintenance organizations, and any other entity delivering or issuing for delivery medicare supplement policies or certificates.

(5) "Direct response issuer" means an issuer 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.

(6) "Disability insurance" is insurance against bodily injury, disablement or death by accident, against disablement resulting from sickness, and every insurance relating to disability insurance. For purposes of this chapter, disability insurance includes policies or contracts offered by any issuer.

(7) "Health care expense costs," for purposes of WAC 284-66-200(4), means expenses of a health maintenance organization or health care service contractor associated with the delivery of health care services that are analogous to incurred losses of insurers.

(8) "Policy" includes agreements or contracts issued by any issuer.

(9) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(10) "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 issuer in consideration for the policy is deemed part of the premium. "Earned premium" means the "premium" applicable to an accounting period whether received before, during or after that period.

(11) "Prestandardized medicare supplement benefit plan,"

"prestandardized benefit plan" or "prestandardized plan" means a group or individual policy of medicare supplement insurance issued prior to January 1, 1990.

(12) "Replacement" means any transaction where new medicare supplement coverage is to be purchased, and it is known or should be known to the proposing agent or other representative of the issuer, or to the proposing issuer if there is no agent, that by reason of the transaction, existing medicare supplement coverage has been or is to be lapsed, surrendered or otherwise terminated.

~~((12))~~ (13) "Secretary" means the Secretary of the United States Department of Health and Human Services.

(14) "1990 standardized medicare supplement benefit plan" means a group or individual policy of medicare supplement insurance issued on or after January 1, 1990, and prior to June 1, 2010, and includes medicare supplement insurance policies and certificates renewed on or after that date which are not replaced by the issuer at the request of the insured.

(15) "2010 standardized medicare supplement benefit plan" or "2010 plan" means a group or individual policy of medicare supplement insurance with an effective date for coverage on or after June 1, 2010.

AMENDATORY SECTION (Amending Matter No. R 2006-13, filed 2/26/07, effective 3/29/07)

**WAC 284-66-063 Benefit standards for policies or certificates issued or delivered after June 30, 1992 and before June 1, 2010.**

No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards.

(1) General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A medicare supplement policy or certificate may not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.

(b) A medicare supplement policy or certificate must provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment or coinsurance amounts. Premiums may be modified to correspond with such changes.

(c) A medicare supplement policy or certificate may 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.

~~((c))~~ (d) Each medicare supplement policy must be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under ~~((c))~~ (d)(v) of this subsection, the issuer must offer certificateholders an individual medicare supplement policy that (at the option of the certificateholder) provides for continuation of the benefits contained in the group policy, or provides for benefits that otherwise meet the requirements of this subsection.

(iv) If an individual is a certificateholder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must offer the certificateholder the conversion opportunity described in (c) (iii) of this subsection, or at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(v) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy may not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

~~((d))~~ (e) Termination of a medicare supplement policy or certificate must be without prejudice to any continuous loss that began while the policy was in force, but the extension of benefits beyond the period that the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of medicare Part D benefits will not be considered in determining a continuous loss.

~~((e))~~ (f) If a medicare supplement policy or certificate eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug Improvement and Modernization Act of 2003, the modified policy or certificate is deemed to satisfy the guaranteed renewal requirements of this section.

~~((f))~~ (g) (i) A medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate must be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four months) that the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate

within ninety days after the date the individual becomes entitled to the assistance.

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

(iii) Each medicare supplement policy must provide that benefits and premiums under the policy will be suspended (for any period that may be provided by federal regulation) at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862 (b) (1) (A) (v) of the Social Security Act). If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy must be automatically reinstated (effective as of the date of loss of coverage within ninety days after the date of the loss).

~~((g))~~ (h) Reinstitution of the coverages ~~((7))~~:

(i) May not provide for any waiting period with respect to treatment of preexisting conditions;

(ii) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of the suspension. If the suspended medicare supplement policy or certificate provided coverage for outpatient prescription drugs, reinstatement of the policy for medicare Part D enrollees must be without coverage for outpatient prescription drugs and must otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

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

(2) If an issuer makes a written offer to the medicare supplement policyholders or certificateholders of one or more of its plans, to exchange his or her standardized plan to a 2010 standardized plan during a specified period, the offer and subsequent exchange must comply with the following requirements:

(a) An issuer need not provide justification to the commissioner if the insured replaces a 1990 standardized policy or certificate with a 2010 standardized policy or certificate.

