SUBCHAPTER T. Minimum Standards for Medicare Supplement Policies
28 TAC §§3.3303 – 3.3309, 3.3312, 3.3320, 3.3322, 3.3324, and 3.3325

1. INTRODUCTION. The Commissioner of Insurance adopts amendments to §§3.3303 – 3.3309, 3.3312, 3.3320, 3.3322, 3.3324, and 3.3325 concerning minimum standards for Medicare supplement policies. Sections 3.3305, 3.3306, 3.3308, 3.3312 and 3.3322 are adopted with changes to the proposed text as published in the November 26, 2004 issue of the Texas Register (29 TexReg 10873). Sections 3.3303, 3.3304, 3.3307, 3.3309, 3.3320, 3.3324, and 3.3325 are adopted without changes.

2. REASONED JUSTIFICATION. These amendments are necessary to implement provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), as well as to make under age 65 persons losing eligibility for health benefits under Medicaid eligible for guaranteed issuance of Medicare supplement Plan A. After December 31, 2005, the MMA prohibits issuers of Medicare supplement policies from renewing outpatient prescription drug benefits for both prestandardized and standardized Medicare supplement policyholders who enroll in Medicare Part D.

3. HOW THE SECTIONS WILL FUNCTION. Section 3.3303 revises definitions to conform to the MMA, as does §3.3304. Section 3.3305 alters requirements for issuance and renewability of plans including an outpatient prescription drug benefit to conform to the MMA. Section 3.3306 revises minimum benefit standards to conform to the MMA

and the phase-out of the existing forms of outpatient prescription drug benefits; revises payment standards for Medicare Part A expenses; and defines the benefits included in new Plans K and L. Section 3.3307 amends loss ratio standards for HMOs to conform to the MMA. Section 3.3308 requires issuers to comply with notice requirements of the MMA. Section 3.3309 revises standards for applications in accordance with the MMA. Section 3.3312 changes standards for guaranteed issuance to conform to the MMA and makes under age 65 individuals losing eligibility for health benefits under Medicaid eligible for guaranteed issuance of Medicare supplement Plan A. Section 3.3320 prohibits issuing Medicare supplement coverage to an individual enrolled in Medicare Part C unless the effective date is after the termination of the Part C coverage. Section 3.3322 makes changes to filing requirements to conform to the MMA. Section 3.3324 adds §3.3312 to the list of exceptions to an issuer's authority to apply a preexisting condition provision. Section 3.3325 addresses the effect of out-of-network expenses on out-of-pocket annual limits in Plans K and L and makes other changes to conform to the MMA.

The department added language to §3.3312, in response to comments, to clarify which products are guaranteed issue for eligible persons under 65 years of age losing eligibility for Medicaid. In §§3.3305, 3.3306, 3.3308 and 3.3322 the department has made minor changes to correct form, typographical errors and update and correct citations.

4. SUMMARY OF COMMENTS AND AGENCY'S RESPONSE TO COMMENTS.

General: Commenters have made several suggestions regarding the effective date of the rules and their effect on a carrier's ability to offer and issue certain plans. Some commenters requested that the department revise the rules to permit insurers to continue to use currently approved forms as appropriate through December 31, 2005. Another commenter requested that the rules specify that insurers may begin to offer plans with the newly adopted changes prior to January 1, 2006, subject to approval by the Commissioner of Insurance.

Agency Response: While the department declines to revise the proposal in the manner requested by commenters, the department does confirm that insurers can continue to use currently approved plans as appropriate, reminding carriers of their obligation to offer the standard plans which include prescription drugs until the advent of Medicare Part D prescription drug coverage. The department also confirms that, once the adopted rules take effect and prior to January 1, 2006, insurers may offer approved plans as authorized by these rules.

§3.3312(b) (8): Some commenters expressed concern that the proposed amendment providing guaranteed issue rights to Medicare recipients losing Medicaid eligibility would allow the newly–eligible individuals access to Plans A, B, C, and F.

Agency Response: Texas law guarantees to Medicare recipients under the age of 65 access only to Plan A. Staff has had several discussions with the commenters, as well

as with the National Association of Insurance Commissioners (NAIC), the Center for Medicare and Medicaid Services, and the Texas Health and Human Services Commission staff regarding this issue. The department has added language to §3.3312(c) to clarify that an under 65 Medicare recipient losing coverage under Medicaid would be entitled only to guaranteed issuance of Plan A.

5. NAMES OF THOSE COMMENTING FOR AND AGAINST THE SECTIONS.

For, with changes: America's Health Insurance Plans, Texas Association of Life and Health Insurers, and UnitedHealth Group.

Against: None.

6. STATUTORY AUTHORITY. The amendments are adopted under the Insurance Code §1652.051 (formerly Article 3.74, §2(f)) and §1652.005 (formerly Article 3.74, §10), and §36.001. Section 1652.051 provides that the department's rules must include requirements that are at least equal to those required by federal law, rules, and standards, including 42 U.S.C. §1395ss. Section 1652.005 provides that the department shall adopt rules in accordance with federal law applicable to the regulation of Medicare supplement insurance coverage that are necessary for the state to obtain or retain certification as a state with an approved regulatory program under 42 U.S.C. §1395ss, as well as any other reasonable rules that are necessary and proper to carry out this article. Section 36.001 provides that the Commissioner of Insurance may adopt

any rules necessary and appropriate to implement the powers and duties of the Texas Department of Insurance under the Insurance Code and other laws of this state.

7. TEXT.

§3.3303. Definitions. The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

(1) Applicant--

(A) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance or other health benefits.

(B) In the case of a group Medicare supplement policy, the proposed certificate holder.

(2) Bankruptcy--The situation that occurs when a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in this state.

(3) Certificate--Any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state regardless of the place where the policy was delivered or issued for delivery.

(4) Continuous period of creditable coverage--The period during which an individual was covered by creditable coverage, if, during the period of the coverage, the individual had no breaks in coverage greater than 63 days.

(5) Creditable coverage--Any coverage of an individual as defined in §21.1101 of this title (relating to Definitions).

(6) Employee welfare benefit plan--A plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

(7) Health Maintenance Organization (HMO)--An entity as defined in 42 U.S.C. §300e(a).

(8) Insolvency--The situation which occurs when an issuer has had an order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

(9) Issuer--An insurance company, fraternal benefit society, health care service plan, health maintenance organization, or any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(10) Medicaid--Grants to States for Medical Assistance Programs, Title XIX of the Social Security Act Amendments of 1965 as Then Constituted or Later Amended.

(11) Medicare--The Health Insurance for the Aged Act, Title XVIII of the Social Security Act Amendments of 1965 as Then Constituted or Later Amended.

(12) Medicare Advantage organization--An entity as defined in 42 U.S.C. §1395w-28(a)(1).

(13) Medicare Advantage plan--A plan of coverage for health benefits under Medicare Part C as defined in 42 U.S.C. §1395w-28(b)(1), and includes:

(A) coordinated care plans which provide health services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

(B) medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

(C) Medicare Advantage private fee-for-service plans.

(14) Medicare Advantage private fee-for-service plan--An entity as defined in 42 U.S.C. §1395w-28(b)(2).

(15) MMA--The Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(16) Medicare Select policy or Medicare Select certificate--A Medicare supplement policy or certificate, respectively, that contains restricted network provisions.

