

TO: All Carriers Licensed to Write Accident & Sickness Insurance, Health Services Plans, and All L&H Interested Parties

RE: Repealing Rules Governing Conversion of Medicare Supplement Insurance Benefits and Premiums

On May 19, 2026, the State Corporation Commission entered an Order Establishing Proceeding regarding a proposal by the Bureau of Insurance to repeal rules set forth in Chapters 150 and 160 of Title 14 of the Virginia Administrative Code, entitled "Rules to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions" (14 VAC 5-150-10 *et seq.*) and "Rules to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of the Medicare Catastrophic Coverage Act" (14 VAC 5-160-10 *et seq.*) (collectively, "Rules"). The order number is [INS-2026-00042](#).

The Bureau recommends repealing Chapters 150 and 160 because the Rules are now obsolete. Chapters 150 and 160 provided direction during a transitional time when benefit changes were taking place under the federal Medicare program, and new Medicare supplement insurance benefits and premiums needed to change as well so coverage would not be duplicated. The Rules were superseded with the enactment of Chapter 170 of Title 14 of the Virginia Administrative Code, 14 VAC 5-170-10 *et seq.*

Notice of the proposal to repeal the Rules is given to the public, and interested persons are provided an opportunity to file written comments or request a hearing on the proposal to repeal the Rules.

On or before July 31, 2026, any interested person may comment on, or request a hearing on, the proposal to repeal the Rules by following the instructions on the Commission's website: scc.virginia.gov/case-information/submit-public-comments.

Those unable, as a practical matter, to submit such documents electronically may file such comments by U.S. mail to the Clerk of the State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218-2118.

All documents shall refer to Case No. INS-2026-00042.

Any request for hearing shall state why a hearing is necessary and why the issues raised in the request for hearing cannot be addressed adequately in written comments

Information about these changes may also be found at: [Virginia SCC – Insurance Companies](#).

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

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*State Corporation Commission
Document Control Center
05/19/2026 – 8:41 AM*

AT RICHMOND, MAY 19, 2026

COMMONWEALTH OF VIRGINIA, *ex rel.*

STATE CORPORATION COMMISSION

Ex Parte: In the matter of Repealing the Rules
Governing the Conversion of Medicare Supplement
Insurance Benefits and Premiums

CASE NO. INS-2026-00042

ORDER ESTABLISHING PROCEEDING

Section 12.1-13 of the Code of Virginia (“Code”) provides, in relevant part, that “[i]n the administration and enforcement of all laws within its jurisdiction, the [State Corporation Commission (“Commission”)] shall have the power to promulgate rules and regulations[.]” Section 38.2-223 of the Code provides that the Commission may issue any rules and regulations necessary or appropriate for the administration and enforcement of Title 38.2 of the Code. Section 38.2-3608 of the Code provides that the Commission may issue regulations to establish minimum standards for payment of claims under Medicare supplement policies and for marketing practices, compensation arrangements, requirements for loss ratio refunds or credits, Medicare select policies and certificates, and reporting practices of insurers providing such policies. The rules issued by the Commission pursuant to §§ 38.2-223 and 38.2-3608 of the Code are set forth in Title 14 of the Virginia Administrative Code.¹

The Bureau of Insurance (“Bureau”) has submitted to the Commission a proposal to repeal the rules set forth in Chapters 150 and 160 of Title 14 of the Virginia Administrative Code, entitled “Rules to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions”

¹ Available at <https://law.lis.virginia.gov/admincode/title14/agency5/chapter150/>, <https://law.lis.virginia.gov/admincode/title14/agency5/chapter160/>, and <https://law.lis.virginia.gov/admincode/title14/agency5/chapter170/>.