(b) An issuer may not apply new preexisting condition limitations or a new incontestability period to the replacement policy for those benefits contained in the former exchanged policy or certificate of the insured, but may apply preexisting condition limitations of no more than three months to any benefits contained in the new 2010 standardized policy or certificate that were not contained in the former exchanged policy.

(c) The new policy or certificate must be offered to all policyholders or certificateholders within a given plan, except where the offer or issue would be in violation of state or federal law.

(3) Standards for basic ("core") benefits common to benefit plans A-J. Every issuer must make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance benefit plans in addition to the basic "core" package, but not in place of the basic "core" package.

(a) Coverage of Part A medicare eligible expenses for hospitalization to the extent not covered by medicare from the sixty-first day through the ninetieth day in any medicare benefit period;

(b) Coverage of Part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the medicare hospital inpatient coverage including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under medicare Parts A and 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) unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital; outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under Part B regardless of hospital confinement, subject to the medicare Part B deductible;

~~((+3))~~ (4) Standards for additional benefits. The following additional benefits must be included in medicare supplement benefit plans "B" through "J" only as provided by WAC 284-66-066.

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

(b) Skilled nursing facility care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A;

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

(d) Eighty percent of the medicare Part B excess charges: Coverage for eighty percent of the difference between the actual

medicare Part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge.

(e) One hundred percent of the medicare Part B excess charges: Coverage for all of the difference between the actual medicare Part B charge as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge.

(f) Basic outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible, to a maximum of one thousand two hundred fifty dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a medicare supplement policy after December 31, 2005.

(g) Extended outpatient prescription drug benefit: Coverage for fifty percent of outpatient prescription drug charges, after a two hundred fifty dollar calendar year deductible to a maximum of three thousand dollars in benefits received by the insured per calendar year, to the extent not covered by medicare. The outpatient prescription drug benefit may not be included for sale or issuance in a medicare supplement policy after December 31, 2005.

(h) Medically necessary emergency care in a foreign country: Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician, and medical care received in a foreign country, that would have been covered by medicare if provided in the United States and that began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars, and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive medical care benefit: Coverage for the following preventive health services not covered by medicare:

(i) An annual clinical preventive medical history and physical examination that may include tests and services from (ii) of this subsection and patient education to address preventive health care measures.

(ii) Preventive screening tests or preventive services, the selection and frequency that is determined to be medically appropriate by the attending physician.

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

(j) At-home recovery benefit: Coverage for services to

provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury, or surgery.

(i) For purposes of this benefit, the following definitions apply:

(A) "Activities of daily living" include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(B) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide, or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(C) "Home" means any place used by the insured as a place of residence, provided that the place would qualify as a residence for home health care services covered by medicare. A hospital or skilled nursing facility is not considered the insured's place of residence.

(D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive four hours in a twenty-four hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

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

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by medicare.

(C) Coverage is limited to:

(I) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits may not exceed the number of medicare approved home health care visits under a medicare approved home care plan of treatment.

(II) The actual charges for each visit up to a maximum reimbursement of forty dollars per visit.

(III) One thousand six hundred dollars per calendar year.

(IV) Seven visits in any one week.

(V) Care furnished on a visiting basis in the insured's home.

(VI) Services provided by a care provider as defined in this section.

(VII) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

(VIII) At-home recovery visits received during the period the insured is receiving medicare approved home care services or no more than eight weeks after the service date of the last medicare approved home health care visit.

(iii) Coverage is excluded for: Home care visits paid for by medicare or other government programs; and care provided by family members, unpaid volunteers, or providers who are not care providers.

~~((4))~~ (5) Standardized medicare supplement benefit plan "K" must consist of the following:

(a) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any medicare benefit period;

(b) Coverage of one hundred percent of the Part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any medicare benefit period;

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Medicare Part A deductible: Coverage for fifty percent of the medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (j) of this subsection;

(e) Skilled nursing facility care: Coverage for fifty percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a medicare benefit period for post-hospital skilled nursing facility care eligible under medicare Part A until the out-of-pocket limitation is met as described in (j) of this subsection;

(f) Hospice care: Coverage for fifty percent of cost sharing for all Part A medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in (j) of this subsection;

(g) Coverage for fifty percent, under medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulation) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (j) of this subsection;

(h) Except for coverage provided in (i) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (j) of this subsection;

(i) Coverage of one hundred percent of the cost sharing for medicare Part B preventive services after the policyholder pays the Part B deductible; and

(j) Coverage of one hundred percent of all cost sharing under medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and

Human Services.