(17) Medicare supplement policy--A group or individual policy of accident and sickness insurance or a subscriber contract of a hospital service corporation subject to the Insurance Code, Chapter 20, or, to the extent required by federal law, an evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act, which policy, subscriber contract, or such

evidence of coverage is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare. The term does not include:

(A) a policy, contract, subscriber contract, or evidence of coverage of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organizations;

(B) a policy or health care benefit plan including a policy or contract of group insurance or group contract of a hospital service corporation subject to the Insurance Code, Chapter 20, or group evidence of coverage issued by a health maintenance organization subject to the Texas Health Maintenance Organization Act, when such policy or plan is not marketed or held to be a Medicare supplement policy or benefit plan; or

(C) an individual or group evidence of coverage issued pursuant to a contract under the Federal Social Security Act, §1876 (42 USC §§1395, et seq.) by a health maintenance organization subject to the Texas Health Maintenance Organization Act (Texas Insurance Code, Chapters 20A and 843);

(D) a Medicare Advantage plan established under Medicare Part C;

(E) an Outpatient Prescription Drug plan established under Medicare Part D; or

(F) a Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Federal Social Security Act (42 USC §§1395, et seq.)

(18) Point-of-service--A benefit option as defined in 42 C.F.R. §422.2.

(19) Provider-Sponsored organization--An entity as defined in 42 U.S.C. §1395w-25(d)(1).

(20) Qualified actuary--An actuary who is a member of either the Society of Actuaries or the American Academy of Actuaries.

(21) Secretary--The Secretary of the United States Department of Health and Human Services.

§3.3304. Policy Definitions and Terms. No insurance policy, subscriber contract, certificate, or evidence of coverage may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless such policy, subscriber contract, certificate, or evidence of coverage contains definitions or terms which conform to the requirements of this section.

(1) "Accident," or "Accidental Injury," or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an

accidental means test or use words such as "external, violent, visible wounds," or similar words of description or characterization.

(A) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance or health coverage is in force."

(B) The definition may provide that injuries do not include injuries for which benefits are provided under any workers' compensation, employer's liability, or similar law, or motor vehicle no-fault plan, unless prohibited by law.

(2) "Benefit Period" or "Medicare Benefit Period" may not be defined as more restrictive than as that defined in the Medicare program.

(3) "Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined more restrictively than as defined in the Medicare program.

(4) "Health Care Expenses" are, for purposes of §3.3307 of this chapter (relating to Loss Ratio Standards and Refund or Credit of Premiums), those expenses of health maintenance organizations associated with the delivery of health care services and analogous to incurred losses of insurers.

(5) "Hospital" may be defined in relation to its status, facilities, and available services, or to reflect its accreditation by the Joint Commission on

Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

(6) "Medicare" shall be defined in the policy, certificate, or evidence of coverage. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended" or "Title I, Part I of Public Law 89-97, as Enacted by the 89th Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

(7) "Medicare Approved Amounts" refer to the level of service or amount of health care reimbursement recognized and approved for a particular medical or health care service or procedure by Medicare.

(8) "Medicare Eligible Expenses" are health care expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

(9) "Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN). If the words "nurse," "trained nurse," or "registered nurse" are used without specific instruction, then the use of such terms requires the issuer to recognize the services of any individual who

qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of Texas.

(10) "Physician" shall not be defined more restrictively than as defined in the Medicare program. An issuer must recognize and accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(11) "Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of a covered person which first manifests itself after the effective date of insurance or health coverage and while the insurance or health coverage is in force." The definition shall not be construed to limit §3.3306(1) of this title (relating to Minimum Benefit Standards). The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability, or similar law.

§3.3305. Policy Provisions.

(a) Except for permitted pre-existing condition clauses described in §3.3306(1)(A) of this title (relating to Minimum Benefit Standards), no policy or certificate may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

(b) No Medicare supplement policy or certificate may use waivers to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

(c) No Medicare supplement policy, contract, or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

(d) Subject to §3.3306(1)(D) and (E) of this title, a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Part D at the option of the policyholder.

(e) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

(f) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

(1) the policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual’s coverage under a Part D plan; and

(2) premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

§3.3306. Minimum Benefit Standards. No insurance policy, subscriber contract, certificate, or evidence of coverage may be advertised, solicited, or issued for delivery in this state as a Medicare supplement policy unless the policy, contract, certificate, or evidence of coverage meets the applicable standards in paragraphs (1) - (3) of this section. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

(1) General standards. The following standards apply to Medicare supplement policies and are in addition to all other requirements of this subchapter, the Insurance Code, Article 3.74, and any other applicable law.

(A) A Medicare supplement policy shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because they 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 six months before the effective date of coverage.

(i) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting condition waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

(ii) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy or certificate shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits.

(iii) If a Medicare supplement policy or certificate is issued to an applicant who qualifies under §3.3312(b) of this title (relating to Guaranteed Issue for Eligible Persons) or §3.3324(a) of this title (relating to Open Enrollment), the issuer shall reduce the period of any preexisting condition exclusion as required by §3.3312(a)(2) of this title and §3.3324(c) and (d) of this title.

(B) A Medicare supplement policy may not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(C) A Medicare supplement policy shall 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 amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

(D) No Medicare supplement policy shall 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, or be cancelled or nonrenewed by the insurer solely on the grounds of deterioration of health.

(E) Each Medicare supplement policy shall be guaranteed renewable and shall comply with the provisions of clauses (i) – (v) of this subparagraph.

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

(ii) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided in clause (iv) of this subparagraph, the issuer shall offer certificate holders Medicare supplement coverage which provides benefits as set out in subclauses (I) or (II) of this clause, as follow:

(I) an individual Medicare supplement policy which (at the option of the certificate holder):

(-a-) provides for continuation of the benefits contained in the group policy; or

(-b-) provides for benefits that otherwise meet the requirement of this paragraph; or

(II) continuation of benefits under the group plan until there are no longer any certificate holders remaining who have opted for continuation of benefits under the group policy terminated by the policyholder.

(iii) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(I) offer the certificate holder conversion opportunity described in clause (ii) of this subparagraph; or

(II) at the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(iv) 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 shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion of preexisting conditions that would have been covered under the group policy being replaced.

(v) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(F) Termination of a Medicare supplement policy shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

(G) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder 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 certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance.

(i) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted (effective as of the date of termination of entitlement) as of the termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(ii) Each Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder or certificate holder if the policyholder or certificate holder 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 certificate holder loses coverage under the group health plan, the policy or certificate shall be automatically reinstated (effective as

of the date of loss of coverage) if the policyholder or certificate holder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(iii) Reinstitution of such coverages shall provide for the following:

(I) waiver of any waiting period with respect to treatment of preexisting conditions;

(II) resumption of coverage which is substantially equivalent to coverage in effect before the date of such suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of the suspension; and

(III) classification of premiums on terms 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 not been suspended.

(H) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the MMA, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this paragraph.

(2) Standards for the basic (core) benefits common to benefit plans A - J. Every issuer shall make available a policy or certificate including only the basic "core" package of benefits described in subparagraphs (A) - (E) of this paragraph 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 lieu of it. The basic core benefits shall consist of the following:

(A) coverage for Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(B) coverage for Part A Medicare eligible expenses, to the extent not covered by Medicare, incurred as daily hospital charges during use of Medicare lifetime hospital inpatient reserve days;

(C) upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100% 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 365 days. The provider shall 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 regulation) unless replaced in accordance with federal regulation; and

(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) Standards for Additional Benefits. The additional benefits as uniformly defined in subparagraphs (A) - (K) of this paragraph shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided in paragraph (5)(A) - (I) of this section.