(14 VAC 5-150-10 *et seq.*) and “Rules to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Repeal of the Medicare Catastrophic Coverage Act” (14 VAC 5-160-10 *et seq.*) (collectively, “Rules”). Specifically, the Bureau proposes repealing Chapters 150 and 160 because the Rules are now obsolete. Chapters 150 and 160 provided direction during a transitional time when benefit changes were taking place under the federal Medicare program, and new Medicare supplement insurance benefits and premiums needed to change as well so coverage would not be duplicated. However, the Rules were superseded with the enactment of Chapter 170 of Title 14 on July 30, 1992, which comprehensively provides rules for Medicare supplement policies or certificates issued for delivery prior to July 30, 1992; Medicare supplement policies delivered on or after July 30, 1992, and prior to June 1, 2010; Medicare supplement policies delivered on or after June 1, 2010; and Medicare supplement policies delivered to individuals newly eligible for Medicare on or after January 1, 2020.

NOW THE COMMISSION, upon consideration of this matter, is of the opinion and finds that a proceeding should be established to consider repealing the Rules. To initiate this proceeding, the Bureau has prepared a proposal that Chapters 150 and 160 of Title 14 of the Virginia Administrative Code be repealed, which is appended to this Order Establishing Proceeding (“Order”). The Commission finds that notice of the proposal to repeal the Rules should be given to the public, and that interested persons should be provided an opportunity to file written comments or request a hearing on the proposal to repeal the Rules.

Accordingly, IT IS ORDERED THAT:

- (1) This case is docketed and assigned Case No. INS-2026-00042.
- (2) All comments and other documents and pleadings filed in this matter shall be

submitted electronically to the extent authorized by 5 VAC 5-20-150, *Copies and format*, of the Commission's Rules of Practice and Procedure ("Rules of Practice").² Confidential and Extraordinarily Sensitive Information shall not be submitted electronically and shall comply with 5 VAC 5-20-170, *Confidential information*, of the Rules of Practice. Any person seeking to hand deliver and physically file or submit any pleading or other document shall contact the Clerk's Office Document Control Center at (804) 371-9838 to arrange the delivery.

(3) On or before July 31, 2026, any interested person may comment on, or request a hearing on, the proposal to repeal the Rules by following the instructions on the Commission's website: scc.virginia.gov/case-information/submit-public-comments. Those unable, as a practical matter, to submit such documents electronically may file such comments by U.S. mail to the Clerk of the State Corporation Commission, c/o Document Control Center, P.O. Box 2118, Richmond, Virginia 23218-2118. All documents shall refer to Case No. INS-2026-00042. Any request for hearing shall state why a hearing is necessary and why the issues raised in the request for hearing cannot be addressed adequately in written comments.

(4) The Bureau shall file its response to any comments or requests for hearing filed pursuant to Ordering Paragraph (3) on or before August 28, 2026.

(5) If a sufficient request for hearing is not received, the Commission may consider the matter and enter an order based upon the comments, documents or other pleadings filed in this proceeding.

(6) The Bureau shall provide notice of this Order to all carriers licensed in Virginia to write Medicare Supplement Insurance Policies or Certificates and to any other interested persons as the Bureau may designate.

² 5 VAC 5-20-10 *et seq.*

(7) The Commission's Office of General Counsel shall provide a copy of this Order, together with the proposal to repeal the Rules, to the Virginia Registrar of Regulations for publication in the *Virginia Register of Regulations*.

(8) Interested persons may download unofficial copies of the Order and the proposal to repeal the Rules from the Commission's website: scc.virginia.gov/case-information/.

(9) This matter is continued.

A COPY hereof shall be sent by the Clerk of the Commission to: John E. Farmer, Jr., Senior Assistant Attorney General, jfarmer@oag.state.va.us, Office of the Attorney General, Division of Consumer Counsel, 202 North 9th Street, 8th Floor, Richmond, Virginia 23219-3424; and the Commission's Office of General Counsel and the Bureau of Insurance in care of Deputy Commissioner Julie Blauvelt.

State Corporation Commission, Bureau of Insurance
Rules to Implement Transitional Requirements for the Conversion of Medicare
Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions
(Repeal of 14 VAC 5-150-10 et seq.)