~~((+5))~~ (6) Standardized medicare supplement benefit plan "L" must consist of the following:

(a) The benefits described in subsection (4)(a), (b), (c) and (i) of this section;

(b) The benefit described in subsection (4)(d), (e), (f) and (h) of this section but substituting seventy-five percent for fifty percent; and

(c) The benefit described in subsection (4)(j) of this section but substituting two thousand dollars for four thousand dollars.

#### NEW SECTION

**WAC 284-66-064 Benefit standards for policies or certificates issued or delivered on or after June 1, 2010.** No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit standards. Benefit standards applicable to medicare supplement policies or certificates issued before June 1, 2010, remain subject to the requirements of WAC 284-66-060 and 284-66-063.

(1) General standards. The following standards apply to medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

(a) A medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than three months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within three months before the effective date of coverage.

(b) A medicare supplement policy or certificate must provide that benefits designed to cover cost sharing amounts under medicare will be changed automatically to coincide with any changes in the applicable medicare deductible, copayment or coinsurance amounts. Premiums may be modified to correspond with such changes.

(c) No medicare supplement policy or certificate may 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.

(d) Each medicare supplement policy shall be guaranteed renewable and:

(i) The issuer may not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(ii) The issuer may not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(iii) If the medicare supplement policy is terminated by the group policyholder and is not replaced as provided under (d) (v) of this subsection, the issuer shall offer certificateholders an individual medicare supplement policy which, at the option of the certificateholder:

(A) Provides for continuation of the benefits contained in the group policy; or

(B) Provides for benefits that otherwise meet the requirements of this subsection.

(iv) If an individual is a certificateholder in a group medicare supplement policy and the individual terminates membership in the group, the issuer must:

(A) Offer the certificateholder the conversion opportunity described in (d) (iii) of this subsection; or

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

(v) If a group medicare supplement policy is replaced by another group medicare supplement policy purchased by the same policyholder, the issue of the replacement policy must offer coverage to all persons covered under the old group policy on its date of termination.

(vi) Termination of a medicare supplement policy or certificate must 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 conditioned 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. Receipt of medicare Part D benefits will not be considered in determining a continuous loss.

(vii) (A) A medicare supplement policy or certificate must provide that benefits and premiums under the policy or certificate are suspended at the request of the policyholder or certificateholder for the period not to exceed twenty-four months in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of the policy or certificate within ninety days after the date the individual becomes entitled to assistance.

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

(C) Each medicare supplement policy must provide that benefits and premiums under the policy must be suspended for any period that may be provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862 (b) (1) (A) (v) of the

Social Security Act. If suspension occurs and if the policyholder or certificateholder loses coverage under the group health plan, the policy must be automatically reinstated effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within ninety days after the date of the loss and pays the premium attributable to the period, effective as of the date of termination of enrollment in the group health plan.

(viii) Reinstitution of coverages as described in this section:

(A) Must not provide for any waiting period with respect to treatment of preexisting conditions;

(B) Must provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

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

(2) Every issuer of medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M, and N must make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other medicare supplement insurance plans in addition to the basic core package, but not in lieu of it.

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

(b) Coverage of Part A medicare eligible expenses incurred for hospitalization to the extent not covered by medicare for each medicare lifetime inpatient reserve day used;

(c) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the issuer's payment as payment in full and may not bill the insured for any balance;

(d) Coverage under medicare Parts A and 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, unless replaced in accordance with federal regulations;

(e) Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of medicare eligible expenses under Part B regardless of hospital confinement, subject to the medicare Part B deductible.

(f) Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

(3) The following additional benefits must be included in

medicare supplement benefit Plans B, C, D, F, F with high deductible, G, M, and N as provided by WAC 284-66-066:

(a) Coverage for one hundred percent of the medicare Part A inpatient hospital deductible amount per benefit period.

(b) Coverage for fifty percent of the medicare Part A inpatient hospital deductible amount per benefit period.

(c) Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A.

(d) Coverage for one hundred percent of the medicare part B deductible amount per calendar year regardless of hospital confinement.

(e) Coverage for all of the difference between the actual medicare Part B charges as billed, not to exceed any charge limitation established by the medicare program or state law, and the medicare-approved Part B charge.