(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 21st day through the 100th day in a Medicare benefit period for post-hospital 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 80% of the difference between the actual Medicare Part B charge as billed

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

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

(F) Basic Outpatient Prescription Drug Benefit--Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(G) Extended Outpatient Prescription Drug Benefit--Coverage for 50% of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

(H) Medically Necessary Emergency Care in a Foreign Country--Coverage to the extent not covered by Medicare for 80% 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 60

consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(I) Preventive Medical Care Benefit or Services--Coverage for the preventive health services described in clauses (i) and (ii) of this subparagraph. Coverage for preventive medical care benefits or services shall be for the actual charges up to 100% 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 $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare:

(i) an annual clinical preventive medical history and physical examination that may include tests and services from clause (ii) of this subparagraph and patient education to address preventive health care measures;

(ii) preventive screening tests or preventive services, the selection and frequency of which are determined to be medically appropriate by the attending physician.

(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 in subclauses (I) - (IV) of this clause shall apply.

(I) 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.

(II) Care provider means a duly qualified or licensed home health aide or 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.

(III) Home shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

(IV) 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 24-hour period of services provided by a care provider is one visit.

(ii) Coverage requirements and limitations.

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

(II) 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.

(III) Coverage is limited to:

(-a-) 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 shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(-b-) the actual charges for each visit up to maximum coverage of $40 per visit;

(-c-) $1,600 per calendar year;

(-d-) seven visits in any one week;

(-e-) care furnished on a visiting basis in the insured's home;

(-f-) services provided by a care provider as defined in this section;

(-g-) at-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(-h-) 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:

(I) home care visits paid for by Medicare or other government programs; and

(II) care provided by family members, unpaid volunteers, or providers who are not care providers.

(K) New or Innovative Benefits--Any benefit which an issuer may, with the prior approval of the commissioner, offer 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 benefit shall not include an outpatient prescription drug benefit.

(4) Requirement of uniformity for all Medicare supplement benefit plans. An issuer shall make available only those groups, packages or combinations of Medicare supplement benefits as described in this section, unless otherwise permitted by provisions of paragraph (3)(K) of this section and in §3.3325 of this title (relating to Medicare Select Policies, Certificates and Plans of Operation). Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plan "A,"

defined as the basic core plan of benefits in paragraph (2) of this section and described in paragraph (5)(A) of this section, and benefit plans "B" through "J," described in paragraph (5)(B) - (L) of this section. All benefit plans shall conform to the definitions set out in §3.3303 of this title (relating to Definitions) and §3.3304 of this title (relating to Policy Definitions and Terms). Each benefit shall be structured in accordance with the format provided in paragraphs (2) and (3) of this section. Each benefit plan shall list the benefits in the order shown in paragraph (5)(A - (L) of this section. For purposes of this paragraph, "structure, language, and format" means style, arrangement and overall content of a benefit. In addition to the benefit plan designations required in this paragraph, an issuer may use other designations to the extent permitted by law.

(5) Make-up of Benefit Plans. Subparagraphs (A) – (N) of this paragraph set out the composition of benefit plans. Each benefit plan shall meet the requirements of this subchapter.

(A) Standardized Medicare Supplement Benefit Plan "A." Medicare supplement benefit Plan "A" shall include only the Core Benefits common to All Benefit Plans, as defined in paragraph (2) of this section.

(B) Standardized Medicare Supplement Benefit Plan "B." Medicare supplement benefit Plan "B" shall include only the Core Benefits as defined in paragraph (2) of this section, plus the Medicare Part A Deductible as defined in paragraph (3) of this section.

(C) Standardized Medicare Supplement Benefit Plan "C." Medicare supplement benefit Plan "C" shall include only the Core Benefit as defined in paragraph (2) of this section, 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 paragraph (3) of this section.

(D) Standardized Medicare Supplement Benefit Plan "D." Medicare supplement benefit Plan "D" shall include only the Core Benefit as defined in paragraph (2) of this section, 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 paragraph (3) of this section.

(E) Standardized Medicare Supplement Benefit Plan "E." Medicare supplement benefit Plan "E" shall include only the Core Benefit as defined in paragraph (2) of this section, 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 paragraph (3) of this section.

(F) Standardized Medicare Supplement Benefit Plan "F." Medicare supplement benefit Plan "F" shall include only the Core Benefit as defined in paragraph (2) of this section, 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 paragraph (3) of this section.

(G) Standardized Medicare Supplement Benefit High Deductible Plan "F." Medicare supplement benefit high deductible Plan "F" shall include only the following: 100% of covered expenses following the payment of the annual high deductible Plan "F" deductible. The covered expenses include the Core Benefit as defined in paragraph (2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100% of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in paragraph (3) of this section. The annual high deductible Plan "F" deductible shall consist of out-of-pocket expenses, other than premiums for services covered by the Medicare supplement Plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter 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 $10.

(H) Standardized Medicare Supplement Benefit Plan "G." Medicare supplement benefit Plan "G" shall include only the Core Benefit as defined in paragraph (2) of this section, 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 paragraph (3) of this section.

(I) Standardized Medicare Supplement Benefit Plan "H." Medicare supplement benefit Plan "H" shall include only the Core Benefit as defined in paragraph (2) of this section, 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 paragraph (3) of this section. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(J) Standardized Medicare Supplement Benefit Plan "I." Medicare supplement benefit Plan "I" shall include only the Core Benefit as defined in paragraph (2) of this section, 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 paragraph (3) of this section. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(K) Standardized Medicare Supplement Benefit Plan "J." Medicare supplement benefit Plan "J" shall include only the Core Benefit as defined in paragraph (2) of this section, 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 paragraph (3) of this section. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(L) Standardized Medicare Supplement Benefit High Deductible Plan "J." Medicare supplement benefit high deductible Plan "J" shall include only the following: 100% of covered expenses following the payment of the annual high deductible Plan "J" deductible. The covered expenses include the Core Benefit as defined in paragraph (2) of this section, plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100% of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in paragraph (3) of this section. The annual high deductible Plan "J" deductible shall consist of out-of-pocket expenses, other than premiums for services covered by the Medicare supplement Plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible Plan "J" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter 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 $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

(M) Standardized Medicare supplement benefit Plan “K” shall include only the following:

(i) Coverage of 100% 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 100% 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 100% 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 365 days. The provider shall accept the issuer’s payment as payment in full and may not bill the insured for any balance;

(iv) Medicare Part A Deductible: Coverage for 50% of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in clause (x) of this subparagraph**;**

(v) Skilled Nursing Facility Care: Coverage for 50% of the coinsurance amount for each day used from the 21st day through the 100th 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 clause (x) of this subparagraph;

(vi) Hospice Care: Coverage for 50% of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in clause (x) of this subparagraph;

(vii) Coverage for 50%, 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 clause (x) of this subparagraph;

(viii) Except for coverage provided in clause (ix) of this subparagraph, coverage for 50% 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 clause (x) of this subparagraph;

(ix) Coverage of 100% of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

(x) Coverage of 100% 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 $4000 in calendar year 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary.

(N) Standardized Medicare supplement benefit Plan "L" shall include only the following:

(i) The benefits described in subparagraph (M)(i), (ii), (iii) and (ix) of this paragraph;

(ii) The benefits described in subparagraph (M)(iv), (v), (vi), (vii) and (viii) of this paragraph, but substituting 75% for 50%; and

(iii) The benefit described in subparagraph (M)(x) of this paragraph, but substituting $2000 for $4000.

§3.3307. Loss Ratio Standards and Refund or Credit of Premiums.