CHAPTER 150

RULES TO IMPLEMENT TRANSITIONAL REQUIREMENTS FOR THE CONVERSION OF
MEDICARE SUPPLEMENT INSURANCE BENEFITS AND PREMIUMS TO CONFORM TO
MEDICARE PROGRAM REVISIONS
(REPEALED)

14VAC5-150-10. Purpose. (Repealed.)

This chapter (~~14VAC5-150-10 et seq.~~) is designed to:

- ~~1. Ensure the orderly implementation and conversion of Medicare supplement insurance benefits and premiums due to changes in the federal Medicare program;~~
- ~~2. Provide for the reasonable standardization of the coverage, terms and benefits of Medicare supplement policies or contracts;~~
- ~~3. Facilitate public understanding of such policies or contracts;~~
- ~~4. Eliminate provisions contained in such policies or contracts which may be misleading or confusing in connection with the purchase of such policies or contracts;~~
- ~~5. Modify or eliminate policy or contract provisions which may duplicate medicare benefits;~~
- ~~6. Provide full disclosure of policy or contract benefits and benefit changes; and~~
- ~~7. Provide for refunds of premiums associated with benefits duplicating medicare program benefits.~~

14VAC5-150-20. [Reserved]. (Reserved) (Repealed.)

14VAC5-150-30. Applicability and scope. (Repealed.)

~~This chapter (14VAC5-150-10 et seq.) shall take precedence over other rules and requirements relating to medicare supplement policies or contracts only to the extent necessary to assure that benefits are not duplicated, that applicants receive adequate notice and disclosure of changes in medicare supplement policies and contracts, that appropriate premium adjustments are made in a timely manner, and that premiums are reasonable in relation to benefits.~~

~~This chapter shall apply to:~~

- ~~1. All Medicare supplement policies and contracts delivered, or issued for delivery within this Commonwealth, or which are otherwise subject to the jurisdiction of this Commonwealth, and~~
- ~~2. All certificates issued under group medicare supplement policies as provided in 1. above.~~

~~This chapter applies to all Medicare supplement policies, contracts, and certificates as described in 1 and 2, above, delivered, or issued for delivery on or after the effective date hereof. In addition, 14VAC5-150-50 applies to all medicare supplement policies, contracts and certificates as described in 1 and 2, above, in effect on August 31, 1988.~~

14VAC5-150-40. Definitions. (Repealed.)

~~For purposes of this chapter (14VAC5-150-10 et seq.):~~

~~"Applicant" means:~~

- ~~1. In the case of an individual Medicare supplement policy or contract, the person who seeks to contract for insurance benefits, and~~
- ~~2. In the case of a group Medicare supplement policy or contract, the proposed certificateholder.~~

~~"Certificate" means any certificate issued under a group Medicare supplement policy.~~

~~"Medicare supplement policy" means an individual or group policy of accident and sickness insurance or an individual or group subscriber contract of a health services plan, or health maintenance organization or a certificate issued under a group policy or group subscriber contract,~~

~~offered to individuals who are entitled to have payment made under Medicare, which is designed primarily to supplement Medicare by providing benefits for payment of hospital, medical or surgical expenses, or is advertised, marketed or otherwise purported to be a supplement to Medicare. Such term shall not include:~~

- ~~1. 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;~~
- ~~or~~
- ~~2. A policy or contract of any professional, trade or occupational association for its members or former or retired members, or combination thereof, if such association:~~
 - ~~a. Is composed of individuals all of whom are actively engaged in the same profession, trade or occupation;~~
 - ~~b. Has been maintained in good faith for purposes other than obtaining insurance; and~~
 - ~~c. Has been in existence for at least two years prior to the date of its initial offering of such policy or plan to its members.~~

14VAC5-150-50. Benefit conversion requirements. (Repealed.)