(f) Coverage to the extent not covered by medicare for eighty percent of the billed charges for medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by medicare if provided in the United States and which care began during the first sixty consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars and a lifetime maximum benefit of fifty thousand dollars. For purposes of this benefit, "emergency care" means care needed immediately because of an injury or an illness of sudden and unexpected onset.

AMENDATORY SECTION (Amending Matter No. R 2006-13, filed 2/26/07, effective 3/29/07)

**WAC 284-66-066 Standard medicare supplement benefit plans.**  
Standard medicare supplement benefit plans issued for delivery prior to June 1, 2010, must comply with this section.

(1) An issuer must make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic "core" benefits, as defined in WAC 284-66-063(2) of this regulation.

(2) No groups, packages, or combinations of medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as permitted in WAC 284-66-066(7) and in WAC 284-66-073.

(3) Benefit plans must be uniform in structure, language, designation, and format to the standard benefit plans "A" through "L" listed in this subsection and conform to the definitions in WAC 284-66-030 and 284-66-040. Each benefit must be structured according to the format provided in WAC 284-66-063 (2), (3), (4) or

(5) and list the benefits in the order shown in this subsection. For purposes of this section, "structure, language, and format" means style, arrangement, and overall content of benefit.

(4) An issuer may use, in addition to the benefit plan designations required in subsection (3) of this section, other designations to the extent permitted by law.

(5) Make-up of benefit plans:

(a) Standardized medicare supplement benefit plan "A" must be limited to only the basic ("core") benefits common to all benefit plans, as defined in WAC 284-66-063(2).

(b) Standardized medicare supplement benefit plan "B" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible as defined in WAC 284-66-063 (3) (a).

(c) Standardized medicare supplement benefit plan "C" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3) (a), (b), (c), and (h), respectively.

(d) Standardized medicare supplement plan "D" consists of only the following: The core benefit, as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and the at-home recovery benefit as defined in WAC 284-66-063 (3) (a), (b), (h), and (j), respectively.

(e) Standardized medicare supplement benefit plan "E" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, medically necessary emergency care in a foreign country and preventive medical care as defined in WAC 284-66-063 (3) (a), (b), (h), and (i), respectively.

(f) Standardized medicare supplement benefit plan "F" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, the skilled nursing facility care, the Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3) (a), (b), (c), (e), and (h), respectively.

(g) Standardized medicare supplement benefit high deductible plan "F" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3) (a), (b), (c), (e) and (h) respectively. The annual high deductible plan "F" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "F" policy, and must be in addition to any other specific benefit deductibles. The

annual high deductible plan "F" deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(h) Standardized medicare supplement benefit plan "G" consists of only the following: The core benefit as defined at WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, eighty percent of the medicare Part B excess charges, medically necessary emergency care in a foreign country, and the at-home recovery benefit as defined in WAC 284-66-063 (3) (a), (b), (d), (h), and (j), respectively.

(i) Standardized medicare supplement benefit plan "H" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, basic prescription drug benefit, and medically necessary emergency care in a foreign country as defined in WAC 284-66-063 (3) (a), (b), (f), and (h), respectively. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(j) Standardized medicare supplement benefit plan "I" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B excess charges, basic prescription drug benefit, medically necessary emergency care in a foreign country, and at-home recovery benefit as defined in WAC 284-66-063 (3) (a), (b), (e), (f), (h), and (j), respectively. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(k) Standardized medicare supplement benefit plan "J" consists of only the following: The core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible, one hundred percent of the medicare Part B excess charges, extended prescription drug benefit, medically necessary emergency care in a foreign country, preventive medical care, and at-home recovery benefit as defined in WAC 284-66-063 (3) (a), (b), (c), (e), (g), (h), (i), and (j), respectively. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(l) Standardized medicare supplement benefit high deductible plan "J" consists of only the following: One hundred percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the core benefit as defined in WAC 284-66-063(2), plus the medicare Part A deductible, skilled nursing facility care, medicare Part B deductible, one hundred percent of the medicare Part B excess charges, extended outpatient prescription drug benefit, medically necessary emergency care in a foreign country, preventative medical care benefit and at-home recovery benefit as defined in WAC 284-66-

063 (3) (a), (b), (c), (e), (g), (h), (i) and (j) respectively. The annual high deductible plan "J" deductible must consist of out-of-pocket expenses, other than premiums, for services covered by the medicare supplement plan "J" policy, and must be in addition to any other specific benefit deductibles. The annual deductible is one thousand seven hundred thirty dollars for 2005, and is based on the calendar year. The deductible will be adjusted annually by the secretary to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars. The outpatient prescription drug benefit may not be included in a medicare supplement policy sold after December 31, 2005.