(a) Minimum aggregate loss ratio standard. A Medicare supplement individual or group policy form shall not be delivered or issued for delivery unless the individual or group policy form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregated benefits (not including anticipated refunds or credits) provided under the individual policy form or group policy form, on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service, rather than reimbursement, basis and earned premiums for the applicable period, not including any changes in additional reserves, and in accordance with generally accepted actuarial principles and practices:

(1) at least 75% of the aggregate amount of premiums earned in the case of group policies; or

(2) at least 65% of the aggregate amount of premiums earned in the case of individual policies.

(b) Health maintenance organization loss ratio standard. A health maintenance organization loss ratio, where coverage is provided on a service rather than reimbursement basis, shall be calculated on the basis of incurred claims experience or incurred health care expenses and earned premiums for the period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

(1) home office and overhead costs;

(2) advertising costs;

(3) commissions and other acquisition costs;

(4) taxes;

(5) capital costs;

(6) administrative costs; and

(7) claims processing costs.

(c) Calendar year experience loss ratio standard. For the most recent calendar year, the ratio of incurred losses to earned premiums for all policies or certificates which have been in force for three years or more, as of December 31st of the most recent year, shall be equal to or greater than:

(1) at least 75% in the case of group policies; and

(2) at least 65% in the case of individual policies.

(d) Filing of rates and rating schedules. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards. For individual or group policies issued prior to March 1, 1992, the provisions of paragraph (3) of this subsection must be met with respect to expected claims in relation to premiums. For purposes of submitting a rate filing under this section, policy forms, whether for open or closed blocks of business, providing for similar benefits shall be combined. However, for purposes of the required combination set out in this section, issuers may distinguish between policy forms providing for similar benefits for individuals 65 years of age or over and policy forms providing for similar benefits for individuals under age 65. Once policy forms have been combined, they remain so for all rating purposes. When forms have been so combined, a rate revision request shall not differentiate between the experience of the individual forms. Where significant inconsistencies between rate levels exist between forms providing similar benefits, some deviation in rate revision shall be allowed to reduce the significant inconsistencies.

(1) Each Medicare supplement policy or certificate form shall be accompanied, upon submission for approval, by an actuarial memorandum. Such memorandum shall be prepared and signed by a qualified actuary in accordance with generally accepted actuarial principles and practices, and shall contain the information listed in the following subparagraphs:

(A) the form number that the actuarial memorandum addresses;

(B) a brief description of benefits provided;

(C) a schedule of rates to be used;

(D) a complete explanation of the rating process, including assumptions, claims data, methodology, and formulae used in developing the gross premium rates;

(E) a statement of what experience base will be used in future rate adjustments;

(F) a certification that the anticipated aggregate loss ratio is at least 65% (for individual coverage) or at least 75% (for group coverage), which certification should include a statement of the period over which the aggregate loss ratio is expected to be realized;

(G) a table of anticipated loss ratio experience for representative issue ages for each year from issue over the period of time over which the aggregate loss ratio is to be realized; and

(H) a certification that the premiums are reasonable in relation to the benefits provided.

(2) Subsequent rate adjustment filings, except for those rates filed solely due to a change in the Part A calendar year deductible, shall also provide an actuarial memorandum, prepared by a qualified actuary, in accordance with generally accepted actuarial principles and practices, which memorandum shall contain the information in the following subparagraphs.

(A) The form number addressed by the actuarial memorandum shall be included.

(B) A brief description of benefits provided shall be included.

(C) A schedule of rates before and after the rate change shall be included.

(D) A statement of the reason and basis for the rate change shall be included.

(E) A demonstration and certification by the qualified actuary shall be included to show that the past plus future expected experience after the rate change will result in an aggregate loss ratio equal to, or greater than, the required minimum aggregate loss ratio.

(i) This rate change and demonstration shall be based on the experience of the named form in Texas only, if that experience is fully credible, as set out in paragraph (3) of this subsection.

(ii) The rate change and demonstration shall be based on experience of the named form nationwide, with credibility factors as set out in paragraph (3) of this subsection applied, if the named form is used nationwide and the Texas experience is not fully credible.

(iii) The rate change and demonstration shall be based on experience of the named form in Texas only, with credibility factors as set out in paragraph (3) of this subsection applied, if the named form is used in Texas only and the Texas experience is not fully credible.

(F) For policies or certificates in force less than three years, a demonstration shall be included to show that the third-year loss ratio is expected to be equal to, or greater than, the applicable percentage.

(G) A certification by the qualified actuary that the resulting premiums are reasonable in relation to the benefits provided shall be included.

(3) For purposes of this subsection, if a group or individual policy form has 2,000 or more policies in force, then full credibility (100%) shall be given to the experience. If fewer than 500 policies are in force, then no credibility (0%) shall be given to the experience. The principle of linear interpolation shall be used for in-force numbers between 500 and 2,000. For group policy forms, the reference in this paragraph to the number of in-force policies means the number of in-force certificates under group policies. For purposes of this section, "in force" means either the average number of policies in force for the experience period used to support the need for a rate

revision, or the number of policies in force as of the ending date of the experience period used to support the need for a rate revision. Once an issuer makes a decision as to which definition it will apply to a particular policy form, such decision is irrevocable. An issuer may submit specific alternate credibility standards to the department for consideration. In order for an alternate standard of credibility to be acceptable for application, the issuer must demonstrate that the standards are based on sound actuarial principles, and that the resulting loss ratios are in substantial compliance with the requirements of subsections (a), (b) and (c) of this section.

(4) For individual policies issued prior to March 1, 1992, the expected claims in relation to premiums shall meet:

(A) the originally-filed anticipated loss ratio when combined with the actual experience since inception;

(B) a loss ratio of at least 65% when combined with actual experience beginning with June 1, 1996 to date; and

(C) a loss ratio of at least 65% over the entire future period for which the rates are computed to provide coverage.

(e) Annual filing of premium rates required. Every issuer of Medicare supplement policies and certificates issued before or after March 1, 1992 in this state shall file annually its rates, rating schedule, and supporting documentation, including ratios of incurred losses to earned premiums for the most recent calendar year broken down by calendar year of issue or by policy duration, for purposes of demonstrating that

the issuer is in compliance with the loss ratio standards, and for approval by the Department in accordance with the filing requirements of this section and the requirements of §3.3323 of this title (relating to Increases to Premium Rates). The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years. The annual filing requirements in this subsection shall be as follows:

(1) the NAIC Medicare supplement experience exhibit which summarizes the experience of each individual form with business in force in Texas;

(2) the NAIC Medicare supplement experience exhibit which summarizes the experience of each group form with business in force in Texas;

(3) rates and rating schedules for each form with business in force in Texas;

(4) a certification by the qualified actuary that the policies or certificates in force less than three years are anticipated to produce a third-year loss ratio which is greater than or equal to the applicable loss ratio percentage; and

(5) a certification by the qualified actuary that the expected losses in relation to premiums over the entire period for which the policy is rated comply with the required minimum aggregate loss ratio standard.

(f) Refund or credit calculation. An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the "Medicare Supplement Refund Calculation Form," published as Figure 1 to this section, for each type in a standard Medicare supplement benefit plan. This form is published by the Texas Department of Insurance and copies of this form are available from the Life/Health Group, Mail Code 106-1A of the Texas Department of Insurance, P.O. Box 149104, Austin, Texas 78714-9104.