~~A. Effective 60 days after enactment of federal law mandating Medicare benefit changes, no Medicare supplement insurance policy, contract, or certificate subject to this chapter, in effect on the effective date of this chapter (14VAC5-150-10 et seq.) shall contain benefits which duplicate benefits provided by Medicare.~~

~~B. General requirements.~~

- ~~1. On the later of:~~
 - ~~a. Thirty days prior to the effective date of Medicare benefit changes, or~~
 - ~~b. Sixty days after enactment of federal law mandating Medicare benefit~~

changes,

~~every insurer, health services plan, health maintenance organization or other entity providing Medicare supplement insurance or benefits shall notify its policyholders, contract holders, and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts. Such notice shall be in a format prescribed in Exhibit A and be written in outline form in clear and simple terms so as to facilitate comprehension. Such notice shall not contain or be accompanied by any solicitation.~~

~~2. No modifications to an existing Medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this chapter except to the extent necessary to eliminate duplication of Medicare benefits and any modifications necessary under the policy or contract to provide indexed benefit adjustment.~~

~~3. As soon as practicable, but no longer than 60 days after the effective date of the Medicare benefit changes, every insurer, health services plan, health maintenance organization or other entity providing Medicare supplement insurance or contracts in this Commonwealth shall file with the Commission, in accordance with the applicable filing procedures of this Commonwealth:~~

~~a. Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing.~~

~~b. Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare. Any such riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.~~

~~4. Upon satisfying the filing and approval requirements of this Commonwealth, every~~

~~insurer, health services plan, health maintenance organization or other entity providing Medicare supplement insurance shall provide each covered person with any rider, endorsement or policy form necessary to eliminate any benefit duplications under the policy or contract with benefits provided by Medicare.~~

~~5. No insurer, health services plan, health maintenance organization or other entity shall require any person covered under a Medicare supplement policy or contract which was in effect on August 31, 1988, to purchase additional coverage under such policy or contract unless such additional coverage was provided for in the policy contract.~~

~~6. Every insurer, health services plan, health maintenance organization or other entity providing Medicare supplement insurance shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or contract as will conform with minimum loss ratio standards for Medicare supplement policies and which is expected to result in a loss ratio at least as great as that originally anticipated by the insurer, health services plan, health maintenance organization or other entity for such medicare supplement insurance policies or contracts. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein should be made with respect to a policy at any time other than upon its renewal date. Premium adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if credit is given, or within 60 days of the renewal date if a refund is provided to the premium payor.~~

14VAC5-150-60. Requirements for new policies and certificates. (Repealed.)

~~A. Effective 60 days after enactment of federal law mandating Medicare benefit changes no medicare supplement insurance policy, contract, or certificate shall be issued or issued for delivery in this Commonwealth which provides benefits which duplicate benefits provided by Medicare. No~~

~~such policy, contract or certificate shall provide less benefits than those required under Chapter 36- (§ 38.2-3600 et seq.) of Title 38.2, or existing, Rules Governing the Implementation of the Individual Accident and Sickness Insurance Minimum Standards Act (Chapter 140, 14VAC5-140-10 et seq. of this title) with respect to medicare supplement policies except where duplication of Medicare benefits would result.~~

~~B. General requirements.~~

- ~~1. Within 90 days of August 31, 1988, every insurer, health services plan, health maintenance organization or other entity required to file its policies or contracts with the Commission shall file new medicare supplement insurance policies or contracts 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.~~
- ~~2. The filing required under subdivision 1 above shall provide for loss ratios which are in compliance with all statutory or regulatory requirements.~~
- ~~3. Every applicant for a Medicare supplement insurance policy, contract, or certificate shall be provided with an outline of coverage which in simple accurate terms describes benefits provided by Medicare and the medicare supplement policy or contract along with benefit limitations.~~

14VAC5-150-70. Buyer's guide. (Repealed.)

~~No insurer, health services plan, health maintenance organization or other entity shall make use of or otherwise disseminate any buyer's guide or informational brochure which does not accurately outline current Medicare benefits.~~

14VAC5-150-80. Severability. (Repealed.)