(6) Make-up of two medicare supplement plans mandated by The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA):

(a) Standardized medicare supplement benefit plan "K" consists of only those benefits described in WAC 284-66-063(4).

(b) Standardized medicare supplement benefit plan "L" consists of only those benefits described in WAC 284-66-063(5).

(7) New or innovative benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of medicare supplement policies. After December 31, 2005, the innovative benefits may not include an outpatient prescription drug benefit.

#### NEW SECTION

**WAC 284-66-067 Standard medicare supplement plans issued for delivery on or after June 1, 2010.** No policy or certificate delivered or issued for delivery in this state on or after June 1, 2010, as a medicare supplement policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to medicare supplement policies and certificates issued before June 1, 2010, remain subject to the requirements of WAC 284-66-066.

(1)(a) An issuer must make available to each prospective policyholder and certificateholder a policy form or certificate form containing only the basic or core benefits, as defined in WAC 284-66-064.

(b) If an issuer makes available any of the additional benefits described in WAC 284-66-064 or offers standardized benefit Plan K or L as described in subsection (5) of this section, then the issuer shall make available to each prospective policyholder and certificateholder, in addition to a policy form or certificate form with only the basic or core benefits as described in (a) of this section, a policy form or certificate form containing either standardized benefit Plan C or standardized benefit Plan F.

(2) No groups, packages or combinations of medicare supplement benefits other than those listed in this section may be offered for sale in this state, except as may be permitted in WAC 284-66-064 and 284-66-073.

(3) Benefit plans must be uniform in structure, language, designation and format to the standard benefit plans listed in this section and conform to the definitions in this chapter. Each benefit must be structured in accordance with the format found in WAC 284-66-064 or in the case of Plans K or L, in subsection (5) of this section, and list the benefits in the order shown. For purposes of this section, "structure, language and format" means style, arrangement and overall content of a benefit.

(4) In addition to the benefit plan designations required in subsection (3) of this section, an issuer may use other designations to the extent permitted by law.

(5) Make-up of 2010 Standardized Benefit Plans:

(a) Standardized medicare supplement benefit Plan A may include only the basic core benefits as defined in WAC 284-66-064.

(b) Standardized medicare supplement benefit Plan B may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare part A deductible as defined in WAC 284-66-064.

(c) Standardized medicare supplement benefit Plan C may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B deductible and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(d) Standardized medicare supplement benefit Plan D may include only the basic core benefits as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(e) Standardized medicare supplement regular Plan F may include only the basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, the skilled nursing facility care, one hundred percent of the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(f) Standardized medicare supplement Plan F with high deductible may include only one hundred percent of covered expenses following the payment of the annual deductible set forth in (f)(ii) of this subsection.

(i) The basic core benefit as defined in WAC 284-66-064 plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare Part B deductible, one hundred percent of the medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(ii) The annual deductible in Plan F with high deductible must consist only of out-of-pocket expenses, other than premiums, for services covered by regular Plan F and must be in addition to any other specific benefit deductibles. The basis for the deductible must be one thousand five hundred dollars and will be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the Consumer Price Index for all urban consumers for the twelve-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

(g) Standardized medicare supplement benefit Plan G may include only the basic core benefit as defined in WAC 284-66-064, plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, one hundred percent of the medicare part B excess charges and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(h) Standardized medicare supplement benefit Plan K is mandated by the Medicare Prescription Drug Improvement and Modernization Act of 2003, and may include only the following:

(i) Coverage of one hundred percent of the Part A hospital coinsurance amount for each day used from the 61st through the 90th day in any medicare benefit period;

(ii) Coverage of one hundred percent of the Part A hospital coinsurance amount for each medicare lifetime inpatient reserve day used from the 91st through the 150th day in any medicare benefit period;

(iii) Upon exhaustion of the medicare hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent of the medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system rate or other appropriate medicare standard of payment, subject to a lifetime maximum benefit of an additional three hundred sixty-five days. The provider must accept the insurer's payment as payment in full and may not bill the insured for any balance;