(1) If on the basis of the experience as reported the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

(2) A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. The refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the secretary of health and human services, but in no event shall it be less than the average rate of

interest for 13-week treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

(3) For an individual or group policy or certificate issued prior to March 1, 1992, the issuer, for purposes of complying with this subsection, shall make the refund or credit calculation separately for all individual policies combined and all group policies combined for experience after June 1, 1996.

Figure: 28 TAC §3.3307(f)(3)

TEXAS DEPARTMENT OF INSURANCE
MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE[1]_____SMSBP[2]_____
For the State of _____
Company Name_____
NAIC Group Code_____NAIC Company Code_____
Address_____
Person Completing This Exhibit_____
Title_____ Telephone_____

Line		(I) Earned Premium[3]	(II) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)	_____	_____
	b. Current year's issues[5]	_____	_____
	c. Net (for reporting purposes) (line 1a – line 1b)	_____	_____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for pre-standardized plans.
[3] Includes Modal Loadings and Fees Charged
[4] Excludes Active Life Reserves
[5] This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

2. Past Year's Experience (all policy years) _____ _____

3. Total Experience (line 1c + line 2) _____ _____

4. Refunds Last Year (excluding interest) _____

5. Refunds From All Previous Reporting Years (excluding interest) _____

6. Refunds Since Inception (excluding interest) (line 4 + line 5) _____

7. Benchmark Ratio Since Inception (Ratio 1 from worksheet) _____

TEXAS DEPARTMENT OF INSURANCE
MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____
(Continued)

TYPE[6]_____SMSBP[7]_____
Company Name _____

8. Experienced Ratio Since Inception (Ratio 2) (line 3 col. II) / (line 3 col. I – line 6) _____

9. Life Years Exposed Since Inception _____

If (line 8 < line 7) AND (line 9 > 499), proceed; otherwise stop.

10. Tolerance Permitted (obtained from credibility table) _____

Medicare Supplement Credibility Table	
Life Years 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%

[6] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[7] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for pre-standardized plan.

500 – 999 If less than 500, no credibility.	15.0%

11. Adjustment to Incurred Claims for Credibility (Ratio 3) _____
(line 8 + line 10)

If line 11 > line 7, a refund/credit is not required, otherwise proceed.

12. Adjusted Incurred Claims
(line 3, col. 1 – line 6) x (line 11) _____

TEXAS DEPARTMENT OF INSURANCE
MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____
(Continued)

Type[8]_____SMSBP[9]_____
Company Name_____

13. Refund
[line 3, col. I – line 6 – (line 12/line 7)] _____

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.

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

_____
Signature

_____
Name – Please Print or Type

_____
Title

_____
Date

[8] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[9] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for pre-standardized plan.

TEXAS DEPARTMENT OF INSURANCE
REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____
(Continued)

TYPE[10]_____SMSBP[11]_____
Company Name_____
NAIC Group Code_____NAIC Company Code_____
Address_____
Person Completing This Exhibit_____
Title_____ Telephone_____

(a)[12] Year	(b)[13] 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 Radio	(j) (h)x(i)	(o)[14] 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
15		4.175		0.493		8.684		0.725		0.77
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: (l + n)/(k + m): _____ (Ratio 1)

[10] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[11] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for pre-standardized plans.
[12] 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.)
[13] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[14] 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 loss ratios displayed on this worksheet. They are shown here for informational purposes only.

TEXAS DEPARTMENT OF INSURANCE
REPORTING FORM FOR THE CALCULATION OF BENCHMARK
RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____
(Continued)

TYPE[15]_____SMSBP[16]_____
Company Name_____
NAIC Group Code_____NAIC Company Code_____
Address_____
Person Completing This Exhibit_____
Title_____ Telephone_____

(a)[17] Year	(b)[18] 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 Radio	(j) (h)x(i)	(o)[19] 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		0.80
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		4.175		0.567		8.684		0.838		0.89
Total:		(k):		(l):		(m):		(n):		

Benchmark Ratio Since Inception: (l + n)/(k + m): _____ (Ratio 1)

[15] Individual, Group, Individual Medicare Select, or Group Medicare Select Only.
[16] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for pre-standardized plans.
[17] 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.)
[18] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.
[19] 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 loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(g) Premium adjustments to conform with minimum standards for loss ratios. As soon as practicable, but prior to the effective date of enhancements to Medicare benefits, every issuer of Medicare supplement insurance policies, contracts, or coverage in this state shall file with the commissioner, in accordance with the applicable filing procedures of this state, the items required in paragraphs (1) and (2) of this subsection.

(1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or contracts shall be filed. Documents necessary to justify the adjustment shall accompany the filing.

(A) Every issuer of Medicare supplement insurance or benefits to a resident of this state pursuant to the Insurance Code, Article 3.74 shall make premium adjustments:

(i) necessary to product an expected loss ratio under the policy or contract as will conform with the minimum loss ratio standards for Medicare supplement policies; and

(ii) expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premium by the issuer for the Medicare supplement insurance policies or contracts.

(B) No premium adjustment which would modify the loss ratio experience under the policy, other than the adjustments described in this subsection,

should be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(C) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds, or premium credits deemed necessary to achieve the loss ratio required by this section.

(2) Any appropriate riders, endorsements, or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare shall be filed. The riders, endorsements, or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or contract.

(h) Maintenance of data. Incurred claims and earned premium experience shall be maintained for each policy form with business in force in Texas, by calendar year of issue, and shall be made available to the Texas Department of Insurance.

§3.3308. Required Disclosure Provisions.

(a) General rules.

(1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. The provisions shall be appropriately captioned, and shall appear on the first page of the policy, and shall include any

reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the age of the policyholder.

(2) Except for riders or endorsements by which the issuer effectuates a request made in writing by the policyholder, or by which the issuer exercises a specifically reserved right under a Medicare supplement policy, or by which the issuer is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after the date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After the date of issue of the policy or certificate, any rider or endorsement which increases benefits or coverage with concomitant increase in premium during the policy term shall be agreed to in writing signed by the policyholder, unless the benefits are required by the minimum standards for Medicare supplement insurance policies, or unless the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, the additional premium charge shall be set forth in the policy.

(3) Medicare supplement policies shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

(4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions:

(A) the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations;"

(B) the policy or certificate shall define the term "preexisting condition" and shall provide an explanation of the term in its accompanying outline of coverage; and

(C) the policy or certificate shall include a provision explaining the reduction of the preexisting condition limitation for individuals that qualify under §3.3306(1)(A) of this title (relating to Minimum Benefit Standards), §3.3312(a)(2) of this title (relating to Guaranteed Issue to Eligible Persons), or §3.3324(c) and (d) of this title (relating to Open Enrollment).

(5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if after examination the insured person is not satisfied for any reason.

(6) Issuers of accident and sickness policies, certificates, or subscriber contracts which provide hospital or medical expense coverage on an expense incurred or indemnity basis, to a person(s) eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and the Centers for Medicare and

Medicaid Services of the United States Department of Health and Human Services in no smaller than 12-point type.

(A) For purposes of this section, "form" means the language, format, style, type size, type proportional spacing, bold character, and line spacing.

(B) If a Guide incorporating the latest statutory changes is not available from a government agency, companies may comply with this provision by modifying the latest available Guide to the extent required by applicable law.

(C) Except as provided in this section, delivery of the Guide shall be made whether or not such policies, certificates, subscriber contracts, or evidences of coverage are advertised, solicited, or issued as Medicare supplement policies or certificates as defined in this regulation.

(D) Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Provided, however, issuers shall deliver the Guide to the applicant for a direct response Medicare supplement policy upon request, but not later than at the time the policy is delivered.