~~If any provision of this chapter (14VAC5-150-10 et seq.), or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the chapter and the~~

~~application of such provision to other persons or circumstances shall not be affected thereby.~~

**Rules to Implement Transitional Requirements for the Conversion of Medicare
Supplement Insurance Benefits and Premiums to Conform to Repeal of the Medicare
Catastrophic Coverage Act**

(Repeal of 14 VAC 5-160-10 *et seq.*)

CHAPTER 160.

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

(REPEALED)

14VAC5-160-10. Purpose. (Repealed.)

~~This chapter (14VAC5-160-10 *et seq.*) is designed to~~

- ~~1. Assure the orderly implementation and conversion of Medicare supplement insurance benefits and premiums due to changes in the federal Medicare program;~~
- ~~2. Provide for the reasonable standardization of the coverage, terms and benefits of Medicare supplement policies or contracts;~~
- ~~3. Facilitate public understanding of such policies or contracts;~~
- ~~4. Eliminate provisions contained in such policies or contracts which may be misleading or confusing in connection with the purchase of such policies or contracts;~~
- ~~5. Eliminate policy or contract provisions which may duplicate Medicare benefits;~~
- ~~6. Provide for adjustment of required minimum benefits for Medicare supplement policies;~~
- ~~7. Provide notice to former policyholders of offer to reinstitute coverage;~~

8. Provide full disclosure of policy or contract benefits and benefit changes; and
9. Provide for appropriate premium adjustments.

14VAC5-160-20. [Reserved]. (Repealed.)

14VAC5-160-30. Applicability and scope. (Repealed.)

This chapter (14VAC5-160-10 et seq.) shall take precedence over other rules and requirements relating to Medicare supplement policies or contracts to the extent necessary to assure that benefits are not duplicated and to adjust minimum required benefits to changes in Medicare benefits, applicants receive adequate notice and disclosure of changes in Medicare supplement policies and contracts, appropriate premium adjustments are made in a timely manner, and premiums are reasonable in relation to benefits.

Except as provided in 14VAC5-160-50, this chapter shall apply to:

1. All Medicare supplement policies and contracts delivered, or issued for delivery in this Commonwealth, or which are otherwise subject to the jurisdiction of this Commonwealth, on or after the effective date hereof, and
2. All certificates issued under group Medicare supplement policies as provided in subdivision 1 above.

14VAC5-160-40. Definitions. (Repealed.)

For purposes of this chapter (14VAC5-160-10 et seq.):

"Applicant" means:

1. In the case of an individual Medicare supplement policy or contract, the person who seeks to contract for insurance benefits, and
2. In the case of a group Medicare supplement policy or contract, the proposed certificate holder.

"Certificate" means any certificate issued under a group Medicare supplement policy.

"Medicare supplement policy" means a group or individual policy of accident and sickness insurance.

~~or any other contract which is advertised, marketed or designed primarily to provide health care benefits as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.~~

14VAC5-160-50. Benefit conversion requirements. (Repealed.)

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

~~B. Benefits eliminated by operation of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360, 102 Stat. 683 (July 1, 1988) 42 USC § 1305) transition provisions shall be restored.~~

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

- ~~1. 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;~~
- ~~2. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;~~
- ~~3. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;~~
- ~~4. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90% of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;~~
- ~~5. Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B.~~
- ~~6. Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out of pocket amount equal to the Medicare Part B deductible of \$75;~~
- ~~7. 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), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.~~

D. General requirements:

~~1. No later than January 31, 1990, every insurer, health services plan or other entity providing Medicare supplement insurance or benefits to a resident of this Commonwealth shall notify its policyholders, contract holders and certificate holders of modifications it has made to Medicare supplement insurance policies or contracts. Such notice shall be in the format adopted by the National Association of Insurance Commissioners (Appendix A).~~

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

~~b. The notice shall inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be effective.~~

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

~~d. Such notice shall not contain or be accompanied by any solicitation.~~

~~2. No modifications to an existing Medicare supplement contract or policy shall be made at the time of or in connection with the notice requirements of this section except to the extent necessary to accomplish the purposes articulated in 14VAC5-160-10.~~

14VAC5-160-60. Form and rate filing requirements. (Repealed.)