(iv) Coverage for fifty percent of the medicare part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(v) Skilled nursing facility care coverage for fifty percent of the coinsurance amount for each day used from the 21st day through the 100th day in a medicare benefit period for posthospital skilled nursing facility care eligible under medicare Part A until the out-of-pocket limitation is met as described in (h)(x) of this subsection;

(vi) Coverage for fifty percent of cost sharing for all Part A medicare eligible expenses and respite care until the out-of-

pocket limitation is met as described in (h) (x) of this subsection;

(vii) Coverage for fifty percent under medicare Part A or B of the reasonable cost of the first three pints of blood or equivalent quantities of packed red blood cells as defined under federal regulations unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in (h) (x) of this subsection;

(viii) Except for coverage provided in (h) (ix) of this subsection, coverage for fifty percent of the cost sharing otherwise applicable under medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in (h) (x) of this subsection;

(ix) Coverage of one hundred percent of the cost sharing for medicare part B preventive services after the policyholder pays the part B deductible; and

(x) Coverage of one hundred percent of all cost sharing under medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under medicare Parts A and B of four thousand dollars in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

(i) Standardized medicare supplement Plan L as mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003 may include only the following:

(i) The benefits described in (h) (i) through (vi) and (ix) of this subsection; and

(ii) The benefit described in (h) (i) through (vi) and (vii) of this subsection but substituting seventy-five percent for fifty percent; and

(iii) The benefit described in (h) (x) of this subsection but substituting two thousand dollars for four thousand dollars.

(j) Standardized medicare supplement Plan M may include only the basic core benefit as defined in WAC 284-66-064, plus fifty percent of the medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country as defined in WAC 284-66-064.

(k) Standardized medicare supplement Plan N may include only the basic core benefit as defined in WAC 284-66-064, plus one hundred percent of the medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in subsection (3) of this section, with copayments in the following amounts:

(i) The lesser of twenty dollars or the medicare coinsurance or copayment for each covered health care provider office visit, including visits to medical specialists Part B; and

(ii) The lesser of fifty dollars or the medicare Part B coinsurance of copayment for each covered emergency room visit, however this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a medicare Part A expense.

(6) An issuer may, with the prior approval of the

commissioner, offer policies or certificates with new or innovative benefits in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include only benefits that are appropriate to medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of medicare supplement simplification. New or innovative benefits may not include an outpatient prescription drug benefit. New or innovative benefits may not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan.

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

**WAC 284-66-080 Outline of coverage required.** (1) Issuers must provide an outline of coverage to all applicants at the time an application is presented to the prospective applicant and, except for direct response policies and certificates, must obtain an (~~acknowledgement~~) acknowledgment of receipt of the outline from the applicant.

(2) The "outline of coverage," (~~must be completed in substantially the form~~) is set forth ((in WAC 284-66-092)) on the commissioner's web site, and incorporated by reference herein in this rule. The issuer's form of outline of coverage must be completed in substantially the form set forth on the commissioner's web site, and filed with the commissioner before being used in this state.

(3) If an outline of coverage is provided at the time of application and the medicare supplement policy or certificate is issued on a basis that would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement, in no less than twelve point type, immediately above the company name: "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

(4) The outline of coverage provided to applicants set forth in this section consists of four parts: A cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage must be in the language and format prescribed in WAC 284-66-092 in no less than twelve point type. All plans A-~~(F)~~ N must be shown on the cover page, and the plan(s) that are offered by the issuer must be prominently identified. Premium information for plans that are offered must be shown on the cover page or

immediately following the cover page and must be prominently displayed. The premium and mode must be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant must be illustrated.

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

AMENDATORY SECTION (Amending Order 92-25, filed 12/10/92, effective 1/10/93)

**WAC 284-66-232 Form for medicare supplement refund calculation.**

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE \_\_\_\_\_ SMSBP(w) \_\_\_\_\_  
 For the State of \_\_\_\_\_  
 Washington Policy or Certificate Form No(s). \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

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

11. Adjustment to incurred Claims for Credibility <b>Ratio 3 = Ratio 2 + Tolerance</b>  If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.  If Ratio 3 is less than the benchmark ratio, then proceed.		
12. Adjust Incurred Claims = <b>[Total Earned Premium (line 3, col. a) - Refunds Since Inception (line 6)]</b> <b>X Ratio 3 (line 11)</b>		
13. Refund = <b>Total Earned Premiums (line 3, col a) - Refunds Since Inception (line 6) -</b>  <b><u>Adjusted Incurred Claims (line 12)</u></b> <b>Benchmark Ratio (Ratio 1)</b>  If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.		