(7) Except as otherwise provided in this section, the terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import may not be used unless the policy is issued in compliance with §3.3306 of this title (relating to Minimum Benefit Standards).

(b) Outline of coverage requirements for Medicare supplement policies.

(1) Issuers of Medicare supplement coverage in this state shall provide an outline of coverage to all applicants, including certificate holders under group policies, at the time application is presented to the prospective applicant, and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant.

(2) If a Medicare supplement policy or certificate is issued on a basis which would require revision of the outline of coverage delivered at the time of application, a substitute outline of coverage properly describing the policy or certificate actually issued shall accompany such policy or certificate when it is delivered and contain the following statement in no less than 12-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."

(c) Form for outline of coverage. In providing outlines of coverage to applicants pursuant to the requirements of subsection (b)(1) of this section, insurers shall use a form which complies with the requirements of this subsection. The outline of coverage must contain each of the following four parts in the following order: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed in paragraphs (1) and (2) of this subsection in no less than 12-point type.

(1) All plans A - J shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

(2) The items in subparagraphs (A) - (C) of this paragraph shall be included in the outline of coverage in addition to the items specified in the plan-specific outline-of-coverage forms.

(A) Dollar amounts which are shown in parentheses for each of the plan-specific charts on the following pages are for calendar year 1992. Issuers shall, for each plan offered, appropriately complete outline-of-coverage-chart statements about amounts to be paid by Medicare, the plan, and the covered person by replacing the amount in parentheses with the dollar amount corresponding to each covered service for the applicable calendar year benefit period.

(B) The outline of coverage must include an explanation of any limitations and exclusions. Those limitations and exclusions resulting from Medicare program provisions may be disclosed as such by reference and need not be explained in their entirety. All limitations and exclusions related to preexisting conditions, and all other limitations and exclusions not resulting from Medicare regulations must be fully explained in the outline of coverage.

(C) The outline of coverage must include a statement that the policy either does or does not contain provisions providing for a refund or partial refund of premium upon the death of an insured or the surrender of the policy or certificate. If the policy contains such provisions, a description of them must be included.

(D) The outline of coverage for Medicare Select policies or certificates shall include information regarding grievance procedures which meet the requirements of §3.3325(m) of this title (relating to Medicare Select Policies, Certificates and Plans of Operation).

Figure: 28 TAC §3.3308(c)(2)(D)

(d) Notice requirements.

(1) As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, every issuer providing Medicare supplement coverage to a resident of this state shall notify its policyholders, contract holders, and certificate holders of modifications it has made to Medicare supplement insurance policies, contracts, or certificates. The notice shall:

(A) 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, contract, or certificate; and

(B) inform each covered person as to when any premium adjustment is to be made due to changes in Medicare.

(2) 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.

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

(4) Issuers shall comply with any notice requirements of the MMA.

§3.3309. Requirements for Application Forms and Replacement Coverage.

(a) Application forms shall include the following information, statements and questions designed to elicit information as to whether, as of the date of the application, the applicant currently has another Medicare supplement, Medicare Advantage, Medicaid coverage, or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate currently in force. A supplementary application or other form to be signed by the applicant and agent, except where the coverage is sold without an agent, containing such questions may be used.

(1) The information shall be provided to prospective covered persons in statement form conforming to subparagraphs (A) – (F) of this paragraph.

(A) You do not need more than one Medicare supplement policy.

(B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.

(C) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(D) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(E) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90

days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(F) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

(2) Information shall be elicited from prospective covered persons by asking the questions as follows: If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an “X” to the best of your knowledge.

(A) Did you turn age 65 in the last 6 months? Yes____No____

(B) Did you enroll in Medicare Part B in the last 6 months? Yes____No____

(C) If yes, what is the effective date?

(D) Are you covered for medical assistance through the state Medicaid program?

(i) {NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.} Yes____ No____

(ii) If yes;

(I) Will Medicaid pay your premiums for this Medicare supplement policy? Yes____ No____

(II) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes____ No____

(E) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START __/__/__ END __/__/__

(i) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes____ No____

(ii) Was this your first time in this type of Medicare plan? Yes____ No____

(iii) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes____ No____

(F) Do you have another Medicare supplement policy in force? Yes____ No____

(i) If so, with what company, and what plan do you have {optional for Direct Mailers}?

(ii) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes____ No____

(G) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes____ No____

(i) If so, with what company and what kind of policy?

(ii) What are your dates of coverage under the other policy? START __/__/__ END __/__/__(If you are still covered under the other policy, leave "END" blank.)

(b) Application forms shall include questions to elicit information as to whether the applicant is an eligible person as defined in §3.3312(b) of this title (relating to Guaranteed Issue for Eligible Persons), or whether the applicant is eligible for reduction of any applicable preexisting condition limitation under §3.3324(c) and (d) of this title (relating to Open Enrollment).

(c) Agents shall list the following:

(1) any other health insurance policies or coverages sold to the applicant which are still in force; and

(2) any other health insurance policies or coverages sold to the applicant in the past five years which are no longer in force.

(d) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the issuer, shall be returned to the applicant by the issuer upon delivery of the policy.

(e) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

(f) The notice required by subsection (e) of this section shall be provided in substantially the following form and shall be in a typeface no smaller than 12-point type.

Figure: 28 TAC §3.3309(f)

NOTICE TO APPLICANT REGARDING

REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR

MEDICARE ADVANTAGE

(Issuer's name and address)

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by (Issuer's Name). Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY ISSUER, (OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement

or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

_____ Additional benefits,

_____ Same benefits but lower premiums,

_____ Fewer benefits and lower premiums,

_____ My plan has outpatient prescription drug coverage and I am enrolling in Part D, Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

_____ Other (specify)_____.

I call to your attention the following items for your consideration:

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions waiting periods, elimination periods, or probationary periods. The insurer will reduce any time periods applicable to pre-existing

conditions waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, read and review it carefully to be certain that all information has been properly recorded.

(4) Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

Signature of Agent or Other Representative

_____

Typed Name and Address of Issuer or Agent

_____

(Applicant's Signature)

_____

(Date)

(g) Subsection (f)(1) and (2) of this section (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

§3.3312. Guaranteed Issue for Eligible Persons.

(a) Guaranteed issue.

(1) Eligible persons are those individuals described in subsection (b) of this section who seek to enroll under the Medicare supplement policy during the period specified in subsection (d) of this section, and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) of this section that is offered and is available for issuance to newly enrolled individuals by the issuer, and shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care,

or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(b) Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(A) The certification of the organization or plan has been terminated; or

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(E) The individual meets such other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) - (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection:

(A) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);

(B) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(C) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(D) An organization under a Medicare Select policy; and

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy;

(B) The issuer of the policy substantially violated a material provision of the policy; or

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

(6) The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual

terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Medicaid.

(c) Products to Which Eligible Persons are Entitled. The Medicare supplement policy to which eligible persons are entitled under:

(1) Subsection (b)(1), (2), (3), (4), and (8) of this section is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L offered by any issuer, except that for persons under 65 years of age, it is a policy which has a benefit package classified as Plan A.

(2) Subsection (b)(5) of this section is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in paragraph (1) of this subsection. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, the Medicare supplement policy described in this paragraph is the policy available from the same issuer but modified to remove outpatient prescription drug coverage, or at the election of the policyholder, a policy described in paragraph (1) of this subsection.

(3) Subsection (b)(6) of this section shall include any Medicare supplement policy offered by any issuer.