~~A. As soon as practicable, but no longer than 45 days after the effective date of the Medicare benefit changes, every insurer, health services plan or other entity providing Medicare supplement insurance or contracts in this Commonwealth shall file with the Commission, in accordance with the applicable filing procedures of this Commonwealth:~~

~~1. Appropriate premium adjustments necessary to produce loss ratios as originally~~

~~anticipated for the applicable policies or contracts. Such supporting documents as are necessary to justify the adjustment shall accompany the filing.~~

~~2. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare and to provide the benefits required by 14VAC5-160-50. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.~~

~~B. Upon satisfying the filing and approval requirements of this Commonwealth, every insurer, health services plan or other entity providing Medicare supplement insurance in this Commonwealth shall provide each covered person with any rider, endorsement or policy form necessary to make the adjustments outlined in 14VAC5-160-50 above.~~

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

14VAC5-160-70. Offer of reinstitution of coverage. (Repealed.)

~~A. Except as provided in subsection B, in the case of an individual who had in effect, as of December 31, 1988, a Medicare supplement policy with an insurer, as a policyholder or, in the case of a group policy, as a certificate holder, and the individual terminated coverage under such policy before the date of the enactment of the repeal of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360, 102 Stat. 683 (July 1, 1988) 42 USC § 1305), the insurer shall:~~

~~1. Provide written notice no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder at the most recent available address, of the offer described below, and~~

~~2. Offer the individual, during a period of at least 60 days beginning not later than February~~

~~1, 1990, reinstitution of coverage, with coverage effective as of January 1, 1990, under terms which:~~

- ~~a. Do not provide for any waiting period with respect to treatment of pre-existing conditions;~~
- ~~b. Provide for coverage which is substantially equivalent to coverage in effect before the date of such termination; and~~
- ~~c. Provide for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.~~

~~B. An insurer is not required to make the offer under subdivision 2 above in the case of an individual who is a policyholder or certificate holder in another Medicare supplement policy as of January 1, 1990, if the individual is not subject to a waiting period with respect to treatment of a preexisting condition under such other policy.~~

14VAC5-160-80. Requirements for new policy and certificates. (Repealed.)

~~A. Effective January 1, 1990, no Medicare supplement insurance policy, contract or certificate shall be delivered or issued for delivery in this Commonwealth which provides benefits which duplicate benefits provided by Medicare. No such policy, contract or certificate shall provide less benefits than those required under the existing law or regulation except where duplication of Medicare benefits would result and except as required by these transition provisions.~~

~~B. General requirements.~~

- ~~1. Within 90 days of the effective date of this chapter, every insurer, health services plan or other entity required to file its policies or contracts for approval by the Commission shall file new Medicare supplement insurance policies or contracts which eliminate any duplication of Medicare supplement benefits with benefits provided by Medicare, which adjust minimum required benefits to changes in Medicare benefits, and which provide a clear description of~~

the policy or contract benefit;

2. The filing required under 14VAC5-160-60 A 1 shall provide for less ratios which are in compliance with all statutory and regulatory requirements; and

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

14VAC5-160-90. Filing requirements for advertising. (Repealed.)

Every insurer, health services plan or other entity providing Medicare supplement insurance or benefits in this Commonwealth shall provide a copy of any advertisement intended for use in this Commonwealth whether through written, radio or television medium to the Commission for review. Such advertisement shall comply with all applicable laws of this Commonwealth.

14VAC5-160-100. Buyer's guide. (Repealed.)

No insurer, health services plan or other entity shall make use of or otherwise disseminate any buyer's guide or informational brochure which does not accurately outline current Medicare benefits.

14VAC5-160-110. Severability. (Repealed.)

If any provision of this chapter (14VAC5-160-10 et seq.), or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.