Medicare Supplement Credibility Table

Life Year Exposed Since Inception	Tolerance
10,000+	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If Less than 500	No credibility

MEDICARE SUPPLEMENT REFUND CALCULATION FORM  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE \_\_\_\_\_ SMSBP(w) \_\_\_\_\_  
 For the State of \_\_\_\_\_  
 Washington Policy or Certificate Form No(s). \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

- (w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
- (x) Includes modal loadings and fees charged.
- (y) Excludes Active Life Reserves.
- (z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

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

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name - Please Type

\_\_\_\_\_  
Title

Date \_\_\_\_\_

**WORKSHEET #1 - INDIVIDUAL POLICIES**

REPORTING FORM FOR TIME CALCULATION OF  
BENCHMARK RATIO SINCE INCEPTION  
FOR INDIVIDUAL POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE \_\_\_\_\_ SMSBP (P) \_\_\_\_\_  
FOR THE STATE OF WASHINGTON \_\_\_\_\_  
Washington Policy or Certificate Form No. \_\_\_\_\_  
Company Name \_\_\_\_\_  
NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
Address \_\_\_\_\_  
Person Completing This Exhibit \_\_\_\_\_  
Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

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

**FN for 15+<sup>1</sup>:** To include the earned premium for all years prior to as well as the 15th year prior to the current year.

- Benchmark Ratio Since Inception:  $(1 + n) / (k + m)$ :      (b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
- (a): Year 1 is the current calendar year - 1  
Year 2 is the current calendar year - 2 (etc.)  
(Example: If the current year is 1991, then:  
Year 1 is 1990; Year 2 is 1989; etc.)
- (p) "SMSBP" = ((Standardized))  
Standardized Medicare  
Supplement Benefit Plan
- (o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the ((cumulative)) cumulative loss ratio displayed on this worksheet. They are shown here for informational purposes only.
- k = Total of Column "d"  
l = Total of Column "f"  
m = Total of Column "h"  
n = Total of Column "j"

**WORKSHEET #1 - GROUP POLICIES**

REPORTING FORM FOR TIME CALCULATION OF  
BENCHMARK RATIO SINCE INCEPTION  
FOR GROUP POLICIES  
FOR CALENDAR YEAR \_\_\_\_\_

TYPE \_\_\_\_\_ SMSBP (P) \_\_\_\_\_  
 FOR THE STATE OF WASHINGTON \_\_\_\_\_  
 Washington Policy or Certificate Form No. \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 NAIC Group Code \_\_\_\_\_ NAIC Company Code \_\_\_\_\_  
 Address \_\_\_\_\_  
 Person Completing This Exhibit \_\_\_\_\_  
 Title \_\_\_\_\_ Telephone Number \_\_\_\_\_

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
((15) 15+		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

**FN for 15+:** To include the earned premium for all years prior to as well as the 15th year prior to the current year.

Benchmark Ratio Since Inception:  $(1 + n) / (k + m)$ :      (b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

k = Total of Column "d"  
 l = Total of Column "f"  
 m = Total of Column "h"  
 n = Total of Column "j"

(a): Year 1 is the current calendar year - 1  
 Year 2 is the current calendar year - 2 (etc.)  
 (Example: If the current year is 1991, then:  
 Year 1 is 1990: Year 2 is 1989; etc.)

(p) "SMSBP" = ((Standardized))  
 Standardized Medicare  
 Supplement Benefit Plan

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the ((cumulative)) cumulative loss ratio displayed on this worksheet. They are shown here for informational purposes only.

AMENDATORY SECTION (Amending Matter No. R 2004-08, filed 8/4/05, effective 9/4/05)

**WAC 284-66-243 Filing and approval of policies and certificates and premium rates.** (1) An issuer may not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the commissioner according to the filing requirements and procedures prescribed by the commissioner.

~~(2) ((An issuer must file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state that the policy or certificate was issued.~~

~~(3))~~ An issuer may not use or change premium rates for a medicare supplement policy or certificate unless the rates, rating schedule, and supporting documentation have been filed with and approved by the commissioner according to the filing requirements and procedures prescribed by the commissioner.

~~((4))~~ (3)(a) Except as provided in (b) of this subsection, an issuer may not file for approval more than one form of a policy or certificate of each type for each standard medicare supplement benefit plan.