(4) Subsection (b)(7) of this section is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K, or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

(d) Guaranteed Issue Time Period(s).

(1) In the case of an individual described in subsection (b)(1) of this section:

(A) for a plan that supplements the benefits under Medicare, the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of all supplemental health benefits (or if a notice is not received, the date the individual receives notice that a claim has been denied because of such termination or cessation); or

(ii) the date the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter; or

(B) for a plan that is primary to the benefits under Medicare, the guaranteed issue period begins on the later of:

(i) the date the individual receives a notice of termination or cessation of all health benefits (or if a notice is not received, the date the individual

receives notice that a claim has been denied because of such termination or cessation); or

(ii) the date the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter.

(2) In the case of an individual described in subsections (b)(2), (3), (5), or (6) of this section whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated;

(3) In the case of an individual described in subsection (b)(4)(A) of this section, the guaranteed issue period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated;

(4) In the case of an individual described in subsections (b)(2), (4)(B) and (C), (5), or (6) of this section, who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date of disenrollment;

(5) In the case of an individual described in subsection (b)(7) of this section, the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day period immediately preceding the initial Part D

enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in subsection (b) of this section, but not described in paragraphs (1) – (5) of this subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date of disenrollment.

(e) Extended Medicare Supplement Access for Interrupted Trial Periods.

(1) In the case of an individual described in subsection (b)(5) of this section (or deemed to be so described, pursuant to this paragraph), whose enrollment with an organization or provider described in subsection (b)(5) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment as described in subsection (b)(5) of this section.

(2) In the case of an individual described in subsection (b)(6) of this section (or deemed to be so described, pursuant to this paragraph), whose enrollment with a plan or in a program described in subsection (b)(6) is involuntarily terminated within the first 12 months of enrollment, and who, without an intervening enrollment, enrolls with another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment as described in subsection (b)(6) of this section.

(3) For purposes of subsections (b)(5) and (6) of this section, no enrollment of an individual with an organization or provider described in subsection

(b)(5), or with a plan or in a program described in subsection (b)(6), may be deemed to be an initial enrollment under this paragraph after the 2-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan, or program.

§3.3320. Appropriateness of Recommended Purchase and Excessive Insurance.

(a) In recommending the purchase or replacement of any Medicare supplement policy or certificate, an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

(b) Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

(c) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual’s Part C coverage.

§3.3322. Filing and Approval of Policies, Certificates and Premium Rates; Discontinuance of Forms.

(a) An issuer shall 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 in accordance with filing requirements and procedures prescribed by the Insurance Code and applicable regulations.

(b) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the MMA only with the commissioner in the state in which the policy or certificate was issued.

(c) An issuer shall 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 in accordance with the filing requirements and procedures prescribed by the Insurance Code and this subchapter.

(d) Except as provided in paragraphs (1) and (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan. 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. An issuer may offer, with the approval of the commissioner, one additional policy form or certificate form of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(1) the inclusion of new or innovative benefits; and

(2) the offering of coverage to individuals eligible for Medicare by reason of disability.

(e) Except as provided in paragraph (1) of this subsection, an issuer shall 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 shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(1) 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 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(2) An issuer that discontinues the availability of a policy form or certificate form pursuant to paragraph (1) of this subsection shall 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.

(f) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(g) A change in the rating structure or methodology shall be considered a discontinuance under subsection (e)(1) of this section, unless the issuer complies with the following requirements:

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating

methodology and resultant rates differ from the existing rating methodology and existing rates.

(2) 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 which is in the public interest.

(h) The experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in §3.3307 of this title (relating to Loss Ratio Standards and Refund or Credit of Premiums), except that forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

§3.3324. Open Enrollment.

(a) No issuer shall deny or condition the issuance of effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for a policy or certificate is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is first enrolled for benefits under Medicare Part B. No issuer shall engage in a premium rating practice

which results in higher premiums for any policy solely because such policy is issued pursuant to the provisions of this section. For individuals 65 years of age or older when first enrolled for benefits under Medicare Part B who apply for Medicare supplement coverage under this subsection, each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants without regard to age.

(b) The provisions of paragraphs (1) - (3) of this subsection apply to Medicare supplement issuers with respect to persons who qualify for Medicare before attaining 65 years of age.

(1) An issuer must comply with the first two sentences of subsection (a) of this section with respect to a person who:

(A) qualifies for Medicare before attaining 65 years of age, who first enrolls for benefits under Medicare Part B on or after January 1, 1997 and who applies for a Medicare supplement policy or certificate during the period of eligibility described in subsection (a) of this section; or

(B) enrolled in Medicare Part B before attaining 65 years of age, who applies for a Medicare supplement policy or certificate upon attaining 65 years of age, during the period of eligibility described in subsection (a) of this section that would apply if the person first enrolled in Medicare Part B upon attaining 65 years of age.

(2) An issuer must make available, at a minimum, Plan A of the standard Medicare supplement plans to individuals who qualify under this subsection.

(3) An issuer must comply with the provisions of this subsection with respect to a person who:

(A) enrolled for Medicare Part B benefits before attaining 65 years of age during the period beginning March 1, 1992 and ending January 1, 1997;

(B) was not otherwise eligible to apply for a Medicare supplement policy or certificate on a guaranteed issue basis during that time period; and

(C) applies for a Medicare supplement policy or certificate during the period of eligibility beginning January 1, 1997 and ending July 1, 1997.

(c) If an applicant qualifies under subsection (a) of this section, is 65 years of age or older, and submits an application during the time period referenced in subsection (a) of this section and, as of the date of application:

(1) has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition; or

(2) has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date.

(d) Except as provided in subsection (c) of this section, §3.3312 of this chapter (relating to Guaranteed Issue for Eligible Persons), and §3.3306(1)(A) of this chapter (relating to Minimum Benefit Standards), subsection (a) of this section shall not be construed as preventing the exclusion of benefits under a policy during the first six

months, based on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.

(e) The following examples illustrate the application of subsection (c)(1) and (2) of this section, as prescribed by the Secretary:

(1) Individual A: No preexisting condition exclusion period. Relevant creditable coverage history: Individual A had coverage under an individual policy for four months beginning on May 1, 1998, through August 31, 1998, followed by a gap in coverage of 61 days until October 31, 1998. Individual A had coverage under an individual health plan beginning on November 1, 1998, for three months through January 31, 1999, followed by a gap in coverage of 59 days or until March 31, 1999 on which date Individual A submitted an application for a Medicare supplement policy. Under this example, the Medicare supplement issuer may not apply a preexisting condition exclusion period because Individual A has seven months of creditable coverage without a gap in coverage greater than 63 days.

(2) Individual B: Subject to a three months preexisting condition exclusion period. Relevant creditable coverage history: Individual B is covered under an individual health insurance policy for one month beginning May 1, 1998 through May 31, 1998, followed by a gap in coverage of 61 days from June 1, 1998 through July 31, 1998. On August 1, 1998, Individual B is covered under an association health plan for two months through September 30, 1998, followed by a gap in coverage of 31 days or

until October 31, 1998 on which date Individual B's submitted an application for Medicare supplement coverage. Individual B has three months of creditable coverage. Under this example, the issuer of a Medicare supplement policy must give Individual B a three-month credit against any preexisting condition exclusion period.