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

(i) The inclusion of new or innovative benefits;

(ii) The addition of either direct response or agent marketing methods;

(iii) The addition of either guaranteed issue or underwritten coverage;

(iv) The offering of coverage to individuals eligible for medicare by reason of disability. The form number for products offered to enrollees who are eligible by reason of disability must be distinct from the form number used for a corresponding standardized plan offered to an enrollee eligible for medicare by reason of age.

(c) For the purposes of this section, a "type" means an individual policy, a group policy, an individual medicare SELECT policy, or a group medicare SELECT policy.

~~((5))~~ (4)(a) Except as provided in (a)(i) of this subsection, an issuer must continue to make available for purchase any policy form or certificate form issued after the effective date of this regulation that has been approved by the commissioner. A policy form or certificate form is not considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

(i) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least thirty days before discontinuing

the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer may no longer offer for sale the policy form or certificate form in this state.

(ii) An issuer that discontinues the availability of a policy form or certificate form under (a)(i) of this subsection, may not file for approval a new policy form or certificate form of the same type for the same standard medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

(b) The sale or other transfer of medicare supplement business to another issuer is considered a discontinuance for the purposes of this subsection.

(c) A change in the rating structure or methodology is considered a discontinuance under (a) of this subsection, unless the issuer complies with the following requirements:

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

(ii) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential that is in the public interest.

~~((6))~~ (5)(a) Except as provided in (b) of this subsection, the experience of all policy forms or certificate forms of the same type in a standard medicare supplement benefit plan must be combined for purposes of the refund or credit calculation prescribed in WAC 284-66-203.

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

~~((7))~~ (6) An issuer may set rates only on a community rated basis or on an issue-age level premium basis for policies issued prior to January 1, 1996, and may set rates only on a community rated basis for policies issued after December 31, 1995.

(a) For policies issued prior to January 1, 1996, community rated premiums must be equal for all individual policyholders or certificateholders under a standardized medicare supplement benefit form. Such premiums may not vary by age or sex. For policies issued after December 31, 1995, community rated premiums must be set according to RCW 48.66.045(3).

(b) Issue-age level premiums must be calculated for the lifetime of the insured. This will result in a level premium if the effects of inflation are ignored.

~~((8))~~ (7) All filings of policy or certificate forms must be accompanied by the proposed application form, outline of coverage form, proposed rate schedule, and an actuarial memorandum completed, signed and dated by a qualified actuary as defined in

WAC 284-05-060. In addition to the actuarial memorandum, the following supporting documentation must be submitted to demonstrate to the satisfaction of the commissioner that rates are not excessive, inadequate, or unfairly discriminatory and otherwise comply with the requirements of this chapter:

(a) Anticipated loss ratios stated on a calendar year basis by duration for the period for which the policy is rated. Filings of future rate adjustments must contain the actual calendar year loss ratios experienced since inception, both before and after the refund required, if any and the actual loss ratios in comparison to the expected loss ratios stated in the initial rate filing on a calendar year basis by duration if applicable;

(b) Anticipated total termination rates on a calendar year basis by duration for the period for which the policy is rated. The termination rates should be stated as a percentage and the source of the mortality assumption must be specified. Filings of future rate adjustments must include the actual total termination rates stated on a calendar year basis since inception;

(c) Expense assumptions including fixed and percentage expenses for acquisition and maintenance costs;

(d) Schedule of total compensation payable to agents and other producers as a percentage of premium, if any;

(e) A complete specimen copy of the compensation agreements or contracts between the issuer and its agents, brokers, general agents, as well as the contracts between general agents and agents or others whose compensation is based in whole or in part on the sale of medicare supplement insurance policies. The agreements must demonstrate compliance with WAC 284-66-350 (where appropriate);

(f) Other data necessary in the reasonable opinion of the commissioner to substantiate the filing.

AMENDATORY SECTION (Amending Order R 92-1, filed 2/25/92, effective 3/27/92)

**WAC 284-66-323 Form for reporting multiple medicare supplement policies and certificates.**

Medicare Supplement Regulation

FORM FOR REPORTING  
MEDICARE SUPPLEMENT POLICIES

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Due: March 1, annually

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

Policy and Certificate #	Date of Issuance

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title (please type)

\_\_\_\_\_  
Date

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 284-66-092  
WAC 284-66-247

Form of "outline of coverage."  
Interim rate and form filing requirements for standardized plans H, I and J and prestandardized plans that include outpatient prescription drug benefits.