(3) Individual C: Subject to a six month preexisting condition exclusion period. Relevant creditable coverage history: Individual C is covered under an individual health insurance policy for one month beginning May 1, 1998 through May 31, 1998, followed by a gap in coverage of 61 days from June 1, 1998 through July 31, 1998. On August 1, 1998, Individual C is covered under an association health plan for two months through September 30, 1998, followed by a gap in coverage of 64 days or until November 4, 1998 on which date Individual C submitted an application for Medicare supplement coverage. Individual C has a gap in coverage of greater than 63 days. As a result, under this example, the Medicare supplement issuer can fully apply the preexisting condition exclusion provision to Individual C.

(f) Invitation to contract advertisements, as defined in §21.113(b) of this title (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising) shall include the following statement: "Benefits and premiums under this policy may be suspended for up to 24 months if you become entitled to benefits under Medicaid. You must request that your policy be suspended within 90 days of becoming entitled to Medicaid. If you lose (are no longer entitled to) benefits from Medicaid, this policy can be reinstated if you request

reinstatement within 90 days of the loss of such benefits and pay the required premium."

§3.3325. Medicare Select Policies, Certificates and Plans of Operation.

(a) This section shall apply to Medicare Select policies, certificates and plans of operation, as defined in this section.

(b) No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section.

(c) The following words and terms, when used in this section, shall have the following meanings, unless the context indicates otherwise. These words and terms shall be defined and included in all Medicare Select policies, certificates and plans of operation.

(1) Complaint--Any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

(2) Emergency Care--Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(3) Grievance--Dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

(4) Medicare Select Issuer--An issuer offering, or seeking to offer, a Medicare Select policy or certificate.

(5) Medicare Select Policy or Medicare Select Certificate--A Medicare supplement policy or certificate, respectively, that contains restricted network provisions.

(6) Network Provider--A provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits covered under a Medicare Select policy.

(7) Non-network Provider--A provider of health care, or a group of providers of health care, that has not entered into a written agreement with the issuer to provide benefits covered under a Medicare Select policy.

(8) Restricted Network Provisions--Any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

(9) Service Area--The geographic area approved by the commissioner as part of the plan of operation or amended plan of operation, within which an issuer is authorized to offer a Medicare Select policy.

(d) The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this section and the Omnibus Budget Reconciliation Act (OBRA) of 1990, §4358, if the commissioner finds that the issuer has satisfied all of the requirements of this subchapter.

(e) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner. A Medicare Select issuer may not file a Medicare Select policy under the Insurance Code, Article 3.42(c), until its plan of operation has been approved by the commissioner.

(f) A Medicare Select issuer shall file a proposed plan of operation with the Department, the form and content of which shall be subject to approval by the commissioner. The plan of operation shall contain, at a minimum, the information in paragraphs (1) - (7) of this subsection, and at the time of submission shall have a form number printed or typed on the lower left hand corner of the face page.

(1) The plan must contain evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration of each of the items referenced in subparagraphs (A) - (E) of this paragraph.

(A) Services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in

the local area. Geographic availability shall reflect the usual travel times within the community.

(B) The number of network providers in the service area must be documented by credible statistics to be sufficient, with respect to current and expected policyholders, either:

(i) to deliver adequately all services that are subject to a restricted network provision; or

(ii) to make appropriate referrals.

(C) Written agreements with network providers describing specific responsibilities must be included.

(D) Emergency care availability 24 hours per day and seven days a week must be demonstrated.

(E) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting the providers from billing or otherwise seeking reimbursement from or recourse against any individual covered under a Medicare Select policy or certificate. This subparagraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

(2) A clear description of the service area must be provided by narrative statement and/or a map.

(3) The grievance procedure to be utilized must be described.

(4) The quality assurance program must be described, including:

(A) the formal organizational structure;

(B) the written criteria for selection, retention, and removal of network providers; and

(C) the procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

(5) Network providers must be listed and described, by specialty.

(6) Copies of the written information proposed to be used by the issuer to comply with subsection (k) of this section must be provided.

(7) Any other information requested by the commissioner must be provided.

(g) A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner 60 days prior to implementing such changes. Such changes shall be considered approved by the commissioner after 30 days unless specifically disapproved or unless issuer requests an extension of the 30-day period and the commissioner grants the requested extension.

(h) An updated list of network providers shall be filed with the commissioner at least quarterly. If there is no change to the list of network providers within a particular calendar quarter, correspondence indicating no change from the prior reporting period

to the current reporting period must, at a minimum, be filed to meet the reporting requirements of this subchapter.

(i) A Medicare Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

(1) the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or a condition; and

(2) it is not reasonable to obtain such services through a network provider.

(j) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

(k) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

(1) an outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with other Medicare supplement policies or certificates offered by the issuer and with other Medicare Select policies or certificates;

(2) a description (including address, phone number, and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers;

(3) a description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized (except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans K and L);

(4) a description of coverage for emergency and urgently needed care and other out-of-service area coverage;

(5) a description of limitations on referrals to restricted network providers and to other providers;

(6) a description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer; and

(7) a description of the Medicare Select issuer's quality assurance program and grievance procedure.

(8) For hospital network providers, the statement in 12-point bold-face type: "Only certain hospitals are network providers under this policy. Check with your physician to determine if he or she has admitting privileges at the network hospital. If he or she does not, you may be required to use another physician at time of hospitalization or you will be required to pay for all expenses." This statement shall also be included in the "invitation to contract" advertisement, as that term is defined in §21.113(b) of this title (relating to Rules Pertaining Specifically to Accident and Health Insurance Advertising and Health Maintenance Organization Advertising).

(l) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (k) of this section and that the applicant understands the restrictions of the Medicare Select policy or certificate.

(m) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures. If a binding arbitration procedure is included, the insured must have made an informed choice to accept binding arbitration after having been advised of the right to reject this method of dispute or claim resolution.

(1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage. The in-hospital grievance procedure shall be outlined separately from the grievance procedures for other treatments and/or services. All grievances should be addressed immediately and resolved as soon as possible. Grievances relating to ongoing hospital treatment should be addressed immediately on receipt of any written or oral grievance, and resolved as quickly as possible in a manner which does not interfere with, obstruct or interrupt continued proper medical treatment and care of the patient. The timetable for their resolution shall comply with all applicable provisions of the Insurance Code.

(2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer, both during the period of care and after care.

(3) Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision-makers who have authority to fully investigate the issue and take corrective action.

(4) If a grievance is found to be valid, corrective action shall be taken promptly.

(5) All concerned parties shall be notified about the results of a grievance.

(6) The issuer shall report no later than each March 31st to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature, and resolution of such grievances.

(n) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

(o) At the request of an individual covered under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual covered the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make the policies or certificates available without

requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

(p) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Part B excess charges.

(q) Medicare Select policies and certificates shall provide for continuation of coverage in the event the secretary of health and human services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.

(1) Each Medicare Select issuer shall make available to each individual covered under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

(2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains

one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services, or coverage for Part B excess charges.

(r) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

CERTIFICATION. This agency certifies that the adopted sections have been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

Issued at Austin, Texas, on _____, 2005.

_____
Gene C. Jarmon
General Counsel and Chief Clerk
Texas Department of Insurance

IT IS THEREFORE THE ORDER of the Commissioner of Insurance that amendments to §§3.3303 – 3.3309, 3.3312, 3.3320, 3.3322, 3.3324, and 3.3325 concerning minimum standards for Medicare supplement policies, are adopted.

AND IT IS SO ORDERED.

_____
JOSE MONTEMAYOR
COMMISSIONER OF INSURANCE

ATTEST:

_____
Gene C. Jarmon
General Counsel and Chief Clerk

COMMISSIONER'S ORDER NO._____